



Jeddah Breast Cancer Pilot Screening Program, KSA

7th Global Summit on Cancer Therapy, Oct 5-7, 2015
Dubai, Crown Plaza Hotel

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Why patients were passing through difficulties

Different centers with different approaches.

Personal experience.

No standard practice.

Guide-lines are not followed.

No specialized centers.

Unnecessary work-up, unnecessary interventions.

Educational Plan

Treating physician

(Surgeon, Oncologist, Radiologist, Pathologist)



Primary health care physician



Society

Patient, Family, Friends

Physician Education

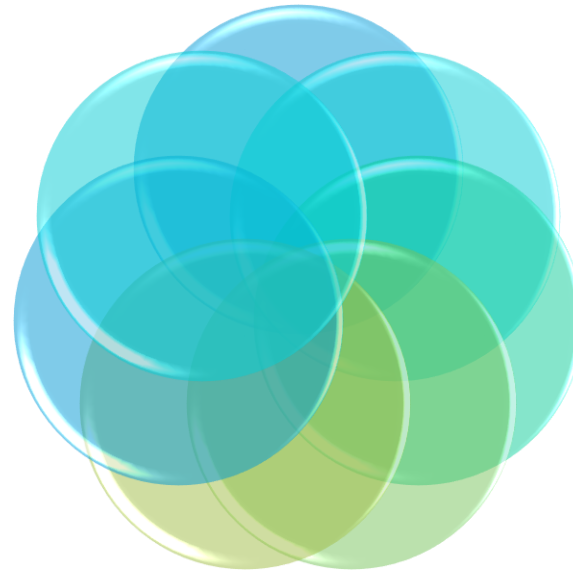
Multidisciplinary
symposia 2003

Proper follow-up
of cases

Regular meeting
between different
centers with case
discussions

Pre-operative
oncology
counseling and
treatment

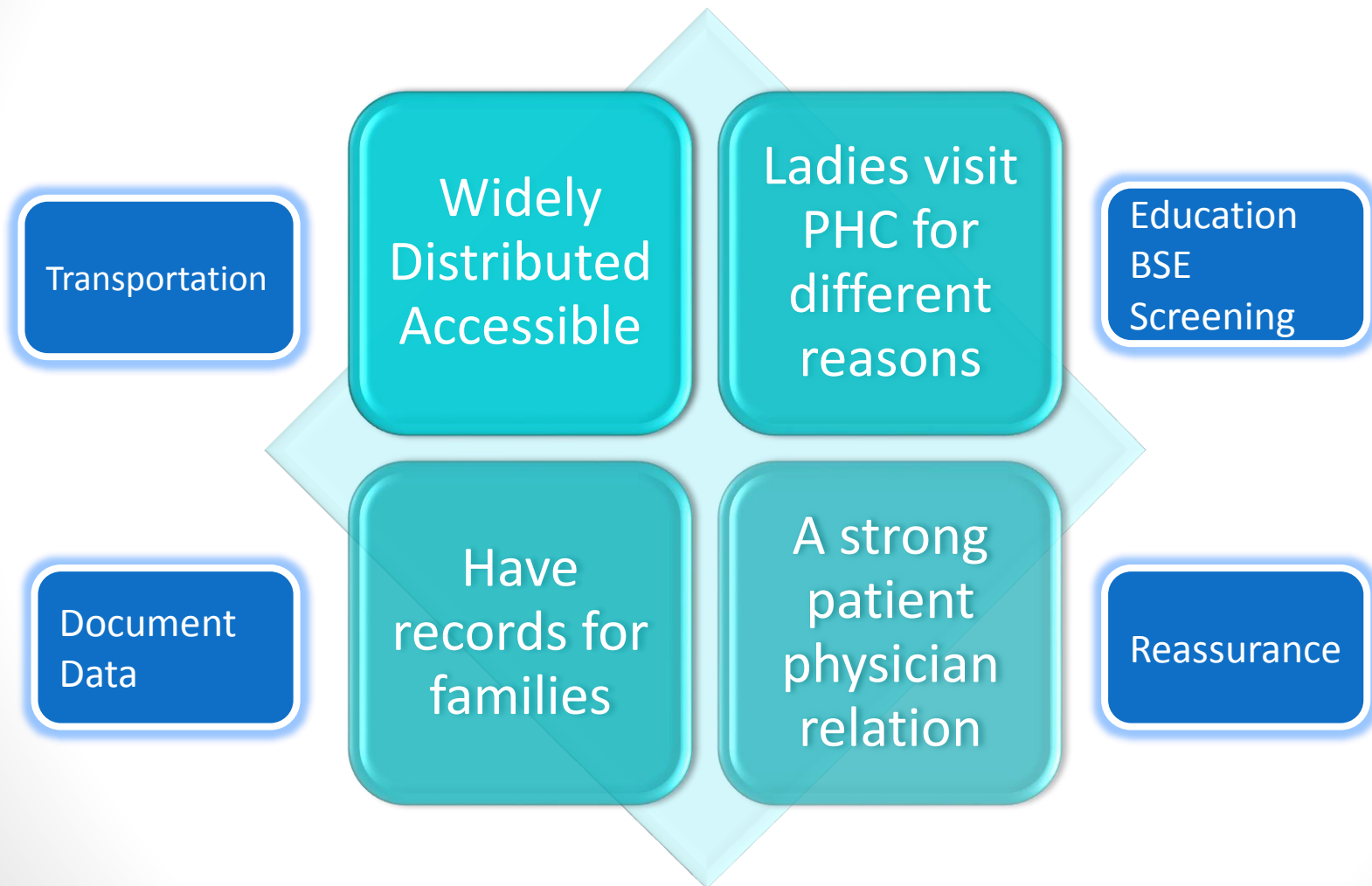
Proper pathologic
assessment and
sample
interpretation



