An investigation of workstation image manipulation usage when examining FFDM images

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ORAL PRESENTATIONS

O1 Validation of a new automated volumetric breast density measurement system as a marker of breast cancer risk
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Purpose To validate the predictive power for determining breast cancer risk of an automated breast density measurement system with full-field digital mammography (FFDM).

Materials and methods Two hundred cancers and 200 controls were imaged with FFDM. Density was measured separately on MLO and CC images using an integrated automated volumetric breast density measurement system (Hologic, Quantra). For each cancer, the contralateral mammogram was used. Each cancer was matched to a control case by date of birth, age at examination and laterality of mammogram used for density determination.

Breast density (percentage of fibro-glandular tissue) was analyzed by Quantra automated volumetric breast density measurement system as a marker of breast cancer risk

Results The percentage of breast density ranged from 6% to 63%. Density declined significantly with age (P <0.001). Overall, there was no significant association of density with risk of breast cancer (P = 0.4). There was a suggestive increase in risk with dense volume higher than 35% (OR = 1.80, 95% CI = 0.96 to 3.39, P = 0.07). There was significant heterogeneity by age in the effect of density on risk (P = 0.04). In women aged <50, density was significantly associated with increased risk (P = 0.02), with odds ratios of 4.06, 3.98 and 10.59 for density volumes of 15 to 24%, 25 to 34% and ≥35% respectively, relative to those with <15%. In women aged ≥50 years there was no association of density with risk (P = 0.5).

Conclusions Quantra automated volumetric breast density measurement is strongly associated with breast cancer risk in women aged under 50, but not in women aged ≥50 years over.

O2 Ultrasound elastography as an adjuvant to conventional ultrasound in the preoperative assessment of axillary lymph nodes in suspected breast cancer: a pilot study
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Introduction NICE guidelines recommend conventional ultrasound (CU) of the axilla as preliminary staging in patients with breast cancer. However, up to one-third of nodes showing normal morphology are metastatic on surgical histology [1]. Ultrasound elastography (UE) uses received radiofrequency data to produce an elastogram depicting tissue stiffness. UE has been researched in the breast but there are no published data regarding UE of the axilla.

Methods Fifty women attending the breast unit as symptomatic GP referrals with breast lesions sonographically suspicious of breast cancer underwent UE of the axilla simultaneously with routine CU examination. Elastograms were visually scored, strain measurements calculated and nodal perimeter and area measurements recorded. UE was compared with CU with histology as the reference standard.

Results Twenty-nine nodes were histologically normal, 21 were metastatic. Normal nodes were indistinguishable from surrounding tissue on UE. Using cut-off points for biopsy selected for the study, sensitivity was 90% for UE visual scoring, 100% for strain scoring and 76% for CU. Specificities were 86%, 48% and 78% respectively. ROC analysis yielded AUC values of 0.9 for UE visual scoring, 0.86 for strain scoring and 0.82 for CU. There was no significant difference between any area and perimeter measurements.

Conclusions UE can demonstrate axillary lymph nodes and differentiate benign from malignant nodes. UE visual scoring shows greatest promise in improving yield without excessive benign biopsies.

Reference

O3 Size matters: second breast cancer size following treatment for primary cancer as a predictor of survival
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Introduction The purpose of surveillance mammography following primary breast cancer treatment is to detect subsequent cancers at the smallest size. We examined the prognostic effect of size of ipsilateral breast tumour recurrence (IBTR) and metachronous contralateral breast cancer (MCBC) to assess potential benefit of surveillance mammography after breast cancer treatment.

Methods Second cancers (IBTR n = 1,174, MCBC n = 975) diagnosed between 1 January 1990 and 31 January 2007 from the West Midlands Cancer Intelligence Unit Breast Cancer Registry were analysed. Survival from diagnosis of second cancer was examined using Cox regression models. Risk factors included were prognostic factors of the primary tumour and size of the second tumour. Outcomes were time to all-cause death and to breast cancer death. Estimates are hazard ratios (HRs) and 95% confidence intervals.

Results There were 613 all-cause deaths and 422 breast cancer deaths after IBTR. For both outcomes, second cancers >2 cm had poorer prognosis compared with those <1 cm, HRs were 1.75 (1.29 to 1.37) and 1.99 (1.37 to 2.89). In MCBC there were 358 all-cause deaths, HR 2.14 (1.49 to 3.06), and 23 breast cancer deaths, HR 1.99 (1.38 to 2.83).
Conclusions With either IBTR or MCBC the size of the second tumour is important, patients with cancers >2 cm in diameter being at a significantly greater risk of death. Lead-time bias from the mode of detection may be a factor in these results. The frequency of surveillance mammography should be considered for maximum benefit.

O4 Reduced breast biopsy rates with a combined high temporal and high spatial resolution MR imaging protocol at 3 Tesla K. Pinter1, W. Bogner2, S. Gruber2, G. Grabner2, S. Trattning1, T.H. Helbich1
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Purpose To develop a 3.0 Tesla breast imaging protocol that combines high temporal and spatial resolution 3D MR sequences for quantitative time course and morphological analysis of breast lesions.

Materials and methods One hundred and sixty-five breast lesions classified by mammography or ultrasound as BI-RADS 4 and 5 were included in this prospective IRB-approved study. The MRI protocol consisted of a coronal T2-weighted TIRM and a coronal combined high temporal and spatial resolution T1-weighted sequence before and after application of a standard-dose Gd-DOTA (VIBE with a high temporal resolution of SI 1.7 mm isotropic; TA 3.45 min for 17 measurements; FLASH with high spatial resolution of SI 1 mm isotropic; TA 2 min). Lesion size and morphology were assessed according to the BI-RADS classification. ROIs for suspicious areas were manually drawn and evaluated for contrast-enhancement behavior by plotting intensity courses against time. Sensitivity and specificity with a 95% confidence interval and the negative predictive value (NPV) and positive predictive value (PPV) were calculated. Diagnostic accuracy was assessed. The histopathological diagnoses were used as the standard of reference.

Results All malignant breast lesions were identified correctly with a sensitivity of 100%, a specificity of 84% and a diagnostic accuracy of 95.7%. PPV was 0.94 and a NPV 1. All seven false positive lesions were lesions with atypia.

Conclusions The proposed combined 3 Tesla MR imaging protocol, comprising both high temporal and spatial resolution, enabled an accurate detection and assessment of breast lesions with high sensitivity and specificity reducing false positive breast biopsies.

O5 MR visible only lesions: what are the predictors for malignant outcome? M. Bhattacharyya, F. Ng, W. Teh
Northwick Park Hospital, Harrow, UK

Introduction To correlate pathological outcomes of MRI vacuum biopsies on MRI visible only breast lesions with lesion morphology, time-enhancement curves and clinical indications to determine the use of these as predictors for malignancy.

Methods A retrospective analysis of 277 patients referred for MRI-guided vacuum biopsies of impalpable breast lesions visible only on MRI was performed. All patients had a minimum follow-up period of 11 months. MRI biopsies were undertaken on a 1.5 T magnet using a minimum of 12 passes of vacuum-assisted biopsies. The pathological findings were correlated against BI-RADS appearances and time-enhancement characteristic of the lesions and against the clinical indications for MRI examination.

Results A total of 286 vacuum biopsies were undertaken. Eighty-one were malignant (28.3%), of which 72.8% are masses and 27.2% are nonmasses. Only two malignant lesions had a type 1 curve (2.5%), compared with malignant lesions with type 2 (54.3%) and type 3 curves (43.2%). Both malignant lesions with type 1 curve had a suspicious morphology. Nonmalignant lesions with type 3 enhancement included lymph nodes, fibroedematomatoid hyperplasia, papillary lesions, fibrocystic change and lobular neoplasia.

