Transcription for videos: Innovation in Cancer Screening – Intensive Quality Improvement: Workshop 1

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SECTION 1: Community Led Cancer Screening – A Quality Improvement Perspective

Speaker: Dr Richard Bills, General Practitioner, Brooke Street Medical, Quality Improvement Clinical Advisor Speaker:

Angela Ouroumis: Dr. Richard Bill's is our Quality Improvement expert. Dr. Richard Bills is a general practitioner and a member of the Department of Health and Human Services, Victorian Clinical Council. He is a GP with a strong interest in clinical quality improvement. He's been engaged with the Improvement Foundation of Australia since its inception in 2005, and has assisted in quality improvement activities in both urban and rural settings in the eastern seaboard states and South Australia. He currently sits on the Department of Health and Human Services, Victorian Clinical Council, where he advocates for better data sharing and integration between primary care and acute care. Dr. Richard Bills will set the scene for us and I thank you for being here.

Dr. Richard Bills.: Thanks Angie. So my job is to make you feel un-frightened. And I think when we talk about quality improvement, it can sometimes be a slightly scary topic, and yet it's something you guys actually do every single day. And it's something you do, not just in your clinical context, but also in your home life. It might be about thinking about a better way to get to work, or a better way, a better time to do your supermarket shopping, or something else that you might need to do on a regular basis.

Dr. Richard Bills: The whole idea is looking for me at the science of that process today, and just taking you through some of that stuff. So what have you all signed up for? This is obviously the start of this project for you guys, and community-led cancer screening is something that you're not the first group to do. So that's a little hint, which I'll come back to a bit later on. You are special. You're always very special. I want to make that point. But it is something that other people also have been engaged in. And so that can be very helpful for you, thinking about not having to design wheels. It might be that what you need to do is find people or find examples of other wheels that are going to deliver for you.

Dr. Richard Bills: So in this particular thing, the cancers we're focusing on are three. So we're looking at breast cancer, bowel cancer and cervical cancer. I think you're well aware of that. You've done a predisposing question and answer sheet to look at

that. And we are particularly focusing on some communities who we know are poorly screened, thinking about those three cancers. So Aboriginal and Torres Strait Islanders, culturally and linguistically diverse, and low socioeconomic group patients are people who we know have poorer screening numbers. And Wendy and Chris and Meron will probably talk a bit more about that, specifically related to their particular areas of expertise.

Dr. Richard Bills: I really want to highlight the fact that what you're taking is a quality improvement journey. Has anyone here been involved and Australian primary care collaboratives? One two. Good. So a lot of what I'm going to say is going to be very familiar to you. And for the people that haven't, I want to just really reinforce this concept. Quality improvement is something you get to do every day, consciously and unconsciously in your practice. And at the moment what you're going to be engaged in for the next 12 months is a very conscious look at that, to do with these particular three cancer screening clusters.

Dr. Richard Bills: So one of the things you need to think about is where are we now? And Angela was showing me some of the responses to getting people to look at their populations, et cetera. I was marvelling at one of them where I saw what numbers of your population are over 49 years of age? Now, in my practice where I've been for almost 30 years, I couldn't tell you how many hundreds and hundreds of people are over 49 years of age. But I saw in someone's response that they'd noted that they've got about 35 people who are over 49 years of age, in the clientele that they see.

Dr. Richard Bills: And that's what I love about this because we are all different. And one of the key things about this journey is understanding who you see. If you're a GP who only sees males, we've already just rubbed out pretty much two of these groups. Although 1% of breast cancers occur in men, clearly you're not going to be doing much cervical screening, and you're not going to be doing much focus on breast cancer. So understanding who you're dealing with, where are you now is really important.

Dr. Richard Bills: I will say, and I'm sure there are other people who have this, that my practice has a particular interest in transgender medicine. And so I actually see a number of me and who I do cervical screening on, because they still have cervixes, and they've had penetrative sexual experiences in the past. And so they still need to be screened for cervical cancer. But for the bulk of people, I think you understand that males are not going to be your target audience. What do we hope to achieve? And some of this is about understanding from where you are, what it is you're wanting to improve.

Dr. Richard Bills: I think one of the scary things about quality improvement journeys, is sometimes discovering things you thought you did really well, you actually don't do as well as you thought. And I think that's a great place to motivate you to think about how you could do this better. And we know at a population level, those three specific populations, the Aboriginal and Torres Strait Islander, CALD and low socioeconomic groups are people who universally tend to be more

poorly screened. And yet there are some areas in the country that are doing spectacular jobs with specific groups that I've mentioned. And I guess there're opportunities for all of us to be able to improve what we do.

Dr. Richard Bills: And finally, how we know if we've got there, and this is really just a story about one word, and that word is measurement. Finding out where we are now is about assessing how well we can measure what we do do, and what we don't do. What we're hoping to achieve is determining what it is we want to do differently, what we'd like to make happen, and then we need to measure to see if we've actually got there. Who here has heard of that PDSA cycle? Hopefully quite a few of you. If you haven't, it's going to be banged into you over the next 12 months. But that plan-do-study-act cycle, which is the heart of good quality improvement. And that's really about taking those three statements and just reiterating them.

Dr. Richard Bills: How do we know if we've got there? We measure it. Are we happy with that outcome? Have we achieved everything we set out to achieve? And if not, what are we going to do from there? So we now know our new now, where we are, and what are we going to try and achieve from there? At a practice level, I talked about measurement. And that's about data, and that data is something that's maybe easy, or maybe quite difficult for people to get hold of. And that's part of this journey. For those people who have been involved before, you'll know that getting data out of your practice information systems, for some things is really easy, and for other things is not so easy at all. And so discovering where we can find that data, and it might not just be in your practice.

Dr. Richard Bills: So you might discover that VCS has a heck of a lot of data that might be really helpful for you to establish who has and hasn't been screened in your practice. Pathology companies might be able to provide that data for you. And generally, people in those fields are really, really happy to help you try and discover what you are doing at the moment, and therefore understanding what your gap is.

Dr. Richard Bills: About communication, and that's communication, primarily within your practice, but also with outside providers. So within your practice, you need to find effective ways to share this journey that you're going through. You need to find effective ways to get other people onboard in this process. And that's going to engage them in teams. And although we're talking about three clinical subjects, breast, bowel and cervical cancer, it's really important to understand that the teams of people are going to help manage that are going to include nonclinical people as well. I'm often asked this question about quality improvement. I've done some fabulous studies about this. In general practice, who is the single most important person involved in quality improvement, in terms of their effect on the patient, on the client. Who is the single most important craft group in your practices?

Dr. Richard Bills: You've heard me speak before, you see. The single most important person is receptionist. And I'm sorry for all the doctors, the nurses, the practice managers. The single most important person is the receptionist. That's the first

person the patient sees when they walk into your centre, and the last person they see when they leave. And the messages they get, and it's not about just clinical messages. It's about how they feel embraced by the practice, how they feel like they're part of this place that cares for them, as much as the fact that that person might say to them, "Oh by the way, you've got an appointment to see the nurse for a pap smear. Don't forget that on Thursday", is a critical part of that whole process.

Dr. Richard Bills: The clinical providers provide a very important part. I'm not diminishing that. I'm a GP. I'm not trying to dis my own profession, but it's really important to know that in terms of how we actually manage that, your teams need to involve nonclinical people as well. You need to be clearly documenting things. And for those people that have been involved in quality improvement collaboratives before, you know that there is a ritual to this. You know that there is paperwork, and the PHN staff will help guide you through that process to log what you're doing.

Dr. Richard Bills: And the reason for that is it's like learning to drive, or learning a new skill. To start with, you really need to carefully document what those changes are. What is it we're hoping to achieve? How are we going to do that? What's the first step we're going to take in that journey? Where, once you get good at it, once you've been doing it for a decade or more, then perhaps there's a little bit less of that rigid documentation, and you've got more recognized pathways that keep track of what's going on.

Dr. Richard Bills: You are not in this alone. And so, think about the support networks. Your PHN is incredibly supportive in terms of resources, both people and physical resources they can offer you, but there might be other people. There might be people within your practice, if you're part of a corporate set of practices that might be in a wider set of practices. It might be friends or other people you know in other parts of the country who might be able to support you in this journey, depending on what element you're wanting to look at.

Dr. Richard Bills: The first place in terms of that support starts in your practice. How many people here do an annual, every 12 months, performance review of every single member of your staff? One of the reasons we do that in my practice is because every year, some of my staff had been working in the practice for 30 years. Every year I discover new things about people at work in my practice. I have 68 staff in my practice. It's a big practice. One of my staff members is the gardener. People often laugh, but I talk about the receptionist. My gardener is the guy that comes in, he says, "Do you know... I saw Mrs. Jones get out of her car. There's something she's really battling to get in and out of that car at the moment. I don't know whether there's something that she's not telling people."

Dr. Richard Bills: That's an interesting thing for the gardener to tell me. He's got no clue about medicine, but he knows a lot about people, and he's out there, and he sees the people. They come in, you know what they're like. You know the difference between doing a home visit by surprise on someone, and discover that their

house is just an absolute mess, and they're not out of their pyjamas at three o'clock in the afternoon, versus the little old lady that comes in to see me and she looks absolutely immaculate. She spent five hours getting that good, to come in and see me for 15 minutes, and go out again.

