



IMPORTANT DATES

ASBD 12th Scientific Meeting
Gold Coast, 10-12 October 2019

ASBD AGM 2019
Gold Coast, 11 October 2019

Applied Ultrasound for Clinicians
Melbourne, 29 August 2020

Leura 2020 International Breast Cancer Conference, 27-31 October 2020

Dedicated to promoting knowledge in the areas of prevention, diagnosis and management of breast disease

Edition No.16 | August 2019

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President's Report



Welcome to a new ASBD newsletter with an update on a wide range of topics that are relevant to the rapidly expanding field of breast cancer care.

ASBD is the only truly multidisciplinary society in Australia and New Zealand, bringing together health professionals from all disciplines involved in the care of women with breast cancer and other breast disease.

The feedback from the course in Applied Ultrasound for Clinicians that was held in Melbourne in March this year was again overwhelmingly positive. This year we also introduced a workshop in Communication that was expertly developed and facilitated by Professor Jane Turner. This workshop was also very well received and the society will certainly continue to provide educational opportunities in this area.

I would like to thank our executive officer, Ms Kerry Eyles for her organisational talent and marvellous job behind the scenes.

I hope you will join me at the ASBD 12th Scientific Meeting on the Gold Coast 10-12 October. The program looks very exciting indeed, featuring internationally renowned speakers such as Dr Terry Mamounas, Dr Debra Ikeda, Dr Guiseppe Viale, and Dr

Anne Koch. The conference offers an update on key areas in breast care and provides a forum for discussion as well as informal networking. During the first day there will be a series of workshops to choose from, including breast imaging, breast pathology for non-pathologists, dilemmas in ethics and law, approaches to oligometastatic disease, survivorship and a radiation oncology masterclass. The conference itself will feature a mix of minisymposia, case discussions, lectures and poster displays covering everything from immunotherapy, genomic profiling, PMRT and latest trends in breast reconstruction to the role of AI in clinical practice, evidence based supportive care and controversies in benign breast disease. If you haven't already registered, have a look at the program yourself at www.asbd2019.com.

Looking forward to seeing you in October at the Gold Coast!

Assoc Prof Elisabeth Elder,
ASBD President

TELL US WHAT YOU THINK

We want to hear from you!

ASBD wants to remain relevant to its members' needs. If you have any articles to submit, feedback or suggestions on meetings, membership or other issues please take a few moments to email Kerry at: kerrye@asbd.org.au



**Dr Andrew See,
Radiation Oncologist, ASBD member**

In excess of 5000 delegates attended this year's European Society for Therapeutic Radiation Oncology ASM held in Milan during the early European spring with the weather holding out to allow an opportunity to explore the historic city centre between conference sessions.

In a gold plenary session on Monday, 29 April, Birgitte Offersen from Aarhus University hospital in Denmark presented the newly completed European radiotherapy contouring guidelines for women undergoing either implant based or autologous immediate breast reconstruction (IBR).

These guidelines, overseen by a consensus panel comprising of oncoplastic breast surgeons, radiation oncologists, pathologists and radiologists have, for the first time, correctly pointed out that applying conventional CT simulator based contouring guidelines for women undergoing standard breast conservation therapy are not applicable for the IBR population. The guidelines, soon to be published in the 'Green journal' (Radiotherapy and Oncology) emphasise a 'nuanced' approach to contouring including anatomic volume additions and deletions which reflect different styles of reconstruction and a knowledge of anatomic regions where subclinical tumour contamination may reside following the above.

A plethora of papers looking at cardiac dose minimisation for women undergoing left-sided breast radiotherapy via either respiratory gated, coached deep inspiratory breath hold or through treating women in nonconventional positions (i.e. prone position) were once again able to consistently show that modern radiotherapy techniques significantly reduce dose to the LAD coronary artery particularly when compared to techniques employed in the 1970s and 1980s.



Austrian ABCSG 8A trial

Dr Fastner from Austria presented 10 year follow-up data from the Austrian ABCSG 8A trial which randomised 869 women with low risk breast cancer undergoing conservation to either whole breast radiotherapy (n=439) versus hormone therapy alone (n=430) finding that with a median follow-up of 9.89 years the 10 year local control rate was 97.5% in the irradiated arm versus 92.4% in the hormone arm ($p < 0.01$). Overall survival was not different between arms.

Although this data is not unique, of interest was the observation that of the 519 patients where PAM 50 gene expression information was available, a biological high risk profile seemingly did not translate into higher IBR rates (HR 2.12, $p = 0.14$).

ABLATIVE study

Dr Vasmel from UMC Utrecht, The Netherlands, presented 18-month follow-up for 32 patients recruited in the ABLATIVE study. This very novel protocol assessed both pathologic and radiologic responses following a single 15 Gray MRI guided pre-operative dose applied to early stage unifocal breast cancer. Treatment encompassed the visible tumour as per MRI with a small margin (2cm). Women subsequently underwent wide local excision at six months post RT showing a 33% pCR rate although women in whom surgery was delayed to 8 months

fared better with a pCR rate at 41%. The treatment arm was well tolerated with minimal morbidity. MRI proved inaccurate as a predictive test in the assessment for pCR. This trial is ongoing and there is local interest in repeating a similarly designed trial so 'watch this space'.

