has been done manually using a concordancer. A concordancer is a tool which makes it possible to view the occurrences of the terms in the texts and therefore specify their meanings. Expressions having the same meaning were grouped into one concept, and concepts were structured using different relationships.

We identified over 1300 concepts expressed by over 3000 terms. Patients use a language different from the one used by health professionals. Building such terminologies will help to bridge the gap between the two languages.

Friday, 24 March 2006 13:00–14:00

SPECIAL SESSION

Breast cancer and its management in the emerging world

442 Invited

Overview of breast cancer in Latin America

Abstract not received.

443 Invited

Overview of breast cancer in India

I. Mittra. *Bhopal Memorial Hospital and Research Centre, Bhopal, India*

India is vast country with a female population of approximately 500 million. 82,951 women develop breast cancer and 44,795 women die of the disease in the country every year. Breast cancer incidence in India is low as compared with the west with an age adjusted incidence of 19.1 per 100,000 women and a crude incidence of 16.5 per 100,000 women. These are average figures obtained from the several cancer registries located in the major cities and large towns; however, in metro cities like Mumbai and Delhi the figure is nearer 30 per 100,000. The only population based rural registry at Barshi in the State of Maharashtra has recorded a lower age adjusted rate of 8.1 per 100,000 women. This is presumably related to earlier age at first child birth, larger number of children delivered, longer duration of lactation and possibly a protective diet that are prevalent in rural India. There are no organized screening programmes in the country but some opportunistic screening with mammography is practiced in major cities. Similarly, mammography machines are largely aggregated around the metros, but no accreditation programmes are in place and there are few radiologists who are specifically trained in mammography. As a country as a whole, 60% women present with locally advanced (LABC) or metastasis (MBC) breast cancer. At Tata Memorial Hospital (TMH) in Mumbai, the premium Cancer Centre in the country, 30% patients present with LABC and 14% with MBC (most having had prior primary surgery elsewhere). Modified radical mastectomy is the standard treatment of operable causes, although at TMH 50–60% of patients undergo breast conserving treatment (BCT) and 30% of LABCs undergo BCT after anterior chemotherapy. Hormone receptor assays are available in many major cities and towns or are outsourced to commercial concerns in metro cities. There are 203 radiotherapy centers with 259 ^{60}Co teletherapy units, 68 linear accelerators and 135 brachytherapy facilities. Most hormonal and chemotherapy drugs are commercially available but Tamoxifen and CAF/CMF are the most commonly used systemic agents. Several national and international collaborative trials are being conducted in the country, while the Indian Breast Group is the only national collaborative research organization.

444 Invited

Overview of breast cancer in the Arabic world

N.S. El Saghir. *American University of Beirut Medical Center, Department of Medicine/Hematology-Oncology, Beirut, Lebanon*

Breast Cancer represents 22% of all female cancer cases worldwide. Data on breast cancer in Developing countries and Arabic countries is variable. Some countries have national or regional tumor registries, others have population studies, and many have hospital-based registries and studies. Breast cancer is the most common cancer among Arabic women. According to reported data, breast cancer constitutes between 13% to 35% of all female cancer cases in Arab countries. Lower rates are reported from Morocco, Tunisia and Algeria. There is also an increased proportion of younger-aged women with breast cancer at presentation. Almost half of patients reported are below the age of 50 and median age is 49–52 years, while in the USA and Europe a median age of around 63 years is observed and only about 25% of patients are under the age of 50 at presentation. A suspected high prevalence rate was recently concluded from Egypt when a detection rate of 8 per 1000 breast cancer cases was found upon first screening of a target group of 4116 invited women aged 35–64 living in a geographically defined area in Cairo. Some countries have reported increased incidence rates. For example, studies from Lebanon show that breast cancer represents 23% to 35% of cancer in women and that age-standardized incidence rates (ASR) have recently increased from 20 to 40.6 per 100.000 women per year. Incidence of breast cancer increased by 93.7% from 1970 until 1995 in Palestinian women.