Conclusions Lesion morphology and time-enhancement curves are useful predictors of malignancy and can be used to develop an algorithm to help direct appropriate biopsy of MRI-detected lesions. We recommend that in the absence of suspicious morphology, only lesions with type 2 and type 3 curves should be subjected to MRI-guided biopsy.
P2
Flat epithelial atypia: biological significance on core biopsy
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Introduction Flat epithelial atypia (FEA) is seen with increasing frequency following biopsy of calcification detected through screening. FEA is often associated with more significant lesions including atypical ductal hyperplasia and ductal carcinoma in situ (DCIS). It is postulated that FEA may even represent the earliest morphological manifestation of DCIS and a precursor to invasive carcinoma. However, the significance of pure FEA still remains unclear. We aim to review the radiological and pathological features of FEA and evaluate the significance of FEA on needle core biopsy.

Methods We performed a retrospective analysis of all needle core biopsies containing FEA in the pathology database from April 2008 to April 2010. For each case the following data were recorded: mammographic features, method of further sampling (mammotome or diagnostic surgical biopsy) and histology from needle core biopsy, mammotome biopsy and surgical biopsy.

Results There were 35 needle core biopsies that contained pure FEA, of which 89% (31/35) were associated with mammographic calcification. Following initial core biopsy, 21 patients had further sampling with mammotome biopsy, 13 patients underwent diagnostic surgical biopsy and one patient was not suitable for further intervention. There was an upgrade to DCIS in 18% (6/34) and invasive carcinoma in 3% (1/34).

Conclusions Pure FEA on core biopsy is upgraded to carcinoma in 21% (7/34) of cases on further sampling and it is vital that we do not underestimate the biological significance of FEA. Increasing the awareness of FEA is crucial to ensure consistent and appropriate patient management.

P3
Two-view 2D digital mammography versus one-view digital breast tomosynthesis
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Introduction In routine breast screening using 2D digital mammography (2DM), mediolateral-oblique (MLO) and cranio-caudal (CC) views are performed to maximise cancer detection. Digital breast tomosynthesis (DBT) improves the visibility of lesions by eliminating the problem of superimposition of normal structures, and there is uncertainty regarding the need for two views. The purpose of this study is to compare the accuracy of two-view 2DM with one-view DBT.

Methods Five hundred and one cases were evaluated from the DBT trial dataset of clients recalled for further workup after their initial film-screen mammography. Bilateral two-view 2DM and DBT examination were performed in all study subjects. Mammography scores (1 to 5) based on RCR Breast Group criteria were recorded and an overall score for 2DM was established based upon the highest value of MLO and CC scores. Unblinded interpretation of the 2DM followed by MLO-alone DBT was carried out. Statistical analysis was done using the receiver-operatory characteristic (ROC).

Results There were 111 (22.1%) cancers. The ROC area under the curve (AUC) for two views combined 2DM was 0.915 and for MLO-alone DBT was 0.960 (difference 0.045; P = 0.009). The distribution of M-scores against the histology-proven malignant lesions is presented in Table 1.

Conclusions In this series, one-view (MLO-alone) DBT had superior sensitivity compared with two-view 2DM.

Table 1 (abstract P3)

<table>
<thead>
<tr>
<th>Imaging score</th>
<th>Imaging combined 2DM, n (%)</th>
<th>MLO-alone DBT, n (%)</th>
<th>Percentage difference, Δ</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>M2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>M3</td>
<td>28 (25.2%)</td>
<td>18 (16.2%)</td>
<td>↓9%</td>
</tr>
<tr>
<td>M4</td>
<td>32 (28.9%)</td>
<td>26 (23.4%)</td>
<td>↓5.4%</td>
</tr>
<tr>
<td>M5</td>
<td>50 (45.0%)</td>
<td>67 (60.3%)</td>
<td>↑15.3%</td>
</tr>
</tbody>
</table>

P4
Accuracy of breast cancer detection with full-field digital mammography and integral computer-aided detection correlated with breast density as assessed by a new automated volumetric breast density measurement system
K Pinker1, N Perry2, S Milner3, K Mokbel1, S Duffy4
1Department of Radiology, Division of Molecular and Gender Imaging, Medical University Vienna, Austria; 2Princess Grace Hospital, The London Breast Institute, London, UK; 3Wolfson Institute, Queen Mary College, University of London, UK; 4Breast Cancer Research 2010, 12(Suppl 3):P4 (doi: 10.1186/bcr2657)

Purpose To assess the diagnostic performance of computer-aided detection (CAD) for full-field digital mammography (FFDM) correlated with breast density assessed by an automated breast density measurement system (Hologic, Quantra) in breast cancers and age-matched healthy controls.

Materials and methods Two hundred breast cancers imaged with FFDM and 200 age-matched healthy controls were evaluated retrospectively using CAD. A CAD mark was scored true-positive if it correctly indicated a malignant lesion. All other CAD marks were considered false. CAD sensitivity and specificity were calculated and correlated with mammographic breast density (%).

Results CAD correctly identified 157 of the 200 cancers, a sensitivity of 79%. Sensitivity was suggestively but nonsignificantly lower with increased density (P = 0.09). In those cancer cases with density at or below the median of 20%, sensitivity was 82%, compared with 75% in those with density above the median. The presence of one or more false CAD prompts was suggestively but not significantly more likely in controls than cases (87% vs. 80%, P = 0.06). The number of false prompts was significantly higher in controls (average 3.6 vs. 2.6, P <0.001). False prompts were significantly less likely with higher density (P = 0.008). False prompts were present in 86% of cases and controls with density at or below the median, and in 81% of those with density above the median.

Conclusions Increased breast density is significantly associated with higher specificity of CAD, and there is suggestive evidence that it is also associated with lower sensitivity.

P5
Surveillance following breast cancer: is it cost-effective?
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1Health Services Research Unit, University of Aberdeen, UK; 2Health Economics Research Unit, University of Aberdeen, UK; 3Division of Applied Medicine, School of Medicine and Dentistry, University of Aberdeen, UK; 4Aberdeen Royal Infirmary, NHS Grampian, Aberdeen, UK; 5Aberdeen Biomedical Imaging Centre, University of Aberdeen, UK

Introduction There is debate about the role and optimal organisation of follow-up following treatment for primary breast cancer. We estimated using the best available evidence whether early detection by surveillance of ipsilateral breast tumour recurrence (IBTR) and metachronous contralateral breast cancer (MCBC) was cost-effective.

Methods An economic model compared alternative surveillance strategies involving mammographic surveillance and/or clinical follow-up performed at differing surveillance intervals. The model structure was based upon discussions with the clinical experts involved in the study, a survey of UK breast surgeons and radiologists, and the literature. Data to populate the model came from a series of systematic reviews and an analysis of the West Midlands Cancer Intelligence Unit Breast Cancer Registry. Results of the model were presented as incremental cost per QALYs – a measure of relative efficiency.

Results The surveillance strategy most likely to be cost-effective was mammographic surveillance alone provided every 12 to 24 months. This result held for women who had previously received either breast-conserving surgery or mastectomy. Results were sensitive to primary tumour characteristics (size,
grade, nodal involvement) used to define the likelihoods of developing an IBTR or MCBC. More intensive follow-up of women with higher likelihood of developing IBTR or MCBC may be worthwhile.

**Conclusions** Our conclusions remain tentative due to the paucity of the underlying evidence base but suggest surveillance is likely to improve survival, with a strategy of mammography alone every 12 to 24 months appearing cost-effective.

### P6

**A pilot study to evaluate assisted freehand ultrasound elasticity imaging in the sizing of early breast cancer: a comparison of B-mode and assisted freehand ultrasound elasticity ultrasound with histopathology measurements**

R. English1, L. Li2, A. Parker1, D. Roskell2, R. F. Adams1, V. Parulekar1, J. Baldwin2, Y. Chi2, A. Nicol2


**Purpose** Preoperative breast cancer sizing is required for surgical planning. Breast ultrasound is widely used but may not be accurate. Assisted freehand ultrasound (AFUSON) of the breast is a novel method of ultrasound scanning, combining semi-automated elasticity ultrasound with B-mode imaging. This pilot study investigates whether AFUSON sizing corresponds more closely with wide local excision tumour dimensions than with B-mode alone.

