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1 Operational Sites

NSBSP Administration Site and Central Mammography Booking
7001 Mumford Rd
Unit 603L
Halifax, Nova Scotia
B3L 2H8
Toll Free: 1-800-565-0548 (Mobile van, fixed site and diagnostic mammography bookings)
Halifax: 902-473-3960 (District 9 fixed sites and diagnostic mammography bookings)
Fax: 902-473-3959
Toll-Free Fax: 1-866-470-3959
breastscreening.nshealth.ca

NSBSP PATIENT NAVIGATION
Sarah McCarthy
Toll Free: 1-877-738-9898
Halifax: 902-470-6370
## CENTRAL MAMMOGRAPHY BOOKING AFFILIATES

### District 1

South Shore Regional Hospital  
90 Glen Allen Dr  
Bridgewater, NS  
B4V 3S2  
Tel: 902-527-5246  
Fax: 902-543-9793

### District 2

Yarmouth Regional Hospital  
60 Vancouver St  
Yarmouth, NS  
B5A 2P3  
Tel: 902-742-3541  
Fax: 902-742-5320

### District 3

Valley Regional Hospital  
150 Exhibition St  
Kentville, NS  
B4N 5E3  
Tel: 902-678-7381 (2720)  
Fax: 902-678-0098

### District 4

Colchester East Hants Health Centre  
600 Abenaki Rd  
Truro, NS  
B2N 0C4  
Tel: 902-893-5554  
Fax: 902-893-5534

### District 5

Cumberland Regional Health Care Complex  
110 East Pleasant St  
Amherst, NS  
B4H 1N6  
Tel: 902-667-5400 (6155)  
Fax: 902-667-6307

### District 6

Aberdeen Hospital  
835 East River Rd  
New Glasgow N.S  
B2H 3S6  
Tel: 902-752-7600  
Fax: 902-755-2541

### District 7

St. Martha’s Regional Hospital  
25 Bay St  
Antigonish, NS  
B2G 2G5  
Tel: 902-863-2830  
Fax: 902-867-4724

### District 8

Cape Breton Regional Hospital  
1482 George St  
Sydney, NS  
B1P 1P3  
Tel: 902-567-7788  
Fax: 902-567-7812

### District 9

Cobequid Community Health Centre  
40 Freer Lane  
Lower Sackville N.S  
B4C 0A2  
Tel: 902-869-6129  
Fax: 902-869-6121

### District 9

IWK Health Centre  
5850-5980 University Ave.  
Halifax NS  
B3K 6R8  
Tel: 902-473-3960  
Fax: 902-473-3959
2 Vision

Reduce the mortality from breast cancer in Nova Scotia women aged 50-69 years of age by 30% within ten years following development of a province-wide screening program.

Mission Statement

To provide quality standardized mammography access with timely assessment, informed patient navigation and appropriate follow-up of women who have abnormal mammograms on screening, through diagnostic work-ups in accredited work-up centers, before consideration of surgical alternatives.
3 Management & Operations Teams

MANAGEMENT TEAM

Medical Director
Dr. Judy Caines

Acting Program Manager
Theresa Foley

Department of Health & Wellness Advisors
Tracey Barbrick, Associate Deputy Minister of Health & Wellness
Paula English, Chief of Program Standards & Quality
Sandra Christie, Executive Director, Acute & Tertiary Care
Anne Yuill, Director, Acute & Tertiary Care

Manager, PACS Operations & Applications
Rick Nickerson

Epidemiologist
Dr. Jennifer Payne

Consultant Statistician
Prof. Mohamed Abdolell, Diagnostic Radiology, Dalhousie University

Chief Information Officer
Sandra Cascadden
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**Promotion and Navigation**  
Sarah McCarthy  
Nichole Halliday  
Marian Brine  
Treena Landry

**Data Management**  
Theresa Foley

**Data Analyst**  
Olivia Tong

**PACS Specialist MIS/DRS**  
Robert MacDonald

<table>
<thead>
<tr>
<th>Radiologists</th>
<th>QEII HSC (Halifax)</th>
<th>CBHCC</th>
<th>YRH (Yarmouth)</th>
<th>CEHCC (Truro)</th>
<th>SSR</th>
<th>VRH</th>
<th>AH</th>
<th>St. MH</th>
<th>CRHCC</th>
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</thead>
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<tr>
<td>Dr. Judy Caines</td>
<td>Dr. Joy Borgaonkar</td>
<td>Dr. Gerald Schaller</td>
<td>Dr. Eric Woods</td>
<td>Dr. Nancy McNeil</td>
<td>Dr. Arthur Marshall</td>
<td>Dr. Michael Dunn</td>
<td>Dr. Dan Hoffman</td>
<td>Dr. Brian Nicholson</td>
<td>Dr. Sanjeev Kaul</td>
</tr>
<tr>
<td>Dr. Joy Borgaonkar</td>
<td>Dr. Robinette Butt</td>
<td>Dr. Nadeem Shrafat</td>
<td>Dr. April Moore</td>
<td>Dr. Eric Versnick</td>
<td>Dr. Chen Meng</td>
<td>Dr. David Acton</td>
<td>Dr. Ronald MacEachern</td>
<td>Dr. Skyz Do</td>
<td>Dr. Susan Thompson</td>
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<td>Dr. Lori McDonald</td>
<td>Dr. Sian Iles</td>
<td>Dr. Syed Raza</td>
<td>Dr. Lynette Foster</td>
<td>Dr. Skyz Do</td>
<td>Dr. Sangeeta Kalyan</td>
<td>Dr. Maureen Madigan</td>
<td>Dr. Maureen Madigan</td>
<td>Dr. Lynette Foster</td>
<td>Dr. Eva Barkova</td>
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<td>Dr. Peter Brown</td>
<td>Dr. Heather Curtis</td>
<td>Dr. Derek Karanwal</td>
<td>Dr. Beth Furey</td>
<td>Dr. Lynette Foster</td>
<td>Dr. Eva Barkova</td>
<td>Dr. Ryan MacDougall</td>
<td>Dr. Eva Barkova</td>
<td>Dr. Daniel Petrie</td>
<td>Dr. Eva Barkova</td>
</tr>
</tbody>
</table>

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CRH  
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CRHCC  
SSR  
VRH  
AH  
STMH  

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Nichole Halliday  
Treena Landry  
Marian Brine  
Denise Wright  
Sandra Rose  
Linda Roy  
Cheryl Crowe  
Dona Ripoll  
Jodi Myles
4 Executive Summary

The Nova Scotia Department of Health & Wellness established and funded the Nova Scotia Breast Screening Program (NSBSP) as a provincial program in 1991. Nova Scotia was the 5th province in Canada to offer organized breast screening. All ten provinces and two of the three territories now have an organized breast screening program. Nova Scotia is in a unique position in that all breast imaging in the province, screening or diagnostic, is captured under the umbrella of the provincial breast screening program in a single database. This total population capture has eliminated opportunistic screening in this province and allows for population-based decision-making to be well informed and supported.

As of December 31, 2014 993,463 screens have been performed on 203,440 women finding 4,543 cancers. Cancer detection rates for this period can be seen in table 4.1. The combined screening + diagnostic participation rate in Nova Scotia for women 50-69 is currently 60.6%.

Full Field Digital Mammography (FFDM) has been implemented in all fixed sites, screening and diagnostic, across the province. Included in the FFDM rollout was the implementation of the Diagnostic Reporting System (DRS) throughout the province. All but three districts (3, 4, & 7) are utilizing the DRS to report diagnostic breast imaging. Complete tracking of diagnostic breast imaging for women in these districts is not possible at this time. It is anticipated that all districts will be reporting all breast imaging in the new information system once implemented in 2016.

NSBSP has made some great improvements in wait time reporting along every step of the clinical trajectory. Providing the districts with these quarterly reports has resulted in a significant reduction of wait times over the past two years. The wait time for “Abnormal Screen to Resolution without tissue biopsy” is now hovering around the Canadian target of 35 days. This wait was as high as 56 days before the wait times initiative and has dropped to as low as 26 days.

One main goal of the NSBSP is to standardize the mammography process throughout the entire province. “Lack of full organization may result in sub-optimal program operation, performance and resource efficiency.” Progress in Cancer Control: Screening: Canadian Cancer Society/National Cancer Institute of Canada: Canadian Cancer Statistics 2006.

It is through this goal of standardization that the delivery of mobile mammography has been changed. Three mobiles units, two film-based and one digital, have been supplementing the 11 fixed screening sites. The purpose of mobile mammography is to service remote and hard to reach populations. Beginning in 2013 mobile mammography was delivered to 30 stops across the province using a single, digital mobile unit. This ensured that all women in the province had equitable access to the best screening mammography services available.

Through the systematic use of stereotactic needle core biopsy (a procedure perfected through the NSBSP) Nova Scotia has achieved the lowest Benign:Malignant breast surgery rate in the country. The stereotactic method accounts for 92% of all needle core biopsies performed in Nova Scotia. The remaining 8% are ultrasound-guided. The stereotactic method is performed with a regular mammographic table with an adaptable stereotactic device. This is done as an outpatient procedure, has highly reproducible results and has proven to reduce the number of unnecessary open breast surgeries.

Finally the NSBSP has made great progress in rolling out enhancements to its current information system. A rewrite of the existing system ensures the 25 years of collected data remains intact as the design of the information system changes making it more user friendly and sustainable. The registration and technologist components for both screening and diagnostic have been rolled out across the province in 2015 as well as many of the listings. The radiologist reporting sections is currently being rewritten and HL7 interfaces for connectivity with the breast imaging system and the hospital information systems are being developed. It is anticipated these will operational in 2016.
Table 4.1: Cancer Detection Rates (all ages and all years)

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<th>Age</th>
<th># of Cancers</th>
<th># of Exams</th>
<th># of Women</th>
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<th>Rate per 1000 Women</th>
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<td>&lt; 40</td>
<td>0</td>
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<td>0</td>
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<td>60897</td>
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<td>45 – 49</td>
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<td>50 – 54</td>
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<td>88914</td>
<td>11239</td>
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5 Nova Scotia Breast Screening Program

5.1 NSBSP Organizational Chart
## 5.2 Central Mammography Booking (CMB) Participants

Table 5.1: Central Mammography Booking (CMB) Participants

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<td>Mobile 1 (Cape Breton)</td>
<td>Sept 1994</td>
</tr>
<tr>
<td>Mobile 2 (Western)</td>
<td>July 1997</td>
</tr>
<tr>
<td>Mobile 3 (Northern)</td>
<td>Jan 2003</td>
</tr>
<tr>
<td>Mobile 4 (Replaced Mobile 1)</td>
<td>July 2007</td>
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<tr>
<td><strong>Fixed (11)</strong></td>
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<tr>
<td>Halifax Shopping Centre</td>
<td>Jan 1991</td>
</tr>
<tr>
<td>Sydney - Hospital</td>
<td>May 2000</td>
</tr>
<tr>
<td>Yarmouth - Hospital</td>
<td>Apr 2001</td>
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<td>Truro - Hospital</td>
<td>Jun 2002</td>
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<td>Dartmouth - Hospital</td>
<td>Jan 2003</td>
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<tr>
<td>Amherst - Hospital</td>
<td>June 2004</td>
</tr>
<tr>
<td>Bridgewater - Hospital</td>
<td>July 2005</td>
</tr>
<tr>
<td>Kentville - Hospital</td>
<td>Jan 2006</td>
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<td>New Glasgow - Hospital</td>
<td>Jan 2007</td>
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<tr>
<td>Cobequid - Community Health Centre</td>
<td>July 2007</td>
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<td>Antigonish - Hospital</td>
<td>Oct 2008</td>
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<td><strong>Diagnostic Sites (10)</strong></td>
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<td>Halifax</td>
<td>Dec 2000</td>
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<td>Sydney</td>
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6  Strategic Planning

6.1 Provincial Program Model Approach

Within the Acute and Tertiary Care Branch the following provincial programs are currently funded by the Department of Health & Wellness: Cancer Care Nova Scotia, Nova Scotia Diabetes Care Program, Reproductive Care Program, Nova Scotia Breast Screening Program, Cardiovascular Health, Nova Scotia Provincial Blood Coordinating Program, the Nova Scotia Hearing and Speech Program and the Legacy of Life Program.

The Acute and Tertiary Care Branch has developed an Accountability Framework for Provincial Programs to assist in determining whether a provincial program approach is the appropriate solution to address particular health care issues related to acute and tertiary care. In addition, this accountability framework will provide support for existing Provincial Programs where reporting relationships, roles and responsibilities are not clear. *Provincial Program Model, Acute and Tertiary Care Branch Proposal, April 2, 2004.*

6.2 Provincially Supported Screening Mammography Policies

With 100% participation of provincial mammography sites, further standardization of policies and procedures has become a priority. In past years, measures implemented with provincial approval include:

- involvement of the 40-49 and over 69 age groups
- mandatory site accreditation for all participating NSBSP sites
- evidence-based reporting intervals
- mandatory program evaluation
- elimination of BSE teaching as a complement for mammography

6.3 Programmatic Screening of Ages 40-49

In 1993 it was recognized that women themselves were demanding mammography at age 40 and appropriate tracking mechanisms did not exist for these examinations. Until further meta-analyses are published on the subject, NSBSP (after consultation with the Department of Health & Wellness) determined these women should be able to self-refer for screening mammography. Automatic recall on an annual basis for women 40-49 was instituted in 1995. Current evidence suggests screening the 40-49 age group is beneficial providing that quality assurance aspects of the program are in place and outcomes can be monitored.

One study from Sweden compared the breast cancer mortality of women who were invited to screening at ages 40 to 49 years (study group) and women in the same age group who were not invited (control group). The results from this study, *Effectiveness of population-based service screening with mammography for women ages 40 to 49 years: Evaluation of the Swedish Mammography Screening in Young Women (SCRY) cohort,* were published in *Cancer: n/a. doi: 10.1002/cncr.25650.*

This study took place between 1986 and 2005. Results of this comprehensive study showed that screening was an efficient resource in the reduction of breast cancer mortality for women ages 40 to 49 years old. Similar feasibility studies are also in progress in other European countries. These trials recognize that if early detection of breast cancer is to be effective in younger women, the intervals between screen episodes must be shorter.
7 Requirements for a Breast Screening Program

Breast Cancer is an important health problem which has a recognizable latent or early non-symptomatic stage. The screening test must be efficacious (sensitivity and specificity) and acceptable, and diagnosis and treatment must be acceptable with facilities available. The cost must be balanced against medical care funding as a whole and should be ongoing. WHO 1968, Criteria for Screening Program.

7.1 CAR Accreditation

The Nova Scotia Breast Screening Program has been instrumental in encouraging high quality mammography through accreditation of staff and equipment by the Canadian Association of Radiologists (CAR). NSBSP has taken a lead to promote this process. It is one of many organized steps towards achieving and maintaining favorable program indicators. All mammography sites in Nova Scotia are currently accredited or in the process of accreditation. Re-accreditation is required every three years. Presently the CAR has increased the required number of screens from 480 to 1000 per radiologist.

In 2005, it became policy in Nova Scotia that fees for mammography services would not be paid by the province unless CAR accreditation and a process for accreditation maintenance is in place. This policy was supported by the Nova Scotia Association of Radiologists, the Medical Society of Nova Scotia (Doctors, Nova Scotia), and the Department of Health & Wellness.

7.2 Radiology Reading Volumes Study

Nova Scotia was one of the provinces contributing data to the Pan Canadian Study by a working group of the Canadian Breast Cancer Screening Initiative. This study was to look at cancer detection rates and radiologist performance, in relation to volumes of mammograms interpreted. The results from this study, Organized Breast Screening Programs in Canada: Effect of Radiologist Reading Volumes on Outcomes, were published in Radiology: Volume 238: Number 3, (809- 815) - March, 2006.

The working group concluded that cancer detection did not vary with reading volume. The average Positive Predictive Value (PPV) for individual radiologists improved as reading volume rose up to 2,000 mammograms per year; it stabilized at higher volumes. In North America required volumes are comparatively low, at 480 mammograms per year, compared with the 2,000 mammograms required in Australian screening programs and 5,000 mammograms required in United Kingdom Screening Programs Radiology: Volume 238: Number 3, (810) - March, 2006.