PAPBI trial

In a similar genre, Dr Bosma from the NCI in the Netherlands presented an update on the PAPBI trial looking at accelerated partial volume preoperative radiotherapy (10 x 4Gy and 5 x 6Gy) followed by wide local excision six weeks after completion of assigned radiotherapy. Preoperative APBI provides several advantages compared to conventional post-operative radiotherapy including improved target localisation, accurate tumour delineation, the possibility for response evaluation and excision of the high-dose irradiated volume. At five years, 133 patients were analysed showing promising outcomes including excellent cosmetic assessments with limited fibrosis. Importantly post-operative complications were considered comparable to the standard moiety of complications seen with conventional sequencing. Of note was the fact that there were four patients in whom developed a local recurrence within the biopsy tract necessitating a protocol amendment requiring surgical adjustment and removal of the biopsy route at time of wide local excision.

ASBD 2019 ANNUAL GENERAL MEETING

ASBD members are invited to attend the 2019 ASBD AGM to be held at the 12th Scientific Meeting on Friday 11th October at 1230 pm in the Norfolk / Karrie Webb rooms at RACV Royal Pines Resort.

Lunch will be available in the room.

Please confirm your attendance by emailing kerrye@asbd.org.au so that adequate catering can be arranged.

WHAT'S THE PROBLEM WITH BREAST IMPLANTS?



Assoc Prof Elisabeth Elder ASBD President

Each year, approximately 20 000 women undergo breast implant surgery in Australia. Cosmetic augmentation accounts for about 80% and the remainder is reconstruction after mastectomy for breast cancer or for risk-reduction or rarely to correct developmental abnormalities. Recently there has been much publicity about risks associated with implants, particularly in relation to Breast-Implant Associated Anaplastic Large Cell Lymphoma (BIA-ALCL).

BIA-ALCL is a rare form of non-Hodgkin lymphoma, which in 2016 was classified as a distinct clinical entity separate from other categories of ALCL. Characteristically it is ALK-negative and CD30 positive.

As the awareness of this condition has increased and more systematic research has been conducted, recent reports have shown that BIA-ALCL is more common than previously appreciated, with an estimated incidence of 1/1 000 – 1/10 000 people with breast implants. Furthermore, it has been shown that the risk of BIA-ALCL is related to the roughness, or degree of texturing of the surface of the implant, rather than the filling material or shape of the implant. The most likely cause is T-cell stimulation due to development of a chronic bacterial biofilm. The higher the degree of texturing, the larger surface area, and the higher risk for biofilm formation.

As of April 2019, there have been 76 confirmed cases of BIA-ALCL in Australia and all of these patients have had textured implants at some point – many of them have had multiple implants over a number of years.

There is some controversy regarding the most accurate classification system for implants but broadly speaking the surface texture can be divided into smooth, micro-textured and macro-textured. Example of smooth implants are Motiva; Mentor Siltex and Nagor are commonly used microtextured implants and Allergan Biocell as well as Eurosilicone are macro-textured due to different manufacturing processes. Polyurethane implants, such as Silimed, are different in that they are covered with a type of foam that adheres to the tissue and can therefore not be directly placed in the classification above, however, they have also been associated with a high risk of BIA-ALCL. The reason for using textured implants rather than smooth is better tissue adhesion causing less risk for malpositioning and potentially lower risk for capsular contracture. 82% of all implants used in Australia today are textured.

Earlier in the year, the French and Canadian regulators decided to ban macro-textured and polyurethane coated implants from their markets because of safety concerns. However, Allergan implants were already withdrawn from the EU market as well as from Brazil, due to a lapse in the EC certification. In July, the US regulator FDA requested that Allergan recall their Biocell textured implant and tissue expanders and subsequently Allergan has decided to recall all their non-implanted macro-textured breast devices globally, including in Australia.

Regulatory authorities around the world have issued alerts and warnings. The TGA has proposed regulatory action (ie suspension or cancellation) in a relation to a broad range of textured implants and a final decision is expected later in the year.

The most common presentation of BIA-ALCL is a delayed seroma formation around the implant occurring on average after 8 years, with 95% of cases occurring between 3 and 14 years after insertion of the implant. Occasionally BIA-ALCL may also present as a lump in the breast or axilla.

All patients who develop swelling around an implant should have an ultrasound to confirm the presence of fluid and evaluation of any potential mass or regional lymphadenopathy. However, it's important to bear in mind that most cases of seroma are not caused by BIA-ALCL. An ultrasound-guided aspiration (biopsy) should be performed and the fluid (tissue) sent for BIA-ALCL specific analysis including cytology (histology) and flow cytometry +/- molecular studies. MRI +/- PET/CT should be performed in confirmed cases to evaluate the extent of the disease and a new MBS item number has been introduced for MRI in this setting. There is currently no role for mammography in the investigation of BIA-ALCL.