**Methods** Twenty-three patients with early breast cancer were recruited with ethical approval through the NHSBSP. B-mode ultrasound and AFUSON images were acquired in predefined planes. Pathology slices were taken in the corresponding longitudinal plane and were digitally scanned. Assessment of tumour dimensions, area and contour were made on B-mode, AFUSON and histopathology scans. The findings were correlated.

**Results** Although there were significant limitations in this pilot study, the tumour dimension accuracy increased from 66% (B-mode alone) to 82% (AFUSON). Tumour area accuracy increased from 61% (B-mode alone) to 90% (AFUSON). Some AFUSON contour images showed a high visual correlation with the equivalent histopathology scans.

**Conclusions** This pilot study suggests that AFUSON may be useful in early breast cancer sizing. Further studies will be done to acquire more data and to address some of the shortfalls in the study.

### P7

**Promoting early symptomatic presentation in older women with breast cancer in the NHS breast screening programme**

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**Introduction** Women over 70 have poorer breast cancer survival than younger women, and this may be due to late stage at presentation [1]. Promoting early presentation with symptoms in older women attending for their final round of breast screening may reduce stage at diagnosis cost-effectively, and is unlikely to lead to overdiagnosis. We tested the efficacy of the 10-minute radiographer-delivered Promoting Early Presentation (PEP) Intervention to promote early presentation by increasing breast cancer awareness in the NHS Breast Screening Programme.

**Methods** We randomised 867 women attending their final round of screening to receive the PEP Intervention or usual care, measuring breast cancer awareness at baseline and 1 year. We systematically reviewed the evidence of effectiveness of interventions to promote cancer awareness and early presentation.

**Results** At 1 year, the intervention increased the proportion breast cancer aware compared with usual care (24% vs. 4%; odds ratio = 13.2, 95% CI = 4.8 to 47.8). The systematic review found one randomised trial of a one-to-one intervention that showed a much smaller effect on breast cancer awareness.

**Conclusions** The PEP Intervention is more effective than any other intervention to promote breast cancer awareness. It will now be offered to all women attending for a final mammogram in three NHS breast screening services, to assess costs and feasibility and to measure its effect on breast cancer awareness in routine clinical practice. If implemented across the whole Programme, the PEP Intervention has the potential to reduce avoidable deaths from delayed symptomatic presentation in older women.

### P8

**Mammographic follow-up of patients after treatment for breast cancer: is 5 years enough?**

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1. Velindre Cancer Centre, Cardiff, UK; 2. University of Wales, Cardiff, UK


**Introduction** Velindre Cancer Centre (VCC), Cardiff provides radiotherapy and oncology services to the population of 1.5 million across southeast Wales. Historically at Velindre, breast cancer patients are followed up for at least 10 years, with annual mammography underpinning the service. The optimal length for continued annual surveillance has been debated and reduction to 5 years follow-up suggested. Therefore, a retrospective audit of breast cancers diagnosed on follow-up mammograms was undertaken to support the proposed reduced length of mammographic follow-up.

**Methods** Using the RIS and HIS electronic databases, follow-up mammograms over a 3-year period from 1 June 2006 to 31 May 2009 were collected and their report codes checked. All mammogram reports are coded using the Breast Imaging Reporting and Data System (BI-RADS). All mammograms coded 3 and above were identified. Subsequent radiological and histological reports were reviewed to identify confirmed malignancies.

**Results** In this 3-year period, there were 6,294 follow-up mammogram examinations at VCC. Ninety-seven reports were coded 3 or above (1.5%). Fifty-six new malignancies were confirmed. Of these, 44 (79%) occurred more than 5 years from original diagnosis.

**Conclusions** The results do not support reducing the length of follow-up to 5 years. Further analysis of original pathology will be undertaken to attempt to risk-stratify patients and thus allow tailored follow-up regimes to be developed.

### P9

**An investigation of workstation image manipulation usage when examining FFDM images**

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1. Loughborough University, Loughborough, UK; 2. Nottingham Breast Institute, Nottingham, UK; 3. University of Dundee, UK


**Introduction** With the introduction of digital breast screening across the UK, screeners need to learn how best to inspect these images. A key advantage over mammographic film is the facility to use workstation image manipulation tools.

**Methods** Forty-two breast FFDM cases, representing malignant, normal and benign appearances, were examined by 14 radiologists and advanced practitioners from two UK screening centres. For half the cases, the mammography workstation image manipulation tools could be employed; and for the other half these were not used. Participants classified each case and indicated whether an abnormality was present. Throughout the study, the participants visual search behaviour as well as their image manipulations were recorded.

**Results** Whether or not image manipulation tools were used made very little difference to overall performance (t test, P >0.05) as confirmed by JAFROC analysis of the images, and indicated whether an abnormality was present. Throughout the study, the participants visual search behaviour as well as their image manipulations were recorded.

**Conclusion** For these cases, whilst using imaging tools was not necessary to identify abnormalities, their use improved confidence, especially in identifying normal appearances. With experience, less use of such tools was evident.
Introduction ShearWave™ elastography (SWE) provides a quantitative assessment of tissue stiffness with high spatial resolution and may improve characterization of breast masses. The goal of this study was to evaluate the reproducibility of SWE and the impact of adding SWE features to the BI-RADS classification of breast masses from the first 1,000 cases in a prospective multicenter trial.

Methods SWE studies were performed on a prototype of the Aixplorer system (SonoMed, Aix-en-Provence, France). A subset of 192 breast lesions (42.71% malignant) was analyzed. Reproducibility of SWE images and measurements was assessed; logistic regression analysis was performed to predict the pathology findings. SWE features were added to the ultrasound BI-RADS to generate models that were challenged by comparing the areas under the ROC curves (Az), and the sensitivity and specificity scores.

Results In the preliminary analysis, intra-operator reproducibility of SWE size (R = 0.903) and mean elasticity (R = 0.688) measurements were in near-perfect agreement. Using the best three-variable model (BRADS + elasticity shape + maximum elasticity), the Az increased from 0.77 to 0.93 and specificity increased from 61.8% to 87.3%, although sensitivity decreased from 92.7% to 87.8%. Adding more variables did not effect further improvements.

Conclusions In this ongoing study, SWE provided reproducible information (elasticity values and SWE mapping) that improved the characterization of breast lesions. These features are directly linked to the characteristics of SWE: local quantification and millimeter resolution. Further evaluation of the study is in progress.
P14 Can touch imprint cytology replace fine needle aspiration within current clinical practice?
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Southern Health and Social Care Trust, Portadown, UK

Introduction To investigate whether touch imprint cytology (TIC) of needle core biopsy (NCB) is as effective as fine needle aspiration cytology (FNAC) for providing same-day diagnosis of benign and malignant breast lesions at our one-stop symptomatic breast clinic.

Methods We prospectively studied 426 women with image-detected breast lesions who underwent FNAC and NCB with subsequent TIC. All of the FNAC and TIC samples were sent for immediate reporting. These were read by one of five consultant cytopathologists. The TIC results were subsequently compared with the definitive histopathology from either the core biopsy or the final surgical specimen.

Results Complete data were present for all patients. TIC was compared with FNAC in providing an accurate and definitive same-day diagnosis in lesions graded C2 (benign) and C5 (malignant). For FNAC, C2 = 75/426 and C5 = 210/426 allowing 66.8% of women a definite same-day diagnosis. For TIC, C2 = 92/426 and C5 = 223/426 allowing 73.8% of women a definite same-day diagnosis. There were no false positive results.

Conclusions The accuracy of TIC is at least equivalent to FNAC when used as a stand-alone technique for definitive same-day diagnosis from a single biopsy. We therefore conclude that FNAC is no longer necessary, thus saving a second invasive procedure.

Figure 1 (abstract P15). Left: tumour visualisation with conventional analysis DCE-MRI. Middle: CAD curve shape map (red, wash-out; green, plateau; blue, persistent). Right: kinetic curve.