Dr. Richard Bills: So the staff in your practice may have hidden skills that are really valuable, and it's very engaging for staff across the spectrum to feel like they're contributing to some practice-wide improvement. It's really powerful to do that. You guys have this device. I have it online, but you guys, I assume, have it both in paper and online. A really, really valuable resource for you. The PHN has gone to a lot of trouble to put this together. It's gold. It's gold. It's not boring reading, it's gold. And I'd encourage you to engage anyone who's in your team to have a look at it. There's things in there for everybody. Really valuable resource.

Dr. Richard Bills: I mentioned about the PHN staff, I also mentioned about the staff at Victorian Cytology at Breast Screen, at National Bowel Cancer Screening Program. They all have advisors. They all have people who can assist you in answering questions. They also have people who've seen this before. They also have people who can point you, if there's something specific, you've got a particular population of people you're wanting to target, they might be able to point you to other people who have a similar population that you might be able to steal shamelessly from, or in their case, share generously with you, so that you're not having to reinvent those wheels. That's a really valuable thing.

Dr. Richard Bills: I said you're not alone. Just within this room, there's a heck of a lot of resources. And you might discover when you analyse your own data, that there are some things you do really well, and some things that you do less well, and that other people have a different mix. And so it might be the practice down the road that can help you with something that they are doing with breast screening, and you might be able to share something you're doing with cervical screening that is a quid pro quo for them.

Dr. Richard Bills: I did mention about the fact that there are other practices. So for example, in eastern Melbourne, the PHN went through this process early last year,] and late the year before. And so there are practices out in eastern Melbourne for example, that are doing this stuff. There's some really good initiatives in New South Wales. So some of the inner western Sydney practices that have been involved in screening, particularly to a cervical screening. So there are all opportunities for you to just do a little bit of trawling, and see perhaps if there's somewhere that you're particularly wanting to focus on to lift your numbers, see whether someone else is doing that. Just put in your search question and see about that. And there's a little bit of incentive money does help make the wheels go round.

Dr. Richard Bills: This is one of my nurses. When we went to a staff development day, as we have every year, which is just a staff-only, six-hour extravaganza, we do a range of things. Some of it's chat fest, but some of it's about other activities. And you discover that people who are the calmest, sweetest nurses, are the most

aggressive people when you put them into a go cart, and young Claire here threshed the other 67 starters after a series of heats, we whittled it down. And Claire put a few people off the track. It didn't seem to bother her at all, for the mildest nurse I've got in the practice, quite interesting really. So yeah, I'll just put that out there.

Dr. Richard Bills: So I mentioned I want to talk about just a few of those resources in your practice. Untapped resources. So it might be people, it might be things that you have lying around in your practices. It might be a spare room, it might be some sort of a tool or device that you can use that might be something you can throw into this mix to help you in this process. It might be that it comes from the brains trust in your practice. And so it might be that you get to sit round over lunch table, or specifically a meeting about what you're going to be doing for this quality improvement exercise, and that as a consequence, someone comes up with something. That is gold. Does anyone have a process here, in their practices, where when you immunize someone, and you send them out to the waiting room for 15 minutes, that you give them some card or sheet to read? Something like that? Has anyone seen this process?

Dr. Richard Bills: Years ago, 16 years ago, we were starting on the journey, and wanting to improve immunisation rates in the day. And we had a new receptionist. She was 17 years of age. She had no formal training at all. We were having a meeting about this, and she made a suggestion about, "Why don't you give them brightly-coloured sheet of paper so that we can see. The receptionist can see those people that had a vaccination sitting in the waiting room." And so we thought, "What a great idea." And then we modified that slightly to put information on the sheet. If you're going to be seeing there for 15 minutes, you might as well be reading about all the other great things we do in our clinic other than just vaccinate people. And so to this day, if you get vaccinated in my clinic, you go out into the waiting room with a brightly coloured sheet of paper, a laminated sheet of paper, just gets recycled. But it's got stuff about what we do at Brooke Street Medical Centre, for example. So it's a win-win-win situation. Really clever idea from somebody who had no medical training, no thinking about immunisation. She'd been in the job, literally, for less than two weeks at that time.

Dr. Richard Bills: Modifying things that you already do. Accessing data and using that to drive stuff within your practice. Power of data is really, really important. And as I said at the start, tapping into the things that other people can think about. And often, that's where those innovative ideas come from. People who may not have just had a traditional training in nursing, or allied health, or medicine, can come from a completely different place to throw up some fabulous ideas for you. Sometimes you just have someone in your practice who can just deal with absolutely everything. I don't know how many Dr. Jumas there are out there, but they can pretty much ... Maybe they should be the health minister. I don't know. Fix anything.

Dr. Richard Bills: I want to emphasize for you something really important. This is not a pilot. This is not a pilot. You're not about to do something in your practice for 12 months and then go, "Great. Did that." Put that away. You're on a journey. You are going to learn to use Plan-Do-Study-Act cycles. You're going to learn to use other quality activities that you're going to embed in your practice. The last thing we want is to see people go, "Great. Yeah. Back in 2019 we absolutely ... That's that peak up there on the chart of how many breasts, cervical and bowel screens we did. And now we're back to our norm down here." That's a fail, with a capital f. You are needing to look at ways we can do this better.

Dr. Richard Bills: Those ways need to be sustainable. So saying, "Oh great, we're going to employ three full-time nurses from the moment that doors open in the morning till the moment the doors shut in the afternoon, and they're going to screen everybody that walks in the door." That's fantastic. But I'd love to see the funding model that shows me you can still be doing that in six months, or 12 months, or two years' time. You've got to find ways to do this sustainably. And sustainable is not just about money. Sustainable is about your sanity. Sustainable is about that this works in my practice.

Dr. Richard Bills: So have some great ideas. Think about the ways you're going to change something to create the improvement you're looking for, and be really clear. It needs to be sustainable. If it's not sustainable, it doesn't fly. And in 12 months' time, in two years' time, you'll be back to wherever you were at the moment. You need to change something. All improvement requires change. Not all change is improvement. So it needs to be sustainable change in your practice.

Dr. Richard Bills: And that process can continually be refined. It's like anything. I went off and did an advanced driving course a couple of years ago, because I don't live in the city and spend a fair bit of time driving, and I'd been driving at that stage for 30 years. It's quite interesting to see the things you can learn that can make your driving better, even after you've been driving for 30 years. And it's the same with quality improvement. There are always new things that you could adopt. You need to keep going over your data, just keeping it on those gauges to see how you're going. Keeping your eyes and ears out to see what opportunities exist to do things better.

Dr. Richard Bills: I've travelled extensively talking to people who are quality improvement. I've yet to see someone who puts their hand up and says, "I don't want to improve what I'm doing." We can all do, whatever we're doing, we can do it better. Sometimes it's actually about things you just hadn't thought of. And the solution is actually really straightforward.

Innovation in Cancer Screening – Intensive Quality Improvement: Workshop 1

SECTION 2:
Cervical Cancer Screening
Speaker: Dr Wendy Pakes, General Practice Liaison, Victorian Cytology Service

Dr. Richard Bills: I want to introduce Wendy, who's going to talk from her role as a liaison physician for Victorian Cytology Service. So Wendy is a Melbourne GP who has extensive general practice background with a particular focus in medical education, women's health and sexual health. Her previous role includes a position as the Director of the Sensitive Examinations Program, the Department of Medical Education at the University of Melbourne. In her role as VCS liaison, physician, Wendy provides education to GPs, nurses and other clinicians involved in cervical screening. Please welcome Wendy.

Dr. Wendy Pakes: Good. Thank you. So I'll just take this opportunity to remind everybody that VCS pathology continues unchanged. A lot of people have been confused by the VCS registry, which is ceasing function. But pathology, we're still there at the end of a phone. Cervical cancer screening. This is just to put in to say, "How lucky are we to live in Australia? If you look down the bottom here, set to eliminate cervical cancer in Australia by 2028. The first country in the world. So we are so incredibly lucky. So for many years we've had almost the lowest cervical cancer mortality in the world. And if we just counted Victoria, then we would always have the lowest cervical cancer in the world.

Dr. Wendy Pakes: We were also the first country to have Gardasil, so 2007. And because I think in large part, to the incredible work that people like our clinical nurse, Sarah, are doing with the Stop Anti-Vacs network, or whatever they call themselves now, in Australia, that anti-vacs message is not as out there as in many other developed countries in the world. So it means that in Australia, we've actually got the largest cohort of HPV-vaccinated patients in the world. And we've already shown that incidents, or the circulating prevalence of HPV-16 and 18 has reduced by about 90% in our vaccinated. And with herd immunity in that age cohort of women who've had access, and now men having access to the HPV vaccine.

Dr. Wendy Pakes: We're the second country to implement a national HPV-based cervical screening program. And as I pointed out, we have extraordinary coverage for our HPV vaccination. And some of you might be interested, we're currently the first in the world to be looking at the efficacy of the HPV screening pathway in a vaccinated community. So some of you may be interested in continuing to be involved in Compass.