The only treatment required in most cases is removal of the implants as well as complete excision of the capsule around the implant, but chemotherapy and radiotherapy may be indicated in the rare instance of metastatic spread, and all cases should therefore be treated in specialised centres in a multidisciplinary setting. The prognosis is usually excellent although deaths have been reported in advanced cases.

The international consensus is that there is no evidence to support the replacement of current implants, unless there is a clear diagnosis of BIA-ALCL or other symptoms.

There is also consensus that registries are an important tool in the surveillance of breast implants. The Australian Breast Device Registry (ABDR) is a Commonwealth Government health initiative that was established in 2015 and is currently almost completing its national roll-out. It records information on surgeries involving breast implants, tissue expanders and acellular dermal matrices. Its purpose is to identify and report on trends and complications associated with breast device surgery; to track the long-term safety and performance of implantable breast devices; and to identify best surgical practice and optimal patient health outcomes. All surgeons, including plastic, breast and cosmetic surgeons, who are performing implant surgery (including explanation of implants) are strongly encouraged to participate in the ABDR and report all their cases.

Much of the safety data from registries will be enhanced by the pooling of data from similar breast implant registries existing in other countries. The International Collaboration of Breast Registry Activities (ICOBRA) was established as an Australian initiative to achieve this goal via the use of an agreed minimum dataset.

It is important to remember that although more common than previously thought, BIA-ALCL is still a rare condition and for breast cancer patients, the risk of developing BIA-ALCL needs to be put in perspective and is far less than the risk of developing recurrent breast cancer. Immediate or delayed breast reconstruction has been shown to have psychological benefits for women who need to undergo a mastectomy. Depending on a woman's individual circumstances, an implant-based reconstruction is often the best choice.

RESOURCES FOR ASBD MEMBERS

The following medical resources are available on the ASBD website:

- [A guide to Invasive Breast Cancer Histopathology Reporting](#)
- [ASCO CAP 2018 HER2 Testing for Breast Cancer Guidelines - Recommendations for Practice in Australasia](#)

12th General Breast Imaging Meeting – Perth, WA

13-16 March 2019

Dr Jennifer O’Sullivan
breast physician, ASDB director

Held in the vibrant city of Perth, Western Australia, the 12th General BIG Meeting program had to tempt us away from the glorious sunshine outside, and it succeeded.

Breast mammographic density was a major focus throughout the conference, and Prof. Nehmat Houssami began Session 1 by discussing the findings of the two ASTOUND trials which looked at screening with tomosynthesis versus ultrasound in women with mammography negative dense breasts. It seems there may be little incremental cancer detection from adding tomography to 2D mammography if you plan to do ultrasound.

Dr Chris Comstock from MSK New York gave an overview of the current status and future directions for abbreviated Breast MRI and outlined the PRISM trial that will compare MRI and standard mammography plus ultrasound for screening.

Dr Fleur Kilburn-Toppin gave us the Cambridge UK protocols for imaging premenopausal women, explaining that in their experience biopsy can be safely avoided in symptomatic women with no suspicious clinical, mammographic or ultrasound findings, provided they are not at high risk for any other reason such as family history. If any clinical doubt remains, a clinical core biopsy is preferable to an MRI.

Dr Donna Taylor from WA gave an overview of Contrast-enhanced spectral mammography (CESM), the use of which is slowly increasing in centres around the world, though there is at present a lack of evidence for the benefits of CESM for screening women at moderately increased risk of breast cancer.

Carolyn Nickson presented results on the prospective validation of the NCI Breast Cancer Risk Assessment Tool (Gail Model) on 40,000 Australian women. Cancer Australia is currently working on modifications to better suit the local population including ethnic profile, and incorporating other factors including mammographic density and polygenic risk scores.



Breast Density in clinical practice

Prof. Christobel Saunders looked at how we use breast density in clinical practice, asking how can we incorporate this into risk assessment profiles and tailored screening options: this would require the accurate and reproducible measurement of breast density, as well as standardised reporting. She discussed the fact that currently there is no evidence for more frequent screening of women with dense breasts who have no other risk factors, and that supplemental screening can lead to more biopsies, more anxiety, and an increased risk of prophylactic surgery.

Western Australia is currently the only state that informs women about their breast density when they have a screening mammogram. Jennifer Stone presented results of a survey showing that more than 70% of women would like to know their breast density, but that although being told can give a sense of feeling informed, some women also felt anxiety and confusion. Body mass index is a strong predictor of post-menopausal breast cancer risk, yet can confound the association between mammographic breast density and breast cancer risk. Jennifer also outlined a WA pilot trial of voluntary height and weight measurement at screening visits to gather data in this regard.