P15 A novel threshold-independent computer-aided detection algorithm for breast MRI
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1Sheffield Teaching Hospitals NHS Foundation Trust, Sheffield, UK; 2Image Analysis Ltd, Leeds, UK

Introduction Image degradation due to motion artefact in breast MRI represents a diagnostic challenge. Tumours are often detected manually by a radiologist or with computer-aided detection (CAD) systems, which utilise areas of enhancement that meet a predefined threshold. The aim of this study was to test a new threshold-independent CAD algorithm and to correlate its findings to the conventional manual analysis.

Methods CAD was tested on retrospectively acquired MRIs of 14 patients with pathologically proven carcinomas. CAD results were obtained in a fully automated manner and the expert was blinded to the CAD findings. Noise artefacts were eliminated with the patient motion reduction algorithm and suspicious tissues were delineated using a novel all-timepoint-based, threshold-independent parametric map approach. The algorithm evaluates the shape of the curve as a whole and uses the noise integral to the image to discriminate malignant from benign tissues.

Results All CAD-identified tumours and generated kinetic curves were comparable with those of the manual analysis. In particular, tumour conspicuity was enhanced in two cases where image degradation by motion artefacts made data interpretation challenging to conventional analysis. See Figure 1.

Conclusions CAD results were favourably viewed by experts and 100% correlated to conventional manual tumour detection. In particular, CAD appears to increase tumour conspicuity in cases with motion artefacts. Prospective analysis is required to test this model further.

P16 Educational abstract
Educational abstract not submitted for online publication.

P17 Clinical value of hybrid imaging for staging breast cancer in a district general hospital
FR Canavan, E Lloyd, D Jones, J Edwards, M Powell
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Introduction Hybrid imaging, integrating anatomical computed tomography (CT) with functional single-photon emission computed tomography (SPECT), has emerged as a powerful diagnostic tool in breast cancer imaging. This dual modality increases the specificity of skeletal scintigraphy in detecting bony metastases and achieves accurate sentinel lymph node mapping, directly influencing the surgical approach. For patients with high-grade breast cancer, hybrid SPECT/CT provides the opportunity for a ‘one-stop shop’ with important implications for patient care, cost-effectiveness and follow-up.

Methods We included 50 women with >15 mm grade 2 or grade 3 invasive breast cancer attending our imaging department over 6 months. Each underwent SPECT/CT imaging protocol using a 16-slice Phillips Precedence. A questionnaire assessed type/number of imaging visits and perceived anxiety levels. Change to patient management, radiation dose and estimated costs were also collected from the trust patient and imaging information systems and multidisciplinary notes, to assess overall value.

Results One-third of patients underwent significant change in medical or surgical management based on hybrid imaging. Overall, >90% of patients surveyed reported higher satisfaction following a ‘one-stop’ visit. Cost and total radiation dose of combined imaging were more favourable than for single visits.

Conclusions Whilst hybrid SPECT/CT in breast imaging remains in its infancy, its potential to add value for the clinician and patient is clear. The positive advantages for patient management and convenience/cost suggested in our pilot study suggest it is likely to influence future breast cancer management protocols.

P18 Comparison of 1.5T and 3T in assessment of suspicious breast lesions
SK Arcot Ragupathy,1 T Gagliardi1, TW Redpath2, S Flynn1, B Jagpal1, JKP Begley1, FJ Gilbert2
1Aberdeen Royal Infirmary, Aberdeen, UK; 2University of Aberdeen, UK

Introduction MRI at 3T has advantages of increased spatial and temporal resolution but with known transmit field inhomogeneity problems. The objective of this study is to compare the confidence in characterising the breast lesions in 1.5T and 3T MRI examinations performed and to compare the conspicuity of the lesions.

Materials and methods Patients referred for a diagnostic MRI examination as part of their clinical work-up for a suspicious lesion or for preoperative...
staging were recruited into this study following informed consent. The MRI was undertaken on a 1.5T GE CVI/NVI (Milwaukee, WI, USA) and a 3T Philips Achieva (Best, the Netherlands). T2W, dynamic T1W (voxel size 0.85 x 1.19 x 2 mm – 1.5 T MRI, and 0.6 x 0.6 x 2 mm – 3T MRI) and high-resolution fat-suppressed T1W postcontrast sequences (single-dose contrast) were carried out. The confidence level in morphology and contrast kinetics (three-point scale) and conspicuity for each lesion (five-point scale, –2 to +2) was assessed by a single observer (SKAR).

**Results** Seventeen patients were included in the study. Eleven patients had one or more lesions, giving 22 lesions. The confidence level in assessing morphology was high in 16/22 and 19/22 and in assessing contrast kinetics was high in 12/22 and 16/22 in 1.5T and 3T examinations, respectively. The mean and standard deviation of the conspicuity score are 1.09 ± 0.88 for 3T.

**Conclusions** The confidence in characterising and conspicuity of the breast lesions is improved and no lesions identified at 1.5T were missed at 3T MRI. 3T MRI can be used safely in clinical practice.

**P19**

**Effect of region of interest size in quantitative diffusion-weighted magnetic resonance imaging of the breast**

N AlRashidi, T Gagliardi, T Ahearn, T Redpath, F Gilbert

University of Aberdeen, UK


**Introduction** In breast MRI, morphological and dynamic enhancement features determine whether a lesion is benign or malignant but specificity is low. Diffusion-weighted magnetic resonance imaging (DW-MRI) measures microscopic motion of water and gives quantitative measurement known as the apparent diffusion coefficient (ADC). This study was conducted to determine whether the whole of the lesion should be included within the region of interest (ROI) or whether a small ROI would differentiate benign from malignant disease.

**Methods** Fifteen female patients with 15 suspicious lesions were imaged on a 3T MRI machine (Philips HealthCare, Best, the Netherlands). DWI-MRI was performed with b-values of 0, 150, 800 s/mm² using single-shot SE-EPI (TR/TE = 9.543 ms/50 ms). The ROI of the lesion and of fibroglanular tissue was used to calculate ADC values. Histology or follow-up data were available for all lesions.

**Results** The mean ADC value of malignant lesions (13) from two small ROIs was 0.954 ± 0.145 mm²/second and for benign (2) was 1.69 ± 0.17 mm²/second (Figure 1a). The ADC values for the whole lesion were 1.027 ± 0.23 mm²/second and 1.78 ± 0.293 mm²/second, respectively (Figure 1b).

**Conclusions** There is a significant difference between ADC values from large and small ROIs (P < 0.05), with small ROIs giving greater differentiation. DWI is a promising technique to improve specificity of breast MRI.

**Figure 1** (abstract P19). Box plot of ADC values for benign, malignant and normal tissue using (a) two small ROIs and (b) a large ROI.
Auxiliary lymph node fine needle aspiration in breast cancer staging: diagnostic impact of a second 20G spinal needle

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Introduction All breast cancer patients in our centre undergo ipsilateral axillary ultrasound, followed by fine needle aspiration (FNA) where appropriate in line with NICE guidelines. We use two needle passes into a suspicious node, without suction. Improved preoperative detection of nodal metastasis allows patients improved triage to appropriate axillary surgery. We present our analysis of the impact of the second needle in our axillary FNA procedure.

Methods All breast cancer patients undergoing axillary FNA from April 2010 to July 2010 were included, where possible. The first FNA was labelled ‘1’ and the second ‘2’. Individual and overall FNA results were compared with final surgical pathology, where available.

Results The study included 27 female patients. There was a difference in the cytology grading (described LN0 to LN5) allocated between the first and second needle in five cases (19%). The second needle’s increased sample adequacy on three (11%) occasions. Of the 17 patients that had axillary surgery, three had no lymph node metastases and the preoperative FNA cytology was LN2. There were no false positive cytology results. Preoperative cytology was LN5 overall in 11/14 (79%) patients with nodal metastases, with LN5 obtained only in the second pass in 4/14 (29%) cases (first-pass results: LN2/LN2/LN0/LN0). No complications were reported.

Conclusions A second needle pass into suspicious axillary lymph nodes in breast cancer patients has been validated by this study, increasing our preoperative rate of detection of lymph node metastases.