Digital mammography,
MRI, Image guided
biopsy & stereotactic
techniques

Avoid unnecessary &
extensive disfiguring
procedure, avoid
incisional biopsies

Role of primary health care centers



PHC Education

Repeated courses on Breast Diseases Symptoms and Signs by multidisciplinary team

Workshops on how to perform Clinical Breast Examination

PHC physicians visit the Breast Clinic and Examine Patients

Smooth referral pathway from the PHC to the hospital

Category of Referral: Routine VS Urgent

PHC refer patients for imaging

PHC physician initiate treatment in some cases

Breast Cancer Awareness Campaign 2007

The first multi-institution
campaign

Structured educational
activities for the
physicians and the public

807 ladies screened in
main hospitals, 8 cases
detected (1.1%)

Outcome:

- More women asking for screening
- Improved society knowledge
- Improved communication between centers
- **In the periphery, probably same situation**

Poor knowledge about the disease and it's mode of presentation

Misconception: Breast feeding is an absolute protection

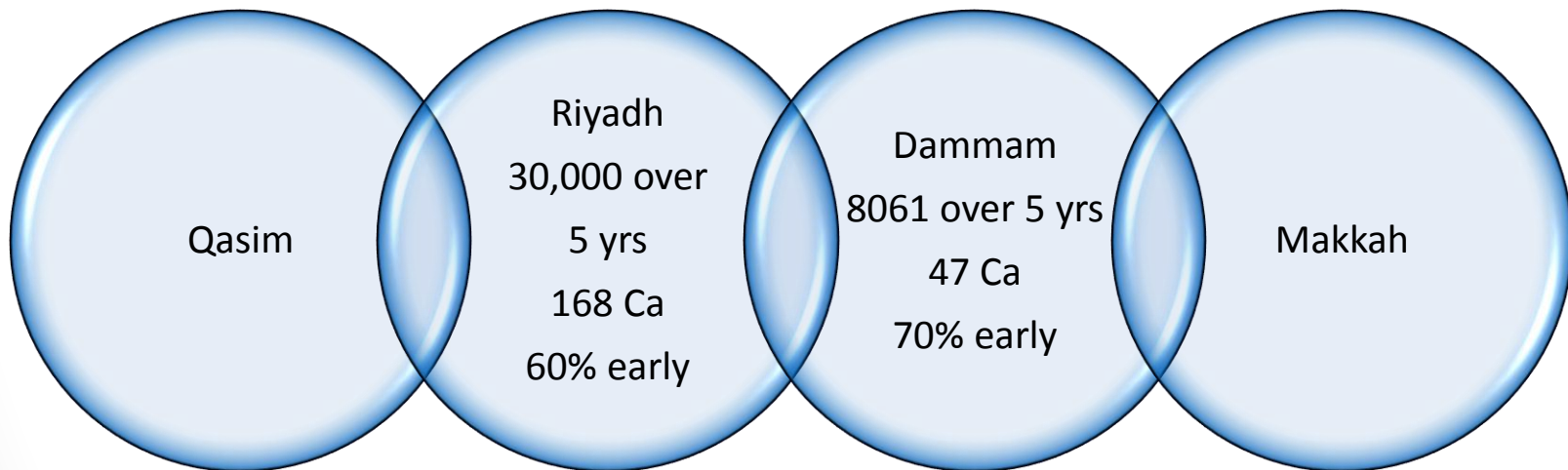
Cancer is a killing disease regardless of the treatment provided