The Nova Scotia Breast Screening Program utilized the 3,000 case reading volume as its guideline from the beginning of the program in 1991. Based on NSBSP outcome results and a British Columbia study Standardized Abnormal Interpretation and Cancer Detection Ratios to Assess Reading Volume and Reader Performance in a Breast Screening Program; Radiology 2000; 215: 563-567, NSBSP lowered the reading volume recommendation to 2,500 per year in the year 2000. Future recommendations for NSBSP policy change in this area will be based on further NSBSP analysis.
7.3 Double Read System

Since the beginning of the program every tenth screening mammogram has been selected for a second interpretation by a different radiologist. These cases are computer selected and this process requires that these images be re-read following reporting sessions. Radiologist scheduling must be taken into consideration to avoid delays. In addition to this formal approach, an unofficial double read system has been encouraged and may include peer review at a different hospital. Although this is work intensive for the entire NSBSP team, it has been done with the notion that it decreased work-up rates and is in the best interest of the clients. A study was conducted in 2012 that examined the outcomes from double read cases. Results from the study found:

- Double reading of screening mammograms resulted in increased work ups in all age groups regardless of screen order or technology
- Double reading also resulted in increased cancer detection in women aged 50-69
- Double reading may be more beneficial in certain subgroups (Subsequent screens or women aged 50-59) of the screening population to help increase cancer detection without adding too many additional workups
- Limited data on “digital only mammography” demonstrates trends consistent with those seen in the full data set

7.4 Annual Radiologist Mailing

Each year radiologists associated with the program receive feedback containing their individual cancer detection rates and positive predictive values from the previous year. They also receive combined results for their site as well as the province as a whole. In this way the learning curve trends inherent to the interpretation of screening mammography are directly shared, and can be monitored by each screener for enhancement of results. These ‘report cards’ also serve as a self improvement tool for radiologists.

7.5 New Clinical Breast Exam Policy

After consulting with the appropriate stakeholders in Nova Scotia, respective breast screening programs across Canada, and synthesizing evidence from research literature, the NSBSP is recommending the discontinuation of modified clinical breast exams in conjunction with screening mammography in Nova Scotia as of January 1st, 2015.

The decision to discontinue clinical breast exams as part of a screening mammography visit will align Nova Scotia with the overwhelming majority of provincial breast screening programs in Canada.
The NSBSP Advisory Council (NSBSP-AC) supports a coordinated, provincial approach to breast imaging by reducing variability in service delivery and practice approaches, improving the uptake of standards and guidelines, and enhancing cooperation in improving identified health outcomes across the continuum. The terms of reference for the NSBSP-AC can be found in Appendix A.

With the reconvening of the Nova Scotia Breast Screening Program Advisory Council (NSBSP-AC) in 2013, the NSBSP-AC identified the need to update the current vision and mission of the NSBSP and develop a strategic plan to provide a framework for planning and decision-making for the next five years.

In August 2013, NSBSP staff and selected members of the NSBSP-AC came together with a consultant (termed the planning working group) to discuss the development of a strategic plan for the Program. A meeting was convened in October 2013 with the NSBSP-AC to adapt/revamp the vision and mission of the Program and to develop strategic directions and outcomes.

The strategic plan for the NSBSP is a document that will be reviewed and updated on an ongoing basis. While the current strategic plan serves as a strong foundation for the NSBSP, it will evolve based on evaluation, new evidence, and the changing landscape and realities within Nova Scotia.

A final report presenting the NSBSP Strategic Plan including the framework, strategic directions, and outcomes has been drafted and is in the final stages of acceptance by the NSBSP-AC. At subsequent NSBSP-AC meetings, objectives will be developed and prioritized for each of the strategic directions.

The finalized strategic plan will be included as an appendix in the 2016 Annual Report.
9 Core Business Functions

9.1 Population Health

Increasing the number of mammography facilities (capacity) and standardizing a mammography service province-wide to provide relevant research material for responsible health care reform

9.1.1 Mortality Rates

The most recent actual data for 2014 showed the breast cancer mortality rate in countries with “organized” breast screening programs to be at its lowest since 1950. Since 2000, incident rates for breast cancer have stabilized and death rates have declined at a rate of 2.4% annually. There is evidence for improved survival due to the organized mammography screening programs detecting cancer earlier and advances in adjuvant therapies following breast cancer surgery. National Cancer Institute of Canada: Canadian Cancer Statistics 2014.

Decreased mortality of breast cancer requires early detection of the disease as well as prompt and appropriate treatment. For 2014, it is reported that there will be an estimated 24,400 new cases of female breast cancer and 5,000 deaths in Canada. In Nova Scotia for 2014, it is estimated that there will be 760 new cases of breast cancer and 130 deaths. Breast cancer is the most common cancer and most common cause of death among females aged 30-49, accounting for 25% of cancer diagnoses and 16% of cancer deaths. Cancer Institute of Canada: Canadian Cancer Statistics, 2014.

During their lifetimes, 1 in 9 women (11%) are expected to develop breast cancer, and 1 in 30 (3.3%) are expected to die from it. Only 30% of breast cancers are diagnosed at age 70 or older, 52% between ages 50 and 69 and 18% under age 50. Amongst all cancer survivors that had been diagnosed with cancer within the previous 10 years, 1% of them are female survivors of breast cancer. Presently 1.0% of females are survivors of breast cancer diagnosed within the previous 15 years. Canadian Cancer Society/National Cancer Institute of Canada: Canadian Cancer Statistics, 2014.

For 2014 estimated age standardized incidence rates for breast cancer in Nova Scotia are 101/100,000 with an estimated 760 new cases. In 2010, actual data reported 720 new cases for an actual age-standardized incident rate of 103/100,000. Incidence is increasing due to the implementation of breast screening programs and greatly improved methods of data collection both of which NSBSP has been active in developing and promoting.

The estimated age standardized mortality rate for Nova Scotia for 2014 is now the lowest in Canada at 14/100,000 based on 130 estimated deaths. Actual data for the age standardized mortality rate for breast cancer in Nova Scotia for the year 2009 was 20/100,000, a decrease from the actual rate of 25/100,000 in 2002. There were 150 deaths recorded in Nova Scotia in 2009.

In Canada in 2009 there were 94,700 Potential Years of Life Lost (PYLL) due to breast cancer (16.6% of all causes of PYLL) compared to 94,200 in 2002. With regard for the most common cancers in women and men, the PYLL from breast cancer far exceeded the PYLL from prostate cancer (35,600) reflecting the relatively young age that women die from breast cancer. Canadian Cancer Statistics 2014.

The five year relative survival ratio for breast cancer cases diagnosed 2006 to 2008 in Canada was 88% (87% in Nova Scotia). Cancer Institute of Canada: Canadian Cancer Statistics 2014. On average, fourteen Nova Scotia women will be diagnosed with breast cancer every week. On average, three Nova Scotia women will die of breast cancer every week. Canadian Cancer Statistics 2014.

9.2 Database Surveillance and Evaluation

Providing quality assessment and provincial outcomes
9.2.1 Nova Scotia Mammography Database

Central Mammography Booking Database (CMB): Includes (1) screening and (2) diagnostic booking and follow-up modules

1. NSBSP Database: Includes self referred bookings for asymptomatic women ages 40 to 69 and over age 70 (if otherwise in good health). *The Canadian Association of Radiologist’s Guidelines for Screening Mammography.*

2. Diagnostic Mammography Database (DMB): An improved diagnostic database which has been designed to complement the NSBSP database and to provide one provincially standardized diagnostic mammography reporting module with upgraded services. Presently it is in use at the IWK Women’s Health Centre in Halifax, Cape Breton Regional Hospital (CBRH) in Sydney, Dartmouth General Hospital (DGH) in Dartmouth, South Shore Regional Hospital in Bridgewater, Aberdeen Hospital in New Glasgow, Yarmouth Regional Hospital in Yarmouth and Cumberland Hospital in Amherst.

In 2015 the NSBSP rolled out significant modifications to both the registration and technologist components of the existing Mammography Information System (MIS) and the Diagnostic Reporting System (DRS) which has been renamed Breast Imaging System (BIS). These modifications have improved user accessibility, standardization and work flow. Work is currently underway of to modify the radiologist reporting sections for both screening and diagnostic as well work has started on interfacing this new system to the hospital information system. This is expected to be completed in 2016.

The NSBSP guidelines for booking both screening and diagnostic breast imaging are included as Appendix B. A draft copy of the new diagnostic mammography requisition which must be correctly filled out and faxed to CMB by the referring physician (office), is included as Appendix C.

If resources are allocated for data collection and outcome analysis, it will promote the best possible quality initiatives, staff performance and results at all levels. Timely annual report production has been a significant NSBSP accomplishment, made possible by aggressive NSBSP database development. This has resulted in a yearly effort to close the books on cases, and has also provided organized safe-guards for women to prevent cases from falling through cracks in the healthcare system.

Cumulative, annual and biennial figures and charts are contained in this report. Target age group (50-69) numbers are used when calculating Program Indicators, but other charts and figures include women outside the NSBSP targeted age group. The NSBSP database also ensures that every tenth mammogram has been blind read by a second radiologist. In 2014, 13 women were classified as “Lost to follow-up”, and 12 women with abnormal screening reports refused one or more recommended follow-up procedures, resulting in a status of “Refused”.

From the beginning of the program in 1991, there have been 100 women “Lost to Follow-up” and 111 have “Refused” recommended work-up procedures. These women are therefore classified as non-compliant and are categorized appropriately for the particular screening episode. These cases have been reviewed at NSBSP team approach rounds and many have since undergone subsequent re-screening or diagnostic mammography.

Quality is the key word for successful breast cancer screening. Without a reliable database, the organization is extremely difficult. Providers of screening have a responsibility to insist that the program be well organized. If done properly, the cost-benefit analysis will reveal a reasonable cost per screen and cost per cancer detected.

9.3 Education

Promoting awareness of service availability, breast screening guidelines and the Clinical Practice Guidelines for the Care and Treatment of Breast Cancer
9.3.1 The Nova Scotia Breast Screening Program Website

The Nova Scotia Breast Screening website, accessible at breastscreening.nshealth.ca, contains a wealth of information for the general public including background information on the program, program guidelines, various quality initiatives, and information on the screening sites that are part of the program including contact information. Also included on the site are links to the mobile van schedule (always kept current) and various statistics including Nova Scotia Annual Statistics, NSBSP Annual Reports, and Public Health Agency of Canada Biennial Reports.

The NSBSP website experienced a major update in the summer of 2011. A fresh design and an intuitive layout of content has improved the functionality and feel of the site.
10 Performance Indicators

In order to achieve reductions in breast cancer mortality and morbidity and to minimize undesirable effects of breast screening, the delivery of organized screening must be of high quality. Performance Measures and Targets were selected on the basis of assessing program progress toward desired goals. The eleven performance indicators met the following criteria:

- data for the measure was regularly available
- data available for the measure was of high quality
- meaningful targets could be defined on an evidentiary basis
- measures and targets would be useful for national comparison
- monitoring on an annual basis would be valuable
- each measure was widely accepted for use in program evaluation

A routine biennial report is produced at the national level using data from the Canadian Breast Cancer Screening Database (CBCSD). Although there are many differences in the manner in which the provinces have set up their individual programs, this monitoring role provides useful feedback and comparisons, as well as a mechanism to share processes and provide definitions. The targets set have provided goals and formats for the ten differently structured provincial breast screening programs in the interest of producing more standardized provincial data reports. In 2006, the Evaluation Indicators Working Group, a sub-committee of the Canadian Breast Cancer Screening Initiative published the document “Guidelines for Monitoring Breast Screening Program Performance”, second edition. A list of eleven performance indicators and definitions can be seen in section 10.1.

The NSBSP Performance Indicators for 2011, 2012, 2013 and 2014 plus the Canadian Breast Screening Database Indicators, most recently available for the combined years of 2007 and 2008 can be seen in Table 10.1. All Program Indicators are for the target age group (50-69). More information on each indicator can be found on the specified pages.

Additional imaging and interventional indicators are being looked at by some provinces as an overall client-based service delivery measure and program quality exercise. “Future methods should be directed toward developing new screening methods as well as methods of improving the sensitivity and specificity of mammography. Methods of reducing surgical biopsy rates and complications of treatment should also be studied, as should communication of the risks and benefits associated with screening.” Ann Intern Med, 2002; 137:347-360.

10.1 Definitions

**Participation Rate:** Percentage of women who have a screening mammogram (calculated over a 30-month period) as a proportion of the eligible population (section [10.2.1])

**Retention Rate:** Estimated percentage of women who are re-screened within 30 months of their previous screen (section [10.2.2])

**Abnormal Call Rate:** Percentage of women screened referred for further testing because of abnormalities found with a program screen (section [10.2.3])

**Invasive Cancer Detection Rate:** Number of invasive cancers detected per 1,000 women screened (section [10.2.4])

**In Situ Cancer Detection Rate:** Number of ductal carcinoma in situ (DCIS) cancers (rather than invasive cancer) during a screening episode per 1,000 women screened (section [10.2.5])
Diagnostic Interval:  *Total duration from abnormal screen to resolution of abnormal screen* (section 10.2.6)

Positive Predictive Value: *Proportion of abnormal cases with completed follow-up found to have breast cancer (invasive or in situ) after diagnostic work-up* (section 10.2.7)

Benign to Malignant Open Biopsy Ratio: *Among open biopsies, the ratio of number of benign cases to the number of malignant cancer cases* (section 10.2.8)

Invasive Cancer Tumor Size: *Percentage of invasive cancers with tumor size of <10mm and < 15mm in greatest diameter as determined by the best available evidence: 1) pathological*, 2) radiological, 3) clinical (section 10.2.9)*

* (> 99.9% of tumor sizes input into NSBSP database are pathological)

Node Negative Rate in Cases of Invasive Cancer: *Proportion of invasive cancers in which the cancer has not invaded the lymph nodes* (section 10.2.10) **

** For Nova Scotia this figure also includes node negative cases of DCIS. Although rare, surgical pathology reports of DCIS can have positive node pathology.

Post Screen Detected Invasive Cancer Rate: *Number of women with a diagnosis of invasive breast cancer after a normal screening within 12 and 24 months of the screen date for women screened on an annual or biennial basis respectively*

10.2  Indicators (National and Provincial)

Table 10.1 presents both the national provincial performance indicators.

10.2.1 Participation Rate

*Percentage of women who have a screening mammogram (calculated over a 30-month period) as a proportion of the eligible population*

Target: ≥ 70% of the target population

The NSBSP participation rate for the timeframe of 2013 - 2014 was 55.38% of the target population in Nova Scotia.

Over the past year there was a biennial participation rate change of -0.14%. In the same time-frame the number of screens decreased by -0.3%, compared to a -1.1% decrease one year ago. The actual number of women screen has decreased from 78245 to 78048 in the past year.
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</tr>
</thead>
<tbody>
<tr>
<td>Number of screens</td>
<td>N/A</td>
<td>2371837</td>
<td>45005</td>
<td>42128</td>
<td>41436</td>
<td>41819</td>
</tr>
<tr>
<td>Number of 1st screens</td>
<td>N/A</td>
<td>443608</td>
<td>2540</td>
<td>1997</td>
<td>1949</td>
<td>2484</td>
</tr>
<tr>
<td>Number of cancers</td>
<td>N/A</td>
<td>11073</td>
<td>218</td>
<td>211</td>
<td>216</td>
<td>273</td>
</tr>
<tr>
<td>Participation Rate</td>
<td>&gt;70% of the eligible population</td>
<td>53.2%</td>
<td>58.79%</td>
<td>57.13%</td>
<td>55.52%</td>
<td>55.38%</td>
</tr>
<tr>
<td>Retention Rate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1st screen</td>
<td>&gt;75% re-screened within 30 months</td>
<td>68.7%</td>
<td>57.4%</td>
<td>52.2%</td>
<td>56.5%</td>
<td>53.6%</td>
</tr>
<tr>
<td>Re-screen</td>
<td>&gt;90% re-screened within 30 months</td>
<td>82.4%</td>
<td>81.4%</td>
<td>80%</td>
<td>86%</td>
<td>84.3%</td>
</tr>
<tr>
<td>Abnormal Screen Rate</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>1st screen</td>
<td>&lt;10% of screens reported as abn</td>
<td>13.2%</td>
<td>13.1</td>
<td>15.3</td>
<td>16.3</td>
<td>14.8</td>
</tr>
<tr>
<td>Re-screen</td>
<td>&lt;5% of screens reported as abn</td>
<td>6.3%</td>
<td>4.8</td>
<td>5.2</td>
<td>5.4</td>
<td>5</td>
</tr>
<tr>
<td>Invasive Cancer Rate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1st screen</td>
<td>&gt;5 per 1000</td>
<td>4.5</td>
<td>6.3</td>
<td>11.02</td>
<td>11.29</td>
<td>10.87</td>
</tr>
<tr>
<td>Re-screen</td>
<td>&gt;3 per 1000</td>
<td>3.6</td>
<td>3.6</td>
<td>3.56</td>
<td>3.93</td>
<td>4.96</td>
</tr>
<tr>
<td>In Situ cancer Rate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1st screen</td>
<td>Surveillance and Monitoring Only</td>
<td>1.1</td>
<td>1.97</td>
<td>1</td>
<td>3.08</td>
<td>2.01</td>
</tr>
<tr>
<td>Re-screen</td>
<td>per 1000 screens</td>
<td>0.8</td>
<td>0.94</td>
<td>0.92</td>
<td>0.86</td>
<td>1.07</td>
</tr>
<tr>
<td>Diagnostic Interval</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No open biopsy</td>
<td>&gt;90% within 5 weeks (no tissue bx)</td>
<td>77.7%</td>
<td>84.3%</td>
<td>89.6%</td>
<td>76.5%</td>
<td>78.7%</td>
</tr>
<tr>
<td>With open biopsy</td>
<td>&gt;90% within 7 weeks (with tissue bx)</td>
<td>52.2%</td>
<td>57.4%</td>
<td>69.4%</td>
<td>67.9%</td>
<td>62.8%</td>
</tr>
<tr>
<td>Positive Predictive Rate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1st screen</td>
<td>&gt;5% of abn screens</td>
<td>4.4%</td>
<td>6.6%</td>
<td>8.5%</td>
<td>8.8%</td>
<td>8.7%</td>
</tr>
<tr>
<td>Re-screen</td>
<td>&gt;6% of abn screens</td>
<td>7.2%</td>
<td>9.5%</td>
<td>9%</td>
<td>8.9%</td>
<td>12.4%</td>
</tr>
<tr>
<td>B : M open biopsy ratio</td>
<td>&lt;1:1 initial screen open biopsies</td>
<td>2.6 : 1</td>
<td>0.2 : 1</td>
<td>0 : 1</td>
<td>0.1 : 1</td>
<td>0.1 : 1</td>
</tr>
<tr>
<td></td>
<td>&lt;1:1 re-screen open biopsies</td>
<td>1.6 : 1</td>
<td>0.1 : 1</td>
<td>0.1 : 1</td>
<td>0.2 : 1</td>
<td>0.1 : 1</td>
</tr>
<tr>
<td>Invasive ca tumor size</td>
<td>&gt;25% &lt; 10mm</td>
<td>25%</td>
<td>40.38</td>
<td>41.79</td>
<td>33.97</td>
<td>42.64</td>
</tr>
<tr>
<td></td>
<td>&gt;50% &lt; 15mm</td>
<td>50%</td>
<td>60.4%</td>
<td>62.91</td>
<td>63.18</td>
<td>63.16</td>
</tr>
<tr>
<td>Node negative cancers</td>
<td>&gt;70% node negative</td>
<td>75.3</td>
<td>78</td>
<td>84</td>
<td>81</td>
<td>84</td>
</tr>
</tbody>
</table>
Table 10.2: Performance Indicators under review (ages 50-69)