Fine needle aspiration versus touch imprint cytology in ultrasound-guided core of breast masses

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Introduction The aim of this study was to compare the results of fine needle aspiration (FNAC, current practice) with imprint cytology (CIC) from ultrasound-guided cores taken in the one-stop clinic setting. CIC allows same-day results with one biopsy procedure. Literature suggests CIC provides a higher sensitivity/C5 rate, although there are few direct comparisons of CIC with FNAC.

Methods From October 2009 to April 2010, wherever possible, CIC was performed in patients undergoing both ultrasound-guided FNAC and core biopsy. CIC slides were independently reported blind to FNA results. Results were compared with core biopsy histology and therapeutic excision histology, when available.

Results The series included 90 female patients with 93 masses (54 malignant, 39 benign masses based on final histology). In the malignant group the C5 rate was 61% (33/54) for FNAC, 83% (45/54) for CIC and 85% (46/54) for the combination of FNA and CIC. No cancers in this sample had an initially benign core result with malignant FNA or CIC result. In the benign group the C2 rate was 41% (16/39) for FNA, 69% (27/39) for CIC, and 64% (25/39) for the combination of FNA and CIC. There were no false positive C5 results. Imprints were easy to perform and there was no damage to the core biopsy material. Cytologists encountered no problems interpreting CIC.

Conclusions The use of CIC in ultrasound-guided core biopsies in place of conventional FNAC has been validated by this study. No significant obstacle to adopting core imprint cytology has been identified.

Educational abstract

Educational abstract not submitted for online publication.


Educational abstract

Educational abstract not submitted for online publication.


Effect of the introduction of preoperative MRI scans for lobular cancer in an individual breast unit

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2Royal Elizabeth Hospital Cytology Department, Gateshead, UK


Introduction NICE guidelines suggest that patients with lobular breast cancer should be offered an MRI scan to measure the tumour size and to exclude multifocality and contralateral tumours. The aim of this study was to ascertain the effect of this guideline.

Methods This guideline was introduced in January 2009. Patients with lobular cancer were selected from before and after this date. Cases were reviewed and compared for type of surgery, positive resection margins and alteration in patient management. The number of additional targeted USS and biopsies was also recorded.

Results Sixty-nine patients were included in the study, of which 22 had preoperative MRI scans. There was no significant difference in mastectomy rates (MRI = 45.5% vs. no MRI 57.5%, P = 0.44) and no significant difference in positive margins following WLE (MRI 41% vs. no MRI 35%, P = 0.23). Of the 22 MRIs 11 additional findings were reported, six in the contralateral breast, leading to nine targeted USS and eight further core biopsies. Three of these core biopsies confirmed malignancy. Two MRI scans demonstrated multifocality and one diagnosed contralateral DCIS. Four patients' management was altered due to the MRI result, one of these was due to an increase in size. There was one case of multifocality that was invisible on all imaging.

Conclusions This study has shown that the guideline for preoperative MRI scanning in lobular cancer will alter the surgical management in approximately 20% of patients. An additional 20% of patients will undergo additional imaging and biopsies that do not alter management.

Educational abstract

Educational abstract not submitted for online publication.


An audit to assess the impact of introducing a protocol of bilateral whole breast and axillary ultrasound for assessment of screen-detected cancers

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Introduction: Our protocol for assessment of women with screen-detected malignancy was changed to include bilateral whole breast and axillary ultrasound (BBUS) following a prospective study that confirmed the benefit of this in 2002 [1]. This audit assesses the impact of introducing this change.

Methods Biopsy results for all women with screen-detected cancer diagnosed between April 2003 and March 2009 were reviewed to identify cases where multiple biopsies had been performed. The reason for additional biopsy and subsequent management were recorded. The data were compared with control data (2001) obtained prior to the introduction of the protocol, and with national outcome data for screen-detected cancer.

Results A total of 199,307 women were screened during the audit period, and 1,700 women were diagnosed with breast cancer. Table 1 demonstrates the findings for women diagnosed with cancer who had additional biopsies,
Compared with the control population. Data for 2008/09 show that this unit has a repeat operation rate of 18% for non-invasive disease and 16% for invasive disease compared with national averages of 28% for non-invasive and 23% for invasive cancer [2].

Conclusions Additional cancers and axillary node metastases were detected as a result of introducing a policy of proactive assessment of disease extent. The unit has a favourable rate of re-operations compared with national data.

References

**P31**

Educational abstract
Educational abstract not submitted for online publication.
Methods A retrospective analysis of all incident cancers with their previous screening round mammograms diagnosed between April 2006 and March 2008 at the North London Breast Screening unit was performed.

Results Two hundred and forty cancers were reviewed. In 187 cases (77.9%) the previous round mammograms were normal (group A), in 53 cases (22.1%) an abnormality was detected (group B). Of these, five (9.4%) were classified as normal/benign, 40 (75.5%) were uncertain and eight (15.1%) were suspicious. There was no significant difference in the size of the lesions between the two groups; there was, however, a significant increase in size between 1 March 2008 and 1 March 2010.

Conclusions In 22% of incident cancer cases an abnormality is present on the previous screening round mammogram, and the most frequently overlooked lesions are microcalcifications.

References

P35
Vacuum-assisted core biopsy of B3 lesions showing atypia on needle core biopsy: a worthwhile exercise?
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Introduction There has been increasing interest in the use of vacuum-assisted core biopsy (VACB) over the past two decades. There remains some uncertainty about its role in the presence of cytological or architectural atypia on needle core biopsy (NCB). We have recently been offering VACB for selected B3 cases with atypia. MDT discussion, where technical suitability was suspicious. There was no significant difference in the size of the lesions (22.1%) an abnormality was detected (group B). Of these, five (9.4%) were classified as normal/benign, 40 (75.5%) were uncertain and eight (15.1%) were suspicious. There was no significant difference in the size of the lesions between the two groups; there was, however, a significant increase in size between 1 March 2008 and 1 March 2010.

Conclusions In 22% of incident cancer cases an abnormality is present on the previous screening round mammogram, and the most frequently overlooked lesions are microcalcifications.

References

P36
Educational abstract
Educational abstract not submitted for online publication.

P37
Role of imaging in gynaecomastia: results of a Royal College of Radiologists Breast Group Annual Scientific Meeting 2009 survey
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Introduction Gynaecomastia is a benign enlargement of male breast tissue that has no proven excess risk of breast cancer. Clinical evaluation is required to exclude breast cancer, but the role of imaging in the male breast is unclear. Our aim was to determine practice in other units, review literature and formulate informed and realistic departmental guidelines.

Methods A questionnaire was created, and copies placed on delegates’ seats. Descriptive statistics applied.

Results Of approximately 160 delegates, 90 questionnaires were returned from at least 58 different units. Delegates reported (estimated) greater than 864.75 years collective experience, each performing (on average) 4.3 male breast assessments per month. Sixty-five per cent (58/89) of delegates that responded reported routine imaging in clinically typical gynaecomastia, rising to 89% (79/89) in clinically typical unilateral gynaecomastia. However, 78% (68/87) of responding delegates agreed with the statement ‘Imaging is not necessary in cases of clinically typical gynaecomastia’. Three delegates reported experiencing a case of ultrasonically typical gynaecomastia that subsequently proved to be breast cancer. Imaging protocol and biopsy practice varied greatly between units. Delegates volunteered concerns that the NHS breast service is inequitable between males and females, and that guidelines were needed to rationalise imaging.

Conclusions Based on questionnaire findings and literature review, guidelines have been now been drawn up in our unit. There is great variation evident in UK gynaecomastia imaging practice. National discussion and agreement on evidence-based guidelines could help rationalize use of precious NHS resources and reduce imaging of this benign condition.
Introduction Mammographic calcification may be the only sign of breast malignancy often requiring diagnostic biopsy. If visible, this calcification may be biopsied using ultrasound guidance or using X-ray guidance if not. Ultrasound biopsy is quicker, cheaper and more comfortable for the patient. Any technique that improves ultrasound calculation visualisation is desirable. MicroPure™ (Toshiba Medical Systems Corporation, Otawara, Japan) is a new ultrasound processing technology designed to achieve this.