Lack of the social support

Breast cancer is almost always painless

Lack/inaccessible good medical service

Screening and Educational Activities in the Kingdom



Breast Cancer Awareness Campaign 2010

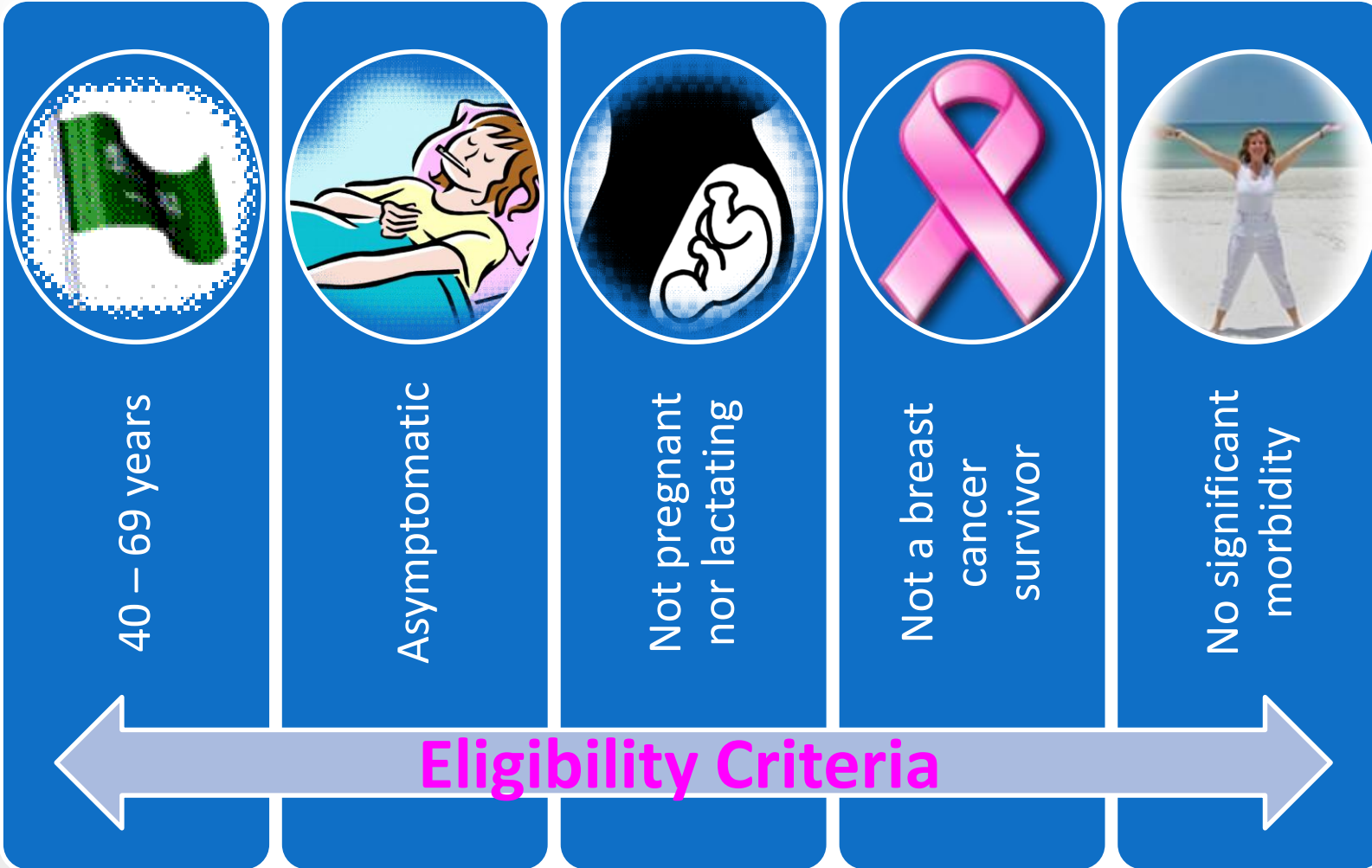
Jeddah (2nd
largest city)
Saudis:
1,729,007,
Females:
830,992