<table>
<thead>
<tr>
<th></th>
<th>Canada</th>
<th>Nova Scotia</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2003+04</td>
<td>2011</td>
</tr>
<tr>
<td>Benign open biopsy rate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1st screen</td>
<td>Surveillance and monitoring per 1,000 screens</td>
<td>4.5</td>
</tr>
<tr>
<td>Re-screen</td>
<td>Surveillance and monitoring per 1,000 screens</td>
<td>2.6</td>
</tr>
<tr>
<td>B : M ratio - direct to open bx</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surveillance and monitoring</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1st screen</td>
<td>1.7 : 1</td>
<td>1 : 1</td>
</tr>
<tr>
<td>Benign core biopsy rate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1st screen</td>
<td>Surveillance and monitoring per 1000 screens</td>
<td>11.6</td>
</tr>
<tr>
<td>re-screen</td>
<td>Surveillance and monitoring per 1000 screens</td>
<td>4.7</td>
</tr>
<tr>
<td>B : M core bx ratio</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1st screen</td>
<td>Surveillance and monitoring</td>
<td>2.8 : 1</td>
</tr>
<tr>
<td>re-screen</td>
<td>Surveillance and monitoring</td>
<td>1.5 : 1</td>
</tr>
</tbody>
</table>

*Captured by the province of Nova Scotia only, to obtain a quality performance indicator for facilities in this province where breast surgery is performed*
The most frequent “self-reported” reason for participation in NSBSP continues to come from recommendations for regular mammography screening by family physicians. This strongly supports the Program’s decision to focus promotional funding on increasing physician awareness of early detection by mammography screening and the associated cost benefit. Of interest as well, is the fact that the most common reason for Gynacological Screening is due to reminders by NSBSP, at the time of breast screening examinations.

In 2013, 10.2% of women screened were over age 69. This remained at 10.2% in 2014. In 1997, 4% of NSBSP’s clientele were over the age of 69. Following policy change in 1998 to accept these women into the program (but not send them reminder letters) these figures have been watched carefully for the resulting affect on program capacity, as it increasingly affects available bookings for the target age group of 50-69. However, many in this group had started with the program when in the target age group and if still asymptomatic, should not need to have examinations in and tie up the diagnostic system. After age 70, screening mammography is recommended if a women’s life expectancy is anticipated to be ten years or more. The NSBSP is currently reviewing its policy on reminder notices with an eye to extending this practice to women 70-74.

In the initial six months of the program the policy to not accept the 40-49s was clearly not enforced and 20% of women attending were in this age group. However, physicians and women in their 40s lobbied strongly in an effort for them to officially become part of the program. Following a relatively high cancer detection rate and a high number of node positive cases seen in this group in 1992, it was decided to change policy and accept these women in order to provide organized outcomes for this younger group for whom surveillance and monitoring should also occur. If this had not been done, they also would have continued to have screening mammography in the diagnostic mode, resulting in unnecessary appointments in the diagnostic sector, increase cost to the health care system, and no tracking of outcomes. In 1995, it officially became policy to send recall letters to these younger women using the annual screen protocol.

In 2014, 25.6% of NSBSP participants were aged 40-49.

The commitment of the Nova Scotia Department of Health & Wellness to the Nova Scotia Breast Screening Program has resulted in linear increases in participation rates. Support given by the Department of Health & Wellness toward provision of a truly comprehensive, provincial mammography program continues to be apparent. For the two year period of 2013 and 2014, there were 78048 (Table 10.3) screening mammograms performed through the NSBSP on women in the target age group.
Figure 10.1: NSBSP Biennial Participation (ages 50-69)
Table 10.3: NSBSP Biennial Participation Rate and Trend by District Health Authority ages 50-69

<table>
<thead>
<tr>
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<tr>
<td>Unknown</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>206</td>
</tr>
<tr>
<td>1 South Shore</td>
<td>10229</td>
<td>55.3%</td>
<td>55.07%</td>
<td>52.3%</td>
<td>52.16%</td>
<td>-0.15%</td>
<td>5335</td>
</tr>
<tr>
<td>2 SW Nova</td>
<td>9364</td>
<td>61.47%</td>
<td>59.94%</td>
<td>57.18%</td>
<td>54.31%</td>
<td>-2.86%</td>
<td>5086</td>
</tr>
<tr>
<td>3 Annapolis Valley</td>
<td>12927</td>
<td>54.47%</td>
<td>53.09%</td>
<td>51.27%</td>
<td>49.64%</td>
<td>-1.63%</td>
<td>6417</td>
</tr>
<tr>
<td>4 Colchester E. Hants</td>
<td>10631</td>
<td>63.29%</td>
<td>55%</td>
<td>51.76%</td>
<td>51.13%</td>
<td>-0.63%</td>
<td>5436</td>
</tr>
<tr>
<td>5 Cumberland</td>
<td>5100</td>
<td>53.95%</td>
<td>54.95%</td>
<td>51.8%</td>
<td>52.18%</td>
<td>0.37%</td>
<td>2661</td>
</tr>
<tr>
<td>6 Pictou</td>
<td>7400</td>
<td>57.07%</td>
<td>56.39%</td>
<td>56.74%</td>
<td>55.45%</td>
<td>-1.3%</td>
<td>4103</td>
</tr>
<tr>
<td>7 Guys/Ant</td>
<td>7175</td>
<td>54.46%</td>
<td>56%</td>
<td>55.32%</td>
<td>55.65%</td>
<td>0.33%</td>
<td>3993</td>
</tr>
<tr>
<td>8 Cape Breton</td>
<td>19820</td>
<td>54.71%</td>
<td>52.5%</td>
<td>50.91%</td>
<td>50.8%</td>
<td>-0.11%</td>
<td>10069</td>
</tr>
<tr>
<td>9 Capital</td>
<td>58277</td>
<td>61.49%</td>
<td>60.3%</td>
<td>59.06%</td>
<td>59.62%</td>
<td>0.55%</td>
<td>34742</td>
</tr>
<tr>
<td>Total</td>
<td>140923</td>
<td>58.79%</td>
<td>57.13%</td>
<td>55.52%</td>
<td>55.38%</td>
<td>-0.14%</td>
<td>78048</td>
</tr>
</tbody>
</table>

*The 2013 population estimates (data modelled from Statistics Canada) places the number of woman aged 50-69 at 140923, up from 2012 estimates of 137373
Table 10.4 contains in addition to data in Table 10.3 diagnostic data from facilities booking diagnostic mammography using the Central Mammography Booking Database. The data presented in Table 10.4 shows 85462 women having at least one bilateral mammogram in a two year period at either a screening or diagnostic site. The resulting mammography participation rate is 60.64% a change of 0% over 2013.

Italicized numbers in column three, indicate numbers of women by DHA having had a bilateral diagnostic examination outside the screening program, and who have not already had a screening mammogram in the same year. The majority of Nova Scotia hospitals are effectively channelling appropriate screening cases to the program mode and six have implemented the provincial diagnostic reporting system. Breast Imaging performed in diagnostic centers must be ordered by faxed requisition or ordered proactively. “Diagnostic” bookings comprise symptomatic cases, abnormal screen work-ups, women with previous breast cancer, and short term follow-up cases following core biopsy, surgery or previous mammography. See Appendices B and C.

Figure 10.2: 2013/2014 Combined Provincial Mammography Participation Rates per DHA (ages 50-69)

Table 10.5 has in addition to data in Table 10.3 the cancer detection rate of surgically removed cancers
by district.

It is important to remember that the cancer rates in Table 10.5 do not reflect the overall provincial cancer detection rates. These figures include only findings from the Nova Scotia Breast Screening Program database and represent approximately two-thirds of the annual cancer detections in this province.

Table 10.6 is similar to Table 10.4 except for the addition of the ages 40 to 49. This age group (recalled on an annual basis, although not actively recruited) is accepted by NSBSP for purposes of data collection and other benefits available only through the organized program. In Table 10.6 it can be seen the provincial screening plus diagnostic participation rate when including the 40-49 age group for 2014 is 58.43% (59.61% one year ago). Analysis of data on women under age 50 is now possible when reporting is done through the provincial diagnostic database.

### 10.2.2 Retention Rate

*Estimated percentage of women who are re-screened within 30 months of their previous screen*

**Target:**

<table>
<thead>
<tr>
<th>Initial Screen</th>
<th>Re-screen</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥ 75% re-screened within 30 months</td>
<td>≥ 90% re-screened within 30 months</td>
</tr>
</tbody>
</table>

NSBSP Retention rates for this report are calculated on the number of eligible women that have returned to the program for a subsequent screen within 30 months of their previous screen if aged 50-69 and 18 months for ages 40-49. Women over the age of 69 are not included in this calculation as they are accepted into the program but are not sent reminders. Optimal benefits of screening are brought about by regular participation in the screening program (at least every 2 years). At present there is no indication that the benefits of screening are lost if rescreening occurs up to 6 months after the recommendation interval. "Guidelines for monitoring Breast Screening Performance" Second Edition Aug 2007 page 8.
Figure 10.3: Retention Rates by Year (ages 50-69)
Table 10.4: Diagnostic and Screen Biennial Participation Rates ages 50-69

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Unknown</td>
<td>-</td>
<td>648</td>
<td>854</td>
<td>648</td>
<td>854</td>
</tr>
<tr>
<td>1 South Shore Regional</td>
<td>10229</td>
<td>584</td>
<td>5919</td>
<td>60.9%</td>
<td>57.8%</td>
</tr>
<tr>
<td>3 Yarmouth Regional</td>
<td>9364</td>
<td>555</td>
<td>5641</td>
<td>65.1%</td>
<td>62.8%</td>
</tr>
<tr>
<td>3 Valley Regional</td>
<td>12927</td>
<td>48</td>
<td>6465</td>
<td>57.4%</td>
<td>51.7%</td>
</tr>
<tr>
<td>4 Colchester Regional</td>
<td>10631</td>
<td>116</td>
<td>5552</td>
<td>57.9%</td>
<td>52.9%</td>
</tr>
<tr>
<td>5 Cumberland Regional</td>
<td>5100</td>
<td>230</td>
<td>2891</td>
<td>59.9%</td>
<td>56.2%</td>
</tr>
<tr>
<td>6 Aberdeen</td>
<td>7400</td>
<td>414</td>
<td>4517</td>
<td>61.7%</td>
<td>62.2%</td>
</tr>
<tr>
<td>7 St. Martha’s</td>
<td>7175</td>
<td>64</td>
<td>4057</td>
<td>59.1%</td>
<td>56.1%</td>
</tr>
<tr>
<td>8 Cape Breton Health Care</td>
<td>19820</td>
<td>1375</td>
<td>11444</td>
<td>59.3%</td>
<td>57.8%</td>
</tr>
<tr>
<td>9 QEII HSC and DGH</td>
<td>58277</td>
<td>3380</td>
<td>38122</td>
<td>66.2%</td>
<td>64.9%</td>
</tr>
<tr>
<td>Total</td>
<td>140923</td>
<td>7414</td>
<td>85462</td>
<td>63.01%</td>
<td>60.73%</td>
</tr>
</tbody>
</table>

<sup>a</sup>The 2013 population estimates (data modelled from Statistics Canada) places the number of women aged 50-69 at 140923, up from 2012 estimates of 138373
### Table 10.5: 30-Month Participation and Cancer Detection Rate by District ages 50-69

<table>
<thead>
<tr>
<th>District Health Authority (DHA)</th>
<th>Target Population</th>
<th>Women Screened</th>
<th>Participation rate</th>
<th>Invasive Cancers</th>
<th>In situ Cancers</th>
<th>All Cancers</th>
<th>Cancer Rate per 1000 women screened</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unknown District</td>
<td>-</td>
<td>206</td>
<td></td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>7.3</td>
</tr>
<tr>
<td>1 South Shore</td>
<td>10229</td>
<td>5335</td>
<td>52.16%</td>
<td>33</td>
<td>6</td>
<td>39</td>
<td>7.1</td>
</tr>
<tr>
<td>2 South West Nova</td>
<td>9364</td>
<td>5086</td>
<td>54.31%</td>
<td>34</td>
<td>2</td>
<td>36</td>
<td>7.1</td>
</tr>
<tr>
<td>3 Annapolis Valley</td>
<td>12927</td>
<td>6417</td>
<td>49.64%</td>
<td>42</td>
<td>3</td>
<td>45</td>
<td>7</td>
</tr>
<tr>
<td>4 Colchester E. Hants</td>
<td>10631</td>
<td>5436</td>
<td>51.13%</td>
<td>41</td>
<td>9</td>
<td>50</td>
<td>9.2</td>
</tr>
<tr>
<td>5 Cumberland</td>
<td>5100</td>
<td>2661</td>
<td>52.18%</td>
<td>29</td>
<td>3</td>
<td>32</td>
<td>12</td>
</tr>
<tr>
<td>6 Pictou County</td>
<td>7400</td>
<td>4103</td>
<td>55.45%</td>
<td>25</td>
<td>2</td>
<td>27</td>
<td>6.6</td>
</tr>
<tr>
<td>7 Guysborough / Antig</td>
<td>7175</td>
<td>3993</td>
<td>55.65%</td>
<td>24</td>
<td>7</td>
<td>31</td>
<td>7.8</td>
</tr>
<tr>
<td>8 Cape Breton</td>
<td>19820</td>
<td>10069</td>
<td>50.8%</td>
<td>65</td>
<td>7</td>
<td>72</td>
<td>7.2</td>
</tr>
<tr>
<td>9 Capital</td>
<td>58277</td>
<td>34742</td>
<td>59.62%</td>
<td>232</td>
<td>65</td>
<td>297</td>
<td>8.5</td>
</tr>
<tr>
<td>Total</td>
<td>140923</td>
<td>78048</td>
<td>55.38%</td>
<td>525</td>
<td>104</td>
<td>629</td>
<td>8.1</td>
</tr>
</tbody>
</table>

*The 2013 population estimates (data modelled from Statistics Canada) places the number of women aged 50-69 at 140923, up from 2012 estimates of 138373.*
Table 10.6: Diagnostic and Screen Biennial Participation Rates ages 40-69