Dr. Wendy Pakes: Now, I've put this up because it's a reminder, if we look at where we are, way down here, it's fantastic. But remember, many of our patients are coming from patients where cervical screening is just not on the agenda. They don't know about it. And so we have to be very mindful of that in our practices, that many of our patients from other countries around the world would have no idea what cervical cancer is, let alone screaming or vaccination to prevent it. So I think as primary care clinicians, we have a role to remember. We want to keep, or engage all of our patients down that end, and not let some languish up this end because we're not understanding where they're coming from, and not explaining to them why it's so important.

Dr. Wendy Pakes: So you would all be well aware now that we've changed our cervical screening program to an HPV-based program. So our pap smear program has been incredibly successful, but international evidence really has helped us to understand the role of HPV in the development of cervical cancer, and around the world, people or countries will be moving to that. So in Australia about 93% of cervical cancer is actually due to the HPV strains. And I've forgot to put in here, that's in Gardasil 9. So as our young people coming through from 2018, 93% of the oncogenic HPV is going to be hopefully, largely eradicated. But until they come, another 12 or 13 years till they reach screening age, we still have to remember that many of these HPVs are still circulating.

Dr. Wendy Pakes: Now, overwhelmingly, and it's really important that the vast majority of people, they have intimate contact, that they will be exposed to HPV] But overwhelmingly, it's transient, asymptomatic, and it goes away. Now, in our language, unfortunately, as we've moved to HPV testing, it suddenly hit home to everybody that, "Oh, it's a virus, and it's transmitted by having sex." And it's women who bear the burden of being told that. And so I think it's very important in our discussion of HPV, that we actually really normalize it for them, and reassure them because we at VCS are getting many younger and older women who are out ringing us for advice because they're actually very distressed. That they have got this STI, what are they going to tell their partners? How will they manage it? And so it's really important that we actually understand the impact that this is having on our patients, in this transition period where it's new knowledge for a lot of people.

Dr. Wendy Pakes: Now, most low grades are a reflection of an acute HPV infection and they just resolve. And that's why, really, the majority of low grades, it's just transient. We don't really mind if we ... We don't want to pick them up particularly. Importantly, by the time somebody is 20, it's estimated that about 50% of HPV infections that cause cervical cancer, they would have already had been exposed. And by the time you're 30, you would have been exposed to about 75% of oncogenic HPV.

Dr. Wendy Pakes: But HPV only causes cancer in those women where it becomes persistent. And that also, people are thinking, particularly if they've got an HPV-16 and they're going off to colposcopy, they think they have cancer. So we have to be very carefully of explaining, "It's just wallets there. You may be at slightly increased

risk. We're just going to monitor you until it goes." And in the vast majority of people, it will go. Now, before I go onto this one, just note over in that corner, that the big one, "90% of women and men will be exposed to HPV in their lifetime."

Dr. Wendy Pakes: Now, the little paragraph under there, I think is really important in that clearance does not necessarily mean that it's gone. No, I've had chickenpox. Am I at risk of getting shingles? Do I know? Do we know? Do some people clear chickenpox completely? Do we know? No. HPV is the same. So clearance means it's not detectable and not clinically relevant. It does not necessarily mean that it can't reactivate. And this is particularly important in encouraging people who are in monogamous relationships that, yes, you're negative now, but you still need to come back in five years time. And particularly the older women, and encouraging all the women to come back to their exit tests.

Dr. Wendy Pakes: Now, who's still having problem with under 25-year olds coming in saying, "My mom wants me to have this test. She'll pay for it." So briefly, we've got a dedicated specimen reception person at VCS, who rings clinics when we get an asymptomatic under 25 coming in for a screening test, and he says, "Do you really want this? Are you aware your patient will be billed?" And then we say, "Oh yeah, that's fine." So it just remember, I've put this up. This is a slide. This is post Gardasil. Not Gardasil 9, Gardasil 4. So these are just all the non-oncogenic HPVs. But if we look at this group here, HPV-16 circulating at roundabout 1.5%. Six, 11 and 18, incredibly unlikely. But look at all of these. These are all the others.

Dr. Wendy Pakes: So these young women, it's almost normal that they will be positive at some time. And this is why it's really important that you actively discouraged them, because there's also acute HPV infections can sometimes cause what looks to be high grade change. And there's a recent international study at which the Royal Women's was also involved in, that shows that a significant proportion of women with high grade abnormalities under the age of 25, they resolve without treatment, within two years. Now, if your 19-year old's got an acute HPV infection, has a high grade, goes off, has a colposcopy, shows they've got a high-grade abnormality, they may well be treated.

Dr. Wendy Pakes: Now, if they then get a further infection in their 20s and get another high-grade abnormality, they might be treated again. And this is where you're looking at increasing risk of obstetric complications. So please, don't let them do it. You don't want to do it. It doesn't matter. So you all know this, new screening starts at 25. If you're negative, come back in five years. Exit test is now 70 to 74. The first test is the HPV test, testing for 14 oncogenic HPV. And that's what we call the CST. Now the CST also includes a reflex cytology. So they'll do a cytology on any HPV positive test.

Dr. Wendy Pakes: Now, symptomatic women can be tested at any age, requesting a co-test and documenting the clinical symptoms. Now there's other, and particularly, remember pregnancy is not a contra indication to screening. And early onset

sexual activity, I've put that down. A lot of people are very anxious about this. There is a little subset. If a woman became sexually active under the age of 14 and before Gardasil, they are eligible for, or they can have one HPV test between 20 and 24 years of age. There is no evidence to say that they're in increased risk, but there is no evidence to say that there are not. And so it's a reflection of some women may be very anxious about this. And you can offer it to them, but you do not go and need to case find.

Dr. Wendy Pakes: Now, I'm sure by now you all are very clear with what the renewed pathway is. Just a couple of things to remind you. If an HPV 16 or 18 is detected, the reflex liquid-based cytology is not to change the recommendation. It's to inform the colposcopist And so people with an HPV 16 or 18, they are referred for colposcopy, irrespective of this cytology. And there is a lot of confusion about that. And so it's very, very important. You don't think, "Oh, cytology negative. That's fine." If the colposcopist sees that there's high-grade changes or glandular abnormalities that they then don't see at the time of colposcopy, they will look much harder. So it's to advise them. It's not to change the recommendation.

Dr. Wendy Pakes: So unsatisfactory, if there's an unsatisfactory test, repeat in six to 12 weeks. So if the HPV test is unsatisfactory, you still don't know whether you're going to need a reflex cytology or not. So make sure that you allow for the possibility that you're going to need cytology, wait for six to 12 weeks. Now, if there's a reflex cytology with a non 16, 18 and it's unsatisfactory, again, retest that in six to 12 weeks. Please only ask for a follow-up liquid-based cytology. If you ask for a CST or a co-test, your patient will be billed for the HPV component of it. They only may need the LBC.

Dr. Wendy Pakes: Now, I've put this slide in because explaining to our patients, they've got a high-risk HPV. So if they've got HPV 16 or 18 at baseline, over time, if it persists, their risk of developing a high-grade abnormality is significantly increased. Whereas if they've got a non 16, 18, over time, it's yeah, you've got a bit of a risk, but nowhere near as 16 or 18. So they're the intermediate risk. And if you don't have HPV, then your risk is extremely low. And that's why there's this a partial genotyping, and we treat the 16s differently. So it's a risk-based approach. It's also taking into account their screening history, and what you're putting on the clinical notes.

Dr. Wendy Pakes: Now their screening history may be causing a few of you grief at present. So all of those women who've had their historic high-grades treated in 1990, and they've never had their test of cure, they're now coming in with these really scary letters from the NCSR saying, "I've got to have this test because you told me my HPV was negative, but now I've got a reminder." And it's because they've not completed their test of cure. And we know that women who had a previous high-grade treated, they were at increased risk of getting recurrence, sometimes decades down the track. And we know that was because they were the women who did not clear their HPV. So just be aware that many of these women won't even remember they've got a past history, and you may not know

it as well, but they'll be coming in. So check their history with the NCSR. So the HPV test is a test of risk. The reflex LBC is our triage. We then go to colposcopy. And that is to tell us, "Is there disease?" The co-test is only in a symptomatic woman, for test of cure in women who have been previously treated, or surveillance.

Dr. Wendy Pakes: So I was just going to briefly go through, "How do you take an effective CST?" So one of the important questions is, "Do you still have to sample the transformations zone?" Now, many of you would be aware we cannot can now do HPV self-collection. So why do we need a cervix? Now we need the cervix because that reflex LBC. So we don't know, "Is our patient going to have an HPV positive test result?" We don't. So we have to take all our samples with the assumption that she may be HPV positive, because your sample will then be triaged for reflex cytology. So if you've got an HPV non 16 positive woman, and you sort of think you got somewhere near the cervix, how reliable is that triage going to be when you're determining, "Will she come back next year? Or will she be referred to colposcopy? So it is actually still very important.

Dr. Wendy Pakes: And just a reminder that the transformation zone can, in young women, particularly, be quite far out. So you really have to take your instrument along way out. Now, HPV onsets unsats are much less than cytology. We need far fewer cells, but we still need cells. And the biggest reason for not getting cells, or an unsatisfactory, are due to low cell count. And 10% are because the lubricant globs with the cells, and it means that they're effectively insufficient cells. So when we're using lubricant, well, ideally you're just using lukewarm water. If you do need to use a lubricant, only use no more than a five centimetre diameter size on the outer part of the speculum, avoiding the tip. Now with your vilevial, make sure that you use three identifiers. So it's not a a NATA (National Association of Testing Authorities, Australia) requirement. We get lots of people saying, "why has my report come back with mislabeled?" And it's because you have to have a first name, a last name and a date of birth, which are on the request form as well as on the vial.

