phn NORTH WESTERN MELBOURNE

An Australian Government Initiative

Breast density, risk management and inclusive cervical screening: a primary care update

Wednesday 04 November 2026

The content in this session is valid at date of presentation

In collaboration with

PHN Southern Alliance

Australian Centre for the Prevention of Cervical Cancer

BreastScreen Victoria

Cancer Council

Acknowledgement of Country

North Western Melbourne Primary Health Network would like to acknowledge the Traditional Custodians of the land on which our work takes place, the Wurundjeri Woi Wurrung People, the Boon Wurrung People and the Wathaurong People.

We pay respects to Elders past, present and emerging as well as pay respects to any Aboriginal and Torres Strait Islander people in the session with us today.



Housekeeping

All attendees are muted

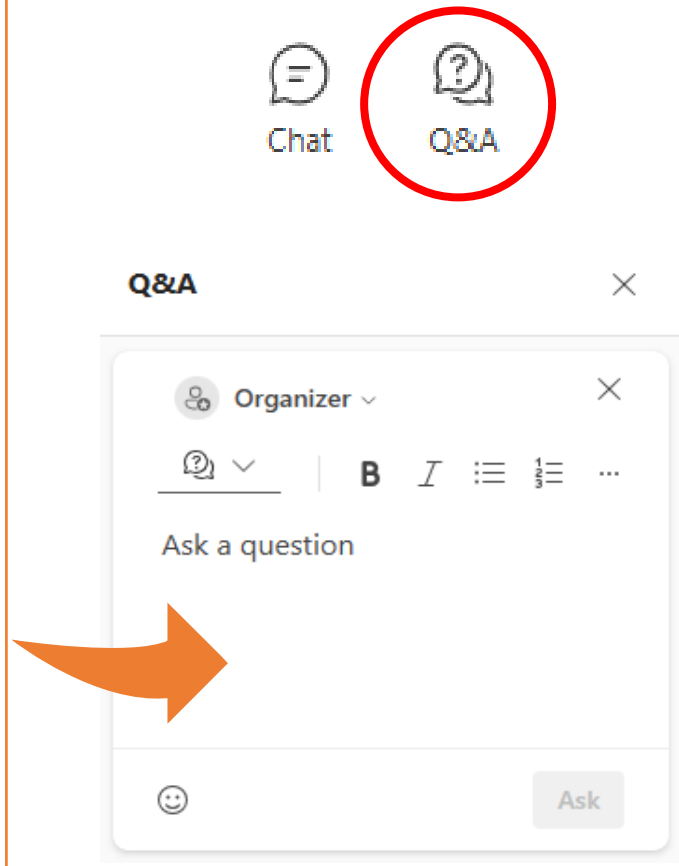
Please ask questions via the Q&A box only

- Q&A will be at the end of the presentation
- Questions will be asked anonymously to protect your privacy

This session is being recorded.

You will receive a link to this recording and copy of slides in post session correspondence.

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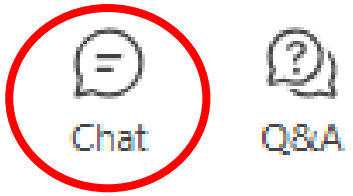


Housekeeping

Is your teams name the same as your registration?

To ensure we can issue your certificates and CPD please ensure you have joined this session using the same name that you originally registered with via the NWMPHN website (or phone number, if you have dialled in).

Not sure if your name matches - send a chat message to identify yourself.



Speakers

Dr David Speakman is a breast, melanoma and skin services clinician at Peter MacCallum Cancer Centre and State Clinical Director of BreastScreen Victoria, where he chairs the Quality and Accreditation Committee. A former Peter Mac Chief Medical Officer, he contributes to cancer education, clinical guidelines and optimal care pathways. In 2022, David received the Medal of the Order of Australia for service to medicine.

Sarah Mills has been the State Radiographer with BreastScreen Victoria since 2023 and has worked in screening and assessment since 2014. She is involved in policy and project work within the coordination unit, monitors image quality across the state and participates in quality committees.