<table>
<thead>
<tr>
<th>Diagnostic Mammography Facilities by DHA</th>
<th>Target Population</th>
<th>Biennial Mammograms</th>
<th>Biennial Participation Rates</th>
<th>Combined Participation Rates</th>
<th>Combined Participation Rates</th>
<th>Combined Participation Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unknown</td>
<td>-</td>
<td>1123</td>
<td>334</td>
<td>56.2%</td>
<td>54.2%</td>
<td>53.4%</td>
</tr>
<tr>
<td>1 South Shore Regional</td>
<td>14354</td>
<td>961</td>
<td>7672</td>
<td>61%</td>
<td>59.3%</td>
<td>55.7%</td>
</tr>
<tr>
<td>2 Yarmouth Regional</td>
<td>13514</td>
<td>1026</td>
<td>7528</td>
<td>58%</td>
<td>57.2%</td>
<td>54.3%</td>
</tr>
<tr>
<td>3 Valley Regional</td>
<td>18522</td>
<td>1938</td>
<td>10065</td>
<td>57.3%</td>
<td>55.4%</td>
<td>54.3%</td>
</tr>
<tr>
<td>4 Colchester Regional</td>
<td>16024</td>
<td>1297</td>
<td>8700</td>
<td>55.1%</td>
<td>53.7%</td>
<td>53.3%</td>
</tr>
<tr>
<td>5 Cumberland Regional</td>
<td>7190</td>
<td>487</td>
<td>3831</td>
<td>58.5%</td>
<td>58.5%</td>
<td>56.9%</td>
</tr>
<tr>
<td>6 Aberdeen</td>
<td>10557</td>
<td>757</td>
<td>6008</td>
<td>58.5%</td>
<td>58.5%</td>
<td>56.9%</td>
</tr>
<tr>
<td>7 St. Martha's</td>
<td>10089</td>
<td>830</td>
<td>5913</td>
<td>57.5%</td>
<td>58.1%</td>
<td>58.6%</td>
</tr>
<tr>
<td>8 Cape Breton Health Care</td>
<td>27706</td>
<td>2464</td>
<td>15222</td>
<td>58.3%</td>
<td>56%</td>
<td>54.9%</td>
</tr>
<tr>
<td>9 QEII HSC and DGH</td>
<td>90167</td>
<td>8136</td>
<td>56341</td>
<td>65%</td>
<td>63.5%</td>
<td>62.5%</td>
</tr>
<tr>
<td>Total</td>
<td>208123</td>
<td>19019</td>
<td>121614</td>
<td>61.04%</td>
<td>59.61%</td>
<td>58.43%</td>
</tr>
</tbody>
</table>

\(a\)The 2013 population estimates (data modelled from Statistics Canada) places the number of women aged 40-69 at 208123, up from 2012 estimates of 207909.
10.2.3 Abnormal Call Rate (%)

Percentage of women screened referred for further testing because of abnormalities found within a program screen

Targets: < 10% of 1st screens and < 5% of re-screens

Figure 10.4: Abnormal and PFNS Recall Rates by Reporting Group 2014 (ages 50-69)

In 2014, 2337 screens in the target age group were reported as abnormal (Table 10.7). Abnormal reporting rates were 5.6% overall (14.8% for 1st screens and 5% for re-screens). An additional 54 cases (Table 10.8) were reported based on clinical findings categorized as Physical Findings Not Seen or “PFNS”. This compares 53 a year ago and 50 in 2012. Generally the “PFNS” reporting selection is being used, but the number of reports is minimal and not always significant enough to reflect as a percentage in Figure 10.4.

There were 15692 women having 17978 core biopsies (by screen exam date) through NSBSP from 1991 until 2014 (2003 women had more than one core biopsy at different times or bilaterally). Of the 1317
Table 10.7: 2014 Abnormal call rates and cancer detection rates (50-69)

<table>
<thead>
<tr>
<th>Screens</th>
<th>n</th>
<th>Abnormal Reports</th>
<th>Abnormal Call Rate (%)</th>
<th>Abnormal Cancers</th>
<th>Cancer detection Rate/1000 Screens</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st</td>
<td>2484</td>
<td>368</td>
<td>14.8</td>
<td>32</td>
<td>12.9</td>
</tr>
<tr>
<td>Re-Screen</td>
<td>39335</td>
<td>1969</td>
<td>5</td>
<td>241</td>
<td>6.1</td>
</tr>
<tr>
<td>All</td>
<td>41819</td>
<td>2337</td>
<td>5.6</td>
<td>273</td>
<td>6.5</td>
</tr>
</tbody>
</table>

Table 10.8: 2014 Physical Finding Not Seen (PFNS) call rates and cancer detection rates (50-69)

<table>
<thead>
<tr>
<th>Screens</th>
<th>n</th>
<th>PFNS Reports</th>
<th>PFNS Call Rate (%)</th>
<th>PFNS Cancers</th>
<th>Cancer detection Rate/1000 Screens</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st</td>
<td>2484</td>
<td>7</td>
<td>0.28</td>
<td>1</td>
<td>0.4</td>
</tr>
<tr>
<td>Re-screen</td>
<td>39335</td>
<td>47</td>
<td>0.12</td>
<td>2</td>
<td>0.051</td>
</tr>
<tr>
<td>All</td>
<td>41819</td>
<td>54</td>
<td>0.13</td>
<td>3</td>
<td>0.072</td>
</tr>
</tbody>
</table>

core biopsies performed in 2014, 192 were indicated as being done using ultrasound guidance for positioning of the needle. The core biopsy program also collects core biopsy data by core biopsy date for separate studies unrelated to NSBSP annual outcomes. Additional core biopsy outcome data is shown in Table 10.11.

Tables 10.12 and 10.13 are included for use at the district level to provide a baseline for each District Health Authority and perhaps assist in reform at the district level. They include Nova Scotia Breast Screening database results only. Of importance are trends that possibly could become indicators for each district and assist in utilizing resources. NSBSP considers numbers and types of assessment tests to be helpful and relevant information for both provincial and district feedback. It is particularly useful for analyzing how health service providers apply the Clinical Practice Guidelines. These outcomes may be important at the provincial level to assist in providing continuous quality improvements to all services in place in both screening and diagnostic sites. It is hoped that this data may eventually be utilized to benefit women undergoing these procedures.

Table 10.9: 2014 Work-up Assessment (all ages)

<table>
<thead>
<tr>
<th>Assessment Tests</th>
<th>All</th>
<th>Assessment testing per all abnormal screens</th>
<th>Assessment testing per all screens</th>
<th>1st</th>
<th>Assessment testing per all abnormal screens</th>
<th>Assessment testing per all screens</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work-up ultrasounds</td>
<td>1833</td>
<td>46.23%</td>
<td>2.81%</td>
<td>483</td>
<td>57.84%</td>
<td>7.79%</td>
</tr>
<tr>
<td>Work-up mammograms</td>
<td>3563</td>
<td>89.86%</td>
<td>5.47%</td>
<td>719</td>
<td>86.11%</td>
<td>11.59%</td>
</tr>
<tr>
<td>Core Biopsies</td>
<td>1204</td>
<td>30.37%</td>
<td>1.85%</td>
<td>226</td>
<td>27.07%</td>
<td>3.64%</td>
</tr>
<tr>
<td>MRI</td>
<td>45</td>
<td>1.13%</td>
<td>0.07%</td>
<td>5</td>
<td>0.6%</td>
<td>0.08%</td>
</tr>
<tr>
<td>Women to surgery</td>
<td>444</td>
<td>11.2%</td>
<td>0.68%</td>
<td>58</td>
<td>6.95%</td>
<td>0.94%</td>
</tr>
</tbody>
</table>
Table 10.10: 2014 and Cumulative Core Biopsy Outcomes (all ages)

<table>
<thead>
<tr>
<th>OUTCOME</th>
<th>1991-2014</th>
<th></th>
<th></th>
<th>2014</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Stereo</td>
<td>U/S Guided</td>
<td>All</td>
<td>Stereo</td>
<td>U/S Guided</td>
<td>All</td>
</tr>
<tr>
<td>Benign</td>
<td>10401</td>
<td>1157</td>
<td>11558</td>
<td>681</td>
<td>117</td>
<td>798</td>
</tr>
<tr>
<td>Atypical/Suspicious</td>
<td>770</td>
<td>27</td>
<td>797</td>
<td>58</td>
<td>3</td>
<td>61</td>
</tr>
<tr>
<td>Cancer</td>
<td>3850</td>
<td>525</td>
<td>4375</td>
<td>320</td>
<td>57</td>
<td>377</td>
</tr>
<tr>
<td>Invasive</td>
<td>2792</td>
<td>498</td>
<td>3290</td>
<td>235</td>
<td>52</td>
<td>287</td>
</tr>
<tr>
<td>DCIS</td>
<td>994</td>
<td>18</td>
<td>1012</td>
<td>79</td>
<td>2</td>
<td>81</td>
</tr>
<tr>
<td>Lymphoma</td>
<td>10</td>
<td>8</td>
<td>18</td>
<td>0</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>LCIS</td>
<td>54</td>
<td>1</td>
<td>55</td>
<td>7</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Unsatisfactory</td>
<td>89</td>
<td>12</td>
<td>101</td>
<td>0</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Others</td>
<td>1002</td>
<td>90</td>
<td>1092</td>
<td>59</td>
<td>10</td>
<td>69</td>
</tr>
<tr>
<td>Total</td>
<td>16166</td>
<td>1812</td>
<td>17978</td>
<td>1125</td>
<td>192</td>
<td>1317</td>
</tr>
<tr>
<td>Benign:Malignant</td>
<td>2.7:1</td>
<td>2.2:1</td>
<td>2.6:1</td>
<td>2.1:1</td>
<td>2.1:1</td>
<td>2.1:1</td>
</tr>
</tbody>
</table>

*a*Includes unsuccessful and equivocal cases

*b*Results of atypia and LCIS are not included to determin B : M ratios

---

Table 10.11: 1991-2014 Core Biopsy and Definitive Surgery Outcomes

<table>
<thead>
<tr>
<th>Core Biopsy and Definitive Surgery Outcome</th>
<th>1991-2014</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malignant cores benign at surgery</td>
<td>29</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Malignant cores atypical or benign at surgery</td>
<td>23</td>
<td>0</td>
<td>3</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Malignant cores malignant at surgery</td>
<td>4230</td>
<td>323</td>
<td>307</td>
<td>275</td>
<td>356</td>
</tr>
<tr>
<td>Malignant cores - no definitive surgery</td>
<td>93</td>
<td>12</td>
<td>15</td>
<td>15</td>
<td>3</td>
</tr>
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<td>Benign cores benign at surgery</td>
<td>701</td>
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<td>35</td>
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<td>54</td>
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<td>Benign cores atypical or suspicious at surgery</td>
<td>112</td>
<td>6</td>
<td>9</td>
<td>16</td>
<td>8</td>
</tr>
<tr>
<td>Benign cores malignant at surgery</td>
<td>235</td>
<td>18</td>
<td>9</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Benign cores - no definitive surgery</td>
<td>10510</td>
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<td>777</td>
<td>799</td>
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<tr>
<td>Atypical or suspicious cores benign at surgery</td>
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<td>7</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>Atypical or suspicious cores atypical or suspicious at surgery</td>
<td>254</td>
<td>5</td>
<td>14</td>
<td>14</td>
<td>23</td>
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<td>Atypical or suspicious cores malignant at surgery</td>
<td>325</td>
<td>16</td>
<td>34</td>
<td>18</td>
<td>27</td>
</tr>
<tr>
<td>Atypical or suspicious cores - no definitive surgery</td>
<td>80</td>
<td>2</td>
<td>5</td>
<td>9</td>
<td>5</td>
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<tr>
<td>Unsatisfactory or others</td>
<td>1193</td>
<td>108</td>
<td>105</td>
<td>87</td>
<td>74</td>
</tr>
</tbody>
</table>

*a* Of the 29 cases (28 patients - one with two cores) that were malignant on core and benign on surgery

- 2 had chemotherapy prior to surgery
- 7 were invasive on core but benign on surgery. All were reviewed and determined that the core removed the cancer. These are staged as microinvasion.
- 17 were DCIS on core but benign on surgery. All were reviewed and determined that the core removed the DCIS. These are staged as DCIS.
- 2 was LCIS on core that went on to be benign on surgery
10.2.4 Invasive Cancer Detection Rate

*Number of women detected with invasive cancers during a screen episode per 1,000 women screened*

*Target: 1st screen > 5 per 1,000 screens  Re-screen > 3 per 1,000 screens*

Figure 10.5: Invasive Cancer Detection Rates per 1000 Screens 2014 (by age)

There were 293 cases of invasive breast cancer detected in 2014. Shown in ten year age groups above, 222, (76)% of these were in the 50-69 age group for a cancer detection rate overall of **4.5 per 1,000 screens**. Nova Scotia is higher than national targets of more than 5 per 1,000 (**10.9**) for first screens and 3 per 1,000 for re-screens (5). NS has seen an increase in the invasive cancer detection rate since the completion of the roll out of full field digital (FFD) mammography throughout the province in 2010. The rate of invasive breast cancer increases by age group for both initial screens and re Screens.
10.2.5 In Situ Desection Rate

Number of women detected with ductal carcinoma in situ (DCIS) cancer, rather than invasive cancer, during a screening episode per 1,000 women screened

Target: At present collected for surveillance and monitoring purposes only

Figure 10.6: In Situ Cancer Desection Rate per 1000 Screens 2014 (by age)

There were 67 cases of In Situ cancer detected in 2014. Of these, 47, (70%) were aged 50-69. The overall in situ cancer detection rate for this age group was 1 per 1,000 screens similar to the 1% rate at the national level. The Performance Indicator’s Working Group felt it inappropriate to set targets for DCIS due to lack of evidence of the transition of DCIS to invasive cancer and increasing sensitivities of screening techniques. In 2014, there were 7 cases of LCIS, 3 of which were between 50 and 69.
10.2.6 Diagnostic Interval

*Total duration from abnormal screen to resolution of abnormal screen*

**Target:**
1. > 90% within 5 weeks if no tissue biopsy
2. > 90% within 7 weeks if tissue biopsy

Figure 10.7: Abnormal Screen to Diagnosis - no biopsy (all ages)

In 2014, the NSBSP overall (i.e, for all age-groups) “Diagnostic Interval” shows 66.1% of abnormal screens having had no tissue biopsy, are at case completion after five weeks from screening. This is lower than the 75% overall nationally in 2005 and 2006. (Table 10.1).

In 2014 the overall (i.e, for all age-groups) Diagnostic Interval for women having had a tissue biopsy was 12.6%
Figures 10.8 and 10.7 demonstrate the diagnostic interval from abnormal screen to diagnosis with and without biopsy. Numbers of surgeries for which results were based are in Table 10.12 and are for screening cases only.
Figure 10.8: Abnormal Screen to Diagnosis - with biopsy (all ages)
10.2.7 Positive Predictive Value

Proportion of abnormal cases with completed follow-up found to have breast cancer (invasive or in situ) after diagnostic work-up

Target: 1st screens  > 5% of abnormal screens are cancer
Re-screen  > 6% of abnormal screens are cancer

Figure 10.9: High-Low Positive Predictive Values (ages 50-69)

Figure 10.9 demonstrates for the target age group, the individual highest and lowest as well as the average PPV for the indicated years.

As expected, PPV's are lower for the age 40-49 group where breast density is at times greater and can decrease the sensitivity of early detection (Figure 10.10). Initial results of FFDM are showing it to be very beneficial in this age group.
One international publication has stated that Positive Predictive Values (PPVs) for initial mammograms were as high as 37.5% in the Netherlands where corresponding recall was 1.4%, and as low as 5% in the United States where the corresponding recall was 15%. Cancer detection rates did not closely follow the pattern of recall rates. These differences may be influenced by factors including prevalence of cancer in the screening population, radiologist training, quality of the mammograms and fear of malpractice and legal outcomes. Report from the International Breast Cancer Screening Network (IBSN), Draft Paper 24 September 2003.