At present there is little data on breast density in indigenous women, and Ass. Prof. Andy Redfern from Perth gave us an overview of current and future research to improve the outcomes of indigenous women with breast cancer in WA.

Can we manipulate mammographic density to improve breast cancer treatment?

Ass. Prof. Redfern also gave a fascinating talk on what underlies high mammographic density in normal tissue: increased stroma, collagen, and immune infiltrates, as well as alterations in protein expressions. These factors all contribute to the increased risk of breast cancer due to high breast density, and although it seems that cancer biology is no worse, high breast density is associated with higher tumour stage and increased local (but not distant) relapse. High mammographic breast density may correlate with chemoresistance but radiosensitivity, raising the question, ‘Can we manipulate mammographic density to improve treatment?’

Dr David Clouston presented the pathologist’s perspective of breast density, noting that variation in density relates to collagen rather than epithelial tissue. He explained the biological basis of breast density lies in both genetic and environmental factors, including hormonal influences.

Dr Mary Rickard reiterated the need for guidelines for measuring and managing breast density, to better identify women who are at significant risk of breast cancer and better utilize ancillary screening. She outlined the pitfalls of visual assessment and the limitations of current automated systems, noting also that the latter give volumetric measurements which tend to be lower than area measurements. Most risk studies, however, are based on area measurements.

12th General Breast Imaging Meeting – Perth, WA 13-16 March 2019 continued

Neoadjuvant Chemotherapy

The conference also provided updates on imaging challenges in the era of increasing use of neoadjuvant chemotherapy (NAC) and changing surgical management of the axilla. Accurate post-NAC axillary ultrasound can help to lower false negative rates of sentinel lymph node biopsy. Targeted axillary dissection following neoadjuvant chemotherapy aims to provide good prognostic information while minimising loco-regional recurrence.

Breast Cancer Screening

There were updates on breast cancer screening in Australia, New Zealand and the UK. In Australia tomosynthesis is currently used only at assessment. Dr Darren Lockie summarised interim results of the BreastScreen Victoria trial of the feasibility and outcomes of Tomosynthesis screening. These suggest that 3D

screening is feasible in a local setting, but that it is resource intensive with an increase in both reading time and recall rate. This will be examined at the end of the trial later this year in the context of the effect of tomography on cancer detection rates. The UK screening program is currently trialling tomosynthesis in screening, also looking at how this affects reading time and recall rates.

Tailored screening

Tailored screening according to risk is a topic of great interest world-wide, and Prof Christobel Saunders discussed the challenge of how to define risk incorporating family history, hormonal and lifestyle factors, breast density and polygenic risk. iPrevent is a web-based risk assessment and risk management decision support tool which can be used by clinicians to estimate a woman's breast

cancer risk based on well-validated IBIS and BOADICEA risk assessment algorithms. iPrevent will also give tailored estimates of the relative (not absolute) risks and benefits of each risk management option for that woman. The PROCAS trial has shown that 3-yearly screening appears sufficient for low to average risk women, and that higher rates of more advanced cancers may justify annual screening in the population at above average risk.

In summary, the 12th General BIG Meeting was packed program with updates on many topics relevant to current clinical practice, including breast density, tailored screening, changing surgical and oncological practices, and emerging technologies for breast imaging: we've come a long way, but the journey continues.

ASBD STRATEGIC PLANNING MEETING 2019



Drs Nick Repin and Yvonne Zissiadis enjoy refreshments during a break in the meeting. We were thinking ASBD must have a uniform when we saw these two!



ASBD Directors L-R: Dr Nick Repin, Assoc Prof Nirmala Pathmanathan, Dr Yvonne Zissiadis, Dr Cath Shannon, Dr Jennifer O'Sullivan, Dr Minjae Lah, Dr Reena Ramsaroop, Dr Peter Chin, Assoc Prof Elisabeth Elder. Absent: Dr Patty Connor

The ASBD directors met for their annual planning meeting in Sydney in February. The planning day provided the opportunity for face-to-face discussion and planning of all ASBD events for the following year, as well as constitution review, goal setting and review and development of a longer-term strategic plan.

The directors agreed to make a change to the ASBD constitution in order to have one representative of the allied health members as a full director of the Society. The change will also give nurses and allied health members voting rights at the AGM. It is anticipated that these changes will be drafted ready for approval by the membership at the 2019 AGM.

International Senologic Society (SIS)



Global Federation of Breast Healthcare Societies

The Australasian Society of Breast Disease has been approached by the International Senologic Society (SIS) to start building a relationship which may lead to collaboration between the two societies in future.

The Society (Société Internationale de Sénologie) was founded in 1976 as a multidisciplinary medical society for the care of breast diseases.

The SIS aims to bring together the national societies of Senology around the world.

During its development there has been a significant increase in the importance of the senologic national societies and, consequently, of the SIS. The Senologic International Society is being structured step by step towards fulfilling its main role, which is to represent the true alliance between all the senologic entities in the various affiliated countries.