Dr Jennifer Maxwell is a general practitioner, RACGP fellow, medical director and practice owner. She brings more than 15 years of experience across Australia and the United Kingdom. She is an active member of the North Western Melbourne Primary Health Network (NWMPHN) General Practice Expert Advisory Group and recently joined the GP Integration Unit at Western Health as the General Practice Advisor.

Dr Nick Silberstein is a general practitioner working in the Equinox Gender Diverse Health Centre, part of Thorne Harbour Health, which provides gender affirming care to people identifying as gender diverse or transgender. Nick was a member of the Australian Therapeutic Advisory Group for Immunisation for nine years, during which time he participated in policy and recommendations for the vaccine against human papillomavirus and contributed to the development of the cervical cancer elimination program.

BreastScreen Victoria

Breast screening, symptoms, breast density and risk



NWMPHN webinar | 4 November 2026

Dr David Speakman · Sarah Mills

Session outline

Speakers: Dr David Speakman, Clinical Director and Sarah Mills, State Radiographer

- The BreastScreen Victoria program
- The difference between BreastScreen Victoria and a diagnostic pathway
- Breast density reporting
- Risk management
- The role of GPs and practice nurses in the BreastScreen Victoria program

Program outline



BreastScreen Victoria

Symptoms change the pathway from screening to diagnosis

Start with one question: does this person have breast symptoms?

NO BREAST SYMPTOMS

SCREENING

BreastScreen Victoria

Designed for people who are well and do not have breast symptoms.

BREAST SYMPTOMS PRESENT

DIAGNOSIS

Diagnostic referral pathway

Enables the appropriate clinical assessment of the reported symptom.

BreastScreen Victoria is the population screening pathway—not a diagnostic service for clients with breast symptoms.

BreastScreen Victoria

Program's practical support to remove access barriers for multicultural communities

For multicultural clients ask what will make attendance possible.

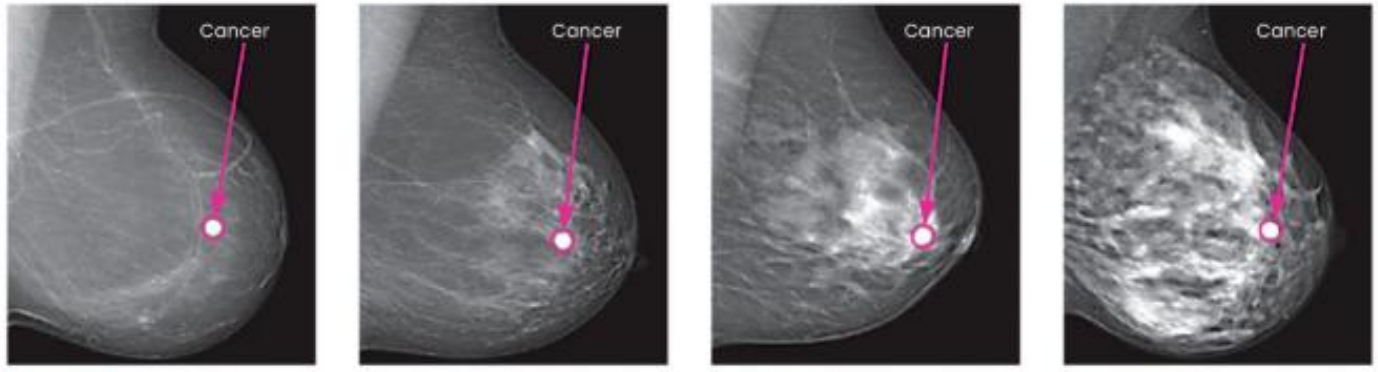
INTERPRETERS	For screening appointments where available, and for assessment appointments when needed.
CLEAR RESOURCES	Easy-to-understand materials in the mammography room for clients with limited English.
GROUP BOOKINGS	Coordinated bookings that make participation easier for community groups.
TRANSPORT	Assistance where required to help clients reach screening or assessment services.

To organise a group booking email: communityengagement@breastscreen.org.au

BreastScreen Victoria

Breast density

Breast density is commonly classified into four categories. People with a Category C or D classification are considered to have dense breasts.