Since the beginning of the program, all participating radiologists have received a letter detailing their individual PPV, abnormal rate and cancer detection rate for both first and subsequent screens. Specialist radiologists detect more cancers, more early stage cancers, recommend less biopsies, and have lower recall rates than general radiologists. Performance Parameters for Screening and Diagnostic Mammography: Specialists and General Radiologists; Edward A Sickles MD, Dulcy E. Wolverton MD, and Katherine E Dee MD; RSNA, 2002.
Figure 10.10: High-Low Positive Predictive Values (ages 40-49)
Table 10.12: 2014 NSBSP Surgical Outcomes by District Health Authority (all ages)

<table>
<thead>
<tr>
<th>DHA</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>Unkn</th>
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<tr>
<td></td>
<td>Screen Exams</td>
<td>4620</td>
<td>4238</td>
<td>5315</td>
<td>4419</td>
<td>2100</td>
<td>3161</td>
<td>3197</td>
<td>7860</td>
<td>29940</td>
<td>272</td>
</tr>
<tr>
<td></td>
<td>Surgical Procedures</td>
<td>36</td>
<td>39</td>
<td>34</td>
<td>57</td>
<td>15</td>
<td>21</td>
<td>34</td>
<td>45</td>
<td>249</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Women to Surgery</td>
<td>29</td>
<td>34</td>
<td>32</td>
<td>40</td>
<td>12</td>
<td>17</td>
<td>27</td>
<td>40</td>
<td>210</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>B : M Ratio</td>
<td>1:3.8</td>
<td>1:7</td>
<td>1:30</td>
<td>1:10.3</td>
<td>1:11</td>
<td>1:3.7</td>
<td>1:11.5</td>
<td>1:6.8</td>
<td>1:8.7</td>
<td>1:3</td>
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<td></td>
<td>Cancer Det Rate</td>
<td>5</td>
<td>6.6</td>
<td>5.6</td>
<td>7</td>
<td>5.2</td>
<td>3.5</td>
<td>7.2</td>
<td>4.3</td>
<td>5.8</td>
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</table>

Table 10.13: 2014 NSBSP: Days to Diagnosis and Surgery Wait Times by District Health Authority (all ages)

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<thead>
<tr>
<th>DHA</th>
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<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
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<tr>
<td></td>
<td>Screen to first core biopsy(benign)</td>
<td>47</td>
<td>64</td>
<td>38</td>
<td>41</td>
<td>36</td>
<td>37</td>
<td>56</td>
<td>84</td>
<td>41</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Screen to first core biopsy(cancer)</td>
<td>42</td>
<td>48</td>
<td>38</td>
<td>31</td>
<td>58</td>
<td>26</td>
<td>39</td>
<td>61</td>
<td>35</td>
<td>27</td>
</tr>
<tr>
<td></td>
<td>Cancer core to first surgery</td>
<td>84</td>
<td>98</td>
<td>82</td>
<td>110</td>
<td>107</td>
<td>67</td>
<td>77</td>
<td>108</td>
<td>92</td>
<td>66</td>
</tr>
<tr>
<td></td>
<td>Benign core to first surgery</td>
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<td>153</td>
<td>215</td>
<td>218</td>
<td>223</td>
<td>135</td>
<td>82</td>
<td>237</td>
<td>168</td>
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<td></td>
<td>First core to first surgery (if multiple cores)</td>
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<td>62</td>
<td>47</td>
<td>83</td>
<td>70</td>
<td>62</td>
<td>48</td>
<td>56</td>
<td>67</td>
<td>39</td>
</tr>
<tr>
<td></td>
<td>No core to first surgery</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>57</td>
<td>74</td>
<td>0</td>
<td>0</td>
<td>60</td>
<td>153</td>
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10.2.8 Benign to Malignant Open Biopsy Ratio

Among open biopsies, the ratio of the number of benign cases to the number of malignant cancer cases

Target: < 2:1 for all open biopsies

Figure 10.11: Benign to Malignant Open Biopsy Ratio by District 2014 (ages 50-69)

Figure 10.11 and table 10.14 demonstrate the 2014 benign to malignant surgical ratios 1 : 10.1 (or 0.1 : 1) for women aged 50-69, indicating that overall for every one benign surgical outcome, there were 10.1 malignant outcomes. The important outcome is to find the greatest number of small cancers with minimum work-up, decreased wait times and decreased number of surgeries.

The relationship between the number of benign surgical outcomes and number of malignant surgical outcomes not having had a core biopsy as part of their work-up remains similar from the beginning of the program. It is also apparent in figure 10.12 that the number of malignant surgical outcomes has increased substantially over the years as the program has grown. It can be seen that the number of cancers subsequently
detected after having a core biopsy, remains in proportion to total number of cancers detected from open surgical outcomes. One benign or malignant surgical outcome per woman is used in Figure 10.12 indicating that benign : malignant outcome ratios of surgery have improved greatly since the start of the program. The number of core biopsies has increased, particularly as new sites joined the organized screening see table 5.1.
Figure 10.12: Malignant (M) : Benign (B) Surgical Outcomes by Year (ages 50-69)
10.2.9 Invasive Cancer Tumor Size

Percentage of invasive cancers with tumor size of $<$ 10mm and $<$ 15mm and in greatest diameter as determined by the best available evidence

Targets: $>$ 25% $<$ 10mm and $>$ 50% $<$ 15mm

Of 4543 cancers of all ages detected from the start of the program, 3591 (79%) were invasive and of these, 11.8% were less than or equal to 5mm, 37.8% were 10mm or less and 64.6% were 15 mm or less (Figure 10.13). Of all invasive cancers in the target age group, 73% were stage 1 or better.

Figure 10.13: Invasive Cancer Tumor Size 1991-2014 (all ages)

During this time 1012 cases of DCIS and 55 cases of LCIS were also detected. Over 99.5% of tumor sizes were obtained from pathology reports, with film measurements needed only in cases where it was not specified in the pathology reports.

In 2014, in the target age group, 273 cancers were detected. Of these, 222 (81%) were invasive and of
these, (11.7%) were 5mm or less, 42.6% were 10mm or less and 64.9% were 15mm or less (Figure 10.14). 62% were stage 1 or better.

During this time, 81 cases of DCIS were detected and there were 7 cases diagnosed as LCIS.

10.2.10 Node Negative Cancers

*Proportion of invasive cancers in which the cancer has not invaded the lymph nodes*

**Target:** > 70% node negative

Since the beginning of the program 82% of all invasive cancers in the target age group were node negative (see figures 10.15 and 10.16).

In addition there have been 173 cases of DCIS with nodal excisions (170 with negative nodes and 3 with
positive nodes). In 2014, there were 222 invasive cancers in the target age group of which 217 (98%) had lymph nodes excised. Of these 84% were node negative. In all age groups there were 304 lymph node dissections and of these, 9%, 31%, 45% and 15% were in the 40-49, 50-59, 60-69 and 70+ age groups respectively.
Figure 10.15: Node Negative Cases by Year (ages 50-69)
Figure 10.16: Node Negative Cases by Year (and by age)
Table 10.14: 2014 Biopsy Results per woman (ages 50-69)

<table>
<thead>
<tr>
<th>Description</th>
<th>B n=</th>
<th>M n=</th>
<th>Ratio</th>
<th>Rate</th>
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<tr>
<td>Benign : Malignant open biopsy ratio</td>
<td>27</td>
<td>273</td>
<td>0.1 : 1</td>
<td>0.6</td>
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<tr>
<td>Benign : Malignant core biopsy ratio (atypical not included)</td>
<td>477</td>
<td>271</td>
<td>1.76 : 1</td>
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<tr>
<td>Benign : Malignant core biopsy ratio (atypical included)</td>
<td>518</td>
<td>271</td>
<td>1.91 : 1</td>
<td></td>
</tr>
<tr>
<td>Benign : Malignant core biopsy ratio (atypical and others included)</td>
<td>563</td>
<td>271</td>
<td>2.08 : 1</td>
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<tr>
<td>Benign : Malignant open biopsy ratio - direct to open biopsy (no core)</td>
<td>3</td>
<td>3</td>
<td>1 : 1</td>
<td></td>
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<tr>
<td>Benign : Malignant open biopsy ratio - after core biopsy</td>
<td>24</td>
<td>270</td>
<td>0.09 : 1</td>
<td></td>
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<tr>
<td>Benign open biopsy rate per 1000 screens</td>
<td>27</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Benign core biopsy rate per 1000 screens</td>
<td>477</td>
<td></td>
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<td>11.4</td>
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11 Former Initiatives

11.1 Comparing Radiation Doses in Mammography Units Across NS

The process of replacing the mammography units with digital technology in the province started in 2007. One benefit of this strategy has been a reduction of about 37\% in the radiation levels which our clients receive. In a recent study performed by Drs. Eva Barkova and Cupido Daniels, the radiation levels for average breast sizes and tissue composition, which clients received in 2006 (pre-digital era) were compared to that of 2008-2009 during which 9 digital units have already been deployed.

The graphs in figure 11.1 compare the distribution of radiation levels in 2006 for 18 non-digital, film-screen units and for 17 units in 2008-2009 consisting of 9 digital units, 1 computed radiography unit (CR), and 7 non-digital units. Important observations include:

1. The radiation levels for non-digital units are very varied and women are exposed to different levels of radiation, albeit all below the maximum allowable amount, depending on where the imaging occurs.
2. The radiation levels for digital units are much lower (by 37\%) than that of non-digital units.
3. The radiation levels for digital units are very consistent from site to site.
Figure 11.1: Radiation doses for film and digital screening systems

Mean Glandular Doses for Average Breasts from 18 Nova Scotia Mammography Units

Mean Glandular Doses for Average Breasts from 17 Nova Scotia Mammography Units (2008–2009)

Mammography Units in Nova Scotia (2006: All non–digital units)
11.2 Understanding Service Delivery through the use of GIS

The NSBSP has worked with the Public Health Agency of Canada as well as two students at the Centre for Geographic Sciences (NSCC) to explore the use of Geographic Information Systems (GIS) in understanding use of breast screening services by women across NS as well as to understand how services are being delivered. The province-wide transition to Full-Field Digital Mammography (FFDM) was completed in May 2010 for all 11 fixed sites and 1 mobile unit. Nova Scotia also remains the only province to encompass all breast imaging in the province under the umbrella of an organized program.

It is within this context that a historical analysis of the use of services in the 5 years preceding the beginning of the FFDM implementation was undertaken. It was then natural that GIS be used as part of this analysis. Ms. Stephanie Lea, an x-ray technologist by background, analysed these data to form her thesis work in the Master’s of Applied Health Services Research at Dalhousie University. She examined trends in participation and retention by District Health Authority (DHA) and over time. She also analysed where women accessed screening services in relation to where they lived. The final piece was to analyse how DHAs vary in their screening service delivery, including variations in capacity as well as the use of mobile versus fixed site service provision.

Participation results varied over time and place but were hard to interpret because of the addition of fixed sites over time. Retention results revealed an overall reduction over time and a greater range across DHAs over time, believed to be due in large part to increasing wait times that made it difficult for women to return to screening in the appropriate time interval. Interestingly, one of the features of Central Booking is that women are free to choose where to have their screening exam performed, but these analyses revealed that most women choose to be screened in their home DHA. The number of screens performed each year has been increasing across the province as a whole and in most DHAs but the number of screens performed for women aged 50-69 as a function of the number of women that age resident in that DHA (i.e., screens per capita) varied substantially over time within DHA and across DHA (Figure 11.2 contains most recent data for women aged 40+). Similarly there was wide variation in the provision of services through fixed vs mobile site over time within DHA and across DHA. This analysis has helped provide a solid foundation for comparison with the post-FFDM data and has produced a new way of thinking about how to analyse service provision across the DHAs, a methodology which over time will be incorporated into the NSBSP Annual Report.
Figure 11.2: Screens per 1,000 Women (Aged 50-69), by DHA
11.3 Database Development

From a simple flat file database available in 1991, a complete rewrite upgraded the NSBSP system to a user friendly and user developed relational database completed in 1997. A second rewrite began in 2002 and when completed in June 2004 resulted in standardized data entry procedures and outcomes for both screening and diagnostic mammography from one database. The diagnostic reporting system (DRS) is currently being used in Halifax, Cape Breton, Dartmouth General, Bridgewater, New Glasgow, Yarmouth and Amherst. Kentville, Truro and Antigonish are waiting for completion of the interface between DRS and the hospital information system before reporting in DRS. Until this occurs patients in those 3 districts cannot be followed up and tracked in the database by Central Mammography Booking as is the practice in all other districts.

In 2015 the NSBSP rolled out a significant modification to the existing MIS (Mammography Information System) and the DRS (Diagnostic Reporting System) which was named the BIS (Breast Imaging System). These modifications will improve user accessibility, standardization, work flow and will be interfaced with the provincial information systems.

11.4 Central Mammography Booking (CMB)

A project designed to book all breast screening appointments, both screening and diagnostic through one call center was completed and implemented in December 2000. Prior to this, it was only the first two mobile vans that utilized the booking center. Funding for computer interfaces and programming for this project was obtained through the federal government’s Infrastructure Support Program and the Canadian Breast Cancer Foundation - Atlantic Chapter. Initially the project enforced standard booking guidelines and booked appointments for two NSBSP vans, one NSBSP fixed site and one diagnostic center. Currently all breast imaging, screening and diagnostic, in the province is booked through Central Booking. Starting dates for diagnostic centers joining with CMB are seen in Table 5.1. All guidelines are strictly followed to ensure asymptomatic women that fit the criteria for screening are booked as such. Core biopsies and all breast ultrasounds, with the exception of District 1, are also being booked through Central Booking. A breast MRI reporting module has been developed with funding from the Public Health Agency of Canada (PHAC). All breast MRI is being centrally booked and reported in the database using synoptic reporting. This process ensures that breast MRI is being utilized appropriately, guidelines developed by the Department of Health & Wellness in 2008 are being followed and recommendations are being tracked in the database and followed up in a timely manner.

There is a considerable body of evidence that an abnormal breast cancer screening precipitates acute anxiety especially upon receipt of notification of the abnormal screen. Anxiety may persist for several months after resolution of the screening episode, even after the woman has been informed that she does not have cancer. Waiting for a Diagnosis after an Abnormal Screen in Canada: Minister of Public Works and Government Services Canada, 2000. With a goal of enabling NSBSP to process the bookings for provincial diagnostic mammography departments and to assist in channelling the flow of asymptomatic women to the screening program, CMB has successfully decreased waiting times at the diagnostic sites. With appropriate integration of diagnostic and screening mammography programs through one Centralized Mammography Booking system, short wait times for diagnostics can be maintained. Urgent situation can be addressed within a few days at all sites.

11.5 The Core Biopsy Program

Under auspices of NSBSP a core biopsy program was started to coincide with the program start in June 1991. Database development has permitted tracking these examinations. Since the beginning of the program in June 1991 until December 2014, a total of 16166 stereotactic core biopsies and a reported 1812 ultrasound guided core biopsies have been performed on 15692 women. Results may be seen in Tables 10.10 and 10.11.
Promotion of stereotactic needle core biopsy as opposed to clinical or ultrasound guided core biopsy is preferred for the following reasons:

- in a screening population, lesions are nearly always identified by mammography, and if the core biopsy is benign they are followed by mammography. If lesions are malignant, they are localized by mammographic guidance and mammographic specimens to confirm excision
- stereotactic localization following stereotactic core biopsy, by design, also localizes the core biopsy track so that this can be removed at the time of surgery
- stereotactic films are very reproducible unlike ultrasound which is operator dependant
- many lesions identified by mammography (especially calcifications) are not seen during ultrasound guided core biopsy, even by experienced ultrasonographers
- documentation of a missed lesion by ultrasound is difficult but clearly present with the NSBSP stereotactic needle core biopsy approach Nova Scotia Breast Screening Program Experience: Use of Needle Core Biopsy in the Diagnosis of Screening Detected Abnormalities, Radiology 1996. For this reason, a negative ultrasound guided core biopsy is not as acceptable to many clinicians and the patient usually must go on to have surgery regardless of negative results.

"Core biopsy is a superior method for the evaluation of non-palpable lesions due to increased diagnostic specificity and reduced rate of inadequate samples." Brenner RJ, Bassett LW, Fajardo LL, Dershaw DD, Evans WP III, Hunt R, et al. Stereotactic core needle biopsy: a multi-institutional prospective trial. Radiology 2001: 218: 866-72. In reports comparing stereotactic core biopsy to surgical biopsy, the sensitivity of core biopsy for diagnosis of malignant lesions varies from 85% to 98%. However in a multi-institutional study in which the results of 1,363 image directed core biopsies were compared with the results of subsequent surgical biopsies there was 98% agreement and only 1.1% false-negative core biopsy outcome (level III evidence). Parker SH, Burbank F, Jackman RJ, Aucreman CJ, Cardenosa G, Cink TM, et al. Percutaneous large-core breast biopsy: a multi-institutional study. Radiology 1994; 193: 359-64. False negative core biopsy outcome from the Nova Scotia Breast Screening Program from 1991 to 2014 is also 1.1%.

Over the first 24 years of the program there have been 29 malignant core biopsies for which the corresponding surgical outcomes were benign, resulting in a false positive rate of 0.2%. The false-positive core biopsy outcome per woman is 0.2%. Atypical/suspicious and benign open surgical results are included when calculating the false positive rate.

For both stereotactic and ultrasound core biopsy to be successful there needs to be a validation process and team management.