Dr. Wendy Pakes: So you can't have "K. Smith", on the vial, and "Kathy Smith", on the referral form. You will be rung by our lab and asked, "Are you happy for us to authorise it?" And if you say yes, you will get, "This is mislabeled." So we cannot process it if they don't match. Now, make sure you seal it correctly. And when you're using the instruments, you really have to be very vigorous to make sure that the cells come off in the . So if you using a broom, you're going squish, squish, squish, squish, squish, squish, on the bottom and then vigorously agitating. If you're adding in a brush, rotate it, pushing against the wall of the vial and then agitate. And we've just got a couple of ... you need to check with your lab what they're happy with.: We know L-Gel and Applicare, which are some of the common ones have carbomer and they're the ones most likely to glob things up.

Dr. Wendy Pakes: And just referring to stats before. We need to know who we are screening, so we know who we're not screening. So please, please fill in these details. It is incredibly important that we have that information because then if we know

there are certain target groups in our population who just rarely are screened, we will be able to work with those communities to develop culturally appropriate ways to engage those people.

Dr. Wendy Pakes: Now, there's lots of angst about exiting the program. We've had probably lots of your patients are coming in with their reminder, or overdue letters saying they now overdue for their cervical screening test. And they say, "But you told me when I was 70, I could stop doing this." And it's because we now have better knowledge of the natural history of HPV. And we know that a woman who's aged between 70 to 74, who does not have HPV detected, her risk of developing cervical cancer in the next 10 years is incredibly remote.

Dr. Wendy Pakes: And I put this up because many patients who are ringing us and saying, "My doctor said I don't need to do this." Or the doctors are ringing and saying, "Oh look, she really doesn't want it because it's pretty uncomfortable", and what have you. Most of them, if you say, "The second peak of cervical cancer in Australia is 80 year olds", and then I talk about chickenpox and shingles, and most of them have just had the shingles vaccine, and I say, "HPV can reactivate as your immune competence declines when you're older." And so having an exit HPV test if, you're negative, is incredibly reassuring. So hopefully we get lots of questions about that. And I think it's really important to, to understand why we need to encourage these women who are coming in and saying, "Well, you told me I didn't need it."

Dr. Wendy Pakes: And just a reminder, we are so lucky. But it requires the ongoing support of all of these organisations and primary care clinicians to make sure that we reach that target of cervical cancer eradication by 2028.

Innovation in Cancer Screening – Intensive Quality Improvement: Workshop 1

SECTION 3: Improving Colorectal Cancer Screening in Primary Care

Speaker: Dr Chris Hogan, GP and A/Prof Chris Hogan, The University of Melbourne

Dr. Wendy Pakes: So I will go on to introduce Chris Hogan now. He's going to be doing the next talk. So he has a wide interest in the practical, theoretical, and academic aspects of general practice. Currently, he's an honorary clinical associate professor in the Department of General Practice at Melbourne University, being a foundation member of the Vic RAN, a general practice-based research networks supported by the department. He is the historian for the RACGP Victoria, and deputy chair of the RACGP history committee, so would have lots of interesting things to talk about. He had been a GP in Sunbury since 1979, and principal of a large multidisciplinary general practice there.

Dr. Wendy Pakes: Of relevance to this talk, he's been a member of RACGP quality assurance committees, a member of the Cancer Council, Victoria, member of Cancer Council's at Australia's Lung Cancer Project, chair of the Central Highlands Division of General Practice and involved with their Diabetes Quality Improvement Project. Amongst other things, he's been an educator for the National Asthma Council's A-team, which involved him lecturing to GPs, allied health staff in Victoria and across Australia.

Dr. Chris Hogan: And I hope you enjoy my talk. Thank you very much. My take home messages are pretty straight forward. But first of all, we need to work cooperatively. Next thing is that we need to provide education. There is more to education than just providing information. Information alone is only part of the process. We need to involve the informal carer when we're doing any education for a patient. The next thing we need to be involved with for cancer control is prevention, screening, early detection, early intervention, post-cancer surveillance, and that's it. That's basically my talk. The rest of it is detail. I'm just about to go through the detail, but you will be sent a copy of my slides.

Dr. Chris Hogan: Now, education is more than the provision of information. It's the process of incorporating new information into a person's pre-existing beliefs. And I said beliefs. It's what they know and what they think they know. It is an extremely important thing. The word doctor means teacher. So as teachers, we have to use educational principles to be able to educate our patients. There's not just telling them. We've got two ears and one mouth. We should use in that ratio. Basically, we should ask questions before we give answers.

Dr. Chris Hogan: Colorectal cancer is the as you can see as the most common cause of cancer related deaths. When detected in the earliest of stages, the cure rate's' 90%. Regular screening with faecal local blood testing is very helpful, as the early

easily treated cancers are symptom-free. Now that's the good news. But currently, only 40% of cancers are intercepted detected early. The rest are detected when symptomatic and therefore at late stage. As I said, prevention screening, and early detection. The diagnosis is basically done by the GP or a specialised service. In treatment, the GP is part of the multidisciplinary team. And if they're not, they should be. Certainly, this is something that Cancer Australia is very, very keen on.

Dr. Chris Hogan: Now the other thing too is post cancer survivors surveillance consists of dealing with people afterwards. Because the risk of recurrence, other cancers or complication of cancer or, it's treatment is very possible. And currently no one has responsibility for that apart from the GP. The groups, the hospitals are getting a little bit better at it. But with they'll be leading towards more, which at times can get even multidisciplinary teams they'll be getting a bit better. Survivorship is an issue. And of course on the other hand, we have palliative care, which is often managed by GPs in association with care teams. It depends on your location, of. Of course, my responsibility is to the whole of Victoria, but basically, we do most of our lectures to the urban and inner urban areas, a. And that's a bit useless.

Dr. Chris Hogan: Now the other thing too, we're talking about cultures, we're talking about people coming in from other countries. Well, the thing is that even in our own culture, chronic illness has only existed in Australia for the last two to three generations. Think of it. Chronic airways disease. When you live in a subsistence community, what happens to you if you can't work? You die. What happens if you've got asthma? You die. What happens if you've got arthritis? You die. What happens if you got tuberculosis? You die. What happens if you've got tuberculosis? Anything along those lines? I was in Italy once at this place called the city of a thousand steps. They lied. It's 2000, and we saw this little old lady going, tick, tick, tick, tick, up the steps, and she had in her hand a stick and a bag of groceries. The other hand, she had a shopping trolley, and she'd go tick tick tick tick.

Dr. Chris Hogan: My wife said, "Give her a hand." I said, "Just wait." And sure enough, 10 minutes later she was still going up. We caught up with her later, unfortunately, and because we could speak Italian, we said to her, "Signora, what happens to the people who can't walk up there." "Oh, they die." But the sad part about all that is there is no understanding or health information from the normal carers about ongoing illness that requires ongoing patient management, particularly in traditional groups, whether they be Anglo or otherwise.

Dr. Chris Hogan: Your patients are sick. Who do they ask first of all, what about what they do with their sickness? Go on. You've got tongues. Shout out. Who's do they ask? Johnny or Giovanni has got a sore throat. Who does he speak to? Who does the mother speak to? It depends on the community. But if they've got an established community, it's usually the grandmother, and it's usually the maternal grandmother they speak to for knowledge. But basically what happens is, we were talking before about how information has changed. What's the used

by date of medical information? If I tell you something today, for how many years can I can guarantee it? Come on, give me a number. (from audience: “One year” Cynic. Give me another number. The universal answer to any question in medicine is, it varies. Yes, you're right. It's about two to five years.

Dr. Chris Hogan: So the thing is, we need to tell the patients that their medical information has a use by date. Because what happens is, "Oh, I was told 10, 15 years ago that I didn't need another pap smear." Great. Fine. That was true then, but it isn't true now. The informal carer obviously may know nothing about chronic illness, and they'll say to me, "When you go into the aboriginal communities and you say you've got such and such." "Oh Doc, how about an injection or an operation to get rid of it?" If you go into the traditional Irish or Celtic communities, and you ask them, their prayer is a full recovery or a quick death. There is no middle ground. We are now in the days of the middle ground, and our cultures and our usual caregivers, our usual grandmothers, the Yaya, the Nonna, the Nannu, the Oma; they know nothing about chronic illness or its management.

Dr. Chris Hogan: Similarly, preventative health screening is relatively new. And the community literacy, it was, I think in the book it says that 60% of knows sweet, precious little about health literacy. I would say that whoever wrote that as an optimist. I would say that even among health professionals, health literacy is not good outside of their areas. And there is no point in educating a patient unless you provide education to their informal carer as well, provided one exists. Because often our communities stay are so mobile. I mean my family is spread from Albany in WA to Brisbane. And that's it. It's usually mum, the Mrs or the grandmas, the person who provides emotional and practical support and health advice to the patient. They can be your best friend, if you involve them, or they can be your worst enemy. And I have seen children die because the informal carer did not believe what the doctor was saying.