Category A
Almost all fatty tissue

Category B
Mostly fatty tissue

Category C
Some fatty tissue

Category D
Hardly any fatty tissue

Not dense

Dense

Extremely dense

BreastScreen Victoria

Breast density matters—but it is one part of the picture

Breast density affects both mammographic sensitivity and breast cancer risk.

THE CENTRAL MESSAGE

ONE
FACTOR

Important—yet best interpreted as part of overall risk.

MAMMOGRAM PERFORMANCE

Density can affect mammographic sensitivity.

CLIENT INFORMATION

Victorian clients receive their density category in their result letter.

CONVERSATION WITH GPs

Address questions and misconceptions without treating density in isolation.

Risk assessment brings density into the full clinical picture

Use breast density alongside the person's broader clinical information and individual risk.

ASSESS THE WHOLE PICTURE

Density

Individual risk

Clinical context

No single factor decides the pathway.

MATCH THE NEXT STEP TO NEED

Breast screen pathway

Additional imaging

More regular tests

Specialist advice

BreastScreen Victoria

Use the right pathway—and keep the resources close

Three actions to take back to practice

1. **CHECK FOR SYMPTOMS**
   before recommending screening
2. **ASSESS RISK IN CONTEXT**
   including—but not limited to—density
3. **SHARE THE RESOURCES**
   to support clear patient conversations

RESOURCES

AUSTRALIAN GOVERNMENT	**Breast density GP guidance**	health.gov.au/breast-density-guidance
BREASTSCREEN VICTORIA	**Breast density information for GPs**	breastscreen.org.au/health-professionals
PETER MAC	**iPrevent breast cancer risk tool**	petermac.org/iprevent
BEHIND THE SCREEN PODCAST	**BreastScreen Victoria program**	breastscreen.org.au/podcast

CONNECT WITH US ON SOCIAL MEDIA

BreastScreen Victoria

Q+A

What would help you apply this in practice with your patients?

GENERAL PRACTICE CASE STUDY

Making breast screening accessible and actionable

Inclusive support • My Health Record • HealthPathways

Dr Jenny Maxwell | GP

CASE STUDY

The case: an opportunity for prevention

Patient

Amina, 62, moved to Melbourne 2 years ago. She speaks conversational English. PMH: hypertension

What brings her in?

Amina is attending for her regular prescriptions. She was seen by the nurse for a BP check prior to seeing you. The practice nurse enquires about preventative health screening. Amina mentions that she has not attended breast screening. She is unsure whether she needs a GP referral, worries about pain, and does not know how she would receive results.

Your task: turn “I haven’t booked” into an informed, supported next step.

Ask permission to discuss screening and explore her concerns without judgement.

Check whether she has any breast symptoms before discussing routine screening.

CASE STUDY

First decision: screening or diagnostic assessment?

NO breast symptoms

Explain that BreastScreen is for people without breast symptoms who are eligible for routine screening.

Support booking through the relevant BreastScreen service.

Breast symptoms present

A new lump, nipple or skin change, or other concerning symptom needs clinical assessment and an appropriate diagnostic pathway—not routine screening alone.

Ask clearly: “Have you noticed any new changes in either breast?”

CASE STUDY

Make participation possible—not just recommended

1. Understand

- Ask what she already knows
- Invite questions and concerns
- Use plain language; avoid jargon

2. Remove barriers

- Offer a professional interpreter
- Use translated / easy-read resources where available
- Discuss transport or group booking options

3. Agree a plan

- Explain what to expect
- Offer help to book or identify the service
- Check understanding with teach-back

“What would make it easier for you to attend?”

BreastScreen Victoria

https://www.breastscreen.org.au/community-engagement/culturally-and-linguistically-diverse-people

Need additional help?



Translated resources

Our introduction to breast screening and other resources are available in a wide range of languages, including Arabic, Mandarin, Punjabi and Dari.

Our website also features a Google Translate plugin - offering translations in over 200 languages, ensuring accessibility for our diverse communities.

Explore translated resources



Interpreter services

To book an appointment through an interpreter, call 13 14 50 and ask to be connected to BreastScreen Victoria.



Group bookings

We can organise for group bookings so that you can travel together and support each other.