Cancer has a significant economic impact in Canada as measured by direct and indirect costs. Direct costs refer to the value of goods and services for which payment was made and resources used in treatment, care and rehabilitation directly related to illness or injury. Indirect costs are defined as the value of economic output lost because of illness, injury-related work disability or premature death (National Cancer Institute of Canada: Canadian Cancer Statistics 2004). In 1998, in Canada, $2.5 billion were direct costs with hospital care costing $1.8 billion and representing 74% of this amount. Physician services to treat cancer cost $333 million, or 14% of direct costs. Approximately $210 million or 9% of direct cancer costs were spent on drugs for cancer treatment. The indirect cost was $11.8 billion. Economic Burden of Illness in Canada, Health Canada 2002. Although the figures above represent costs for all cancers and for all Canadian provinces, the core biopsy program in Nova Scotia has made positive impacts on reducing wait times, hospital stays and physician services. It has made a huge impact in greatly decreasing benign breast surgeries.

Published works of the Nova Scotia Breast Screening Program include:

- Stereotaxis Needle Core Biopsy of Breast Lesions Using a Regular Mammographic Table with an Adaptable Stereotaxic Device (AJR 1994: 163: 317-321)
11.6 The Pink Rose Project and Physician Assisted Navigation

The Pink Rose Project instituted the provision of “Information Packages” to newly diagnosed women at the time of imparting the diagnosis. Started and managed by a volunteer breast cancer survivor under the umbrella of NSBSP, this initiative has been adapted and introduced into most other provincial programs. Begun as a service provided by one hospital, the packages are now funded by the Canadian Breast Cancer Foundation - Atlantic Chapter, and distributed by pathology departments, NSBSP coordinators, Cancer Care personal as well as active survivors throughout the province.

With the development of NSBSP in 1991, physician assisted referral for all abnormal screens to the diagnostic work-up sites was instituted. The physician was always the first point of contact by phone, and with their approval the program would (also by phone) contact the patient with the date, time, place and nature of the work-up test or core biopsy. For even greater efficiency, the phone contact has been replaced with a faxed appointment process. As in all screening programs, results were also mailed to both the women and the physician. This fast tracking resulted in decreased times to diagnoses and overwhelming acceptance of the process. In 1997, requests from the medical community to also navigate women with abnormal reports in the diagnostic sector resulted in a full time navigation position. In addition, through personal contact with physicians and women, the navigator has promoted a heightened awareness of the clinical practice guidelines for mammography. This single NSBSP diagnostic-based navigator position has been closely tied to the largest diagnostic work-up site and is supported by the Pink Rose Project.


All results from the smaller diagnostic work-up sites are monitored by the NSBSP Image and Data Manager pending a status of case “completion”.

Published works of the Nova Scotia Breast Screening Program include:


11.7 NSBSP Post Screen Cancers: Report and Learning Tool

In January 2006, with funding from a Canadian Breast Cancer Foundation - Atlantic Chapter’s Community Health Grant, a project was initiated with the aim to identify, assemble, classify and review the interval breast cancers diagnosed from NSBSP clients. A blitz enabled this work to be completed for the years 1991-2003 and thirty-five data charts were compiled, some results of which will be used for publication in an inter-disciplinary paper presently being written for publication by Imaging, Pathology and Oncology Departments at the QEII Health Sciences Center in collaboration with Dalhousie University.
Table 11.1: NSBSP Post Screen Detected Cancers

<table>
<thead>
<tr>
<th>Number of Women Screened</th>
<th>Radiologists' Diagnosis</th>
<th>Intervals and Other Post Screen Cancers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>91-92</td>
<td>5,848</td>
<td>0</td>
</tr>
<tr>
<td>93-97</td>
<td>29,947</td>
<td>13</td>
</tr>
<tr>
<td>98-99</td>
<td>19,328</td>
<td>16</td>
</tr>
<tr>
<td>00-01</td>
<td>16,192</td>
<td>19</td>
</tr>
<tr>
<td>02-03</td>
<td>23,797</td>
<td>39</td>
</tr>
<tr>
<td><strong>All</strong></td>
<td><strong>93,112</strong></td>
<td><strong>150</strong></td>
</tr>
</tbody>
</table>

Diagnosis is made by three Radiologists, with the coding as follows: 1:3 normal diagnoses, 2:2 normal, 1 abnormal, 3:3 abnormal, 4: 1 normal, 2 abnormal.

Five NSBSP interpretation sites contributed cases for this review which resulted in 96% of all known interval cancers being reviewed in an organized fashion by a minimum of three radiologists. In addition, breast cancer pathology TNM coding was reviewed by pathology staff for accuracy and to provide feedback to the program. Data from the National Cancer Registry is also expected to contribute.

Following the review of films, a file of unique cases was compiled and has been made available for review by of the radiologists as a web based learning file. A summary table of work completed up to the end of 2003 is included. The process is now ongoing.

The true value of screening can only be understood if a screening program is able to follow its participants for all diagnosed cancers, including those not found through screening. The NSBSP is very unusual in being able to capture these data on all of its participants. The results of this review were recently presented at the Annual Meeting of the Radiological Society of North America (RSNA) in Chicago and the results of this review are currently being summarized for publication in the RSNA scientific journal.

### 11.8 Interval Cancers

The review of the post-screen cancers has led to an exciting research project led by Dr. Danny Rayson, a medical oncologist at the Cancer Clinic in Halifax. The research project team is the result of a new collaboration between Dr. Jennifer Payne, Prof. Mohamed Abdolell, Dr. Penny Barnes (pathologist), Dr. Rebecca McIntosh (pathologist), Dr. Tallal Younis (medical oncologist), Dr. Judy Caines, and Ms. Theresa Foley. The project involves understanding the differences between interval cancers and screen-detected cancers and was funded by the Capital Health Research Fund. It is believed that interval cancers are more aggressive in nature (i.e., more aggressive pathology) but it is hard to show this because of a lack of follow-up data of women who have been screened. The preliminary comparison of pathology characteristics between the two groups did in fact reveal that interval cancers were more aggressive in nature than screen-detected cancers. Early results of this were presented at the Annual Meeting of the American Society of Clinical Oncology last year. This past year, the project was expanded to include a comparison of the clinical outcomes of women with interval cancers vs screen-detected cancers. With the help of a 2nd year medical student, Ms. Ariel Burns, who was funded by a Norah Stephens award, the charts of these women were reviewed at both the Halifax and Sydney cancer clinics. Ms. Burns was able to find any missing pathology data as well as collect information on breast cancer recurrence. Ms. Burns presented the completed pathology analysis at the Dalhousie Cancer Research Symposium and received an honourable mention for her poster. This research has since been published. See section 13 for the article reference.
11.9 Needle Core Biopsy

The NSBSP is an unusual screening program because it has incorporated the use of needle core biopsy (NCB) into its clinical practice guidelines. The use of NCB has been shown to reduce the rate of benign surgery in women. In 2008 Dr. Heather Curtis, a 4th year radiology resident working on her residency research project under the guidance of Dr. Jennifer Payne and Dr. Judy Caines, conducted a review of NCB rates within the NSBSP from 1991 through to 2006. This timeframe is extremely critical in that it precedes the introduction of FFDM. The review consisted of summarizing both the rates of NCB as well as the surgery rates within the program as a whole, as well as within each program site, over time. Finally, a similar summary was compiled for the benign:malignant ratio for both NCB and surgery, the latter one being a measure to assist in minimizing the surgery rate for benign (i.e., non-cancerous) growths. What Dr. Heather Curtis found was again a confirmation that the use of NCB is associated with a decrease in the number of benign surgeries. The comparison of figures over time across the sites revealed that although sites might have differed when NCB was first introduced, the variation in rates has been greatly reduced over time. Dr. Curtis presented these results at the Annual Dalhousie Radiology Research Day. This analysis will help the NSBSP set provincial targets for these performance indicators to help ensure that women across the province receive the same high quality care, regardless at which sites they receive their care. This analysis also serves as an important benchmark for comparison once FFDM has been implemented throughout the province.

11.10 Surveillance and Reporting

In 2008, Dr. Jennifer Payne received a one-year community grant from the Canadian Breast Cancer Foundation - Atlantic Region to develop a surveillance framework for the NSBSP. Although the NSBSP reports on a series of nationally agreed upon performance indicators, the NSBSP data holdings are much broader than those of many other provinces and therefore lend themselves to calculations of other indicators, including those both in the area of quality of care as well as service provision. Although the formal grant has been completed, the framework is now being used to review other possible indicators, such as those now developed in the area of wait times (see 11.5), and those produced out of the work in health services utilization (see 11.1) and how these indicators can be used both internally by the NSBSP and externally by stakeholders and to the public at large. In addition, the NSBSP is working on various ways of presenting indicators to stakeholders - as the calculations become complex, it’s important to present information to stakeholders in a format that is useful and meaningful for them. As these forms of reporting are developed, the NSBSP will be consulting with its stakeholders on ways to expand and strengthen reporting of breast screening performance in Nova Scotia.

11.11 NSBSP Annual Report Automation

Prof. Mohamed Abdolell, with collaborators Dr. Jennifer Payne and Dr. Judy Caines, completed a Canadian Breast Cancer Foundation - Atlantic Chapter Community Health Grant funded project, "Automation of the NSBSP Annual Report: a first step toward developing a surveillance system". The primary goal of this project was to fully automate the process of generating the NSBSP Annual Report. In the past, the report has taken up to twelve months to generate manually and has been a major burden on the resources of the NSBSP. Through automation of the process, the report is now generated in 2 hours. Since 2007, the NSBSP annual report has been generated using this system. The natural consequence of developing such a system is that it can be extended to become a fully automated surveillance system that is flexible, customizable, timely, accurate, reproducible, on-demand, and low-cost. The feasibility of applying Statistical Process Control methods in the proposed surveillance system has been evaluated and it has been determined that automatic flagging of emerging trends in the NSBSP to enable proactive intervention in the system to optimize resource allocation and improve access to screening for women in Nova Scotia is achievable. In the
Summer of 2011 the Automated Annual Report was recoded in preparation for the new information system to be used by the NSBSP.

11.12 Reminder Calls

As of Jan 2008 the NSBSP began offering reminder calls to all districts of the province that were booking mammography, both screening and diagnostic, through Central Booking. This service is being provided by Voice Services through the Capital Health and has proven to be very successful. What began as a semi automated process has been upgraded in 2009 to a completely automated system. No shows have been virtually eliminated at all sites since this process was implemented.

11.13 Evaluation of Full Field Digital Mammography (FFDM)

As mentioned earlier, the transition to fixed site FFDM was completed in May 2010. Exploratory work has been underway to understand what this transition means for the women of Nova Scotia in terms of quality of care. In Canada, the performance of breast screening programs is measured through a series of standardized performance indicators, each with its own target. Programs can use these measures to monitor their progress over time and as well as against the country as a whole. These measures have now been evaluated for the one year period prior to the FFDM transition (analog) against the first 12 months of digital mammography, allowing for a 4-month transition period. These preliminary results revealed that digital mammography appears to outperform analog mammography for women aged 40-49 years, and to a lesser extent this is also true for women aged 50-59 years. It must be noted that these data are preliminary in that not all NSBSP sites are at this point in time able to contribute 12 months of data given that some did not transition until spring of this year. It must also be noted that radiologists review screening mammograms in relation to earlier mammograms and that in this specific instance, the earlier ones were analog. Therefore the “final” analysis of the FFDM transition will not be complete until radiologists are able to review digital mammograms in relation to at least one prior digital set of mammograms. As most women in the target age range of 50-69 years are screened only once every two years, it will be a while before we can truly understand the impact of FFDM on quality of care.

11.14 NSBSP Response to Canadian Task Force on Prevention Health Care’s Recommendations for Breast Screening

On Nov 21, 2011 the Canadian Task Force on Preventative Health Care released recommendations for screening mammography in Canada. Although these recommendations did differ somewhat from the current recommendations, NSBSP is operating within these guidelines. In response to the Task Force recommendations the NSBSP developed an information sheet that was sent to stakeholders throughout the province. The contents of that information sheet are presented below.

There are two clinical categories of mammography: screening and diagnostic.

**Screening** mammography is for asymptomatic women aged 40 and over who have no breast symptoms and who do not have a personal history of breast cancer.

**Diagnostic** mammography is for symptomatic women, women with implants, women with a personal history of breast cancer and for workup of anyone who receives an abnormal screening mammogram report. This population should have the shortest wait time for breast imaging. Diagnostic mammograms take longer to perform, longer to be interpreted by a breast imaging radiologist and are more expensive to the health care system.
All breast imaging in Nova Scotia (screening and diagnostic) is booked through NSBSP Central Booking which has enabled Nova Scotia to eliminate opportunistic screening (screening asymptomatic women in the diagnostic sector as opposed to an organized program). This ensures that all eligible asymptomatic women requesting breast screening are screened through an organized program. All outcomes are tracked and readily available for the entire province in real time. Nova Scotia is the only province to date that manages all breast imaging through an organized program.

Although the NSBSP targets women aged 50-69, it became apparent when the program first began back in 1991 that women aged 40-49 were demanding mammography. A conscious decision was made at that time to accept them into the screening program; the cost to the health care system is less and these women can be tracked with readily available outcomes. If women 40-49 were accommodated through physician referrals in the diagnostic sector, the diagnostic sector would become overwhelmed and the true diagnostic patients would suffer increased wait times.

11.14.1 CTFPHC Recommendations vs NSBSP Clinical Practice Guidelines

**Task Force:** Does not recommend routine screening mammography for women aged 40-49 but states women may choose to screen if they place a high value on the small reduction in breast cancer mortality (demonstrated in the randomized controlled trials that they reviewed). The Task Force also notes that access to high quality facilities with the necessary equipment and expertise in mammography is required to undergo screening.

Provincial and regional decision makers should consider whether access is adequate for people in their jurisdiction who reside outside major centers. Mobile screening units may help to increase access to screening among rural/remote dwellers.

**Nova Scotia Breast Screening Program** currently practices within these guidelines: NSBSP accepts women aged 40-49 into the program but does not actively recruit them. If women do opt for screening they are directed to the organized program where they can be monitored and outcomes are available. Similar to the practice for other countries that screen this age group, these women are followed with annual screening mammography. The breast tissue in this age group is generally denser, making early detection more difficult. In addition, breast cancers detected in younger women, although less frequent than older women, are generally more aggressive and grow at a (more) rapid rate.

Currently in Nova Scotia 56% of women aged 40-49 are having screening mammography through the organized program over a two-year period. An organized program ensures there is a certain standard of care across the province and outcomes are monitored and evaluated. In all of the other provinces and territories across the country, breast screening is performed both inside and outside organized programs (known as opportunistic screening) making it difficult or impossible to report on the true participation rates and outcomes. Nova Scotia has eliminated opportunistic screening.

The Task Force review did not include any studies with digital mammography. All fixed screening sites in Nova Scotia utilize digital mammography (thanks to funding from the Nova Scotia Government). Nova Scotia’s initial results show digital mammography is better at picking up cancers with fewer work-ups than film mammography in almost all age groups, especially for women 40-49. This means fewer mammograms are reported as abnormal requiring further imaging and at the same time more breast cancers are being detected.

One reason the CTFPHC does not recommend screening women aged 40-49 is the chance of having a false positive mammogram is higher in this age group and can lead to further investigation including other (potentially) unnecessary procedures such as surgery. Figure 4 demonstrates the estimated rates of unnecessary procedures, according to the Task Force, for a group of women screened every 2-3 years for a period of 11 years. Figure 5 shows the actual rates in Nova Scotia using the same inclusion criteria as the Task Force for women screened in 2000 and followed through to 2011. It would normally be expected that the
<table>
<thead>
<tr>
<th>Screening Mammography for 40-49</th>
<th>Screening Mammography for 50-69</th>
<th>Screening Mammography for 70-74</th>
<th>MRI Screening</th>
<th>Clinical Breast Exam (CBE)</th>
<th>Routine Breast Self Exam (BSE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CTFPHC</td>
<td>Screening is recommended every 2-3 years</td>
<td>Not recommended</td>
<td>Not recommended</td>
<td>Not recommended</td>
<td>Not recommended</td>
</tr>
<tr>
<td>NSBSP</td>
<td>Screening is recommended every 2 years. Recall sent out for annual screen for those who opt in.</td>
<td>Service available but no recall reminders sent out</td>
<td>Not recommended</td>
<td>Modified CBE performed by Technologist at screening</td>
<td>Not recommended</td>
</tr>
</tbody>
</table>

Table 11.2: Comparison of NSBSP guidelines vs. recommendations by CTFPHC

<table>
<thead>
<tr>
<th>Per 1000 women screened</th>
<th>40-49y</th>
<th>50-69y</th>
<th>70-74y</th>
</tr>
</thead>
<tbody>
<tr>
<td>False Positive Mammograms</td>
<td>210</td>
<td>143</td>
<td>76</td>
</tr>
<tr>
<td>Unnecessary (Benign) Biopsies</td>
<td>Needle Core</td>
<td>60</td>
<td>48</td>
</tr>
<tr>
<td></td>
<td>Surgical</td>
<td>12</td>
<td>10</td>
</tr>
</tbody>
</table>

Table 11.3: NSBSP Results (women screened 2000-2011)

false positive rate decreases with increasing age however the actual false positive mammogram rate of women aged 40-49 in Nova Scotia for the most recent 11-year period is lower than that projected by the Task Force rate for women aged 70-74.