27% is the
Target age
group (\geq 40-
69 year)
(224,368).

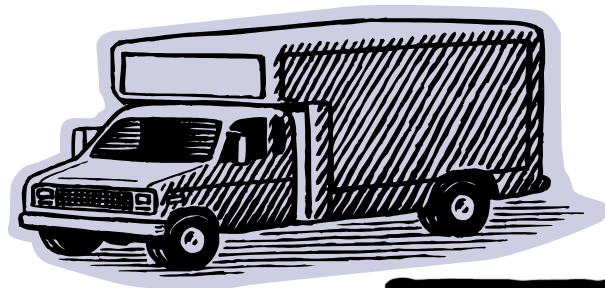
Screen only
1% of the
population
(2,244).

Total period
of screening
52 working
days.

Breast Cancer Awareness Campaign 2010



Breast Cancer Awareness Campaign 2010

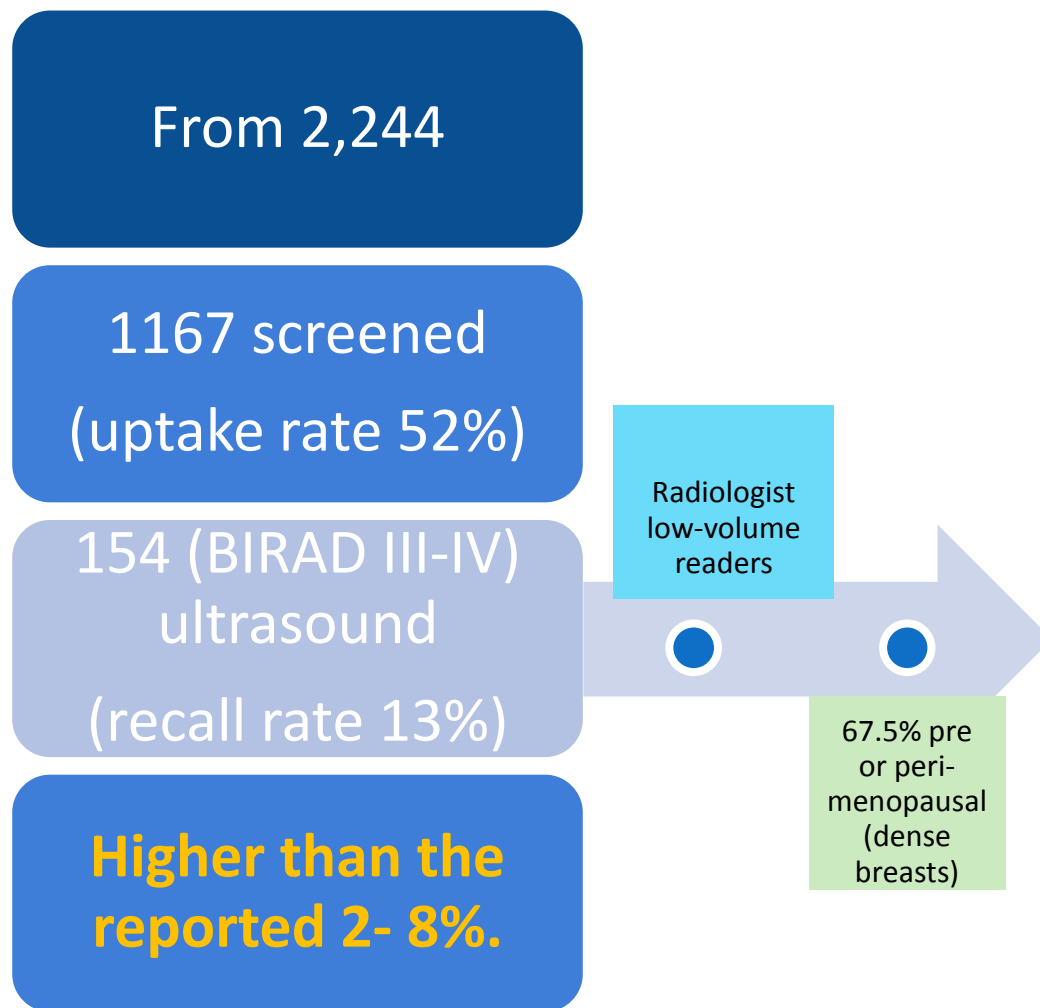


Demographic Data
Risk Factors



National ID Number

Breast Cancer Awareness Campaign 2010



Breast Cancer Awareness Campaign 2010

After ultrasound, 32 cases
required biopsy
(Biopsy Rate 2.7%)

7 confirmed
malignant (0.6 %)

4 IDC, II

2 DCIS

1 ILC

Low risk population

Multi-parity

Early pregnancy and delivery

Breast feeding

Breast Cancer Risk Factors in the History of the Screened Population

Risk Factors	Number (%)
Benign Breast Disease	51/ 1167 (4.4)
Breast Biopsy	15/ 1167 (1.3)
Cyst Aspiration	15/ 1167 (1.3)
Breast Operations	69/ 1167 (5.9)
Oophorectomy*	30/ 1167 (2.6)
Hysterectomy†	48/ 1167 (4.1)
Family History of Breast Cancer‡	29/ 1167 (18.8)
Family History of other Malignancies§	361/ 1167 (31)

