

Vertical Strip Breast Exam Improves Detection

BY PATRICE WENDLING
Chicago Bureau

QUEBEC CITY — Residents trained using the vertical strip clinical breast exam are significantly more likely to detect and be able to describe small breast masses, Elizabeth Steiner, M.D., reported at the annual meeting of the North American Primary Care Research Group.

The vertical strip three-pressure method examines the breast in overlapping vertical strips using the pads of the first three fingers with light, then medium, then deep pressure. It covers a wide area of the chest from the clavicle down to the inframammary ridge and out to the lymph nodes.

Unlike the standard concentric circle or wedge methods, it includes the entire nipple-areolar complex where 15%-20% of breast cancers originate, said Dr. Steiner of Oregon Health and Science University, Portland.

The method has been endorsed as the best breast exam method by the Centers for Disease Control and Prevention and the American Cancer Society (CA Cancer J. Clin. 2004;54:327-44). But it has a drawback: It takes 3-5 minutes per breast to perform.

"One of the things we get from diagnosticians is that this takes too long," Dr. Steiner said in an interview. "But the one factor that has been shown to make a difference in every study about breast exam sensitivity is the time you take. In our study, for every 15 seconds you took, it made you 29% more likely to find a 3-mm mass."

In the study, 72 first-year residents were trained using a 1- to 2-hour online self-study with a video and a 2.5-hour practicum with trained faculty using silicone breast models and a patient surrogate. A total of 93 second-year residents received no training in the vertical strip method beyond what they'd received in medical school.

Standardized, structured clinical exams were performed 3-6 months after training using a silicone model, and were evaluated by trained (but not blinded) observers. Residents who were unavailable because of their clinical responsibilities were excluded from analysis.

A 3-mm mass was detected by 42 of 50 (84%) trained residents and 30 of 65 (46%) untrained residents. The difference was statistically significant.

Of those finding a mass, 62% of trained and 10% of untrained residents were able to document their findings using at least five of eight standardized descriptors.

About 85% of trained residents were able to find a mass within 6 minutes, compared with about 45% of untrained residents.

When the concentric circle or wedge methods with only one or two levels of pressure were used, 70% of trained vs. 40% of untrained residents were able to find the mass.

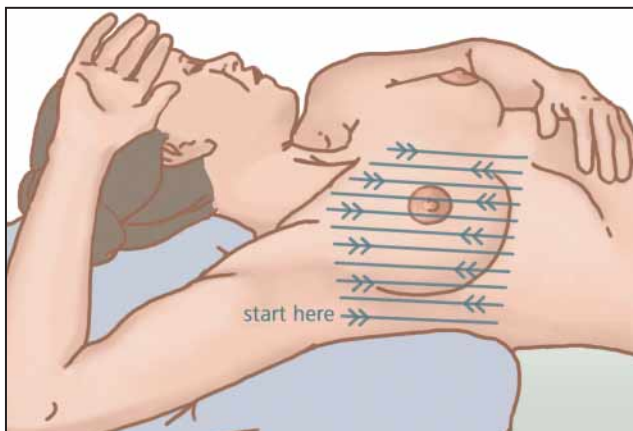
"We believe that this confirms the consensus report recommending the vertical strip, three-pressure method as the most sensitive technique, but also that thorough training improves sensitivity regardless of technique used," Dr. Steiner said.

Based on the study's findings, Oregon

recently became the first state to approve reimbursement for the vertical strip breast exam separate from a comprehensive women's health exam.

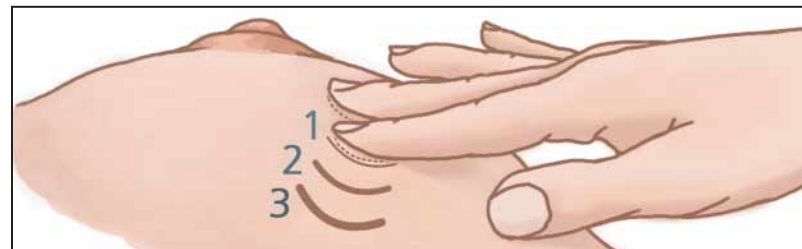
This could lead the way toward greater national acceptance of the method, and also encourage more physicians to teach their patients to use this method at home, said Dr. Steiner.