Dr. Chris Hogan: Guidelines are guides. They have their limitations. That's a whole talk in itself. What we have to do is to provide you with information that is useful to you and your patients. We will hope that you will develop the processes that will optimize patient outcomes in your practices. Now the other thing, is when you develop, you came up with an idea and no one else has had the idea, don't be afraid. Someone has to think of it first. Why shouldn't it be you? There isn't always someone else who's got the same idea, because with Richard's idea of the new receptionist, sometimes you can think it. Sometimes people can come in with an excellent suggestion. There's no copyright in common sense. Just wished it was copied a bit more often as a matter of fact.

Dr. Chris Hogan: Colorectal cancer is a condition, in which family history is important. When a patient is diagnosed with a cancer of familial significance, it is extremely important that the other members of the family be contacted. That's logical, isn't it? Is it? Is it logical? Does it happen? No. I think I found a way that you could improve your cancer detection rates. The family history must be regularly reviewed because how often does the family history change? Come on guys. How often does the family history change? Regularly. It varies. Now the cultural

attitudes to health, this is based ... I stolen some work by Justin C.Tse and obviously he concentrated on the Chinese, but I think it applies equally to a whole range of ... Any traditional culture will have its specific attitudes, but you can see we believe in health, not in promoting our health rather than detecting hidden disease. The Italians, if they don't see it, it's not there. Fatalism and low belief in screening. Health seeking is based on symptoms. The idea of looking for something that isn't there that doesn't produce symptoms doesn't exist in many cultures.

Dr. Chris Hogan: Why? Because they're traditional cultures, and they don't have the cultural experience of chronic illness. Now, even in Australia, it's only existed for the last two or three generations. As it's a historian, I can tell you about the massive effect that we had with introduction of antibiotics into Australia. When did antibiotics become widely used in Australia? What year? Give me a guess. Come on guys. When were they first used? Cynic, do I hit a hear better? They were first used in 1945? Penicillin was first available in 1945. But there you see the importance of the doctor recommendation and explanation. And as I said, when you're explaining to someone before you open your mouth, open your ears. Ask them, "What do you understand is happening? What do you think is happening here? What do you understand by asthma? What do you understand by cancer? What do you understand by dah, Ddah, Ddah, Ddah, Ddah." Ask them.

Dr. Chris Hogan: The reasons for poor participation in screening is limited knowledge about bowel cancer. I would just leave it as limited knowledge. It's an unpleasant test. It's not unpleasant. It's just a poo test. And really, anyone as who's a parent, a modern parent,i.e. over 1960, is often used to changing crappy nappies. You don't even get your fingers dirty for God's sake. There's the fatalistic views about cancer. If they think it's untreatable, that they think it's God's will. Well insha'Allah, God has sent us here to be able to do something about it. And the shame and privacy, which is more traditional, which is more common among the the Aboriginal and Torres Strait Australian Islanders, whose concept of illness and disease is often extremely complex.

Dr. Chris Hogan: And for a culture that's been built for well over 18,000 years, even the idea of sex causing pregnancy is not widespread in the traditional society. In successful programs the GPs ... This is the personal experience of the Avenger Interventions. The GP gives their support and encouragement, but many active interventions are undertaken by the nursing and administrator staff. In other words, the doctor says yes, and the people who do the work do the work... very effectively. So it's basically a cooperative team thing. It's a matter of looking at the whole range. The book goes through the vast majority of techniques that can be used. The consultation is often jam-packed with the priorities of both the GP and the patient, the GP reacting to the patient's priority. So it's important to be able to structure.

Dr. Chris Hogan: Non-doctor staff find it easy to follow protocols. I did say that politely didn't I? Thank you. If a process can be standardised, it can be computerised, automated or delegated. So the idea of whole-of-practice work is very important. With the

plan-do-study-act cycle, a whole of practice consultation is essential. I've worked in a lot of teams in a whole range of nasty areas, and I often find that some of the best ideas come from the most unexpected areas. There is not a copyright on common sense. If you want to know how every job functions, ask the person who does it. Don't ever assume. Please never assume. One of the studies that we did was we looked at what practice nurses did, and then we compared to with what the practice doctors thought they did, and there it was very educating.

Dr. Chris Hogan: This is looking at five system reviews and looking at audit and feedback. More things that are missed by not looking than by not knowing. And the other maxim is that the truth makes liars of us all. If you don't look, you don't find. So just doing audit and feedback, you increased your screening rates, breasts by 14%, cervix by 9%. This is prior to Gardasil, and colorectal by 13%. Often the office system prompts are often useful. The increased screening uptake, you can see was increased by 23%. GP endorsement of screening invitations is extremely important, especially in CRCs, colorectal cancers. The practice organizational change is extremely important. I don't need to go over that.

Dr. Chris Hogan: This is an example of an invitation that was sent out and this leads to a 6% increase in participation rate, better if the GP signs it electronically. Different from the signature you use on your checks please. And it is the potential to implement. No one laughed. Didn't you hear? Anyway, it doesn't matter. Potential to implement screening based on birthdays of at risk groups. These at the survival rates? You can look at that later on, but the prevention of cervical cancer is actually ... There is prevention of a horrible ... First of all, we know that diet is extremely important. Low fat, high fibre, broad-based soluble fiberfibre. Exercise, very important. The other thing too was weight and abdominal girth. Smoking cessation, alcohol reduction. The role of aspirin is under investigation at the moment. There's a big trial, which we expect to have the full results by 2022. Screening programs are based on asymptomatic patients.

Dr. Chris Hogan: Now, as I've said already, culturally we're in a barrier because a lot of people do not culturally have an understanding of preventable illness. It just doesn't exist. And it's not that their knowledge is wrong, it's just not appropriate for modern times. Well for the times in which we find ourselves to be truthful. Whether it's an improvement or not is another story. Now the other thing too, is if a patient presents with symptoms or signs, a thorough history and examination, including PR examination, don't stick your finger in it. You stick your foot in. It should be performed in ... And the typical present presentations include changes in bowel habit, rectal bleeding, unexplained loss of weight, iron deficiency. Iron deficiency is a symptom. It is not a diagnosis. If you know someone who is iron deficient, you want to find out why. And abdominal pain.

Dr. Chris Hogan: Of course, these are the cancer guideline Wikis, which you can see there if you're interested. But the thing that I really pushed it up is I've been heavily involved with the with Casey GESA (Gastroenterological Society of Australia) on the formation ... This is a program for laptop and desktop computers, IBS for

GPS, which looks at the diagnosis and management of irritable bowel syndrome. Very important. We now have technique of being able ... 95% accuracy in diagnosing irritable bowel without colonoscopy. And we have a 90% efficiency in treatment. It's a lot better than anything has been there before.

Dr. Chris Hogan: Bowel screening initiative, as you can see has just recently been started. It's effective, but once again it's got a low uptake. Once again, you'll get a copy of all these slides. It's just for the highlights so you know what to look at. This talks about from 2020, all Australians between 50 and 75 will be having a two- yearly screen. We estimate it will save about 500 patients annually. And significant just the burden of cancer on Australians in the family. But to do it, we need your help. These are the guidelines of screening. Now this is more focused screening other than just randomized population basically. We're drilling down on individuals, so we're looking at family history, and we're talking about category one, and the higher categories. So this is basically just to mention them.

Dr. Chris Hogan: Category two, and you're looking at basically people who are at risk or those, who have one first degree relative with a cancer diagnosed under 55 years, or two first degree relatives with cancer diagnosed at any age, or one first degree relative and at least two second degree relatives diagnosed at any age. All right. The issue that we have here is that there's a high incidence of non- parenting in Australia. I think the incidents of a person whose daddy ain't the daddy, but the daddy don't know is running between two to 2-5% depending on the population in which you go. So relying on family history is in often an exercise in optimism. And this is one of the areas where we hope with the DNA analysis, analysis of the human genome is actually starting to improve. So we will get somewhere.

Dr. Chris Hogan: This talks about the very high-risk, and basically as I said that this is just basically for you to look through at some stage. And these are where your resources will be. Screening for colorectal cancer as part of the cancer continuum, and the general practices should be proactive. It really does make a difference. Early detection is critical. The role of family history. It takes time to clean your data. Taking a history and looking at ... These days, every time a patient turns up we ask for their date of birth, just so we can be sure it's actually them. The same thing comes to cleaning up the family history and the past history. And one of my jobs used to be looking through these sorts of things for medical, legal purposes. And I'm terribly sorry, but they're crap at the moment. Just hopeless.

Dr. Chris Hogan: In my practice what we did was we dedicated a month, a year, where everybody who turned up would have their history reviewed. They'd be given a print out of their history summary. We'd say, "Is this information accurate? Is this information complete? Is there any information on this, which you wish to keep private just to the practice? And is there anything you wish to add?" It was amazing how much work we had to do just to do it. It is really an intense work.

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SECTION 4: Screening for Breast Cancer

Speaker Dr Meron Pitcher, Breast Surgeon, Head of the breast unit and Head of the Sunshine Hospital general surgery unit, Western Health

Angela Ouroumis: I'd like to thank Dr. Meron Pitcher for being here. Meron is a breast surgeon at Western Health and a general surgeon. Meron has worked as a specialist at Western Health since 1993. Her training was in Melbourne and subsequently in London at the Royal Marsden Hospital. She's been a senior examiner in general surgery for the Royal Australian College of Surgeons. At Western Health, she's the Head of Breast Unit, and the Head of the Sunshine Hospital General Surgery Unit and has some responsibility for quality and safety in perioperative services. Her research interests include improving quality of care for breast cancer survivors. Hand it over to you.