In some cases, we can also arrange for group transport assistance – as well as familiarisation visits.

Contact us for a group booking

CASE STUDY

A short, culturally safe conversation

Example wording

“Breast screening is a way to look for early signs of breast cancer before you notice symptoms. It is your choice. I can explain what happens, arrange an interpreter if available, and help you work out how to book. What questions or worries do you have?”

Check understanding

Ask Amina to explain in her own words:

- why she is being offered screening
- how she will book
- who she can contact if she needs help

Respect choice. Avoid pressure, shame or assumptions about beliefs and preferences.

CASE STUDY

Results are part of the care pathway

Before the appointment: ask how Amina would prefer to receive and discuss her result.

Explain that BreastScreen results and reports may be available in My Health Record, depending on the service, upload and timing.

With Amina’s consent, show her how to sign in to My Health Record through an available access route and locate the relevant report.

Read the report together; explain the result in plain language and invite questions.

Agree what happens next—and how she can contact the practice or BreastScreen if she is unsure.

CASE STUDY

My Health Record: a teach-and-check workflow

1 **ACCESS**

Can she sign in? Does she need help with identity, device, language or accessibility? Call the Translating and Interpreting Service on 131 450 and they will connect you to My Health Record.

2 **LOCATE**

Find the relevant health information / documents area and look for the BreastScreen report.

3 **INTERPRET**

Read it together. Clarify the meaning and any recommended follow-up; avoid over-interpreting technical terms.

4 **ACT**

Document the discussion, agree the next step, and make a plan if the report is absent or unclear.

English
Afrikaans
Albanian
Arabic
Armenian
Azerbaijani
Basque
Belarusian
Bosnian
Bulgarian
Catalan