While in-situ has become most commonly seen in more industrialized nations due to the widespread application of screening mammography, advanced disease remains very common in Arabic countries. Personal observations and studies from Egypt, Tunisia, Saudi Arabia, palestinians and others show that patients tend to present with larger tumors and more locally advanced and metastatic disease.

Although significant variations exist between countries, mastectomy is still the most commonly performed surgery for most women with breast cancer in Arab countries. Mastectomy rates still represent more 80% of breast cancer surgeries in many countries. The reason for this practice is mostly due to the lack of close radiation therapy centers which tend be available only in capital or major cities, and to the different training backgrounds of general surgeons. However, it is important to point out that many centers have recently increased their rates of breast-conserving surgery and axillary-conserving sentinel lymph node biopsy.

Population screening is rarely practiced. Awareness campaigns are done in some countries. Although countries with more affluent resources should implement population screening, countries with truly limited resources should reduce the incidence of large tumors and locally advanced disease.

Surgeons education should emphasize breast-conserving surgery. Radiation therapy centers should become more available and better distributed. Other suggestions are also dicussed to improve the current state of suboptimal breast cancer care. Individual and academic work, as well as some governmental planning are being done but more investment in data collection and cancer registries, regular updates and publications, quality medical care and scientific research are suggested and will be discussed.

Friday, 24 March 2006 14:15–16:00

PLENARY KEYNOTE

Breast cancer research and management: striving for the best

445 Invited

European women's expectations

S. Kyriakides. *Europa Donna, Nicosia, Cyprus*

The expectations of society imposed on womens roles, particularly as reflected in areas such as marriage, beauty and employment have changed radically over the last century and still continue to change.

Expectations held by a society defines the roles of its members. Many factors influence the parts that individuals play in their cultures and communities, but education has in fact always been the crucial element in the establishment of social roles. It is education that has acted as a catalyst and over the centuries played a major part in changing the role of women in different societies.

In the latter decades, women's roles have shifted for, in the past they were severely limited by society's concepts of what could be called male supremacy, women's priorities were to run a household, they were discriminated against in employment, in political life and even in education.

But, as women began to receive higher levels of education, their role on society began to change dramatically, women became activists and eventually were in many cases successful in pursuing their demands.

It is this changing role in society that needs to be addressed when discussing the European women's expectations in any one area, not least in that pertaining to health, and, more specifically, to breast care management.

For, there is a diversity in how one could define as the profile of the EUROPEAN WOMAN, as this would depend on her country of origin, culture, religion and even which part of a country she lives in.

Similarly, there is a diversity in what expectations a woman perceives that she is allowed to have in areas of health, depending on the role of women in that specific society. Furthermore, where breast health is concerned, there are possibly many more variables that will determine what her expectations could be.

Women can only have expectations regarding their breast care management if they have been allowed access to education in this. Education breaks the silences, changes the perceptions and this is where advocacy plays a crucial role-in providing information, education, in changing expectations, in allowing women to have a voice in advocating for better breast care.

Breast cancer advocacy spreads different messages to women, and men, in the different countries, lobbying for different goals and objectives, but with one ultimate vision-to raise expectations of each woman, of each citizen in Europe, in order to ask and obtain optimal breast cancer management, to strive for best health care, respecting the woman's needs.

The purpose of this presentation will be to propose how the breast cancer advocacy movement can act as the catalyst, through education and information, to bring about this transformation in the expectations of European women in breast health management issues.

446 Invited

Breast units in Europe – where do we stand?

L. Cataliotti. *University of Florence, Surgery Department, Firenze, Italy*

In October 1998 in Florence the First European Breast Cancer Conference took place. Delegates agreed a consensus on research, genetic predisposition, psycho-social status, treatment and notably quality of care: "The Florence Statement" demanding that all women have access to multidisciplinary breast clinics based on populations of around 250,000; also calling for mandatory quality assurance programmes for breast services.

In this regard Eusoma and EORTC established a working party, which developed the guidelines "The Requirements of a specialist Breast Unit' setting the standards for forming high quality Breast Units across Europe.