Methods We prospectively audited our experience of calcification detection with B-mode ultrasound and MicroPure™ between April and July 2010. Twenty-five women presenting with a dominant mammographic abnormality of calcification were studied. Targeted imaging with both techniques was performed with a Toshiba Apio™ XG ultrasound machine using a 12 MHz linear probe. Technical support to optimise imaging was provided during our audit by Toshiba. We recorded ultrasound visibility with these two techniques and histological diagnosis.

Results Of 24 screening and one symptomatic, 11 (44%) were diagnosed with breast malignancy (six invasive cancers, four DCIS, one LCIS), and 14 (56%) were benign. Overall four (16%) (three malignant and one benign) calculations were visualised by ultrasound. All were detectable using both B-mode and MicroPure™. Subjectively all four were felt to be more conspicuous using B-mode than MicroPure™.

Conclusions Our initial experience has demonstrated MicroPure™ to be no better at detecting benign or malignant mammographic calcification than B-mode ultrasound. MicroPure™ would only be useful if it detects calcifications that are not visualised with B-mode ultrasound therefore reducing X-ray-guided biopsies.

Conclusions These results are reassuring that digital diagnoses similar cancers to analogue screening, and suggest that digital may allow more definitive interval cancer classification.

Table 1 (abstract P41)

<table>
<thead>
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<td>% (95% CI)</td>
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<tr>
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<td>15.2% (9.0 to 21.3%)</td>
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<tr>
<td>Suspicious</td>
<td>15</td>
<td>11.4% (5.9 to 16.8%)</td>
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Methods Forty-two women presenting with a dominant mammographic abnormality of calcification were studied. Targeted imaging with both techniques was performed with a Toshiba Apio™ XG ultrasound machine using a 12 MHz linear probe. Technical support to optimise imaging was provided during our audit by Toshiba. We recorded ultrasound visibility with these two techniques and histological diagnosis.

Results Of 24 screening and one symptomatic, 11 (44%) were diagnosed with breast malignancy (six invasive cancers, four DCIS, one LCIS), and 14 (56%) were benign. Overall four (16%) (three malignant and one benign) calculations were visualised by ultrasound. All were detectable using both B-mode and MicroPure™. Subjectively all four were felt to be more conspicuous using B-mode than MicroPure™.

Conclusions Our initial experience has demonstrated MicroPure™ to be no better at detecting benign or malignant mammographic calcification than B-mode ultrasound. MicroPure™ would only be useful if it detects calcifications that are not visualised with B-mode ultrasound therefore reducing X-ray-guided biopsies.
exhibited, $k = 0.470$. There were significant differences between the levels of agreement amongst the ratings of the radiologists, advanced practitioners and others (all $P < 0.05$).

Conclusions The low agreement rates between participants for density ratings were surprising. That there were differences between the occupational groupings may reflect breast screening experience.

P43
Seeding of tumour cells following breast biopsy: a literature review
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Introduction This literature review examines evidence relating to needle biopsy of the breast and the potential for later tumour cell migration into adjacent tissues.

Methods A literature search was undertaken, using Medline, Embase and the Cochrane Library.

Results The results were analysed by the following: (1) Histological evidence of spread (seven papers addressing this were scrutinised; number of patients reviewed was 1,046). Tumour cell displacement occurs in about one-third of patients, the majority do not survive displacement. Vacuum biopsy techniques may reduce seeding potential. (2) Clinical evidence of recurrent disease (nine papers were scrutinised; number of patients reviewed was 1,575). Sporadic reports of tumour recurrence suspected to be a consequence of a biopsy procedure are described. Care to excise the site of needle biopsy is advised by some, especially if outside the radiotherapy field. (3) Likelihood of seeding dependent upon tumour type (three papers were scrutinised; number of patients reviewed was 258). There is limited evidence to suggest lobular carcinoma is less likely to seed than ductal.

Conclusions There is histological evidence of seeding of tumour cells from the primary neoplastic site into adjacent breast tissue, following biopsy. However, clinical recurrence at the site of a needle biopsy is uncommon. This event may be lessened by use of vacuum biopsy techniques. The site of needle biopsy should be considered at the time of surgery.

P44
How can the prevalent round recall rate be reduced?
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Introduction The prevalent round recall rate is higher than the incident recall rate. Implementation of age extension will lead to two prevalent rounds and with this increased clinical and financial pressure on screening units. Any processes that help reduce the recall rate will be of benefit to screening units.

Methods Retrospective data were collected from April 2008 to March 2009 of prevalent round ladies recalled to assessment clinics. The data recorded included reason for recall, imaging findings and needle test results.

Results A total of 7,627 women were invited for screening in April 2008 to March 2009, of which 5,341 attended. Four hundred and eighty-one ladies were recalled to assessment; 451/481 of the packets available were reviewed. Forty cancers were identified in 39 patients. All cases of malignancy were included reason for recall, imaging findings and needle test results.

Conclusions There is histological evidence of seeding of tumour cells from the primary neoplastic site into adjacent breast tissue, following biopsy. However, clinical recurrence at the site of a needle biopsy is uncommon. This event may be lessened by use of vacuum biopsy techniques. The site of needle biopsy should be considered at the time of surgery.

P45
Educational abstract
Educational abstract not submitted for online publication.

Introduction Imaging alone cannot reliably distinguish benign/malignant breast disease or assess the extent of cancer. This study assesses the feasibility of using additional information obtained at US (BHS) to aid diagnosis and preoperative assessment.

Methods 3D US scans at 8 MHz, 12 MHz, 15 MHz were obtained of breast tissue in normal volunteers in two planes and with/without harmonics. Five volumes of sagittal scans at 8 MHz from three individuals were used to identify normal characteristics and define the baseline. The 3D volume was divided into voxels (0.1 x 2 x 1.5 mm) and raw data from each voxel were analysed by applying linear and nonlinear classifiers to assess 29 statistical characteristics (BHS). The training dataset contained 300,000 voxels. After training, the classifier’s output showed 3% error on both normal and abnormal tissue. The algorithm was tested on 32 further volumes representing 6,000,000 voxels of normal and abnormal tissue from 20 individuals. Abnormal tissue included various biopsy-proven lesions: malignancy (six), papilloma (one), hamartoma (one), fibroadenoma (two), cyst (two), fibrosis (one). Subclassifiers were developed to distinguish between cancer and benign voxels.

Results In 17 normal testing volumes, 3% of isolated voxels were classified as abnormal. In 15 abnormal testing volumes, the subclassifiers differentiated between malignant and benign tissue. BHS in benign tissue showed <1% abnormal voxels in cyst, hamartoma, papilloma and benign fibrosis. The fibroadenomas differed showing <5% and <24% abnormal voxels. Abnormal voxels in cancers increased with the volume of cancer at pathology.

Conclusions Histoscanning reliably discriminated normal from abnormal tissue and could distinguish between benign and malignant lesions.

P46
Breast histoscanning: the development of a novel technique to improve tissue characterization during breast ultrasound
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Introduction In vivo detectability of a signal (tCho) from choline containing molecules at ~3.2 ppm by MR spectroscopy (MRS) can be useful as a biomarker for malignancy. tCho has also been observed in benign, normal, and lactating breast, therefore quantitation is vital. The aim is to assess whether tCho detectability can differentiate between benign and malignant breast disease and to implement internal water-referenced choline quantitation at 3T.

Methods Women with histologically confirmed breast cancer or suspicious features were identified either at MDT or following referral for clinical breast MRI and recruited following informed consent. Studies were performed on 3T Philips Achieva (the Netherlands). Contrast-enhanced MRI localised the region for point-resolved spectroscopy (PRESS) evaluation. Spectral processing was performed with JMRUI. The choline concentration was determined using the unsuppressed intravoxel water resonance as a reference. tCho detectability and choline concentration were correlated with known pathological information. Results were analysed by JKPB.