Dr. Meron Pitcher: Angela, thank you very much for that introduction, and thank you for inviting me here today. Clearly, everyone's here because they want to improve their practices in screening for cancers in general. So I'm really glad you've had time for a cup of tea and something to eat, because I think the after lunch session's pretty deadly, really. So my topic is to talk to you about screening for breast cancer. And my real focus is, in terms of the breast screen program, which is the government-funded program for screening for cancer.

Dr. Meron Pitcher: So the data out of Cancer Council says that in 2017, which is the latest data we have available, there were 4,500 cases of breast cancer, and just under 800 deaths. And so what that says is there's a lot of breast cancer out there, and thankfully the majority don't die of it. I didn't do very well with my cut and paste here, but the purpose of this graph is, again, the data from 2017. On this axis, it's the rate per 100,000 patients on the y axis. And on the x axis is in the age. And so you can see basically there's no one under age 24 in 2017. There's a tiny starting in early 20s, but really the peak age of rate of diagnosis of breast screen is in women late 60s and age 70. And so it increases substantially once women get into their 40s, but particularly after the age of 50. So despite what you might think in terms of watching soap operas or various TV news, breast cancer like most cancers is a disease of aging, but it does occur at younger ages.

Dr. Meron Pitcher: So one of the risk factors for breast cancer, being a female, I didn't put that up, the older we get, family history. I get confronted by advertisements, "Do you know your breast density?" It's a load of complete nonsense, but people with really dense breasts do have an increased risk of breast cancer. And I'll come to that a little bit later. Obesity, substantial risk for breast cancer, particularly post-

menopausal. And sadly, alcohol in any dose is a risk factor, but it is dose-dependent. So the] bits in family history that are particularly significant for breast cancer is really the number of first and/or second degree relatives with breast or ovarian cancer.

Dr. Meron Pitcher: So first degree relative, mother, sister, daughter. Second degree relative, grandmother, aunt, niece. I generally ask my patients, "Is there any family history of breast cancer? Anyone in the family who's had breast cancer or ovarian cancer?" And because breast cancer is such a common disease, most of us have got someone in the family with breast cancer. I'm like, "Great Aunt Ethel had breast cancer at age 72." Well that's very sad for great aunt Ethel, but it probably doesn't have very much implication for that 30 -year old who's worried about breast cancer. So first degree relatives are the most important. Second degree relatives, less so.

Dr. Meron Pitcher: And the other important bit is, what age were these relatives when they were diagnosed? So particularly, age under 40, that to me is a bit of a red flag. There's some data that if your mother, and that's the only relative with breast cancer, was diagnosed after the age of 55, so if you've got a mum diagnosed at 55 or 56, statistically your rate of breast cancer is the same as the community. So that doesn't mean to say that woman or you aren't more concerned because of it because you've seen what's happened to that relative, and it may well be more pertinent to you, but statistically you're not actually in a particularly high-risk group.

Dr. Meron Pitcher: Bilateral breast cancer is a warning sign. Any male breast cancer in the family is a substantial warning sign. The Ashkenazi Jews have a particular founder mutation. So if you've got someone with a Jewish heritage, particularly Ashkenazi, then that is of significance. And clearly, if you've got someone who's the sister of, or even perhaps cousin of someone with a proven genetic mutation, that's going to be significant.

Dr. Meron Pitcher: There are two online tools that are helpful if you have the time and in the appropriate consultation. This is a long consultation. You should charge for a long consultation. I think you have ways and means of doing extra consultations if you're going to do this. The top one (FRA-BOC) that stands for familial risk assessment, breast and ovarian cancer online risk assessment tool. You find that you can put that into Google and you'll get it. It comes up on Cancer Australia. And in that it's a little survey that says, "Who in the family has had breast cancer or ovarian cancer and at what age?" And it will give a calculation. So that's a really helpful one that you can do online anywhere, anytime.

Dr. Meron Pitcher: Peter Mac, through Kellyanne Phillips, if any of you know, Kellyanne, have put together this, again, another online risk assessment tool called iPrevent. And now when I put in, iPrevent to try and find it for you, it went somewhere else. So you needed to put Peter Mac and iPrevent as well. But in essence, again, this is a bit of an annoying tool but there' some good things about it. So it's worth it. It says, "What's the age of the woman who's there with you? What's her history

of breast disease?" In other words, has she had previous breast biopsies or previous diagnoses? "Age of menarche", I think is on it. Her weight, her height", so that BMI is measured. And then the family history. And it wants you to put in every second degree relative.

Dr. Meron Pitcher: So if they come from a family with seven uncles, they really want you to say, "What was uncle Fred? How old was uncle Fred when he had this, that or the other thing?" So the way Peter Mac have started to do it is to give the patient the online tool and get them to fill in all the family history, because my attention span gets lost after about two relatives. So it's fine if they've got mom and grandma and Auntie So-and-so. And what age was it and was there any ovarian? It's quite detailed. So it probably takes ... I've done this with some of my patients who are particularly anxious and want to know what's what. Probably takes a good 20 minutes to go through, but at the end it says, "This person's risk of breast cancer is XX% in the next 10 years." And puts it into a high risk group or a medium risk group or an average risk group and then it says, what are the things that can be modified.

Dr. Meron Pitcher: So that for the lower risk end, they're going to talk about getting to ideal weight, doing exercise, minimising alcohol. And if you do those, what does your risk go down to? Likewise, if you take Tamoxifen or one of those as a risk reducer, you will reduce your risk by x %. So it's really helpful in that space. But I suspect for the majority of you in general practice, you probably haven't got the time and the wherewithal. But if you've got a family where you really want to spend some time or this person's really keen in terms of where you're going, as an online risk assessment tool, both of those can be helpful. Because it's pretty easy. You get in on the Internet and just plug the data in. It's the sort of thing that's worth having a play with yourself just to see. But you need time to do it, but I think they're good and they're clear.

Dr. Meron Pitcher: Alcohol increases your risk of breast, but also many other cancers. Obesity is said, if you've got a BMI of over 25, the increase in risk is 20 to 40%. That's a lot. Again, we know that obesity is a risk factor for many cancers. And so I would take every opportunity to encourage your patients to think about their weight. And I'm sure you all have ways and means of doing that. My current way is to say, "Weight is an issue. Losing weight is really, really hard. The important thing is to not put it on. So please stop putting weight on." To me that seems a bit less confrontational than saying, "You're too fat, you've got to lose weight", which I don't think works.

Dr. Meron Pitcher: But certainly, obesity is particularly true of oestrogen positive breast cancers. And that's particularly true in post-menopausal because fat does some of the aromatisation. So people who are fat are more oestrogenised. And we know that's true of endometrial cancer, those things as well.

Breast density. This is eye mammographic assessment. It's the way you're made. If you're on hormone replacement in your 70s, you'll have dense breasts, right? But if you're premenopausal, about half of us ... I'm sorry, I'm not

premenopausal anymore. We'll have dense breasts. Age is a much stronger factor than density, but you will see that there's various advertising out there, "Know your density." Which to me says, "Well, what am I going to do about it?" Have five kids before you're 25, and that's not going to work for everybody. A part of it, warning, cynical, very cynical. Part of this is radiology industry going, "You could have a breast MRI and that will cost you $600." Thank you very much. And we might find something we don't know what to do with. Excellent. We've got to repeat it. So to me, just be aware of the breast density fabric.

Dr. Meron Pitcher: What I think we're here to try to do is to talk about population screening. Really the average person who comes in wanting their flu vaccs, the opportunity to talk about where are you at with your cancer screening. So to me, I'm going to run through a little bit of the evidence. I want to really highlight that screening for cancer is about people with no symptoms or signs. And a bit like Chris said before, if someone comes in with rectal bleeding and a change in the bowel habit, you've got to examine that person for bowel cancer. You've got to do a rectal examination. The person's going to need a sigmoidoscopy, colonoscopy, what have you, if they've got change in symptoms. Likewise, if a woman says, "I think I've got a lump or I have got a lump", they shouldn't go to Breast Screen, but they should go and have a mammogram and an ultrasound or whatever it is in terms of age-related.

Dr. Meron Pitcher: So to me, my focus is on screening. If you're talking about the population, it's for people with no symptoms. If they've got symptoms, you go down the diagnostic pathway, not into a screening program. Breast Screen started in Victoria as a pilot in 1992, so it's been going for 25 years, a little bit longer. I've got some information from their annual reports about what their outcomes are, and a little bit about what happens at Breast Screen. So the evidence goes back to basically, the late 1980s. The first trials for screening were done in the 1960s. So the data is old and there were many trials. They were about five or six trials that all published in the late 1980s, looking at those people who'd been screened in the 60s and 70s, which demonstrated a survival advantage. And that's why in the early 1990s around the world mammographic screening programs took off.

Dr. Meron Pitcher: And the reported mortality reduction in those which were reported late 80s, early 90s, was about 30% in women aged 50 to 69. And they were having mammograms every two years, which is what we recommend. And they were doing two views. So they were doing craniocaudal from above, mediolateral oblique from the side. So that has been the standard screening that's really been happening since the early 90s. There've been some modifications and we can talk about that. There remains a lot of controversy around the benefits of screening, and those who are strong advocates, and indeed the data of those who turn up for screening, is that maybe, there may be a 50% reduction in mortality.