The last Cancer Registry report 2003-2008 for Nova Scotia showed a 4% reduction in mortality (statistically significant) compared to the previous registry report 5 years before- 1998-2003. Some will say that is because of better treatment but this same report also shows a reduction in newly diagnosed invasive disease in women aged 50-65 by 13%. This cannot be due to treatment but was likely due to early detection in screening women 40-49 for the 10 years prior.

Nova Scotia has the lowest number of benign breast surgeries in the country thanks to the use of needle core biopsy. In Nova Scotia a requirement of the breast screening program is to provide high quality standardized mammography access and care with timely assessment, informed patient navigation and appropriate follow up of women who have abnormal mammograms on screening through complete diagnostic work up including needle core biopsy in accredited work up centers before consideration of surgical intervention. Women do not proceed to breast surgery unless proper work up has been completed and surgical intervention is warranted.
<table>
<thead>
<tr>
<th>Per 1000 women screened</th>
<th>40-49y</th>
<th>50-69y</th>
<th>70-74y</th>
</tr>
</thead>
<tbody>
<tr>
<td>False Positive Mammograms</td>
<td>327</td>
<td>282</td>
<td>212</td>
</tr>
<tr>
<td>Unnecessary (Benign) Biopsies</td>
<td>36</td>
<td>37</td>
<td>26</td>
</tr>
</tbody>
</table>

Table 11.4: CTFPHC Results for 11 year screening period

<table>
<thead>
<tr>
<th>Provincial/territorial breast screening programs that accept women 40-49</th>
<th>Provincial breast screening programs that do not accept women 40-49</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northwest Territories</td>
<td>Saskatchewan</td>
</tr>
<tr>
<td>Yukon</td>
<td>Ontario</td>
</tr>
<tr>
<td>British Columbia</td>
<td></td>
</tr>
<tr>
<td>Alberta</td>
<td></td>
</tr>
<tr>
<td>Manitoba*</td>
<td></td>
</tr>
<tr>
<td>Quebec*</td>
<td></td>
</tr>
<tr>
<td>New Brunswick*</td>
<td></td>
</tr>
<tr>
<td>Prince Edward Island</td>
<td></td>
</tr>
<tr>
<td>Nova Scotia</td>
<td></td>
</tr>
<tr>
<td>Newfoundland &amp; Labrador*</td>
<td></td>
</tr>
<tr>
<td>*With physician referral</td>
<td></td>
</tr>
</tbody>
</table>

Note
The Task Force states that women should be given enough information to make an informed decision in regards to screening mammography. For the past two years the NSBSP has distributed to all physicians across the province copies of the Mammography Decision Aid published by the Public Health Agency of Canada [http://www.phac-aspc.gc.ca/cd-mc/pdf/Information_on_Mammography-eng.pdf].

11.14.2 Summary

The NSBSP is operating within the recommendations of the CTFPHC. Women 40-49 are not actively recruited, but those opting for screening are done through the organized program with high quality standardized care and real time monitoring of clinical outcomes. Women 50-69 are routinely screened every 2 years. Women 70-74 are accepted into the program but are not sent reminders to rebook; this will be reviewed by NSBSP. The NSBSP does provide a modified breast exam to all screening clients. Routine Breast Self Exam is not currently recommended by NSBSP, which is consistent with the Task Force recommendations. The NSBSP does not recommend screening with MRI.

11.15 Reminder Postcards

In the spring of 2012 the NSBSP replaced its aging envelope inserter and postcard printer, two pieces of equipment vital in the preparation of correspondence with women across the province. The NSBSP took this opportunity to update the reminder postcard and its preparation process.

Using specialized mailing software the NSBSP is now able to apply the National Change of Address (NCOA) database to its postcard mailouts. This has drastically reduced the number of pieces returned to the program and, more importantly, insures more clients receive their reminder postcard.

In the redesign process, the NSBSP worked in collaboration with Canada Post to have the postcard designated as Addressed Admail. As a result of this designation the cost of postage for each postcard has been reduced approximately 33%. The cost savings from this has dramatically helped offset the cost of the new envelope inserter and postcard printer.
11.16 Telephony Upgrade

The Nova Scotia Breast Screening Program (NSBSP) has operated its Central Booking Office since the program began in 1991. The booking office has grown in capacity and now receives thousands of calls every week from across the province. The NSBSP Central Booking Office has utilized the same legacy telephony system since 1991, a Central Exchange (Centrex) system.

The legacy telephony system was unable to record incoming calls. This prevents the NSBSP from carrying out quality assurance exercises that would ensure client satisfaction is maintained.

The legacy telephony system was also structured in a way that hindered workflow efficiency. All incoming calls are placed into a single queue that is answered by booking clerks meant to take calls only for screening mammography. There was no mechanism for automatically distributing calls to the appropriate staff. Reporting capability with this system was also limited.

The NSBSP, in close collaboration with HITS-NS and CDHA Voice Services, managed the installation of a new Voice over IP (VoIP) telephony system for the NSBSP Central Booking Office in June of 2013. This modern telephony system (Infinity by AmTelCo) offers a number of features that have enhanced the ability of the NSBSP to monitor and improve its central booking operations; Call Recording, Enhanced Reporting, and Multiple Call Queues. Transitioning to a VoIP-based telephony system has also reduced the operating costs of the NSBSP telephony system.
12 Current Initiatives

12.1 Male Breast Disease

Dr. Kristin Greenlaw, with collaborators Dr. Sian Iles, Dr. Robinette Butt, Dr. Peggy Yen and Dr. Jennifer Payne, are using data from the Nova Scotia Breast Screening Program over a 13 year period to investigate male breast disease. There is very little known about the incidence and the methods of diagnosis of male breast cancer within the population of Nova Scotia, Canada. The objectives of the study were to: describe the burden of male breast disease, including histological features of benign and malignant conditions, describe the utilization of radiological procedures in the investigation of male breast disease in Nova Scotia, and to assess the validity of the BI-RADS grading system in the population of Nova Scotia.

Results showed that the majority of male patients who presented to diagnostic imaging underwent mammography alone, with a smaller proportion undergoing ultrasound and mammography, or ultrasound alone. Mammography alone was shown to have a higher positive likelihood compared to ultrasound. Male breast cancer is rare, with only 16 cases in the 13-year period. In contrast, gynecomastia is very common and can sometimes be difficult to differentiate from malignancy by imaging. There were a high number of false positive cases with gynecomastia and in total, suggesting that more education is required in regard to differentiating the imaging appearance of malignancy and gynecomastia. Results showed that BI-RADS assessment is useful in male patients.

Although uncommon, male breast disease is an important component of breast imaging. The results of this study provide insight into the clinical pathway of male patients, burden of male breast disease, and accuracy of imaging tests.

12.2 Pan Canadian Mortality Study

In the published literature, most of the clinical trials aimed at describing the association between screening and breast cancer mortality were undertaken many many years ago. The results of these studies are limited in their value now, given advances in diagnostic and treatment, and do not represent the value of screening in a real world context. Investigators at the BC Cancer Agency designed a study aimed at examining breast cancer mortality as a function of participation in organized breast cancer screening in Canada, and invited screening programs from across the country to join the study. The Nova Scotia Breast Screening Program, with the collaboration of Cancer Care Nova Scotia, joined as one of the participating provinces (BC, MB, ON, QC, NB, NS, NL). The objective of the project was to observe the breast cancer mortality of women in the province as a function of participation in organized breast cancer screening. The study revealed that women participating in breast screening programs experienced a lower rate of breast cancer death than those who did not participate in these programs. The findings of this study have been published in the Journal of the National Cancer Institute.

12.3 E-FAX Process

In December 2015 the NSBSP began receiving and sending all requests for diagnostic breast imaging digitally. All incoming faxes are sent electronically to the appropriate folder based on the fax number of the originating request. Software allows for the requisitions to be annotated on with the time, date and location of the appointment prior to being e-faxed back to the requesting physician. A copy of the booked appointment is also saved in a shared drive that is accessible to the breast imaging staff at the fixed sites. This initiative is not only cost effective eliminating the need for fax machines, paper and toner but will lower the risk associated with having a wrong fax number enters as the physicians are all selected from a pre-populated drop down list.
12.4 Strength in Numbers

The Nova Scotia Department of Health and Wellness is collaborating with several Mi’kmaq First Nations on the ‘Strength in Numbers’ project. This collaboration involves the Nova Scotia Breast Screening Program, along with several other programs within the NSDHW, including:

- Cancer Care Nova Scotia
- Cardiovascular Health Nova Scotia
- Diabetes Care Program of Nova Scotia
- Nova Scotia Renal Program
- Reproductive Care Program of Nova Scotia
- Public Health
- Mental Health and Addictions
- Business Intelligence Analytics & Privacy
- Nova Scotia Trauma Program

This project builds on the earlier success of the ‘Telling our Stories’ project, a partnership established in 2012 with five Cape Breton First Nations Bands.

By way of the NS First Nations Client Linkage Registry (NSFNCLR), the NSBSP is exploring the feasibility of reporting several screening performance indicators for the target age range of 50-69 for First Nations women. The indicators include:

- Participation Rate
- Retention Rate
- Abnormal Call Rate
- Diagnostic Interval (time to resolution)
- Positive Predictive Value
- Cancer Detection

Where possible, comparisons to Nova Scotia results are being made. This information will aid in identifying areas of improvement in breast cancer screening in the First Nations communities in Nova Scotia.

12.5 NSBSP Screening for High Risk Women

Currently, the NSBSP Clinical Practice Guidelines (CPG) are intended for average risk women aged 40 to 69 years. Opportunities exist for revising the NSBSP CPG to include management of high risk women. These include, but are not limited to:

- Systematically identifying women at high risk for breast cancer.
- Solidifying the role of the patient navigator in coordinating the screening mammogram, MRI and follow-up of abnormal screening results.
- Determining how Central Booking can be used to manage mammography and MRI appointments for high risk women.
- Revising communication of messages and results with patients and physicians regarding high risk screening.
- Collaborating with the Maritimes Medical Genetics Clinic to address current issues in referring high risk women directly to NSBSP.
12.6 Mobile Breast Screening

Breast screening in Nova Scotia began as one fixed site at the Halifax Shopping Centre in 1991 and three mobiles expanded screening services to the rest of the province over the next 11 years. As of 2008 there are 11 fixed sites across the province and until January 2013 there were still three mobile units. Mobile breast screening was revised to compliment the services delivered at the 11 fixed sites. It is with the intent to reach populations distanced from the fixed sites that mobile breast screening operates. In 2009, 62% of all mobile screens were performed within a 30km radius of at least one fixed site.

The objective of this initiative was to examine existing mobile scheduling for the purposes of optimizing time and resources to better serve areas in the province lacking access to breast screening. Specifically, this initiative examined existing routes and booking utilization.

The NSBSP, together with the DHW and the 3 district operators, proposed to move to a single, digital mobile screening unit for the entire province, effect January 2013. In moving to a single, digital mobile unit, every woman in Nova Scotia will be guaranteed to have her mammogram performed digitally.

The mobile focused on providing service to areas that cannot easily access fixed site service. Criteria for mobile stop service include: Distance from a fixed site/other mobile stop(s), hard to reach populations, and utilization.

Increasing capacity at fixed sites will absorb the mobile screens that used to occur in close proximity to these sites. It is anticipated using a single, digital mobile unit for the entire province will make mobile screening more cost-effective. Distances traveled by one mobile will be greatly reduced and mobile utilization will be maximized. In total, 30 stops are part of the provincial, digital mobile route (see table 12.1 and figure 12.1).

<table>
<thead>
<tr>
<th>Sydney</th>
<th>North Sydney</th>
<th>New Waterford</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glace Bay</td>
<td>Neil’s Harbour</td>
<td>Cheticamp</td>
</tr>
<tr>
<td>Inverness</td>
<td>Pictou Landing</td>
<td>Tatamagouche</td>
</tr>
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<td>Indian Brook</td>
<td>Kenetcook</td>
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<tr>
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<td>Middleton</td>
<td>Digby</td>
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<td>Caledonia</td>
<td>Preston</td>
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<td>Canso</td>
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<td>Strait Richmond</td>
</tr>
<tr>
<td>Whycocomagh</td>
<td>Baddeck</td>
<td>Eskasoni</td>
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</tbody>
</table>

Table 12.1: Mobile stops for the digital mobile screening program

Of the 30 mobile stops selected for the provincial digital mobile route, 12 are located on Cape Breton Island and did not require any additional upgrading at the time. The digital mobile has been operating on Cape Breton since 2007 and the sites are already digital-ready. These stops will be reviewed at a later date to ensure they continue to meet all requirements. Electrical and telecommunication upgrades were required at all 18 mainland stops. Only eight mainland stops required ground work to be completed where the mobile would be positioned. Having a level surface for the mobile to park is important to the proper function and maintenance of the trailer and equipment.

Because of time limitations, upgrade work was carried out in the same order as the scheduling of mainland visits to ensure work would be completed in time for each mobile stop. The first mainland mobile stop took place on June 10th, 2013 at Pictou Landing. All work was completed in time for the arrival of the mobile at each of the 18 mainland mobile stops. All 30 stops had a mobile visit in 2013.

A year-end report was completed in 2014 specifically for the mobile unit, highlighting the transition to a single provincial mobile, issues that arose and insights going forward. A comparison of volume of women screened on the mobile over the transition years was completed to ensure that the mobile is being utilized. See chart.
12.7 Developing empirically based BI-RADS scales from FFDM

Prof. Mohamed Abdolell, with collaborators Dr. Peter Gregson, Dr. Gerry Schaller, Dr. Jennifer Payne and Dr. Judy Caines, obtained co-funding from Capital Health Research Fund, the Department of Diagnostic
High breast density is associated with an increased risk of breast cancer, and is currently used by the Nova Scotia Breast Screening Program to adjust screening intervals for high-risk women (e.g., annual recall rather than biennial for women with very dense tissue). Current clinically accepted measures of breast density have been developed on Film Screen Mammography (FSM), and are determined by radiologists' visual assessments. Nova Scotia has been exclusively using Full-Field Digital Mammography (FFDM) since the beginning of 2013, and yet no accepted standard for measuring breast density in FFDM exists.

One of the objectives of this project was to explore the feasibility of automating breast density measurements based on FFDM images that might ultimately lead to standardized measures of density being incorporated into the existing NSBSP data holdings. The results from this study have demonstrated that an algorithm could feasibly generate density measurements from FFDM images that are associated with an increased risk of cancer in women with high breast density. With a standardized and reliable measure of density the hope is that future work will enable development of breast cancer risk models that can guide personalized screening protocols.

12.8 Wait Times

As part of a province-wide initiative within the NS Department of Health & Wellness, the NSBSP has been revising its measurement of wait times and has now joined other areas of diagnostic imaging in reporting wait time publicly.

In the past, wait times for the NSBSP were defined as the wait until the next day with 3 available appointments for a given procedure or test. The NSBSP now follows the standard approach of reporting wait time retrospectively, instead of prospectively. These new measures will now accurately reflect how long people have waited to have procedures performed.

The NSBSP now reports nine wait time indicators to the DHW and all DHAs: Screening Wait Time (Figure 12.2); Screen to Work-up (Figure 12.3); Screen to Report; Report to Work-up; Diagnostic Wait Time; Image to Core; Screen to Core; Work-up to Core and Core to Surgery.

The data elements captured within the NSBSP database make it easy to calculate wait times. The wait times calculated are median (i.e. the number of days 5 out of 10 women waited) and 90th percentile (i.e. the number of days 9 out of 10 women waited). The results are sent electronically every quarter to the Department of Health & Wellness as well as every breast imaging manager, radiologist and lead technologist, and DHA CEO in the province.

For more information on the provincial wait times initiative, please consult the government website (http://waittimes.novascotia.ca).
Figure 12.2: Screening wait times (90th percentile)

<table>
<thead>
<tr>
<th>AM</th>
<th>AN</th>
<th>BR</th>
<th>CQ</th>
<th>DG</th>
<th>HC</th>
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<td>p90 Q4 2013</td>
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Figure 12.3: Work-up Wait Times (90th Percentile)

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<td>60</td>
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<table>
<thead>
<tr>
<th>Wait Time (Days)</th>
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<td>34</td>
</tr>
<tr>
<td>31</td>
</tr>
<tr>
<td>47</td>
</tr>
<tr>
<td>34</td>
</tr>
</tbody>
</table>

- p90 Q1 2013
- p90 Q2 2013
- p90 Q3 2013
- p90 Q4 2013
12.9 NSBSP Governance Restructure

In 2004, the Department of Health approved a Provincial Program Model and accountability framework to guide the operations and governance of “provincial programs”. The approved model identified three criteria for identification as a “provincial program”:

- Significant opportunity to improve health outcomes
- Congruence with vision, mission and strategic direction of the Department of Health
- Benefit to Nova Scotians and DHAs/IWK with a positive cost-benefit, potential to change variance in practice, and potential to alleviate the significant burden of illness.