The SIS has approved the ASBD as an associate member which will allow us to be present at Board Meetings and understand the role and workings of the SIS.

Dr Yvonne Zissiadis, radiation oncologist from Perth and ASBD vice president, has been appointed as the Vice President of Oceania, in order to represent the ASBD within the International Senologic Society. The next SIS Conference is being held in Athens in September 2020. ASBD has been given the opportunity to attend and be involved.



12TH | SCIENTIFIC MEETING | 2019

Precision, Innovation and the Future



Australasian Society for Breast Disease

10-12 OCTOBER 2019

RACV ROYAL PINES RESORT, GOLD COAST

www.asbd2019.com

REGISTER NOW

Registrations are open for the ASBD 12th Scientific Meeting at the RACV Royal Pines Resort on the Gold Coast. To view the full program, or to register visit the conference website asbd2019.com.

INTERNATIONAL SPEAKER HIGHLIGHT



Dr Terry Mamounas

Terry P. Mamounas, M.D., is Medical Director of the Comprehensive Breast Program at Orlando Health

UF Health Cancer Center and Professor of Surgery at University of Central Florida. He is Chair of the NRG Oncology Breast Committee and member of the NCI Breast Cancer Steering Committee. Dr. Mamounas has authored or co-authored over 380 abstracts, manuscripts, and book chapters, and he has given numerous presentations on breast cancer at various regional, national, and international symposia. Dr. Mamounas is also a talented artist and is the guest speaker at the conference dinner where he will discuss work-life balance.

world renowned for research and innovative practices such as the QuickStart Breast Radiotherapy Program.



Dr Giuseppe Viale

Director of the Division of Pathology and Laboratory Medicine at the European Institute

of Oncology in Milan. He is Chairman of the Central Pathology Office of the international Breast Cancer Study Group (IBCSG), lead Pathologist of the Breast International Group (BIG) and co-chair of the Translational Research Committee of the BIG2-98 trial (Trans-TAX). Dr Viale is a member of American Joint Committee on Cancer (AJCC) working group for the TNM classification of breast cancer and the lead pathologist involved in the central laboratory testing for a number of seminal trials.



Dr Debra Ikeda

Dr Ikeda is a Professor of Radiology and Breast Imaging Fellowship Director, Stanford

University School of Medicine, Stanford, California, USA

Founder and leader of the California Breast Density Information Group. Areas of research include analog and digital mammography, digital breast tomosynthesis (DBT), computer-aided detection, breast ultrasound, breast cancer screening, high-resolution dynamic contrast-enhanced MRI and MRI-guided breast biopsy.



Dr Anne Koch

Dr Koch is Assistant Professor of Departments of Medical Biophysics and Radiation Oncology Staff

Radiation Oncologist at Princess Margaret Cancer Centre in Toronto. She is lead for the Breast Radiation Oncology Team and

Extras at the ASBD Conference

Launch of the Cancer Australia Statement: Influencing best practice in metastatic breast cancer.

4.30pm, Thursday 10 October

A Roundtable Discussion of Breast Reconstruction Practice in Australia

1.30pm – 5.30pm, Wed 9 October

This session will be open to registered colleagues attending the ASBD meeting.

There is no additional charge to attend, but places are limited, and will be allocated to those who are first to reply.

More Information. Please RSVP to kathy.flitcroft@melanoma.org.au by Friday 20 September.

Dr Kathy Flitcroft, Chief Investigator, I-BREAST

Breakfast Education Session with Dr Charles Geyer - Recent advances in early breast cancer management

7.15am - 8.30am, Friday 11 October.

Australasian Society of Breast Physicians AGM

5.30pm – 6.30 pm, Friday 11 October. Members Welcome

prosigna
Breast Cancer
Prognostic, Gene Signature Assay

Molecular classification of breast cancer: update on expression profile and somatic mutation research

Saturday, October 12, 2019
7:15 am–8:30am

12th Scientific Meeting of the Australian Society for Breast Disease (ASBD)
RACV Royal Pines Resort, Gold Coast

Speaker:
Torsten Nielsen MD/PhD FRCP
Professor of Pathology & Laboratory Medicine
University of British Columbia

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The ASBD 2020 Study Tour to Paris, Brussels & Barcelona

...including EBCC-12: The 12th European Breast Cancer Conference

There could be an exciting announcement for members in the near future, but, we need your help!

We are currently discussing the possibility of running an exclusive ASBD member tour to the European Breast Cancer Conference – EBCC-12 in Barcelona in March next year.

The conference has become one of the most important Breast Cancer conferences in Europe in recent years. Over three days the event will provide a multidisciplinary platform for scientific exchanges about all aspects of breast cancer and will include presentations of ground-breaking breast cancer research results from a diverse range of experts from all over the world.