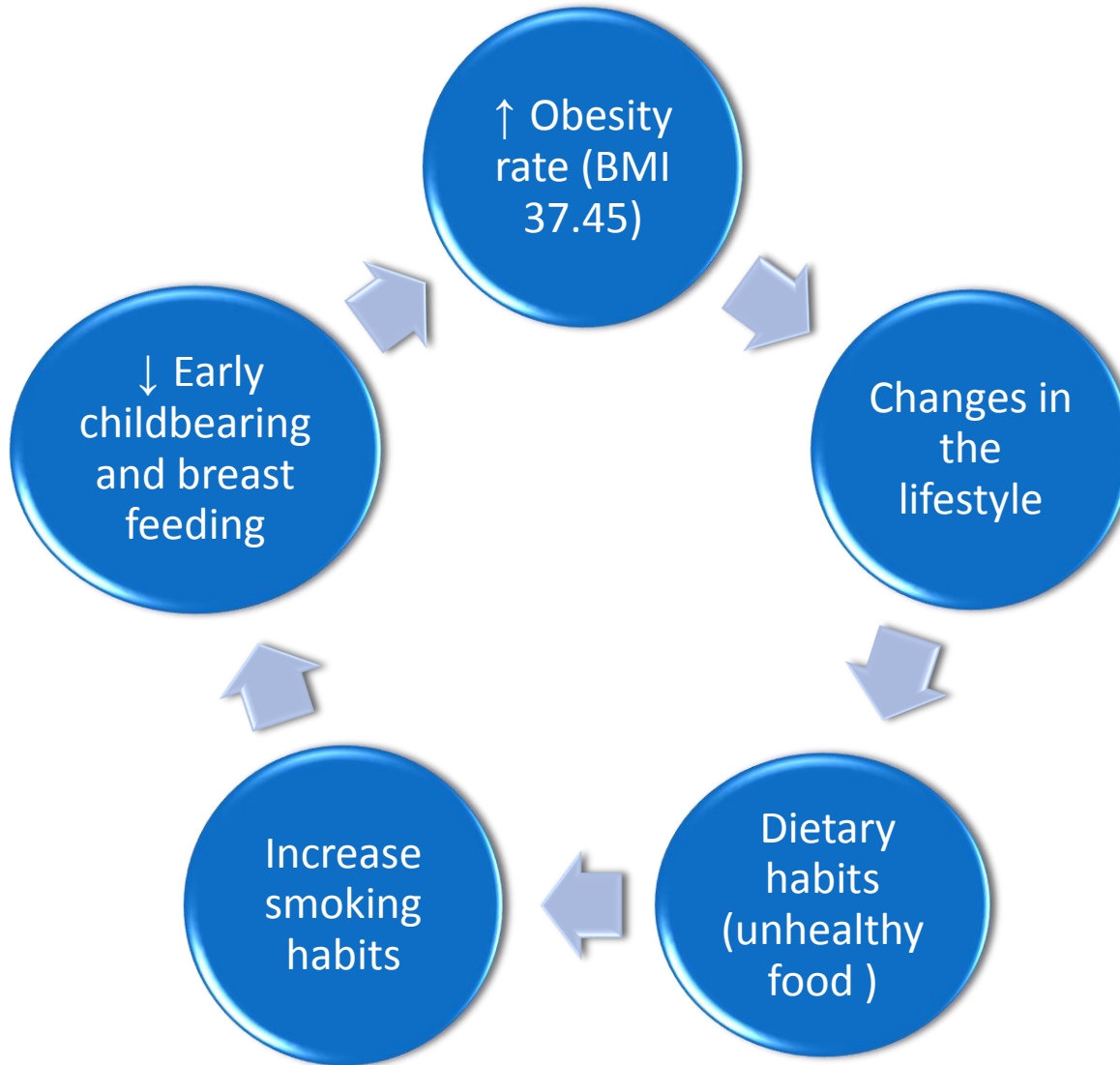
*None was due to malignancies.

† Only 3 had uterine malignancy.

