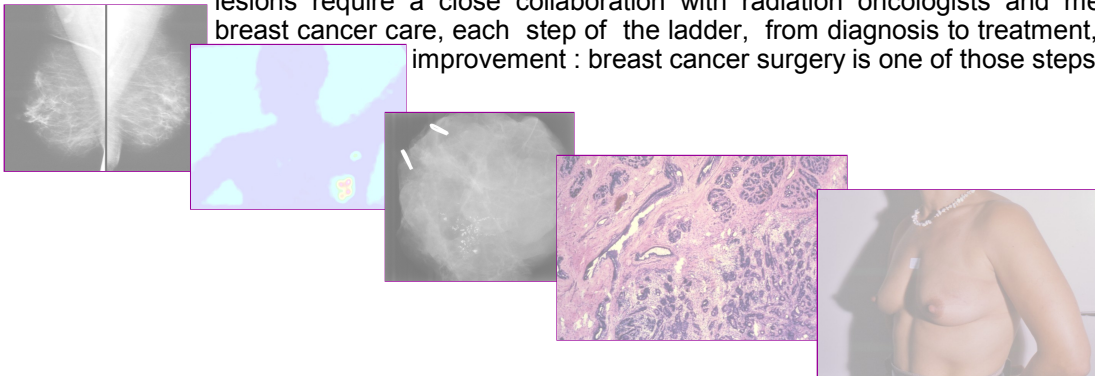


In France, regional breast cancer screening programmes have been implemented since 1989 and a national protocol started in 1994. The national extension was effective in January 2004. During this period major improvements in terms of professional practice have been achieved. Quality control procedures were initially implemented for radiologists, thanks to the national breast cancer screening programme. Our first guidelines based on the “European guidelines for quality assurance in mammography screening” initially involved screening and diagnosis but surgery and breast cancer treatment were not yet considered. Being concerned by the quality of the whole process, from the diagnosis to the treatment, the SFSPM worked on quality assurance together with the national agency for accreditation to develop guidelines for the treatment of breast cancer with a particular effort on surgery.

In the vast majority of cases, surgery is the first treatment applied. Surgery also plays a decisive role in a patient’s cure. An insufficient technical environment or inadequate individual care may lead to serious consequences for the future of the patient. We suggested that the experience of the surgeon is, amongst other factors, related to his/her activity (number of cases annually operated). This criterion has to be considered when choosing specialists for breast cancer surgery, but the present conditions of medical practice in France must also be taken into account. Considering the high number of breast cancer women (42 000 new cases per year) an abrupt stop of the activity of the surgeons who would not be immediately in accordance with the new guidelines could disrupt national senologic activity.

In France, breast surgery is performed in numerous public and private institutions by specialists coming from different specialities : mainly gynaecologists, general or visceral surgeons, surgical oncologists, or more rarely plastic surgeons with an oncologic specificity. Our goal was to ensure that all these surgeons would have a homogeneous approach, to ensure equal quality of care to breast cancer patients throughout the country.

Breast surgery requires a double multidisciplinary organisation : non palpable lesions require close collaboration with both the radiologists and the pathologists (this activity is growing with the national extension of mass screening). On the other hand, taking care and treating invasive lesions require a close collaboration with radiation oncologists and medical oncologists. For breast cancer care, each step of the ladder, from diagnosis to treatment, can be a subject for improvement : breast cancer surgery is one of those steps.



Quality assurance criteria for hospitals are based on :

- Adequate specific equipment.
- Written procedures that must outline the organisation of every step required for the quality of the surgery (preoperative, the surgery itself, and postoperative care). These procedures secure the care of the patient in the hospital from his/her admission to the moment they are allowed home.
- The hospital has to be able to give the surgeon’s activity to the authority’s representatives.
- The hospital has to sign a convention with a regional network for cancer treatment.

Quality assurance criteria for the surgeon himself focus on :

- The training : surgical specialisation (gynaecologic surgery, general surgery) with a specific training in breast surgery.
- Regular participation in a multidisciplinary breast cancer meeting. The surgeon has to personally present his/her patients records to a clearly identified team.
- The surgeon has to be a member of a known regional network of oncology.
- The patient’s medical record has to contain all the data related to the surgery.
- The time allowed between each step of the process has to be in accordance with national recommendations, particularly in case of invasive cancers.
- The surgeon has to be able to demonstrate his/her annual activity in breast surgery in case the representatives of the national authority require it.
- If a minimum level of surgical breast activity was to be considered as a quality criterion, the useful and acceptable level proposed would be between 20 and 30 breast cancer operations annually after 2 to 4 years of practice.

In 2006, these recommendations will be included in a national ministerial order and we hope that they will contribute to a more equal access for women to high quality breast cancer care.