1005 clinic attendees were assessed. 310 women (31%) were low risk, 584 (58%) were moderate risk, and 111 (11%) were high risk. We continue to follow up 511 women (51%). These are the 386 (38%) moderate risk women aged 35–50, the 111 (11%) women over 35 years classified as high risk, and 10 women (1%) who declined discharge. After accurate risk assessment 503 (50%) women attending for screening were eligible for discharge to primary care and/or the national breast screening programme. Overall 995 women (99%) complied with their revised management plan.

Current guidelines and a multi-disciplinary team approach have helped to more clearly define women who should have surveillance due to their family history, allowing them to avoid potentially harmful investigations, and significantly reducing the surgical clinic workload.

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Breast cancer screening is associated with increased appropriateness of surgical treatment

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Introduction: On the basis of a review of the trials on breast screening with mammography, it has been claimed that screening increases mastectomy rates. However, the point is not mastectomy rates, but whether screening modifies breast surgery appropriateness. We describe the situation of breast cancer surgery in the late 1990s in Italy and the impact of screening services on its appropriateness.

Materials and Methods: We collected population data on areas from six Italian regions on all incident cases of in situ and invasive breast cancer in women aged 40 to 79 years from 1997 to 2001. We classified cases according to method of detection in screen detected (SD) at first test, SD at subsequent tests, not screen detected (NSD) with a previous screening test, NSD never compliers and NSD never invited; we also evaluated screening by intention to treat (ITT) according to invited and non invited categories.

Results: We enrolled 2162 in situ and 21,148 invasive breast cancer cases. Overall, 61.1% of cases underwent BCS, with a constant increase during the period of study. The proportion of BCS was around 80% for pTis and pT1a and pT1b, but was less than 50% for cases pT2 $\leqslant$ 30 mm. 75% cases SD at first test and 83% cases SD at subsequent tests had BCS, compared to two thirds cases NSD with a previous screening test and about 50% in those never invited to screening.

At multinomial analysis on cases pTis and pT $\leqslant$ 30 mm, the OR for mastectomy (adjusted by year of diagnosis, age, size of the tumour, method of detection and Centre) decreased by 9% per calendar year. Compared to cases NSD never invited, the odd for mastectomy showed a statistically significant reduction by one third and by half in cases SD at first and subsequent test, respectively, and was reduced by 15% in cases NSD with a previous test. In the analysis by ITT the odd for mastectomy was significantly lower for cases invited to screening (OR 0.74, at $p < 0.001$).

Conclusion: In the late 1990s in Italy there has been an increase in appropriateness of breast surgery, with a reduction of mastectomies in small lesions. The risk of inappropriate mastectomy was lowest in cases screen detected; screening had a positive effect also on cases NSD with a previous screening test, partly due to patients referring to screening' diagnostic and therapeutic services.

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Histological upgrade of atypical ductal hyperplasia diagnosed with percutaneous core biopsy. A review of 58 Chinese patients

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Introduction: Management of atypical ductal hyperplasia (ADH) diagnosed with core biopsy/vacuum assisted biopsy device was usually followed with surgical excision because of its association with malignancy. However, this potentially leads to over-treatment for patients. The present study was to review the upgrade rate for ADH and to identify any predicting factor for upgrade over 5 years period in our centre.

Design of study: Those patients presented with mammographic microcalcifications only and with percutaneous core biopsy yielded ADH were recruited. Wire-guided biopsy was advised to all patients. Histological upgrade was defined as detection of ductal carcinoma in situ (DCIS) or invasive ductal carcinoma (IDC) in subsequent surgical biopsy. Predicting factors for histological upgrade were analyzed using univariate analysis and statistical significance was tested using Chi-Square test.

Results: From July 2000 to June 2005, there were 58,436 patients attending our mammogram screening clinic. Stereotactic biopsies were performed for 625 patients presented with abnormal microcalcifications. 58 Chinese patients had ADH on stereotactic biopsy. 48 patients had subsequent surgical excision and were included in the present study. An upgrade rate of 29% was found. 13 patients had DCIS and 1 patient had IDC. Non-cribriform pattern in histology was found as a statistical significant predicting factor of upgrade when compared with cribriform pattern; 53% (8/15) compared with 18.2% (6/33) ($p = 0.013$). Complete removal of microcalcifications during core biopsy was associated with 20% upgrade, whereas incomplete removal with 31.6%, however, the result was not statistical significant ($p = 0.474$).

Conclusions: Surgical excision is recommended after atypical ductal hyperplasia is diagnosed with core biopsy for mammographic microcalcifications. Our series demonstrated an overall upgrade of 29%. Non-cribriform histological pattern was found to be a significant predicting factor for histological upgrade.

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Results of the new French breast cancer screening programme for year 2003

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The French national breast cancer screening programme set up in 1994 after a pilot phase, was implemented in 32 districts. Evaluation of this decentralised programme showed a good quality but a poor attendance, clearly indicating that this programme was not accepted. The French department of health therefore developed a new protocol which was implemented in 2002. National coverage of the programme with this new protocol, targeted to women aged 50 to 74, was achieved in the first quarter of 2004. The results of the new programme are presented.

Methods: The new protocol comprised, every two years, a systematic clinical breast examination, two views, immediate assessment by the first reader (R1) in case of abnormal mammography, centralised double reading of all normal mammographies by a restricted number of radiologists (R2). Data is collected on a yearly base by the National public health institute (InVS). Data for year 2003 59 districts were available for analysis.

Results: A total of 831,445 women attended the new programme in 2003. The attendance rates reached 32% varying from 20 to 60% one district to another. Abnormal mammography rate before assessment reached 13.8% and 3.6% after immediate assessment. True recall rate after R2 was 2%. Abnormal clinical examination with normal mammography reached 0.3% and decreased to 0.03% after assessment. Overall cancer detection rates were 6.3‰ (prevalence 6.8‰, incidence 5.9‰). Cancer rates of the new programme for women aged 50 to 69 were higher (5.8‰) than the rates observed in the former programme (4.9‰). A total of 8.3% of the cancers were detected by the second reader. DCIS rates were 12.8 and rates of cancers $\leqslant$10 mm were high 35.3% (prevalence 35.8% incidence 38.9%). Positive predictive value of surgical biopsy reached 80%.

Conclusion: The new breast cancer screening programme targets women aged 50 to 74 and offers screening procedures in agreement with the French screening practices in a decentralised health care system. The main aims of the programme are, by promoting quality, to increase attendance and progressively replace individual screening by the organised screening programme.

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Cost implications of the first year of the Hungarian nation wide breast cancer screening programme

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Background and aim: A nation wide organized breast cancer programme was introduced in January 2002 in Hungary for women aged 45–65 and a 2 years screening interval is applied. The aim of this study is to calculate the annual financial burden of the breast cancer screening programme and to calculate the cost of finding one cancer case.

Data and Methods: The data derive from the database of the National Health Insurance Fund Administration containing routinely collected financial data reported by the health care providers (including mammography centres). We calculated the cost of mammography screening, further