Breast Diseases Centers accreditation

The surgery requirements

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Accreditation of a Breast Center

Ensure that the clinical services, interdisciplinary conference and quality management program are in place at the center

Accreditation Benefits

- A model of organizing and managing a breast center to ensure multidisciplinary, integrated and comprehensive breast care services
- Internal and external assessment of breast center performance based on recognized standards to demonstrate a commitment to quality care

Accreditation Benefits

- Recognition as having met performance measures for high quality breast care established by national health care organizations
- International recognition and public promotion
- Participate in a national breast disease database to report patterns of care and effect and effect quality improvement

Surgery requirements

Stage I, II, IIIA, and operable IIIC breast cancer often requires a multimodality approach to treatment.

The following guidelines were based in publications of National Cancer Institute (NCI) National Accreditation Program of Breast Centers (NAPBC) and Senology International Society (SIS)

Surgery requirements

- Diagnostic
- Surgical treatment
- Axillary lymph node surgery
- Reconstructive surgery

Surgery requirements
Diagnostic

Diagnostic biopsy and surgical procedure that will be used as primary treatment should be performed as two separate procedures. In many cases, the diagnosis of breast carcinoma using core needle biopsy or fine-needle aspiration cytology may be sufficient to confirm malignancy.

After the presence of a malignancy is confirmed and histology is determined, treatment options should be discussed with the patient before a therapeutic procedure is selected. Histopathology and IHC is desirable

SIS Requirements

- The majority of women should not have to undergo an operation to determine the diagnosis; the use of non-surgical diagnostic techniques should help limit the operations performed on women who in fact do not have cancer.
- Histological diagnosis of cancer should be known prior to surgery in > 90 % of cases. i.e. the number of surgical biopsy should be < 10%.
- In case of non-palpable lesion, radiography of the specimen should be performed during surgery, and breast conserving surgery should be the treatment of choice for most small detected cancers and should be provided in 70-80% of cases

Surgical treatment

Options for surgical management of the primary tumor include breast-conserving surgery plus radiation therapy, mastectomy plus reconstruction, and mastectomy alone.

Surgical staging of the axilla should also be performed. Survival is equivalent with any of these options as documented in randomized prospective trials

Surgical treatment

Selection of a local therapeutic approach depends on the location and size of the lesion, analysis of the mammogram, breast size, and the patient's attitude toward preserving the breast.

The presence of multifocal disease in the breast or a history of collagen vascular disease are relative contraindications to breast-conserving therapy

Definitions and requirements

- A proportion of at least 50 percent of all patients diagnosed with early stage breast cancer (Stage 0, I, II) are treated with breast conserving surgery, and compliance is evaluated annually.
- Breast conserving surgery for patients with early stage breast cancer is a nationally accepted standard of care in appropriately selected patients. Most centers exceed the 50 percent level and this level should not be used as benchmark. Fifty percent is considered the minimum standard in order to meet NAPBC compliance.

SIS Requirements

- The Surgeon should offer a mastectomy to women who prefer this procedure and to those who are not good candidates for breast conserving surgery due to tumor size, or high risk for recurrence. He should offer the woman the choice of reconstruction at time of surgery or afterward.
- Women with larger tumors should be offered chemotherapy before surgery (neoadjuvant treatment).
- Surgeons should leave clear margins around the removed tumor tissue and the pathologist should document the margins in all patients.
- All surgeons performing the sentinel node procedure should be specifically trained in the procedure and be evaluated.
- The percentage of non-detection of sentinel node must be < 5%
- The surgical specimens of axillary dissection must contain at least 10 nodes in 90 % of the cases.

Axillary Lymph node surgery

- The axillary lymph nodes should be staged to aid in determining prognosis and therapy. Sentinel lymph node (SLN) biopsy is the initial standard axillary staging procedure performed in women with invasive breast cancer.
- Reports demonstrate a 97.5% to 100% concordance between SLN biopsy and complete axillary lymph node dissection (ALND).