Results Nine participants (age range, 38 to 73 years) were successfully examined. tCho was detected at ~3.2 ppm in 24/90 (26.7%) of nine lesions (lesion size, 0.8 to 7.0 cm; mean, 3.0 cm), providing a sensitivity and specificity of 67% and 100%, respectively. The two quantitative values of 2.13 and 5.59 mmol/kg are consistent with previously reported findings.

Conclusions MRS is a non-invasive and non-ionising means of analysing lesion metabolism as an adjunct to clinical MRI. Whilst potentially useful for differentiating between benign and malignant breast diseases, implementation is challenging. Using clinical 3T systems, internal water referencing can successfully quantify choline in patients with breast cancer.
Breast Cancer Research 2010, Volume 12 Suppl 3
http://breast-cancer-research.com/supplements/12/S3

P48
Benefits of CT-angiography localisation in the surgical planning of deep inferior epigastric perforator flap breast reconstruction
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Introduction The aim of breast reconstruction in the postmastectomy cancer patient is to recreate the breast contour and dimensions whilst minimising the cosmetic impact. The deep inferior epigastric perforator (DIEP)-flap is a complex but state-of-the-art procedure that provides a durable and natural result. It is rapidly becoming the preferred choice at many institutions, including our regional plastic surgery unit. In achieving superior cosmesis without sacrificing abdominal wall musculature, a successful DIEP-flap requires painstaking and time-consuming microdissection of the inferior epigastric artery perforators. This relies on a high level of surgical expertise and results in prolonged anaesthetic times. As greater volumes of breast reconstructive surgery are performed, there will be increasing requirements for such preoperative imaging. We describe the required optimisation of CTA protocols to obtain the pertinent information and demonstrate how best to convey this complex information to our surgical colleagues.

Methods Since 2009 we have provided CT-angiography in the preoperative planning for DIEP-flap breast reconstruction. We explored the implications of CT-angiography to optimise localisation of arterial perforators and identified the benefits of this imaging-guided approach.

Results A total of 60 female patients have benefitted from CTA-guided perforator localisation, providing valuable procedural-planning information to our surgical colleagues. We have shown benefits in terms of markedly shorter operative duration with consequently reduced hospital stays and morbidity. Two patients had unsuspected metastatic disease identified, precluding reconstructive surgery.

Conclusions An imaging-guided approach optimises preoperative planning. Accurate identification of arterial perforators enables targeted intraoperative localisation. This results in decreased operative time and patient morbidity, providing benefits for the cost of healthcare provision.

P51
Educational abstract
Educational abstract not submitted for online publication.

P52
Benign solitary breast masses in the prevalent screening round: do they contribute to a high recall rate?
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Background The Breast Test Wales prevalent round recall rate between 2003 and 2006 was 9.07% (above the NHSBSP target of 7%) and remains high. This study was based on the hypothesis that recall of benign solitary masses might be a major contributor to this as no prior imaging is available.

Methods Prospectively collected data from Breast Test Wales (South East Wales) identified all prevalent screens in a 3-year cycle recalled for a benign mass lesion confirmed by core biopsy. All women attended a subsequent screen and remained free of cancer. Mammograms were retrospectively reviewed and the lesions were re-evaluated by applying criteria typical of the benign mass.

Results A total of 2,232 women following a prevalent screen were recalled; 2,069 were returned to routine recall without biopsy (cysts are included in this group), 186 were diagnosed with cancer and 105 had a benign biopsy where mammography had been considered benign or probably benign. The benign to malignant biopsy ratio was 1:1.8. A total 46.6% (n = 49) lesions on retrospective review of mammography showed typical benign characteristics. Dense breast composition and overlying glandular tissue were noted to correlate with higher rates of retrospectively indicated recall.

Conclusions Stricter adherence to applying classification of benign solitary lesions could reduce the recall rate and decrease the psychological distress for these women without adversely compromising the cancer detection rate. The impact on the overall recall rate would be small but would significantly improve the benign to malignant biopsy ratio. The issue of breast density and overlying tissue may be resolved with the advent of digital applications such as tomosynthesis.

P53
Breast MRI screening for high-risk family history: the Sheffield experience
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Introduction Around 5% of breast cancers can be attributed to gene mutations. NICE guidelines have recently advocated the use of MRI screening in high-risk young women. We have retrospectively audited our unit’s experience in this field.

Methods All eligible women were identified from the family history database. Notes, imaging and pathology were reviewed.

Results One hundred and thirty-three breast MRI scans were performed on 91 women with a high-risk family history between 2007 and 2010. Sixteen women were recalled for assessment (one woman was recalled twice). The total recall rate was 12.7%. Of the recalled patients, four had normal ultrasound (US) and follow-up imaging has remained unchanged. Thirteen patients had corresponding US-detected abnormalities. Twelve were biopsied, the other was a normal intramammary lymph node. Eight of the biopsies were benign (benign core biopsy rate 6%), Four biopsies were malignant (age range of women 35 to 45), giving a cancer detection rate of 3%. Three of these were solitary lesions (8 mm, 11 mm and 16 mm). One patient had multifocal malignancy, the largest single lesion being 16 mm. All were node-negative ductal carcinoma. Two patients were oestrogen receptor-positive, all were herceptin receptor-negative. Only the extensive malignant change could be seen on conventional mammography.

Conclusions We suggest that MRI screening is beneficial in these patients, and although our recall rate lies a little above what is to be recommended by the NHSBSP (7 to 10%) we feel this can be attributed to the steep learning curve that introducing a new screening technique to a service invariably brings.
**P54**

**Educational abstract**

Educational abstract not submitted for online publication.


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**P55**

**Correlation of preoperative ultrasound and mammographic measurement of malignant breast masses with operative histology**

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Introduction Preoperative assessment of breast cancer patients is by physical examination, mammography and ultrasound. Mammography and ultrasound measurements inform treatment regimes and prognostic estimates. Our aim was to determine the accuracy of imaging measurement of malignant breast masses in our Trust.

Methods Screening and symptomatic women with breast cancer who had surgery between October 2008 and May 2009 were identified from multidisciplinary team records. The largest dimension of abnormal tissue/breast mass on any projection/probe orientation was documented for mammography and/or ultrasound. Measurements were compared with the largest tumour dimension on final histological analysis of excised tumour.

Results Records were available for 100 patients with invasive breast cancer (66% (66/100) invasive without DCIS, 34% (34/100) invasive with DCIS). Overall size of the malignancy measured at both mammography and ultrasound was not correlated with histological tumour size ($r = 0.54$ and $r = 0.56$, respectively). This correlation was less high for overall size of malignancy when associated with DCIS. Mammography with DCIS ($r = 0.37$) versus mammography without DCIS ($r = 0.77$); ultrasound with DCIS ($r = 0.52$) versus $r = 0.68$ for invasive cancers without DCIS. Multiple regression analysis showed that the combination of mammogram and ultrasound is an effective means of estimating size of malignancy in the presence of a mass ($r = 0.67$).

Conclusions The combination of mammography and ultrasound is an effective means of predicting tumour size; it is more accurate for tumours without DCIS. There is a tendency towards size underestimation, more so for ultrasound than mammography.

**P56**

**Educational abstract**

Educational abstract not submitted for online publication.


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**P57**

**What is involved in a comprehensive breast MRI service? Implications for service provision**

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Introduction MRI as an adjunct to triple assessment is well established, but often identifies additional lesions within the breast necessitating further characterisation. This study addresses the additional investigations generated by MRI.

Methods A retrospective review of the MRI database between 2006 and 2009 identifying patients requiring investigations post MRI.

Results Over 4 years, 1,119 MRIs were performed on 717 patients, with 102 recalled for second-look ultrasound. Three patients were lost to follow-up. A total 124 incidental lesions were identified on MRI. Ultrasound identified 68 lesions, with definitive diagnosis following core biopsy/FNAC (62), surgery (two) core biopsy + repeat MRI (one) and MRI biopsy (three). Twenty-two lesions identified by USS were assessed with X-ray-guided biopsies (two), MRI biopsy (13), interval MRI (five) or surgery (two). Nineteen MRI lesions following normal ultrasound had routine follow-up. Fifteen lesions (12 patients) did not have follow-up USS, as recommended following MDT discussion. Sixty lesions (44 patients) were malignant; MRI identified a primary in four patients presenting with lymphadenopathy and in 39 patients identified additional foci that changed management. Malignant lesions were identified on US biopsy/FNAC (38), X-ray-guided biopsy (one), MRI biopsy (seven) and surgery (14).