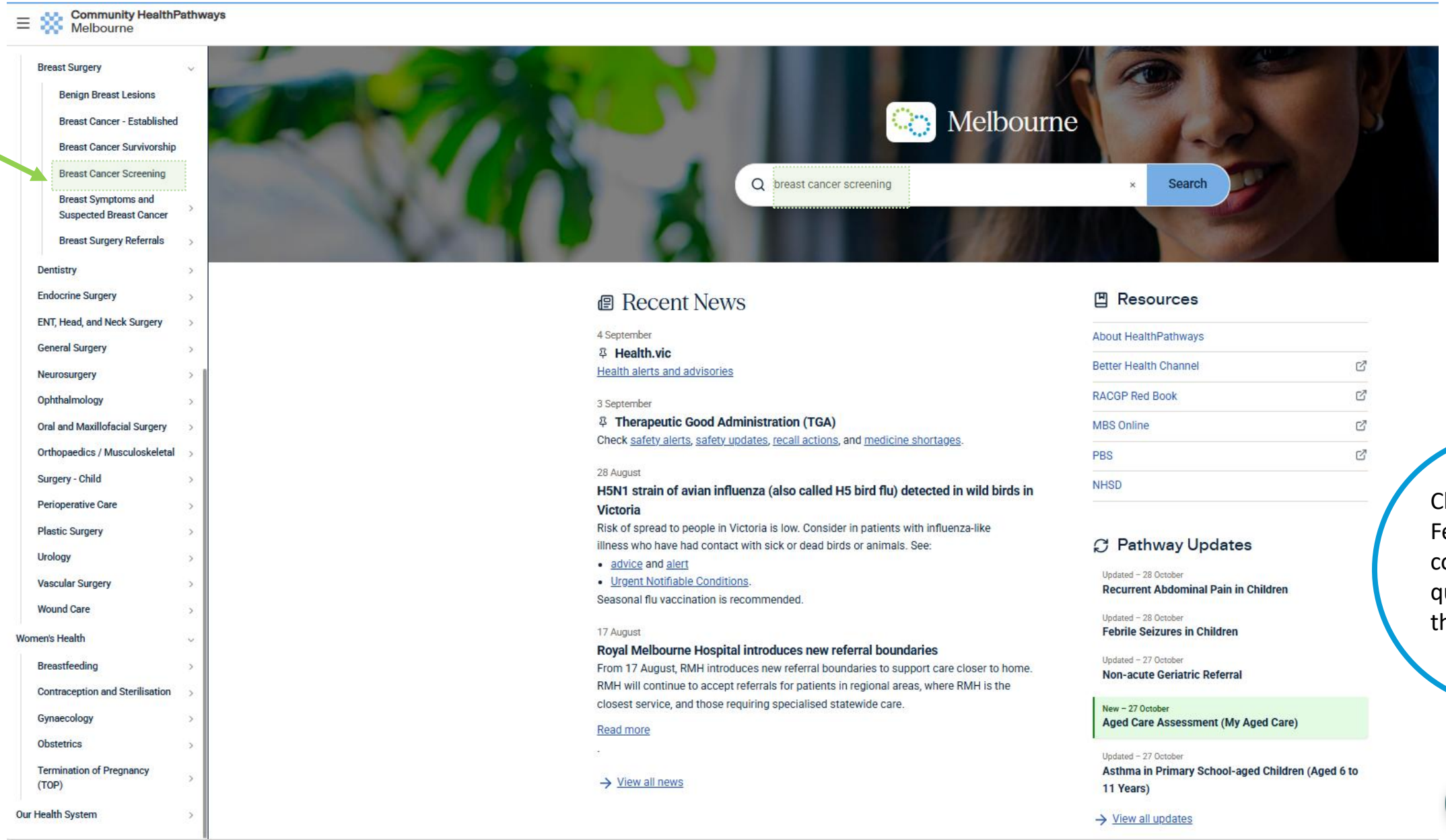
My Health Record

A safe and secure place to keep your key health information, available to you and your healthcare providers anytime, including in an emergency.

Go to My Health Record my Gov



HealthPathways- Cancer Screening Pathways



Click 'Send Feedback' to add comments and questions about this pathway.

CASE STUDY

Close the loop: Amina’s agreed plan

Amina confirms she has no breast symptoms; routine screening is the appropriate discussion.

She chooses to proceed after her questions are answered and an interpreter / practical support is arranged where available.

The practice agrees how she will receive results and offers help to locate them in My Health Record.

A follow-up plan is documented: review the result together, clarify any uncertainty, and act on recommended next steps.

If symptoms emerge at any point, reassess and use a diagnostic pathway rather than relying on routine screening.

Key message: access + understanding + follow-through = more equitable care.

CASE STUDY

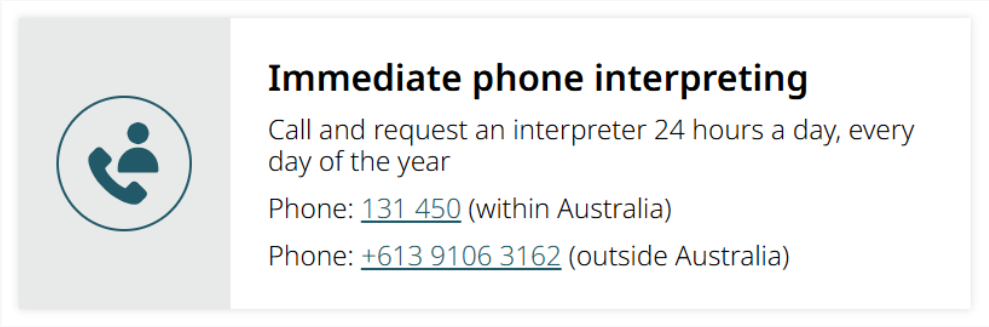
Take-home actions and resources

In every consultation

1. Ask about symptoms first.
2. Offer interpreter and accessible resources.
3. Support booking and practical access.
4. Plan how results will be received and discussed.
5. Use local HealthPathways for clinical decisions.

Useful starting points

- BreastScreen Victoria: breastscreen.org.au
- My Health Record: myhealthrecord.gov.au
- Melbourne HealthPathways: https://melbourne.communityhealthpathways.org/



Cancer Council

Inclusive cervical screening for LGBTIQA+ communities

Dr. Nick Silberstein
Thorne Harbour Health
November 4th, 2026

Acknowledgement of Country

I add my acknowledgement of the traditional owners, and I also add that Equinox in Abbotsford sits very close to the Birrarung, or Yarra River, which I understand has great significance to the Kulin Nation.