We are also talking to representatives from the Marie Curie Institute in Paris and

ECCO – The European Cancer Organisation in Brussels so that we can combine the conference with exclusive ASBD visits to these world-renowned facilities.

We hope to finalise a program soon but it is likely to include:

- 9-11 days visiting **Paris, Brussels & Barcelona**
- Exclusive tours to the **Marie Curie Institute** in Paris and **ECCO – The European Cancer Organisation** in Brussels.
- 3 days at the **European Breast Cancer Conference – EBCC-12 in Barcelona**
- Sightseeing in Paris & Barcelona plus group dinners in both cities with guest after-dinner speakers
- The opportunity for partners to join members on the trip

Your expression of interest?

At this stage we are asking for an “expression of interest” from members to see whether running the tour is viable. Would you be interested in joining your fellow members on such a program?

Please email Kerry Eyles
kerrye@asbd.org.au.

A simple “absolutely yes” or “possibly” would suffice.

Suggestions are also welcome.
Thank you for your assistance.



ASBD Membership

ASBD now has over 350 members and membership is continuing to grow. Encourage your colleagues to join ASBD.

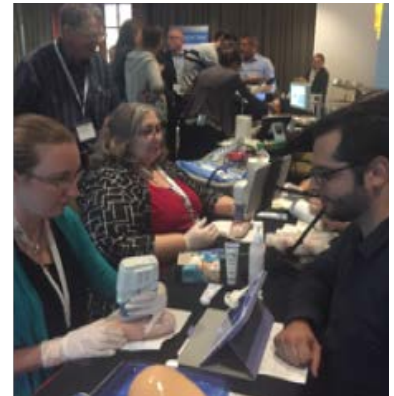
Annual membership renewal is due in June each year. ASBD membership is from July 1 to June 30 each year due to Elsevier's requirements for The Breast subscription. If you have overlooked your renewal [renew online now](#).

Your subscription to The Breast journal will be updated once your renewal is complete.

ASBD membership benefits include:

- print subscription and/or online access to full text articles of The Breast, a peer reviewed, bimonthly journal published by Elsevier.
- discounts on ASBD conference registration, access to ASBD newsletters/ educational events, full website access
- Full Membership (medical practitioners) \$200 (online journal), \$295 (plus hard copy)
- Associate Membership (trainees, nurses, allied health) \$110 (online journal)
- Join at www.asbd.org.au

Applied Ultrasound for Clinicians 2020 SAVE THE DATE



ASBD will be hosting the Applied Ultrasound for Clinicians course at the Melbourne Marriot Hotel on Saturday 29th August 2020. Further information and registration details will be available in future newsletters and at www.asbd.org.au

ASBD COMMUNICATION SKILLS COURSE

A new Communication Skills workshop was developed for ASBD by Prof Jane Turner, University of Queensland in early 2019. This Workshop provides a theoretical framework for understanding the complex determinates of personality and adult adjustment, including discussion of the role of past experiences in shaping response to illness and disease. The workshop is based on a series of illustrative case vignettes in which participants work in small groups to devise strategies for responding to communication challenges and is suitable for all medical practitioners and allied health personnel.

The inaugural workshop was held in Melbourne in March and was praised by delegates for its relevance and usefulness in dealing with communication challenges. A second workshop will be held alongside the ASBD conference in October at RACV Royal Pines Resort, Gold Coast, and is now fully subscribed.

The workshop will be held at various venues in 2020 and will be advertised to ASBD members and on the ASBD website.

Executive Structure

- A/Prof Elisabeth Elder - PRESIDENT**
- Dr Yvonne Zissiadis - VICE PRESIDENT**
- Dr Catherine Shannon - SECRETARY**
- Dr Minjae Lah - TREASURER**
- A/Prof Nirmala Pathmanathan**
- Dr Reena Ramsaroop**
- Dr Jennifer O'Sullivan**
- Dr Nicholas Repin**
- Dr Peter Chin**
- Dr Patricia Connor**

Save the Date!

ASBD 13th Scientific Meeting
23-25 September 2021
Adelaide Convention Centre



BreastScreen Update

Dr Nick Repin radiologist, ASBD director

BreastScreen Australia stands beside the colorectal and cervical cancer screening programs, and uses mammography to screen women for breast cancer. The umbrella organisation Cancer Screening Australia run by the Australian Government Department of Health, operates under policies as articulated by the Standing Committee on Screening (SCoS), and outside the Medicare framework.

Screening complements Diagnostic Testing, expecting to assess asymptomatic women, as opposed those with symptoms such as a lump. The incidence of disease is lower in an asymptomatic population and the potential for harm is significant unless the screening process, particularly sensitivity and specificity, is carefully controlled. Conversely the risks of delay to diagnosis of symptomatic women are increased if they attend a screening service inappropriately.

Population screening frameworks are based on principles articulated by WHO in 1968, namely that the condition should be important, recognisable early, with natural history understood; the test should be suitable and acceptable; the treatment should be available and accepted; there should be agreed policy on whom to treat; with agreement and acceptance on the balance of cost between case finding and expense of medical care; and that case finding is a continuous and not a 'one off' process.