Conclusions MRI identifies additional foci in 14% of patients. Malignant lesions will be identified in 43% of patients recalled. Comparison with 2005 data identifies a decreased recall rate and an increased cancer detection rate. Fifty per cent of additional lesions identified by MRI are malignant, of which 77% were confirmed preoperatively. Provision of a comprehensive breast MRI service must consider the resources needed to deliver the additional diagnostic investigations required.

**P58**

**An audit of pain in ultrasound-guided breast core biopsy**

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University of Dundee, UK


Introduction We audited pain from ultrasound-guided core biopsies (CB) for routine service quality monitoring, to provide baseline data against which to compare new techniques, and to help us develop methodological expertise in pain assessment. Although there is no standard against which to audit CB pain, published comparators are available.

Methods Two self-report pain scales were administered to 64 female patients immediately after ultrasound-guided 14G CB under local anaesthesia. Although we aimed for consecutive patients, some were de-selected by staff on grounds of apparently high levels of cancer anxiety. The scales were a 100 mm visual analogue scale (VAS) and a four-category verbal rating scale (VRS) – None, Mild, Moderate, Severe. Responses were anonymous and no attempt was made to collect data on relevant variables. VAS scores were compared between VRS categories using the Mann–Whitney U test.

Results Sixty questionnaires were adequate for analysis. VAS scores were not normally distributed and ranged from 0 to 80, median 7.5, interquartile range 15 (mean 15.6 ± SD 22.3). The paired VAS and VRS results correlated well and the median VAS scores for the different VRS categories demonstrated clear distinctions between categories ($p < 0.001$).

Conclusions The correlation between VAS scores and VRS categories is evidence supporting the validity of the scales. Our overall mean VAS score was lower than the most comparable values in the literature. We will use our audit to illustrate a discussion of the principles, including scale selection, and the pitfalls of pain assessment in relation to existing relevant literature.

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**P59**

**Educational abstract**

Educational abstract not submitted for online publication.


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**P60**

**Breast cancer screening in the over 70s**

D Eddy1, L Edwards1, K Gower-Thomas1

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Introduction Routine invitation for breast screening currently ceases in Wales over the age of 70 despite the incidence of breast cancer remaining high in this group. Attendance for screening aged over 70 is low compared with the invited population, often attributed to lack of awareness of eligibility and how to access screening. If screening is to be extended, the motivation to attend and outcomes need to be understood.

Methods This audit of prospectively collected data from Breast Test Wales Screening (South East Wales) identified all women over 70 years who attended. In those where cancers were detected, age, pathological data, previous screening history, family history, clinically palpable and breast symptoms were recorded.

Results A total of 5,736 women attended aged 71 to 92 years in a 3-year screening round (1 April 2006 to 31 March 2009) with numbers attending decreasing with higher age. In total, 295 (5.1%) were recalled to assessment and 81 (1.4%) were diagnosed with cancer. A total of 61.5% of the cancers were grade 2, 77% <20 mm and 84% node-negative. The majority had an excellent or good Nottingham Prognostic Index, mirroring national data for the younger invited population. Of those diagnosed with cancer, 61.6% had...
Introduction

Twenty-two per cent of women required further surgery following breast-conserving surgery (BCS) in the UK in 2008 because of involved margins. This study was carried out to see whether it was possible to predict the likelihood of this from preoperative information and thus reduce the re-excision rate.

Methods

Women having BCS following a preoperative diagnosis of invasive cancer were identified from prospectively collected data at Breast Test Wales for South East Wales, over a 3-year screening round (2006 to 2009). In cases where DCIS was found at or within 2 mm of a margin, preoperative imaging was reviewed to look for peripheral calcification.

Results

One hundred and twelve out of 844 women with an invasive tumour had involved margins after BCS. Fifty-nine women had DCIS at the margin of which 60% had calcification within 10 mm of the periphery of the tumour on mammographic review and 30% had DCIS as well as invasive cancer on core biopsy. The postsurgical pathological size was greater than the mammographic size in 79% and greater than the ultrasound size in over 90% of cases. This was significantly changed on further review of the films. On mammographic review, 12% had dense breasts, 88% being fatty or fatty/glandular.

Conclusions

Imaging is underestimating the true size despite background breast tissue being fatty. The presence of calcification on the mammogram in such a high number of cases where DCIS is at the margin may be a useful predictor, but requires further correlation with the presence of histological calcification on the pathological specimen, which is ongoing.

P61
Are there features on imaging or core biopsy that can predict tumour-positive margins after breast-conserving surgery?

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Introduction

Breast cancer in 35 to 39 year olds and imaging: is changing to ultrasound without mammography going to be safe? What are the workload implications?

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Introduction

New guidelines suggest that ultrasound should replace mammography as the primary imaging test for 35 to 39 year olds in symptomatic outpatient clinics. We currently use clinical examination, clinically guided fine needle aspiration and mammograms for women aged 35+ as initial triple assessment. We wanted to understand the implications of introducing the guidelines, based on our current practice.

Methods

We reviewed our workload and cancer detection in symptomatic 35 to 39 year olds attending breast outpatient clinics in our district general hospital over the past 18 months.

Results

Mammograms were taken on all symptomatic patients unless pregnant or breastfeeding. Seven hundred and fourteen patients had mammograms and 442 patients had ultrasound. This was performed on most patients found to have clinically palpable lumps, and on anyone with a clinical examination graded as uncertain suspicious or malignant, or with abnormal mammograms, or with abnormal results on clinically guided needle cytology. Fourteen patients were found to have breast cancer. All 14 had ultrasounds graded as uncertain, suspicious or malignant, an indication for diagnostic core biopsy. Thirteen cancer patients had mammograms. Two were graded as benign and 11 as uncertain or worse. Five cancer patients had clinically normal or benign breast examinations, including one with a benign mammogram report.

P62

Educational abstract

Educational abstract not submitted for online publication.

P63

Ultrasound of the axilla: analysing nodal cortical thickness

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Introduction

Prognosis in breast cancer is dependent upon axillary lymph node status. For breast-conserving surgery, lymph node status can be assessed via sentinel lymph node procedures (SLNP) [1]. This can be time consuming, however, and it would be useful to identify a subset of quantitative nodal features on ultrasound in order to predict metastatic involvement and avoid the SLNP. Peer review states that cortical thickness is one of the best predictive characteristics [1,2]. We wanted to interrogate our own data with a specific focus on this feature.

Methods

A retrospective study of 454 patients audited between August 2007 and October 2009. One hundred and thirty-seven had proven breast cancer and underwent axillary node sampling.

Results

In 75 cases the cortical thickness was recorded. Comparing with sentinel node biopsy or postoperative pathology, the results are as shown in Figure 1.

Conclusions

The study confirms that the nodal cortical thickness correlates well with the presence of disease. It is easy to measure and appears to be a reliable indicator. Further, the minimum cortical thickness for positivity (27 mm) will help us to grade our degree of suspicion in future.

References


Figure 1 (abstract P63). Cortical thickness in nodal disease.
Conclusions Ultrasound missed no cancers but mammograms missed two out of 13. This supports implementing the guidelines. However, this would mean a 38% increase in the number of ultrasounds, 15 extra each month. This extra ultrasound capacity may be hard to provide but will be offset by fewer mammograms.

Cite abstracts in this supplement using the relevant abstract number, e.g.: Rubin G, Zammit C. Breast cancer in 35 to 39 year olds and imaging: is changing to ultrasound without mammography going to be safe? What are the workload implications? Breast Cancer Research 2010, 12(Suppl 3):P64.