These Guidelines have been influential in the introduction of the multidisciplinary working in several countries. The Brussels Statement, following EBCC2 drew attention to these guidelines and demanded that processes of accreditation of breast units be implemented. The importance of the establishment of multidisciplinary breast units was again stressed in the Hamburg Statement which followed EBCC4. Attention was drawn to the approval given to this in the European Parliament (Resolution Number A5–0159/2003).

With the aim of assuring the provision of high quality specialist breast units across Europe, Eusoma has developed in collaboration with Euref and Europadonna a voluntary process of accreditation.

Initial accreditation will be on the potential of the Unit to meet the recommendations set in the guidelines i.e. their buildings, hardware, specialist team, protocols, aims for service provision.

The results of audit cannot be used as a basis for Initial Accreditation since no outcomes will be available. Therefore Units satisfying the criteria will be accorded "Initial Accreditation.

Re-Accreditation will be based on the outcome measures for case management stipulated in the various EUSOMA Guidelines, recorded contemporaneously onto the data base designed for the EUSOMA Network.

The first Re-Accreditation will give the Unit 'Full' Accreditation.

A report based on raw anonymous data will be sent each year to Units which have received Initial Accreditation. This is designed to inform them on how well they are complying to the outcome measures which will be assessed for Full Accreditation at five years.

Full Accreditation may be applied for when a Unit has 5 years of Audit Data, which may include cases treated in years prior to the Initial Accreditation.

447 Invited

Hospital volume specialization, guidelines and outcomes in cancer treatment: importance in quality of cancer care

I. Ray-Coquard. *Centre Regional Léon Bernard, Lyon, France*

An extensive, consistent literature that supported a volume-outcome relationship was found for cancers treated with technologically complex surgical procedures, eg, most intra-abdominal and lung cancers. An association with hospital and surgeon volume in colon cancer varied with the volume threshold. For breast cancer, British studies found that physician specialty and volume were associated with improved long-term outcomes, and an American report showed an association between hospital volume of initial surgery and better 5-year survival. Studies of non surgical cancers, principally lymphomas and testicular cancer, were few but consistently showed better long-term outcomes associated with larger hospital volume or specialty focus. Studies in recurrent or metastatic cancer were absent. Across studies, the absolute benefit from care at high-volume centers exceeds the benefit from break-through treatments. Although these reports are all retrospective, rely on registries with dated data, rarely have predefined hypotheses, and may have publication and self-interest biases, most support a positive volume-outcome relationship in initial cancer treatment.

Another aspect of the quality of cancer care is the conformity with guidelines. Although cancer treatments have been subject to RCTs, not all aspects of the quality of caring for cancer patients have been evaluated in trials. Accordingly, it is also desirable to include measures that are based on guidelines, other consensus statements, and expert opinion about optimal care. Developing measures of overuse of care will require convening panels of clinicians and other experts. Recently, it was demonstrated that conformity with guidelines was significantly correlated to overall survival of patients managed for localized breast cancer.

Improvements have been demonstrated in compliance with evidence-based guidelines or evidence-based medicine, and in short-term length of stay, complication rates, and financial outcomes. However, some attempts to improve practice have been moderately successful in achievement of reduced health care costs, reduced hospital length of stay, and possibly improved outcomes. Other methods that are still in use have been demonstrated to have little effect. Programs that have not succeeded have relied on voluntary change in practice behaviour without incentives to change or have had no accountability component. Further research is needed to assess how guidelines are enacted in organizations other than those demonstrably committed to improvement, ways to improve compliance of health care providers who are not committed to change, and thods to improve accountability.

Also scientific literature supported a real impact of hospital or physician's volume specialisation on cancer patient's outcomes; successful implementation of validated guidelines could be an opportunity to increase quality cancer management whatever is the volume of managed patients. Given the public fear of cancer, its well-defined first identification, and the tumor-node-metastasis taxonomy, actual cancer care should and can be prospectively measured, assessed, and benchmarked. The literature suggests that, for all forms of cancer, efforts to concentrate its initial care would be appropriate.