Dr. Meron Pitcher: But we all know that there are certain groups of people who will turn up for screening and there are certain groups of people who don't turn up for screening. And you've taken me back to a happy place of when I was a junior

registrar and my boss, one of my mentors, Ken Miller, sadly he went to God a couple of years ago. But Ken would say screening is for the willing, the worried and the wealthy. And I think he was right. Now we're trying to actually improve the unwilling in that space. And by and large, the government is funding to reduce the need to be wealthy. But there is a significant selection bias in most of the screening studies.

Dr. Meron Pitcher: So what is the evidence? So Breast Screen Australia, they might have a conflict of interest in terms of what the screening should be, indicated a reduction in breast cancer mortality in this target age group, 50-69, of between, if we said between 20 and 30%. And the current participation rate around the country is about 56%, so it's still low. The data that I remember is that really to make a significant difference, you need to get 70% screened. But 56% is not that bad. And participating in the breast screening program, and as you probably know, the recruitment age has gone up to 74 in the last 10 years, the expectation is that if 1,000 women turn up every two years between 50 and 74, eight deaths will be prevented. So it's a fair number of screens to get eight deaths prevented. But if it's you or your sister or your mom, then that's pretty significant.

Dr. Meron Pitcher: So I think there is good data that screening reduces mortality. But like anything, screening doesn't detect all cancers. Some women who are screened will still die of their cancers. And we have the issue of over-diagnosis, which I'll come to in a moment.

Dr. Meron Pitcher: These are the latest statistics published by Breast Screen Victoria, and they did 260,000 mammograms. And of those, nearly 12,000 got recalled for assessment. And of that, 1,767 cancers were diagnosed: for 1,400 invasive, 360 odd ductal carcinoma in situ. So precancer. So if you remember back to my second slide, something like 4,500 people diagnosed with breast cancer in Victoria. Not quite half of them, perhaps about a third of them, are being diagnosed through the screening program. And that's probably one of the reasons why the incidence of breast cancer has gone up, because we're diagnosing more of it.

Dr. Meron Pitcher: So to me, this is something I hope you can remember. I'll tell you the bit you have to remember in a minute. For women turning up for their first screen, and I'm sorry I missed the bit about your cervical screening talk, because I suspect in women being screened for cervical abnormalities, the first time, there may be more issues. But people from having their first mammogram, it was about 14% of the total. So 35,000, and 11% of that group got recalled. So to me, when a woman is going to have her first mammogram, it's really helpful to warn them that one in 10 will get a recall letter to come in and have some further views, or an ultrasound.

Dr. Meron Pitcher: Because people, they want to be screened to be told there's nothing wrong. You don't want to find anything really. And then ultimately if you do find something, you can go, "well actually it was good that it was found early", but ultimately you don't want to find anything. And many people are very distressed by getting a phone call saying, "You've got to come in to Parkville and do this because we

found something on your x-ray." That's a very stressful time. So it's helpful to say, "For the first mammogram, it's not uncommon that you might get a call back because they haven't got anything to compare." They're the younger age, so they may well have denser breasts. They've got overlapping shadows, they've got cysts and things that will be seen.

Dr. Meron Pitcher: So again, in that group, about 10% of the first rounders get called back, and about 10% of those turn out to be cancer. So there's a pretty, to me, that's a substantial minority that get called back, but only about 10% are actually going to turn out to have cancer. Whereas, if you look at the people who are coming for second or subsequent screens, which is the majority, it's a 4% recall rate. It's a much smaller recall rate. So if they call you back after your third or fourth screen, you should be starting to be a bit concerned. And of those, nearly 20% turn out to have a cancer. So if someone gets recalled after a subsequent strain, it's more risky. Does that make sense?

Dr. Meron Pitcher: So to me, I think that's really important for first screen, which I think is what your tasks are in this program. It's really to get people to go for the first time so they can realize it's actually not too bad and not too scary. But in doing that, warning them. They may find something. It probably won't be cancer, but you might freak out about it.

Dr. Meron Pitcher: So what's the process? To me for Breast Screen, they will accept women over the age of 40. That's because Bob Hawke said, "Women over 40 can have mammograms." Is there any evidence that screening women over 40 reduces mortality? No. Problem with being 40 or younger, denser breasts, more overlapping shadows, higher recall rate. That's not a reason, if someone who's 40 or 43 wants to go. I would say to women who come and see me with a problem. I say, "You should have your mammograms from age 50. If you're 40 something and your best friend gets breast cancer and you're worried about it, go to Breast Screen. That's what you do." But from a point of view of, dare I say, harassing women to get screened, I wouldn't be doing it in the 40- year olds.

Dr. Meron Pitcher: Again, reinforced. This is for breast screen is for women with no particular symptoms. Sore breasts doesn't count as a symptom because all premenopausal women are going to get sore breasts at some particular time. They don't need a referral though I think if you encourage them, that's probably going to be more positive. If you ring Breast Screen, they'll say, "Are you over 40?" "Yes." "Do you have any current problem in your breast?" "No." "Have you had a mammogram in the last 12 months?" And if the answer to that is no, then they'll book an appointment. So to me it's helpful that they don't have to get a referral to have it done. But that's the process. And it's 13, 20, 50 ... Sorry, you've got it in the packs.

Dr. Meron Pitcher: So women from age 50 are actively recruited, I think through the electoral roll. And routinely recalled every two yearsWhen you turn up to Breast S creen, you've got to fill out your name and all those sorts of things, and put in your family history. And there was, I dare say, some of you have seen some of the

fallout from that because you get women in their late 60s who said, "Mom and Auntie Frieda had breast cancer." "Oh, you must be a terribly high risk. You must go and see your doctor about this." I think people go to the doctor to be made to feel better, not worse. But they've actually toned that down a little bit. But what they're trying to do is really, people who do have a substantial history, that they're getting appropriately imaged, rather than on a two -yearly basis. And perhaps if someone's getting one of those high-risk letters from Breast Screen, to me, that might be where you go in one of those online tools to actually work out where they're at.

Dr. Meron Pitcher: The good news is that women who've had their breast cancer treated five or more years ago can enroll in Breast Screen, and get recalled annually. The advantage is Breast Screen are fabulous at picking up the most little tiny things. So in terms of the detection rates, their accreditation means they've got to be very obsessional about it. The patient gets a recall, and they're not getting charged an obscene amount of money from various radiology companies. I do have friends who are radiologists, believe me.

Dr. Meron Pitcher: So the question is, what about the 40 to 50? The incidence of breast cancer is lower. They've got denser breasts, and they've got a higher recall rate, so far more chance of false positives. So as I said, if someone wants to go, very happy for them to do it, so long as they understand that high recall rate. Warning, Meron only quoting from papers which confirms her prejudice. In the Nurses' Health Study which came out ages ago, which was one which had stuff around HRIT, post-menopausal, they looked at mammograms as part of that, and they looked at women in the States who had had a mammogram every 12 or 18 months in their 40s, which of course you can imagine, America being the land of the rich and free were encouraging. They found that in that cohort of women who are having mammograms between 40 and 50, one in two got recalled for further assessment in that 10 -year block. And a percentage of those were so distressed by the experience, they never went back.

Dr. Meron Pitcher: So don't underestimate the negative effect of a recall. Now it's fine if they just take an extra picture and they go, "You're fine, don't worry." But if they go, "It's probably all right, we're not sure we need to do a biopsy." And then they have trouble getting the biopsy, and it's not very nice, and all of that, you can understand, people go, "Why would I go there?" They're relieved that it's not cancer. But to me, again, warning that is my prejudice telling that. But just be aware of that controversy in that. Maybe it's not controversy, but it's just the effect in that younger age group.

Dr. Meron Pitcher: What about the over 75s. I saw a letter from Breast Screen today, of a patient who has been coming to see me for 20 years. She's now 82, and she's just gone to Breast Screen and had a clear mammogram. And I don't know, I think her sister might have had breast cancer at 65. But Alva, that's her name. And she's a really classic 82 -year old, retired teacher, rather somewhat overweight, completely normal breasts. Never had any problem. I think I inherited her from George Tom's, gynaecologist. Some of you remember the lovely George. And

she wants to come and see me every year to have her breasts checked. That's very nice. I have been encouraging her not to, but I've given up having arguments with her. But to me, I like having arguments but it's not worth it.

Dr. Meron Pitcher: But to me what I would say is, what is the purpose of breast screening? And you can argue this for bowel screening or cervical screening. We're trying to find something at the earliest possible stage so that we can treat it so it's not going to cause trouble in that person's lifetime. So what I say to people in their later 70s, and certainly 80 and over, I said, "Do we want to find something that if it's going to cause problems, it'll probably be in the next 10 years' time?" Because the majority of 80 -year olds don't really want to undergo unpleasant biopsy, inappropriate operation, radiation, tablets, over and above what they're already on. And I would say if they've got a lump or they've got a problem, of course we do a mammogram. Of course, we treat them. But do I want to find a low-grade cancer that is not going to affect their life quality and life expectancy?