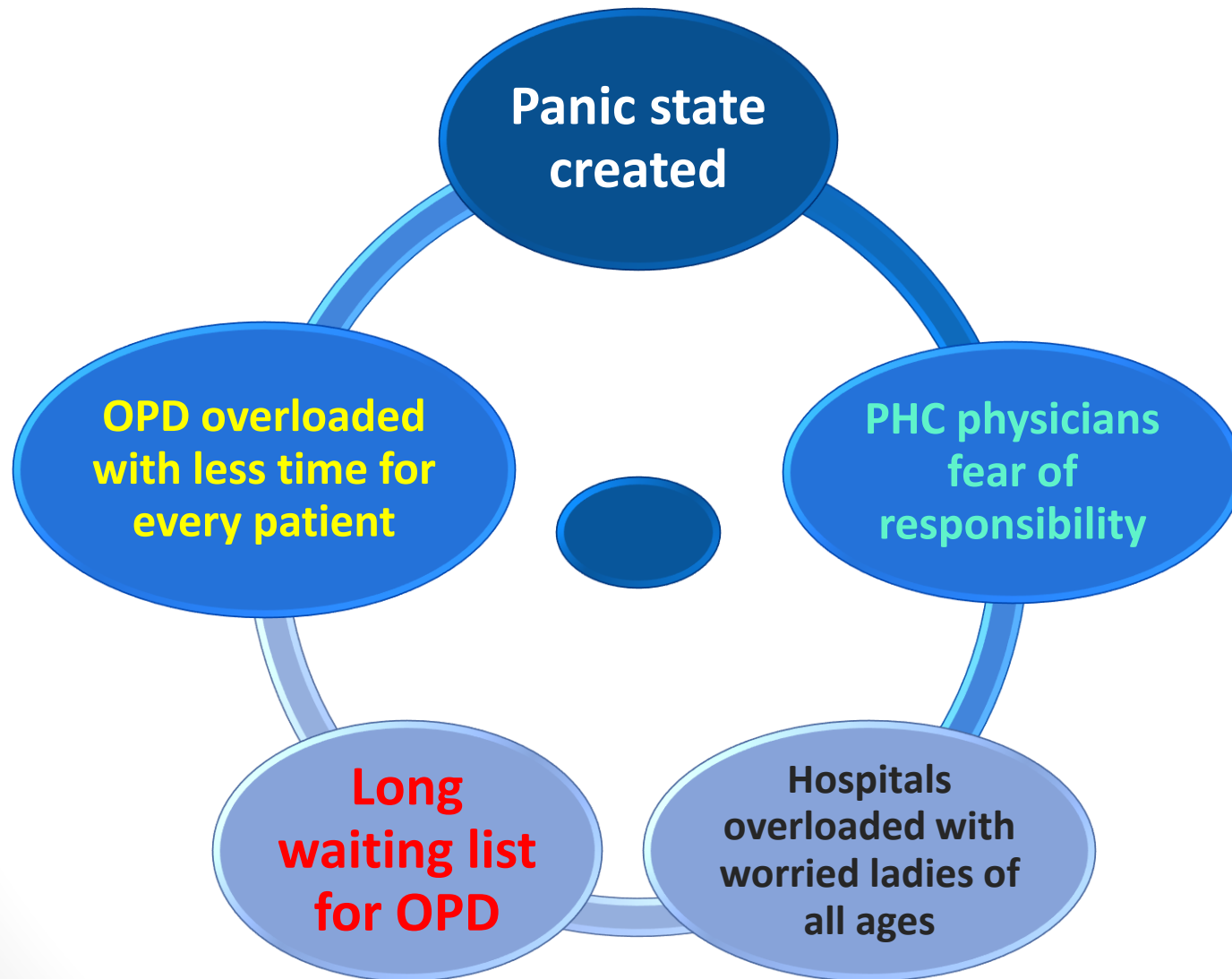
‡ 40.2 % was in 1st degree relatives and 21.5% had ≥ 2 family members with breast cancer.

§ The commonest were uterine, hepatic and lung cancers.