Definitons and requirements

Axillary sentinel lymph node biopsy is considered or performed for patients with early stage breast cancer (Clinical Stage I, II)

Patients currently considered candidates for axillary sentinel lymph node biopsy include those with:

- AJCC Stage I, IIA, and IIB invasive breast cancer with no suspicious axillary lymph nodes.
- Resectable, locally advanced, invasive breast cancer, either before or after, neoadjuvant systemic therapy.
- Extensive DCIS requiring total mastectomy, no suspicious axillary nodes.
- DCIS requiring wide excision in an anatomic location interfering with future, accurate sentinel lymph node mapping, no suspicious axillary nodes.
- Unilateral or bilateral prophylactic mastectomy

Reconstructive surgery

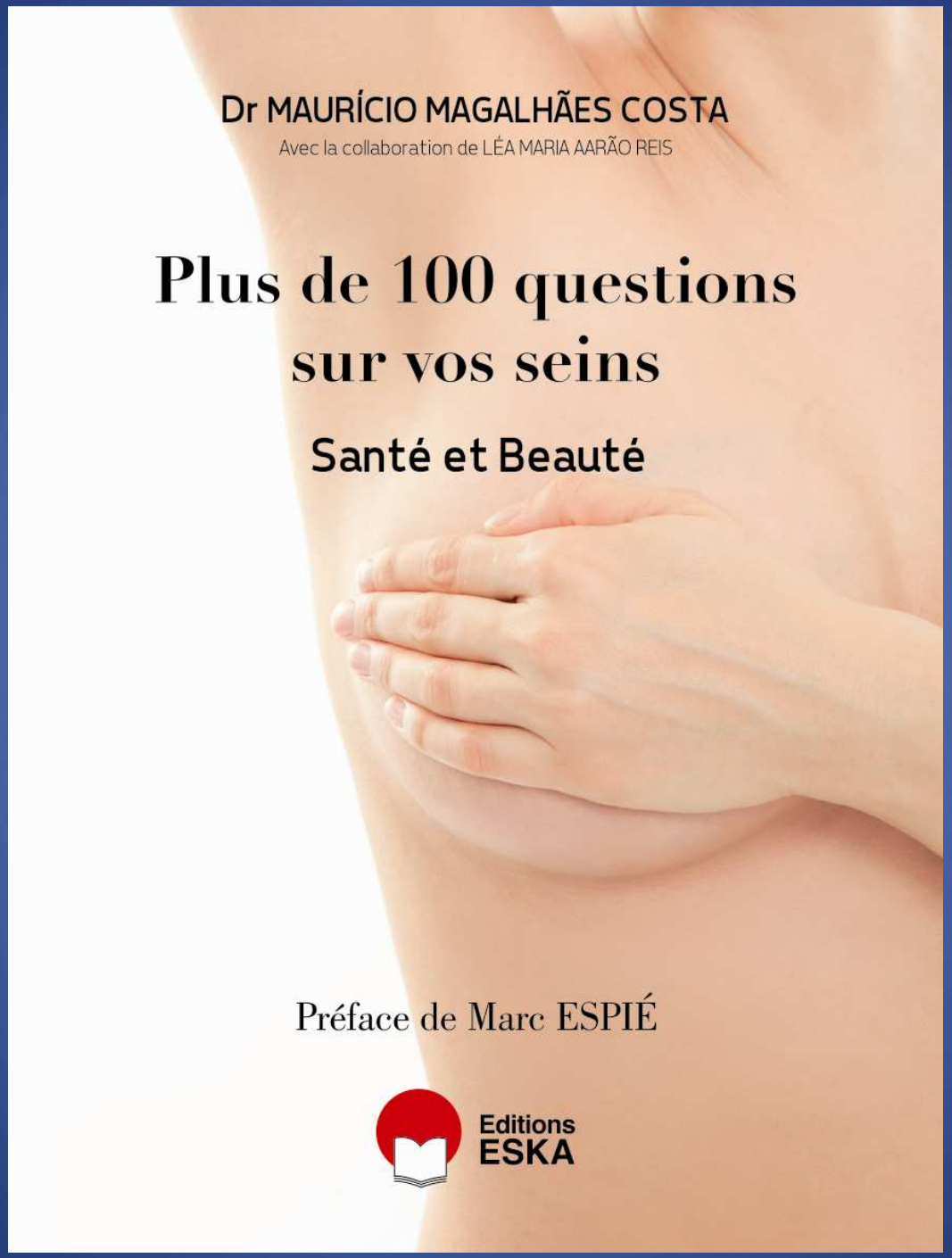
- All appropriate patients undergoing mastectomy are offered a preoperative referral to a reconstructive/plastic surgeon.
- Reconstructive surgery is provided by or referred to reconstructive/ plastic surgeons that are board certified or in the process of board certification.