"A lot of women don't feel very skilled [at the breast self-exam]," she said. "We can do a better job of teaching women to do this exam." ■



The vertical strip pattern allows consistent examination of the entire breast tissue area across the chest wall.

Palpating using light, medium, and deep pressure sequentially increases the likelihood that breast cancers at every level of breast tissue can be detected when small.



The outline shows all areas that could contain breast tissue.

Whole-Breast Irradiation for the Elderly Questioned

BY BRUCE JANCIN
Denver Bureau

DENVER — Whole-breast irradiation coupled with breast-conserving surgery and hormone therapy remains the standard of care in women with favorable early breast cancer, Richard Poetter, M.D., said at the annual meeting of the American Society for Therapeutic Radiology and Oncology.

New data from a large multicenter randomized Austrian trial demonstrate that although lumpectomy plus 5 years of tamoxifen or an aromatase inhibitor provides "excellent" results in such patients, "we can do significantly better if we add whole-breast radiotherapy," said Dr. Poetter of the University of Vienna.

But this assertion was challenged by discussant Kevin S. Hughes, M.D., who argued that the benefits conferred by the addition of radiation therapy (RT), while statistically significant, are modest and do not rise to the level of clinical significance or warrant standard-of-care status.

He urged an individualized approach to

breast RT, a treatment he said most elderly patients are best spared.

"Breast radiation therapy provides less and less benefit as women get older," said Dr. Hughes, surgical director of the Avon Foundation Comprehensive Breast Evaluation Center at Massachusetts General Hospital, Boston. "Most radiation oncology colleagues I know would agree that in elderly patients, breast irradiation plus tamoxifen or an aromatase inhibitor is overkill and is seldom required. Where

we disagree is in deciding who are the elderly."

'We can do significantly better if we add whole-breast radiotherapy.'

DR. POETTER

lymph nodes, and positive tumor estrogen and/or progesterone receptor status. All underwent lumpectomy plus hormone therapy and were randomized to whole-breast RT or not in the Austrian Breast and Colorectal Cancer Study Group trial 8. Patients in the RT arm received 50 Gy to the breast; two-thirds of them got an additional 10-Gy boost.

After a median 42 months' follow-up,

the 5-year local recurrence rate—the primary study end point—was 4.5% in controls, compared with 0.6% in the RT group. The risk of local relapse was increased 13.5-fold by lack of RT.

Dr. Hughes, however, flipped those figures around, noting the Austrians had shown that more than 96% of study participants who were exposed to the cost, inconvenience, and potential toxicities of RT derived no benefit from it.

"Perhaps a more intelligent way of looking at these older patients is to say 'lumpectomy plus radiation therapy' or 'lumpectomy plus tamoxifen.' Both give very good outcomes as patients age," he continued.

Dr. Poetter noted that four cases of contralateral breast cancer arose among controls, versus none in the RT group. However, RT had no significant impact upon distant metastasis or overall survival rates.

The 42-month follow-up in the Austrian trial is relatively brief, Dr. Hughes said. More mature 7-year data are now available from the similarly designed Cancer and Leukemia Group B trial 9343, in which he was the lead investigator. Five-year data already have been reported from the trial, in which 636 women aged 70 years or older with favorable early breast cancer treated by lumpectomy and tamoxifen were ran-

domized to RT or not (N. Engl. J. Med. 2004;351:971-7).

At 7 years, 99% of women in the RT arm remain disease free, compared with 94.4% with lumpectomy and tamoxifen alone. "But whether you irradiate or not, essentially 98%-99% of those women will preserve their breast through the remainder of their lives," the surgeon said. "So we need to think when we give radiotherapy to older individuals, what are we really buying?" ■

Breast Cancer Booklet Available

The Agency for Healthcare Research and Quality has released a booklet that is designed to help Hispanic women recently diagnosed with early-stage breast cancer choose among surgical options. The booklet is the Spanish-language version of "Surgery Choices for Women with Early-Stage Breast Cancer."

To download a copy visit www.ahrq.gov/consumer/brcanchoicesp.htm (Spanish) or www.ahrq.gov/consumer/brcanchoice.htm (English).