The SCoS Population Based Screening Framework of 2018 adds that there should be a strong evidence base, more benefit than harm, and that research outcomes are reproducible in the screening setting; clarifying that screening is not designed to specifically target high risk groups, but policies are considered that allow appropriate identification and management of high risk individuals.

Safety and performance of the BreastScreen program is continuously validated. At the practitioner level all mammography reads are measured against outcomes with

periodic reader feedback. At Service and State levels there is continuous monitoring of indicators including population participation, rescreening rates, recall to assessment rates, invasive cancer and DCIS detection and incidence, sensitivity including interval cancer rates. Funding ultimately depends on satisfactory periodic reaccreditation.

The program has been running since the mid-90s. Recent changes include increase of target age range to 50-74 years in 2013, and changeover to digital acquisition and reading of images, completed in 2014.

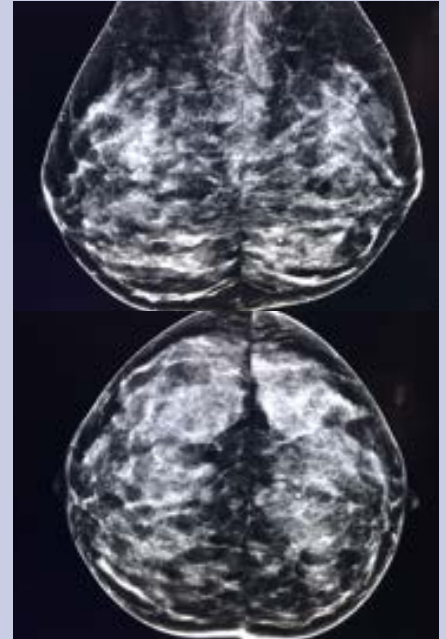
Incremental improvements are also rolling out across the organisation, improving the detection and diagnosis of cancers particularly within clinics after recall to assessment.

Digital breast tomosynthesis is increasingly available for use in assessment clinics. Tomosynthesis is increasingly available to guide mammographic biopsy, displacing stereotactic biopsy and particularly improving targeting of non-calcified lesions unable to be seen on ultrasound. Lateral arm biopsy attachments are becoming available allowing access to thinner breasts and potentially also reducing incidence of marker displacement.

Large bore vacuum assisted biopsy is displacing core biopsy for mammographically guided biopsy, and occasionally for use under ultrasound. Core and large bore vacuum biopsy have largely displaced fine needle biopsy and cytology for assessment of lesions excluding the axilla.

New technologies are emerging. Tomosynthesis is being assessed at multiple sites worldwide as to the potential cost/benefit for use in the initial screening examination as opposed to in assessment clinic after recall. A key emerging issue articulated by the Australian Population Screening Framework is the potential of genomic testing, technologies and knowledge to affect screening, and the need to keep a watching brief.

Several controversial and unclear areas



remain present including overdiagnosis, and the relationship of breast density to screening practice. Non-uniform approaches to breast lesions by BreastScreen assessment clinics create uncertainty and frustration with some clinicians.

The percentage of small cancers being found by BreastScreen continues to be higher than outside the program, and the invasive cancer peak incidence remains shifted from an older population earlier into the target age range, but problems with population access persist and to be addressed with varying strategies.

BreastScreen evolves and change on many fronts responding not only to information from data it collects, but also technical innovation and changes in clinical knowledge.

Further Information:

<http://www.cancerscreening.gov.au>

[Population Based Screening Framework](#)

[BreastScreen Australia monitoring report 2018](#)

» LOOK FOR THE ASBD DESK AT THE 12TH SCIENTIFIC MEETING

Visit the ASBD desk at Royal Pines. Bring your colleague to join ASBD on the spot and both go in the draw for the membership prize. Pick up a free ASBD pen or purchase a limited edition ASBD stainless steel coffee plunger, or just come and say hello!

Right: Winner of the 2018 membership prize, which included a year's free membership was Charmain Bridgwood, a radiographer from Queensland





Case Report – Papillomas of the breast

Introduction:

This case report serves as a basis to discuss papillomas of the breast, especially multiple papillomas (papillomatosis), and the risk of associated atypical lesions and malignancy.

Case Report

The patient is a 74-year old female. She has a past history of left breast DCIS, intermediate and high grade, diagnosed in 2013. This was treated with mastectomy and sentinel lymph node dissection. The left breast contained 60mm of intermediate to high grade duct carcinoma in-situ with no invasive component. The margins were all clear of malignancy and four lymph nodes were also negative.

In the background breast tissue there was fibrocystic change, adenosis, apocrine metaplasia and multiple small papillomas (papillomatosis). Some of the DCIS showed papillary architecture and a larger more central intraduct papilloma was identified.