In 2011 the Department of Health and Wellness initiated a review of provincial programs in Nova Scotia. The scope of review included an assessment of adherence to the 2004 provincial program model, areas for improvement through inter-program collaboration, consolidation or integration, and effectiveness of current approaches (scope and activities, standards development, program delivery mechanisms, education offerings, monitoring and evaluation functions.)

The review resulted in the following direction: The NSBSP will be hosted by the IWK Health Centre and have dual reporting to both the IWK and the Department of Health and Wellness. Initial discussions between the NSBSP, DHW, IWK, and CDHA started in early 2013 to plan the transition. From these discussions it was decided the NSBSP would report to the VP of Patient Care at the IWK for matters related to its service delivery components, whereas the matters related to provincial program aspects of the program would remain under the structure of the Acute and Tertiary Care branch of the DHW.

The transition to a host organization that has a greater focus on women’s health has been beneficial to date for the NSBSP, with great expectations for further collaborations and partnerships in the years ahead.
12.10 Invitation to Screening

The NSBSP was successful in an application to the CBCF-Atlantic Community Grant in 2013 to invite women aged 50-69 to the screening program who have never previously participated or have not returned in the last 5 years. With all breast imaging in the province now affiliated with the NSBSP, and the rollout of Full Field Digital Mammography (FFDM) across the province complete, the timing is right to reach out to the unscreened population.

Starting February 2014, the NSBSP sent an invitation letter to these women, informing them of the free service available, how to book an appointment, and the importance of early detection. This project directly addressed the need to inform un-screened women of the importance of early detection of breast cancer and clearly outlined the process required to book a screening mammogram at a site of their choosing.

The practice of inviting non-participants to an organized screening program is part of other Canadian provinces’ breast screening operations. Nova Scotia did initially send out invitations but has not been able to invite women over an extended period of time due to capacity issues. This roadblock was addressed with the addition of FFDM across the province. By directly targeting un-screened women, the NSBSP is making this initiative as cost-effective as possible.

As of 2011, there are an estimated 140,482 women aged 50-69 in Nova Scotia. In the past five years the NSBSP has screened 97,090 women aged 50-69 in Nova Scotia. The NSBSP estimates there are 41,550 eligible women aged 50-69 in Nova Scotia who have not received screening mammography services. This population was sub-divided into 3 equal groups- one third received a letter only, one third received a letter followed by a phone call and the third group were considered a control group and initially did not receive a letter or a call. After the period of 1 year the third group also received a letter. The calls have been completed in Dec 2015 as this was a considerable amount of work to add to existing staff.

Short-term goals of this initiative are:

- Increase call volume to NSBSP central booking office
- Increase volume of screening mammograms scheduled across Nova Scotia for women 50-69

Long-term goals of this initiative are:

- Increase screening participation rates across all Nova Scotia DHAs
- Reduce mortality rate from breast cancer

The results of this initiative will be detailed in next year’s annual report.

12.11 Technologist Training Tool

In co-ordination with the Nova Scotia Mammography Working Group and the Nova Scotia Diagnostic Imaging Management Advisory Committee, the NSBSP is updating the standard training tool for Medical Radiation Technologists (MRT) new to breast imaging in the province.

The tool is based on MRT qualification requirements from the Canadian Association of Radiologists (CAR) Mammography Accreditation Program (MAP) and designed to provide a robust exposure for MRTs to breast imaging. The tool recommends a training period of 6-12 weeks depending on site volume and scheduling.

An outline of the recommended training schedule is provided below:
Weeks 1-3 (Introduction Phase)

- Provide overview of Safety Code 33: Radiation Protection in Mammography.
- Provide overview of the Nova Scotia Breast Screening Program.
- Provide overview of mammography, ultrasound, needle core biopsy, wire localization, specimen imaging, and galactogram.
- Provide opportunity to liaise with breast imaging radiologist.
- Provide an overview of special mammography views including:
  - Roll views
  - Full magnification
  - Lateral pulls
  - Axillary tails
  - Medial pulls
  - 90
  - Spot compression
  - Ekland views
  - Spot magnification
  - Cleavage views
- Learn about: Clinical Breast Exam (CBE) & Breast Self Examination (BSE) techniques.
- Train: Computer system(s), taking histories, workflow, and mammography QC.
- Allow technologist-in-training to positioning with assistance, when comfortable. Technologist-in-training should be positioning 1/2 of every case (1 CC & 1 MLO) under direct supervision by end of week 1.

Week 2 (Direct Supervision Phase)

- Technologist-in-training should be positioning for entire mammogram procedure under direct supervision.
- Technologist-in-training must complete and record 50 mammograms under the direct supervision of an experienced Technologist.

(Note: due to variations in appointment volume, some sites may require longer than one-week to complete the direct supervision phase of training)

Weeks 3-12 (Close Supervision Phase)

- Technologist-in-training performs mammograms independently, requesting assistance if needed.
- Technologist-in-training continues to have cases checked until the end of training.
- Technologist-in-training must complete and record 300 mammograms under the close supervision of an experienced Technologist.
12.12 Canadian Breast Cancer Foundation (Atlantic) Funding

Meeting, achieving and maintaining high quality screening has largely been due to grants awarded since 1997 to the NSBSP by CBCF. The NSBSP acknowledges and thanks CBCF for funding over the years providing the women of Nova Scotia dedicated breast screening and shares the vision of a future without breast cancer.

Past NSBSP Funding:

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<td>2013</td>
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<td>Invitation to Screening Project</td>
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</tbody>
</table>

Ongoing
- Funding for The Intelligent Patient Guide
- Books included in the Pink Rose Kits
- Promotional Materials
13 Publications, Presentations and Posters

13.1 Publications


• Judy S Caines, MD FRCP; Gerald H Schaller, MD FRCP; Sian E Iles, MD FRCP; Jennifer I Payne, PhD. Stereotactic Needle Core Biopsy in Nova Scotia.


13.2  Poster Presentation (Contributed)


83


13.3 Oral Presentations (Submitted Abstracts)


13.4 Oral Presentations (Invited)


- Payne JI. Panelist Presentation: What can GIS do to help improve the health of populations? Annual General Meeting of the Canadian Association of Radiologists, Montreal, October 22-25, 2006.


A Nova Scotia Breast Screening Program Advisory Council - Terms of Reference

PURPOSE
To support a coordinated, provincial approach to breast imaging by reducing variability in service delivery and practice approaches, improving the uptake of standards and guidelines, and enhancing cooperation in improving identified health outcomes across the continuum. The work of the Nova Scotia Breast Screening Program Advisory Council (NSBSPAC) will be aligned with the Mission, Vision and Strategic Direction of the Department of Health and Wellness.

AUTHORITY
The NSBSPAC is established by and governed by the Department of Health and Wellness.

ACCOUNTABILITY
The NSBSPAC is accountable to the Department of Health and Wellness through the Acute and Tertiary Care branch.

RESPONSIBILITY
- To review a Strategic Plan and Annual Goals for breast imaging services.
- To advise on breast imaging service delivery models respecting the Vision for Breast Screening and the continuum of care for the Province.
- To guide the development of recommendations regarding the development and dissemination of clinical and system standards.
- To review adherence to approved standards and strategize on ways to achieve/enhance outcomes.
- To promote the application of breast imaging data in policy and practice decisions.
- To support Program recommendations and provide ongoing advice to the Department of Health and Wellness, based on environmental scanning of emerging issues, research, best practice, and evaluation.
- To support/ enhance effective two-way communication mechanisms with the District Health Authorities and the IWK, including reporting that supports the Business Planning Cycle.
- To develop a process for evaluating the work of the NSBSPAC.
- To assess new breast imaging technologies (i.e. tomosynthesis, information systems interfaces, breast MRI, 3D U/S, etc.).
- To assess the process and fiscal implications of adoption of new breast imaging technologies for both screening and diagnostic programs.
- To ensure linkage with other screening programs in Nova Scotia (gynaecological and colorectal cancer) and awareness of breast screening initiatives in other jurisdictions.
MEMBERSHIP

The NSBSPAC shall be comprised of 10 to 15 members. Membership will be from across jurisdictions with broad representation from the District Health Authorities, IWK Health Centre, and others within the health service delivery sector (administration, health professionals, and others), including the Nova Scotia Breast Screening Program Medical Director and Clinical Advisors, and aim to represent the continuum of health care.

The NSBSPAC members shall be appointed by the Department of Health and Wellness. Each member will be expected to participate in the majority of the meetings and participate in working groups or committees as requested.

CHAIR

The Chair of the NSBSPAC will be selected by the Department of Health and Wellness and appointed for a two-year term, renewable once.

EX OFFICIO MEMBERS

Ex officio members of the NSBSPAC shall include:

1. Program Manager, Nova Scotia Breast Screening Program
2. Director/Executive Director, Acute and Tertiary Care, Department of Health and Wellness
3. Medical Director for the Nova Scotia Breast Screening Program

NOMINATIONS

Existing NSBSPAC members will forward names of qualified candidates for consideration for appointment by the Department of Health and Wellness.

TERM

Members of the NSBSPAC shall be appointed for terms of two and three years initially and be eligible for one term renewal so as to create a staggered membership. The Membership term will be for two years.

NSBSPAC members will be appointed starting January 2013.

VOTING

At all NSBSPAC meetings, members will strive for consensus. Failing a decision by consensus, the question shall be determined by a simple majority of votes. In the event of a tie vote, the Chair will cast the deciding vote. Quorum shall be fifty percent (50%)

SPECIFIC COUNCIL RESPONSIBILITIES

Council members shall:

1. Recognize the Chair as NSBSPAC Spokesperson.
2. Attend regular NSBSPAC meetings and be prepared for meetings by reading relevant material.
3. Respond to correspondence/requests regarding the Nova Scotia Breast Screening Program business in a timely manner, or if unable to fulfill the request, communicate this in a prompt and courteous manner.
4. Ensure that controversial issues are presented and discussed fairly and without bias.

5. Respect all decisions and so will act in a way that strengthens the functions of the NSBSPAC within the broader community.

CONFIDENTIALITY

The NSBSPAC may at times be privy to information that shall remain confidential to the NSBSPAC members. Each member shall:

1. Respect and protect the proprietary and confidential information entrusted to the NSBSPAC and its members.

2. Avoid public discussions or comments about the Program or Program staff, NSBSPAC, or NSBSPAC members that could reasonably be seen as revealing confidential or potentially harmful information.

RELATIONSHIPS

The Nova Scotia Breast Screening Program provides leadership to reduce the mortality from breast cancer in Nova Scotia women. It does so by developing and sustaining individual and organizational partnerships fostered within an environment of trust, honesty, and respect.

GENERAL

NSBSPAC members shall:

1. Respect the opinions of others and treat all with equality and dignity without regard to gender, race, colour, creed, ancestry, place of origin, political beliefs, religion, marital status, disability, age, or sexual orientation.

2. Act with fairness, honesty, integrity, openness, and in good faith with a view to the best interests of the Nova Scotia Breast Screening Program.

3. Promote the mission, vision, and values of the Nova Scotia Breast Screening Program in dealing with the public, representing agencies/organizations, and stakeholder groups.

EXPENSES

NSBSPAC members shall receive no remuneration, but will be entitled for reimbursement of legitimate expenses for conducting NSBSPAC business.

REPORTING

The Minutes of the NSBSPAC will be submitted to the Department of Health and Wellness.

MEETINGS

While it is acknowledged that the NSBSPAC shall meet more frequently, a minimum of two (2) meetings shall be held annually with minutes duly recorded, approved, and circulated.
Diagnostic Mammography (Physician Referral)

Women who are symptomatic (have new breast problems) should be checked by their family physician and possibly have a Diagnostic Mammogram arranged for them by the physician’s office. A requisition must be completed. Physicians are required to fax requisitions for Diagnostic Mammograms to 473-3959 or toll free at 1-866-470-3959 and a booking time and date will be assigned. The requisition will be faxed back to the doctor’s office to be issued to the woman. These requisitions must indicate specific new signs or symptoms, or other reasons for diagnostic eligibility such as:

- Symptomatic
- Post Surgical Breast Biopsy (if less than 1 year)
- All post "benign" Core Biopsy follow-up mammograms until 2 years has elapsed
- All 6 month follow-up appointments
- Implants
- Pregnant or breast feeding
- Physically or mentally challenged
- Breast cancer survivors
- Women under the age of 40

Screening Mammography - Self-referral

The Canadian Association of Radiologists (CAR), National Standards and Guidelines for Breast Screening recommend mammography screening for asymptomatic women at least 40 years of age.

- Minimum age 40
- No new breast symptoms
- Minimum 1 year since previous mammogram
- Resident of Nova Scotia with a valid Nova Scotia Health card
- Pre HRT mammogram
- Fibrocystic, routine mammograms
- Women with a first degree family history of breast cancer

Frequency

Women aged 40-49 should have annual screening

Women aged 50-69 should have mammography screening at two year intervals unless they have a strong family history of breast cancer (mother, sister, daughter, father, brother, son), are currently on HRT or the radiologist has recommended to return sooner. Provincial/national guidelines recommended are evidence-based.

Women over the age of 70 should have screening mammography at two year intervals if they are in good health.
Ultrasound Guidelines

It is not recommended to use ultrasound as a screening tool. It may be utilized:

- As an additional test if an abnormality is seen on mammography
- As an additional test for a palpable abnormality
- As an initial test on women under the age of 30 if there is a palpable abnormality.

6 Month follow-up Mammography

If requested by the radiologist from a previous mammogram, 6 month mammogram or ultrasound procedures should be booked by the family physician. Following these short term follow-up requests, a return to routine screening is usual.

Benign Core Biopsy Protocol

6 months following a benign core biopsy a unilateral diagnostic mammogram is recommended
12 months following the benign core biopsy a bilateral diagnostic mammogram is recommended
24 months following the benign core biopsy it is recommended to resume regular guideline screening

Atypical Core Biopsy Protocol

Treatment following a core biopsy with a histological diagnosis of "atypical ductal hyperplasia" is recommended to be similar to any borderline lesion. This should involve a surgical consult and probable excisional biopsy.
C Diagnostic Mammography Requisition

---

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<tbody>
<tr>
<td>Phone: 1-800-565-0548</td>
</tr>
<tr>
<td>Fax: 1-866-470-3959</td>
</tr>
</tbody>
</table>

Diagnostic Mammography Consultation Request
Requisition will be returned if the following information is not provided

Appointments Site Requested:  
- Amherst  
- Antigonish  
- Bridgewater  
- Dartmouth  
- Halifax  
- Kentville  
- New Glasgow  
- Sydney  
- Truro  
- Yarmouth

**PATIENT INFORMATION**

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<th>Name</th>
<th>D.O.B</th>
<th>Tel#</th>
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<tbody>
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<td>Address</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>Mode of Transport: Ambulatory / Chair / Stretcher / Portable</td>
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<td></td>
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</table>

If exam is for research purposes, provide Account #: 

**REQUESTED APPOINTMENT** (for internal use only)

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<tr>
<th>Date:</th>
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<tbody>
<tr>
<td>Mammo Appt:</td>
</tr>
<tr>
<td>Ultrasound Appt:</td>
</tr>
<tr>
<td>Site Booked:</td>
</tr>
</tbody>
</table>

PLEASE INFORM PATIENT OF APPOINTMENT

**EXAMINATION REQUESTED**

- Diagnostic Mammogram
- Core Biopsy
- Needle Localization
- Breast MRI
- Other Examination (specify)

Where appropriate, indicate Left / Right

**COMMENTS** (Please be specific)

---

**CHECK WHERE APPROPRIATE**

- Nipple Discharge
- Nipple Retraction
- Breast Implants
- Erythema of Skin
- Papillary Area
- Peau D’Orange
- Ulceration
- Pain Tenderness

**PATIENT HISTORY**

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<td>Previous Surgery</td>
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<td>Date</td>
<td>Previous Radiation</td>
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</tr>
<tr>
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<td>Y / N</td>
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**REQUESTING PHYSICIAN INFORMATION**

Requesting Physician’s Name: 

| Telephone: |
|           |
| Fac:      |

Signature:  

<table>
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<th>Date (YYYY/MM/DD):</th>
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**TECHNOLOGIST INFORMATION** (For internal use only)

Name:  

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<th>Room #</th>
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18 x 24  
24 x 30

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Your Health Matters  

Nova Scotia Health