‘A place of mists and shadows’



What will clinicians take away?

- Recognise barriers and lived experiences that affect cervical screening
- Specific clinical considerations and recommendations when supporting LGBTIQA+ patients, including trans and gender-diverse people.
- Practical strategies for inclusive, affirming and trauma-informed care

Why inclusive screening matters

- A person's gender identity or sexual orientation does not, by itself, establish whether screening is indicated
- Misgendering, judgement and discomfort can undermine trust
- Negative encounters can contribute to delayed or avoided screening
- Respectful care supports informed choice and engagement

Barriers to cervical screening for LGBTIQA+ communities

Barriers can occur at multiple levels and may intersect to influence screening experiences.

INDIVIDUAL

Gender dysphoria; anticipated pain or discomfort; privacy concerns; fear of intimate examination; previous distressing experiences.

INTERPERSONAL

Discrimination, stigma, homophobia or transphobia in healthcare; assumptions about identity, partners or sexual practices.

COMMUNITY & SOCIAL

Limited visibility of inclusive screening information; community stigma; shared negative experiences contributing to mistrust.

STRUCTURAL & SYSTEMIC

Gendered language and unfamiliar terminology; administrative systems that do not reflect identity; limited access to affirming care.

Clinical takeaway • Ask about each person's preferences and needs; provide person-centered, trauma-informed and affirming care.

Cancer Council

Enablers to cervical screening: focus on the person

- Establish screening eligibility using current National Cancer Screening Program guidance and relevant anatomy/clinical history

- Do not assume screening is unnecessary because a patient identifies as lesbian, bisexual, trans or non-binary (ENSURE members of these groups remain in the screening program, especially if changes have been made to the gender markers or name)

- Ask only clinically relevant questions; avoid assumptions about HPV exposure which is irrelevant to the screening program

- Consider individual circumstances and specialist advice where needed

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Enablers to cervical screening: Offer screening choices and explain follow-up

- Explain self-collection and clinician collection options in line with current guidance
- Ensure clients understand the advice that would follow a positive test.
- Self-collection can help reduce barriers offering greater choice, autonomy and control over the screening experience, supporting a more comfortable, inclusive and person-centred approach to care
- Discuss privacy, setting, assistance and patient preferences
- Explain what different results may mean and when additional clinician-collected testing or referral is indicated

Agree how results and follow-up will be communicated (Avoid ‘no news is good news’)

Cancer Council

Inclusive conversations: what to say and do

- Ask which name, pronouns and anatomical terms the patient prefers
- Explain why screening is being offered without making assumptions
- Invite questions and ask what would make the appointment more comfortable
- Use neutral, non-judgemental language in discussion and documentation

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Trauma-informed care in practice

- Ask permission before discussing sensitive issues or beginning an examination. Establish how much communication the person wishes or feels comfortable with.
- Explain each step; check consent throughout
- Offer choice about support person, clinician, positioning and pauses where feasible
- Respect a decision to decline or defer; agree a safe plan for follow-up

Cancer Council

“You’re there to collect my cells, not to judge me”: Co-designing a lived-experience resource for inclusive cervical screening care - Presentation by ELENI GABRIELIDES at ASHM 2026. (Project based at Meridian, ACT)

Participant reported experiences of cervical screening were overwhelmingly negative. Key themes included misgendering, assumptions, provider discomfort, judgement, and experiences of pain, gender dysphoria, and physical and emotional discomfort for patients. These experiences contributed to distress, disengagement, and delayed care, and were often carried beyond the clinical encounter.

In contrast, affirming care was associated with respect, comfort, communication, and trust.

Cancer Council

Cancer screening in LGBTQIA+ populations

AJGP Volume 55, Issue 10, October 2026

Lesbian, gay, bisexual, transgender, queer/questioning, intersex and asexual/aromantic (LGBTQIA+, the plus referring to other sexuality and gender diverse groups) peoples in Australia experience lower levels of cancer screening and preventive activities when compared with the general population. This is especially the case for transgender and gender diverse (TGD) peoples, who experience additional barriers to access and discrimination above the rest of LGBTQIA+ peoples.