In 2019, the patient presented with symptoms related to the right nipple. Mammogram revealed extensive suspicious calcifications, which on biopsy showed DCIS, intermediate nuclear grade. She was treated with a left mastectomy and sentinel lymph node biopsy. The mastectomy specimen contained 40mm of intermediate and high-grade DCIS and an 18mm invasive duct carcinoma, NOS (Fig 1a and b). This was Nottingham Grade 2, with no lymphovascular invasion, ER/PR positive, HER2 negative. The margins were well clear of malignancy and four lymph nodes were negative.

Once again, the background breast parenchyma showed fibrocystic change, numerous papillomas (papillomatosis) (Fig 2). There were numerous small papillomas both in the periphery and central portions of the breast, many of them with benign morphology. One papilloma showed nuclear atypia, with an early cribriform architecture, monomorphic cell population and mild nuclear enlargement (Fig 3a). (Sampling was limited from the left breast)

DISCUSSION:

Papillomas of the breast are common lesions with varying malignant potential. Papillary lesions can be divided into solitary lesions, juvenile papillomatosis and multiple papillomatosis.

Solitary intraductal or central papillomas arise in the larger sub areolar ducts and are defined as a mass like projection, that consist of papillary fronds composed of fibrovascular cores covered by duct epithelium and usually with an intact myoepithelial layer.

This duct epithelium may show benign features – epithelial hyperplasia of usual

type; or atypia – ADH or DCIS, ALH/LCIS.

Central/solitary intraduct papillomas have a lower association with atypical epithelial proliferation compared to multiple papillomas. (1).

Management of solitary intraduct papillomas have evolved over the years. Previous literature dictated excision of all papillary lesions diagnosed on core biopsy. This was based on the technical difficulty of analysing only part of a papillary lesion and the risk of under estimation (2). In more recent times, following a large number of long term follow up studies, the guidance has focused on nuclear atypia within papillary lesions in biopsy material. Lesions with atypia have been shown to have a higher risk of upgrade on excision (2).

Multiple papillomas arise in the terminal duct – lobular units (TDLU). Morphologically they look similar to the solitary lesions but are smaller in size. These lesions are usually occult mammographically. 84.6% of peripheral lesions were known asymptomatic and less in half contain calcifications (3).

Papillary lesions that arise in the TDLU are more frequently associated with epithelial proliferation (hyperplasia) and atypia (AD, DCIS). Authors have shown that multiple papillomas (papillomatosis) have a higher association with atypia and malignancy (DCIS) (32 – 72%) (4). The risk of association with cancer in peripheral papillomas is approximately x3 higher and with atypia this risk increases to x7 higher (7).

Management of multiple papillomas is difficult and varied with no established guidelines. Some recommend that all patients with multiple papillomas (especially with atypia) undergo wide excision with at least 10mm clear margins, followed by annual imaging (6). Others advocate treatment of atypical lesions only with the type of surgery dependent on extent. Both recommendations are difficult in patients with multiple lesions and many tend to have mastectomy. The only consistent recommendation is that patients with papillomas should be followed up carefully.

Bilateral involvement is more common with multiple lesions (as in the index patient). Incidence has been reported as 14% (7).

Recurrences are common in patients with multiple lesions as clear margins are difficult to achieve; this is compounded by the fact that the actual size of the lesion may be hard to estimate by clinical and imaging. Recurrence rates of up to 24% have been reported.

Invasive duct carcinomas associated with multiple papillomatosis is an unusual occurrence (7). More frequently seen with solitary intraduct papillomas with atypia.

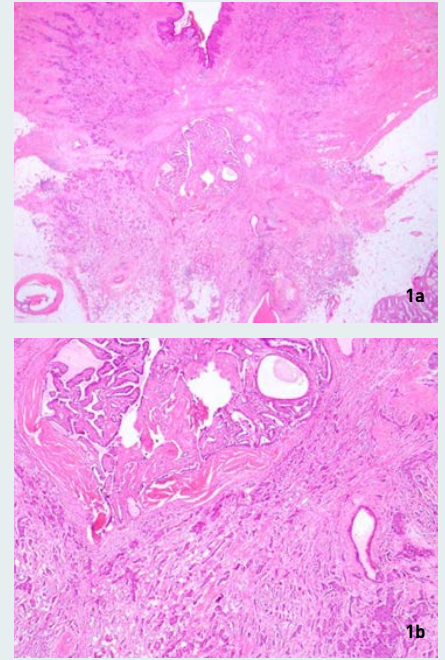


Fig 1a and b: H&E x 20. Invasive duct carcinoma, NOS with portions of papillomas

CONCLUSION:

The index patient is on hormone therapy.

Papillomas of the breast continue to present difficulties in diagnosis, treatment and follow up. Standardised guidelines are lacking, although recent literature appears to provide direction for central solitary papillomas, as they are usually symptomatic, so are biopsied and managed. Multiple papillomas (peripheral), by their occult nature and difficulty to treat need long term follow up.

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