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Letter to the Editor

Letter to the Editor regarding the paper by F. Cardoso *et al.* 'European Breast Cancer Conference manifesto on breast centres/units'

Gianni Saguatti [a], Carlo Naldoni [b], Eva Benelli [c], Chiara Fedato [d], Alfonso Frigerio [e], Vania Galli [f], Livia Giordano [e], Paola Golinelli [f], Doralba Morrone [g], Adriana Paduos [e], Fiammetta Querci [h], Antonio Rizzo [i], Lauro Bucchi [j,*]

[a] *Senology Unit, Bellaria Hospital, Bologna, Italy*
[b] *Department of Health, Regione Emilia-Romagna, Bologna, Italy*
[c] *Zadig Scientific Communication Agency, Rome, Italy*
[d] *Department of Health, Veneto Region, Venice, Italy*
[e] *Centre for Cancer Prevention, Turin, Italy*
[f] *Local Health Authority, Modena, Italy*
[g] *Cancer Research and Prevention Institute, Florence, Italy*
[h] *Local Health Authority, Sassari, Italy*
[i] *Local Health Authority, Asolo, Italy*
[j] *Romagna Cancer Registry, Romagna Cancer Institute (Istituto Scientifico Romagnolo per Lo Studio e La Cura Dei Tumori, IRST, IRCCS), 47014 Meldola, Forlì, Italy*

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Dear Editor,

As members of the Coordinating Committee of the GISMa (Italian Group for Mammography Screening), the multidisciplinary scientific society representing the Italian breast screening programmes, we have read with great interest the paper 'European Breast Cancer Conference manifesto on breast centres/units' [1], in which Cardoso *et al.* complain that the 2016 deadline for the creation of multidisciplinary breast units, set by the European Parliament, has been missed by most Member States of the Union. Italy is among these.

The causes for such a failure are unclear. The budgetary constraints facing the European healthcare systems are an untenable explanation, as breast units allow for overall cost savings. Probably, the political commitment of some central and regional governments is insufficient. However, we must ask ourselves what is the level of commitment of healthcare professionals too and, in particular, to what extent they actually appreciate the value of multidisciplinary work.

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* *Corresponding author.*
E-mail addresses: gianni.saguatti@ausl.bologna.it (G. Saguatti), naldoni.carlo@tiscali.it (C. Naldoni), benelli@zadig.it (E. Benelli), chiara.fedato@regione.veneto.it (C. Fedato), alfonso.frigerio@gmail.com (A. Frigerio), v.galli@ausl.mo.it (V. Galli), livia.giordano@cpo.it (L. Giordano), p.golinelli@ausl.mo.it (P. Golinelli), d.morrone@ispo.toscana.it (D. Morrone), paduos@libero.it (A. Paduos), fiammettaquerci@gmail.com (F. Querci), antonio.rizzo@ulssasolo.ven.it (A. Rizzo), lauro.bucchi@irst.emr.it (L. Bucchi).

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Cardoso *et al.* recommend that mammography screening services be part of (or be located very close to) breast units because of the role of radiologists in both screening and diagnostic imaging and for the convenience of women. We suggest that another – and more compelling – reason is that screening providers can make a substantial contribution to the creation of breast units. In the first place, the screening process is intrinsically multidisciplinary, and the multidisciplinary work experience gained through organised screening programmes must be used as the basis on which to establish breast units.

Second, according to the European Society of Mastology (EUSOMA) guidelines, breast units should cover a defined population. At present, organised screening is the only formally population-based breast care service in Europe. Its providers know too well that an impact on mortality can only be achieved through a high degree of women's access and, thus, a substantial population coverage. Hospital-based healthcare professionals are not so familiar with this idea and may pay insufficient attention to it.

Last, but not the least, the EUSOMA guidelines state that systematic service data collection and analysis are essential – yet challenging – requirements of breast units [2]. Screening programmes are among the most intensely monitored public health services worldwide, and their information infrastructure may provide a critical help.

The paper by Cardoso *et al.* features a call to action for politicians, policy makers, healthcare professionals and patient advocates to promote the availability and quality of breast units. The GISMa is definitely committed to these tasks. In a recent position statement [3], the Group has emphasised that there remain unacceptable interregional differences in breast cancer survival in Italy, and that breast units can ensure the provision of standard services all over the country.

On the technical ground, the document recommends that the characteristics of breast units should not only be compatible with the model outlined by the Italian Ministry of Health guidelines of 18th December 2014, but should also meet the basic requirements established by the EUSOMA [2].

Moreover, the GISMa position statement reaffirms that mammography screening programmes have had – and maintain – a key role in the diffusion of the idea that breast care should be based on models of multidisciplinary team working with specialised training of dedicated staff, continuous monitoring, quality assurance schemes and communication with women. Consequently, the GISMa demands that the active, multidisciplinary, comprehensive, and quality-assured approach to breast care that characterises mammography screening programmes be adopted in the creation of breast units.

Finally, the document states that the GISMa considers it necessary to reiterate the following: (1) that breast units should help to implement mammography screening programmes all over the country according to standard methods [4]; (2) that all radiologists and radiographers staffing the breast units should work in both screening and diagnostic imaging; (3) that breast units should operate using detailed, evidence-based, and publicly available protocols for breast cancer diagnosis and management; (4) that post-treatment follow-up should be centralised in breast units, as recommended by the recent joint guidelines from the GISMa and the Italian College of Breast Radiologists [5]; (5) that breast units should offer well-integrated programmes of risk assessment, genetic counselling and genetic testing for *BRCA1*- and *BRCA2*-related hereditary breast and ovarian cancer coupled with risk reduction interventions including prophylactic surgery; (6) that the management and leadership of breast units should be given to the best-suited persons irrespective of the discipline they belong to; and (7) that the best approaches to implementation of breast units should be identified in order to promote their widespread adoption.

Conflict of interest statement

The authors have no conflict of interest to declare.

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