Dr. Meron Pitcher: And so to me, my cut-off is 80. I don't think 80 year olds should be doing screening, probably for anything. I think most people up to 75, are pretty good. And somewhere between 75 and 80 it changes. And certainly, in my career, and indeed in some of your careers, you'll see all these people you thought would have been dead years ago, they're still alive with their cardiac stents and their renal replacement therapy and all things. My ability to prognosticate is now dreadful. So people are living longer and getting things. But to me, what are we doing diagnosing precancer in a 77 year old? It's cruel and it's expensive and as Chris said, emotionally, it's crippling for some people.

Dr. Meron Pitcher: So Breast Screen, I've gone through that. All x-rays are read by two readers. They get a result in 10 to 14 days. And then if necessary, they're recalled for an assessment center. Our local one from here is Parkville in the old Mount Royal Hospital. So what are the controversies, because of course, there are controversies? Over-diagnosis, and that is diagnosing something which would never cause symptoms in a woman's lifetime. And interestingly, the data of this, again, there are reams and reams of papers that have been written about it, is that if you take 1,000 women who have a two yearly screen, age 50 to 74, we spoke about that before, we said eight women out of 1,000 have their lives saved. But another eight cancers may be found and treated that would not have been found in a woman's lifetime.

Dr. Meron Pitcher: So we're labelling people with cancer, putting them through some pretty unpleasant treatments. But we're also saving lives. So again, you can see that's a pretty big range. If we're actually damaging 21 people, that's quite a lot. So the real difficulty is, if you find someone who's got a bit of pre-cancer or a bit of low grade invasive cancer, if we'd waited until that low grade cancer formed a lump and then we gave them some endocrine therapy when they're 77 because they're already on Apixaban for their AAF, and they've got pulmonary hypertension and a few other things, they still wouldn't have died of their cancer, and it still wouldn't have turned out into a fungating horrible mess. But we've put them through that.

Dr. Meron Pitcher: So to me the question is, you've found something, what do you do with it now? Now it's a bit hard to leave it alone. And most people, once you've found a 'cancer', pre-cancer, other words, they want it out, which is entirely appropriate. But can I put my hand on my heart and say, "I've saved your life?" Nope.

Dr. Meron Pitcher: Ultimately, there are some trials happening which are open in the States for precancer, for observation alone. There's some data that I saw presented at our college meeting in Bangkok a few weeks ago, which says for the over 70s, if they've got a low grade pre-cancer and they survey them, the survival is exactly the same in the over 70s. If you're 40 and you've got something and then probably you should do something about it. 50 to 70, you should probably do something about it. But over 70, probably not much point. But I think in the next generation, there'll be biological ways of working out, "This is a non-significant precancer/ this is a significant one." I hope.

Dr. Meron Pitcher: Implants, that's always a controversy. What do you do? "I've got implants. I don't want my breast squashed. It'll hurt. It'll break the implant." The implants get pushed back so that they get a better view. Sometimes they need a bit more time to take extra images. Sometimes a bit more radiation is required, and there is a small risk of damage to the implant, or more usually that capsule if they've got a hard capsule around the implant. But the risk of damage is really very small. Or, "I'm not having it because it's radiation." I don't really understand millisieverts and I don't expect you to know or remember any of this, but the point of what I've put up there is that getting two views, that's four images, is about a third of the background radiation for the year, with tomograms, which is where that basically the bosom is squashed, but they take a continuous stream, a bit like a cat scan, so to speak. There's a slightly bigger dose. The advantage of tomography is that it can reduce the risk for recall because it can eliminate some of the overlapping shadows. So you'll see a bit of that. But the amount of radiation is similar to an x-ray of the hip or a CT of the head. And the risk of inducing a cancer on a mammogram is perilously low.But yes, there is radiation.

Dr. Meron Pitcher: So this is my take home message. Remember that screening is for people with no symptoms. If they've got symptoms, they need to go down the diagnostic pathway. I should have put up there, warn people, particularly the younger age group or first screen, they might get recalled. So I don't jump off the West Gate Bridge if that happens. I would encourage you to encourage those women in the target group, that is 50 to 75 ... I have put the chance and recall. That was smart. Explain that by my get recalled and go through that process. Thank you.

Innovation in Cancer Screening – Intensive Quality Improvement: Workshop 1

SECTION 5: Quality Improvement and Cancer Screening – A Final Summary

Speaker: Dr Richard Bills

Dr. Richard Bills: I want to inspire you to think about something you could do, because it's something I meant to do, and I'm actually having a sabbatical year off my practice at the moment. So I'm not I'm not able to do it, but I put the challenge out there for you guys, when you think about ways to encourage your patients to increase screening, for example, we often think about the concept of champions, about people who are recognised by our patient population that you're trying to improve screening for, or recognised, and more widely in your practice, for example, as somebody who people look up to whose wisdom or thoughts that they value. And of course, one of the people in your practice that they think that about is their GP, their practice nurse, other people who are relevant to them when they come to your practice.

Dr. Richard Bills: So the thought that I had and the challenge that I'm putting up for you guys to think about is to do with bowel cancer screening. And the idea that I had in my practice is that in fact, I should do the little video about how you do your bowel screen, and put it up on our practice website so we could direct people to it. And they would be seeing someone who's familiar to them doing a screening and realize that this is a really simple process.

Dr. Richard Bills: Now, I wasn't personally planning to bring Sam and the guys into my toilet and do it there. And that's part of the creativity that you guys could even invoke in your own practices. I remember those experiments when I was a medical student, where we had a sausage that was covered with Serratia fluorescents or something. Meron and I went to university together, and you can see that she obviously weathered a lot better than I did in that process. But that's all right. But we have to touch the sausage with toilet paper and then put our hands in an agar plate and then see where the stuff grew to show us that if we'd actually washed our hands in between those two things, we then got much less stuff growing on this agar plate.

Dr. Richard Bills: So you don't have to go the real deal. But you could think about the possibility of posting up a video that you could direct patients to and say, "Look, this is what I do. I'm going to show you how to do it." In a mocked up way, and show you how easy it is to do this test. Because what people get is a little piece of paper. We've all got our bowel screening tests, and it's just a little sheet of card that says, "Oh yes, there's the two little sticks. They're now in the new format. Make sure you realize that you know. Still the red and blue containers and this is what we're going to do." I think it would be quite fun to do that with a sausage

or, I don't know. You could do the vegan version. I'm not sure, but I just put that challenge up there for you.

So I had a couple of closing slides that I was going to use for you. And one of them, probably a really critical one, the first thing was about supporting your team. And I had out with a nice photo of one of our teams, in this case, promoting about organ donation in our practice, because that's something else we've got a very strong philosophy about. But it is really critical. You need to create those teams that are going to work together to help you in your project and you need to support that team. And that might be about having meetings where you put lunch on. It might be about going out somewhere, getting a quiet corner in the pub to discuss something that you're doing. But it's also about nourishing that team and supporting them, and celebrating what you've achieved.

Dr. Richard B. Bills: So one of the things we are really, really poor at in primary care is actually about celebrating success. We're really poor at it. I should challenge all of you to make sure that every individual practice that's represented here gets a photo of at least two or more members of your practice in the local paper about something you've achieved over this 12 months, to do with this. Because the patients absolutely love it. Your staff members grow five centimetres taller, to see their picture in the local paper. It's incredibly powerful. And it reinforces the message. Look at what we've achieved. We're creating stellar results in terms of improving our capture rates for bowel screening, breast screening, cervical screening. Really, really powerful.

Dr. Richard Bills: So I can't emphasize that enough. That's included in communicating things around the practice. Putting up the chart on the fridge, on the whiteboard, outside the kitchen, whatever it is, that shows what our rates are doing. Incredibly powerful, simple visual things. Really, really powerful. I'm getting old enough., I do have to put my glasses on if I can't read it on the big screen, but in summary, what are you going to do?

Dr. Richard Bills: One, you're going to increase cancer screening across your population with some specific target groups in mind. You're going to build a team supported by a practice to do this. All these slides will be available just at the end.just see Ange. she'll be able to put them up for you. You're going to extend yourselves because if you keep doing what you're doing, you're going to keep getting what you're getting. So you've got to do something different. There's nothing magic about this. This is Einstein's third law, law of Insanity. If you keep doing what you're currently doing, you're going to keep getting what you currently get.

Dr. Richard Bills: So you've got to do something that you don't currently do. You've got to learn to follow your hunches, and that's where sitting down your practice is such an incredibly powerful thing. You don't have to have 68 staff. You might only have four staff. But workshop, what it is you are wanting to achieve, and what ways you might be able to make that happen. You need to measure your success and that is critical. That measurement, measuring where you are now, identifying

what you want to achieve and measuring how you're going, and trying to achieve that is critical, and put it up there. Put it up there for people to see. Celebrate success. I can't say that often enough. We have terribly, terribly poor at doing that in primary care. It is really, really powerful to do that. And learn from this experience. I said at the start, this is not a pilot.

Dr. Richard B. Bills: I will say that again. This is not a pilot. Things you learned from this process, you can institute in all sorts of other ways. You're focusing on three sorts of cancers. It wouldn't have helped me if I was coming to your practice. There are other cancers, there are plenty of other things that you can do better. We can all do better. Find the data that shows how you're going, identify things that people are interested in, and use the process to build on that.