Alarming Risk Factors



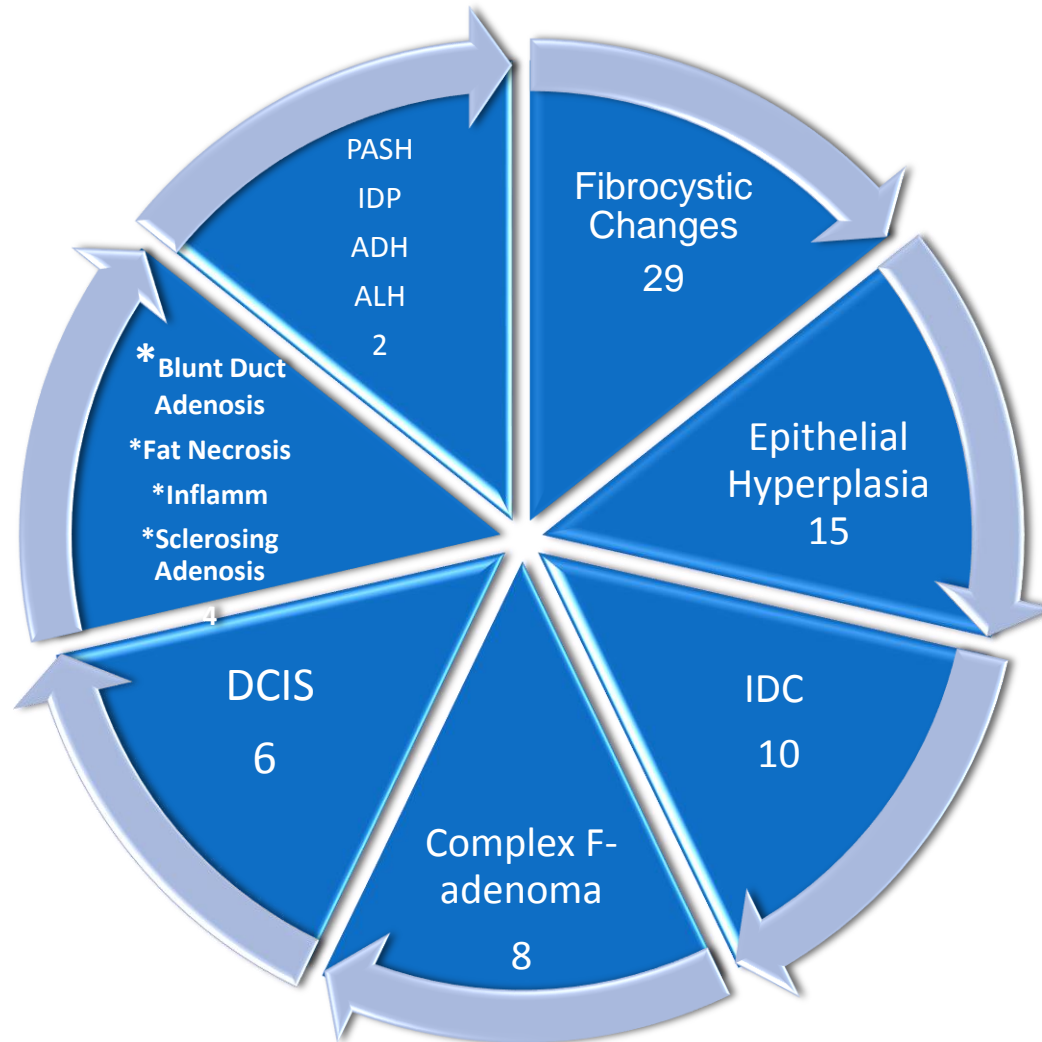
Educational Programs un-wanted effects



% Breast Ca Stages @ King Fahd Hospital

%	2004	2005	2006	2007		2008	2009	2010	2011	2012	2013	2014	2015
I	0	7	0	10		15	14	8	3	17	5	19	5
II	50	10	70	26		60	48	46	55	34	33	24	44
III	27	70	30	61		15	35	29	42	44	57	48	50
IV	23 	13	0	3		10	3	17	?	5	5	9	1

Screen detected lesions



Borderline breast lesions: diagnostic challenges and clinical implications.

Masood S¹, Rosa M.

+ Author information

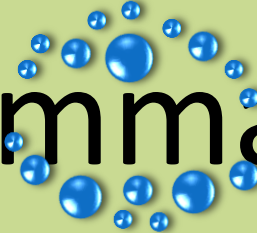
Abstract

Breast cancer remains a global public health awareness, and advances in breast imaging and detection of biopsies has led to increased diagnosis. This has created a challenge for pathologists. In small biopsies, pathologists are now expected to diagnose these lesions. In addition, some proliferative lesions are now being detected in image-guided biopsies. Therefore, classifying these lesions in small biopsies is difficult and risky. Some of the most challenging areas in diagnostic pathology includes the differentiation between atypical ductal hyperplasia and low-grade ductal carcinoma in situ, lobular neoplasia versus solid low-grade ductal carcinoma in situ, the correct interpretation of papillary lesions with atypia, and classifying the spectrum of columnar cell changes. Although these issues have not been fully addressed, this discussion focuses on these areas.

These entities are difficult to diagnose even in tissue sections taken from surgically excised lesions, pathologists are now expected to diagnose them in small and often fragmented tissue/cellular samples obtained from image-guided biopsies.

...differentiation between atypical ductal hyperplasia and low-grade ductal carcinoma in situ, lobular neoplasia versus solid low-grade ductal carcinoma in situ, the correct interpretation of papillary lesions with atypia, and classifying the spectrum of columnar cell changes.

Summary



- In every country, mammography screening guidelines should be tailored according to the local parameters like breast cancer incidence, age groups affected and healthcare resources (40s)
- Different studies in Asian countries concluded that biennial mammography screening for women aged 40 years is cost-effective.
- Saudi women accepted mammographic screening willingly.
- Health practitioners of all specialties need to be ready for the increasing work load and the need for higher skills.