Definitions and requirements

- The type of breast reconstructive surgery is dependent on the nature of the defect and the overall health of the patient. While there is an increasing trend in immediate breast reconstruction utilizing tissue expanders, implants, or autologous tissue transfer, patients should be made aware of all of their options including delayed reconstruction.
- Patients need to be aware that breast reconstruction does not interfere with surveillance or detection of local recurrence.
- Consideration needs to be given to the timing of reconstruction with respect to systemic adjuvant chemotherapy or radiation therapy.
- Some patients may be deemed inappropriate for a breast reconstruction referral and some patients may wish to decline the referral offer

Benefits of becoming an Accredited Breast Center

- A Multidisciplinary, team approach to coordinate the best care and treatment options available
- Access to breast cancer-related information, education and support
- Breast cancer data collection on quality indicators
- Ongoing monitoring and improvement of care
- Information about clinical trials and new treatment options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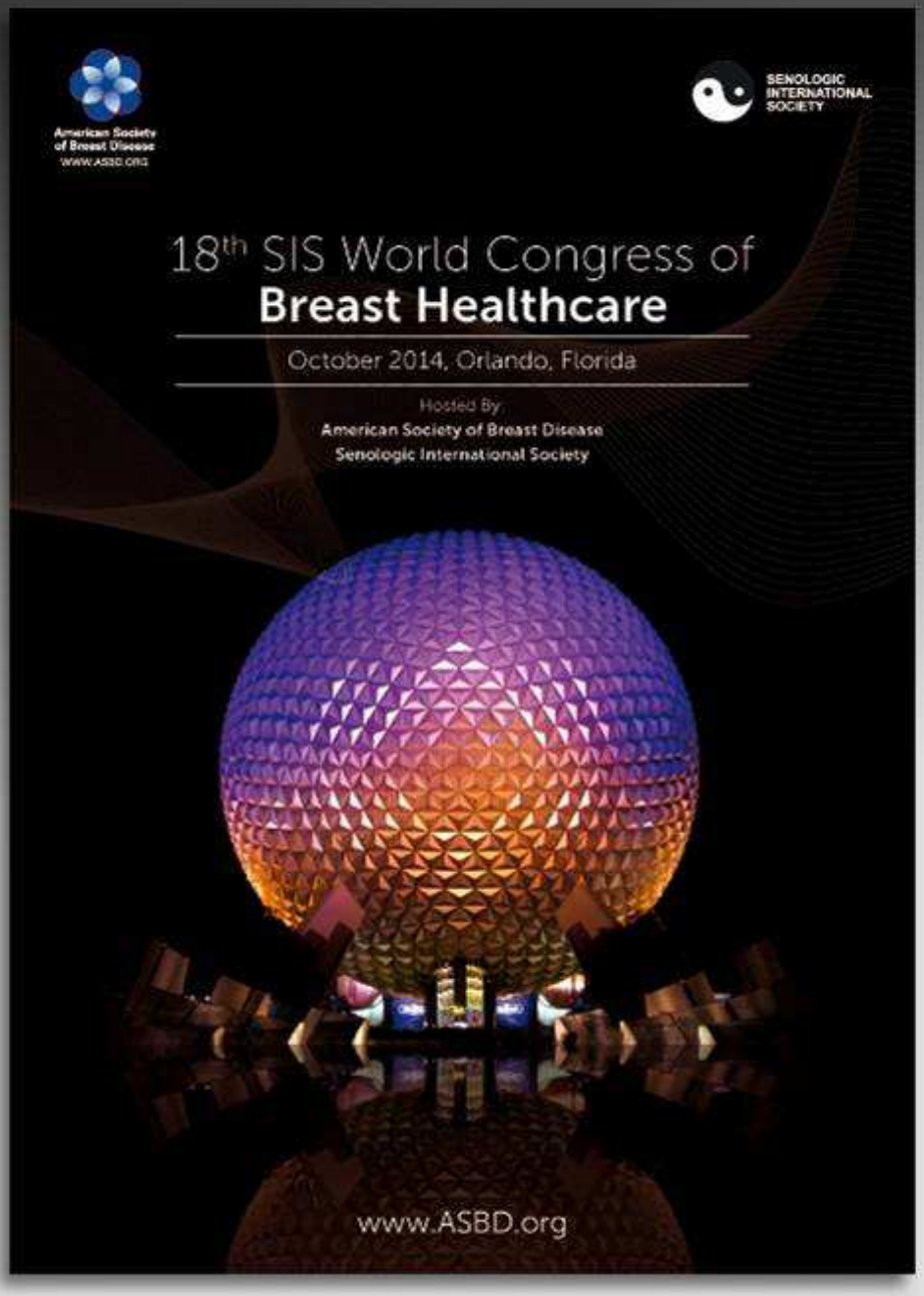
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