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Remember the following (AJGP):

- Treat every patient individually
- Be cautious of assumptions – patients may be keen to engage with screening
- Be aware of some of the barriers to screening for LGBTQIA+ peoples, and where possible, support the patient to navigate these discreetly and comfortably
- Practitioner recommendation improves screening engagement; educate patients appropriately on cancer risks and the relative benefits of screening tests
- Ask about preferred terms for body parts, knowing many patients will be content with anatomical terms
- In most cases, the recommendations of the national cancer screening programs may be followed without alteration for LGBTQIA+ peoples

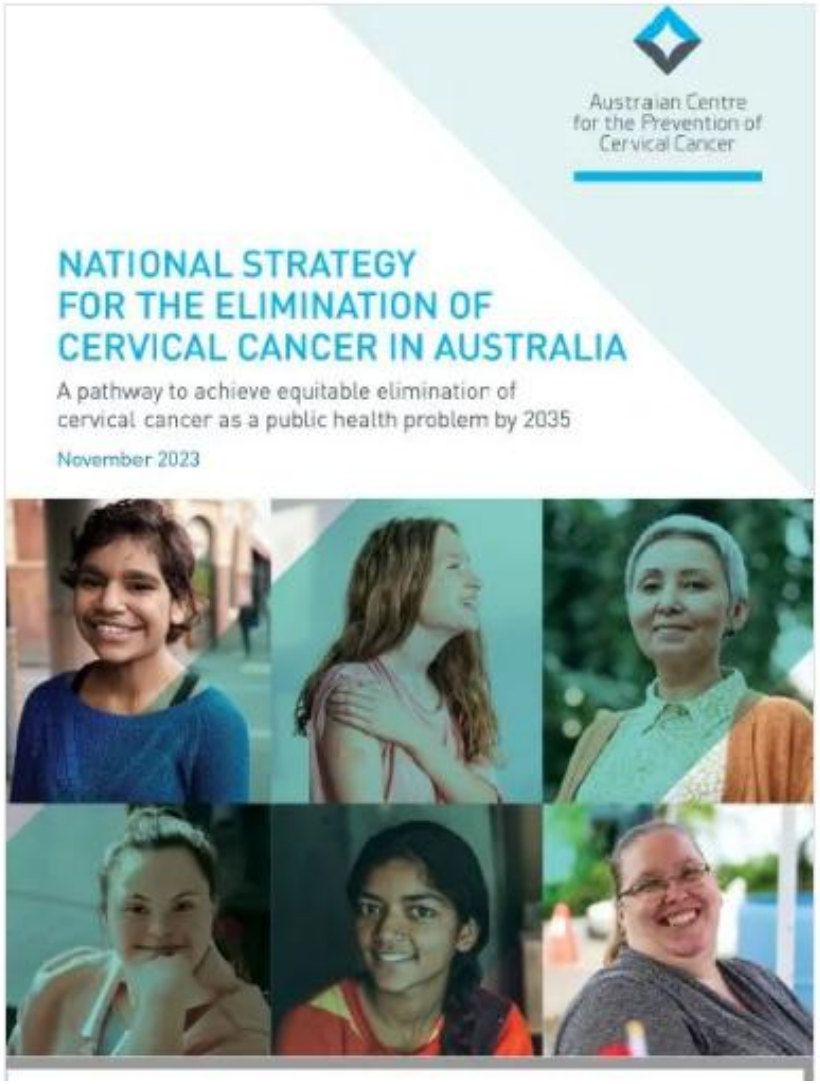
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Naming of body parts (this presentation):

Many people may not consider the naming of certain body parts appropriate to them. It seems difficult to avoid using the word cervix.

Cancer Council

National Strategy for the Elimination of Cervical Cancer in Australia



Cancer Council

The program...



National Cervical Screening Program – National Cervical Screening Policy

The National Cervical Screening Program (NCSP) aims to reduce morbidity and mortality from cervical cancer. This will be achieved through an organised population-based screening pathway to detect pre-cancerous cervical abnormalities in asymptomatic women and people with a cervix.

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Human Papilloma Virus - HPV - is responsible for:

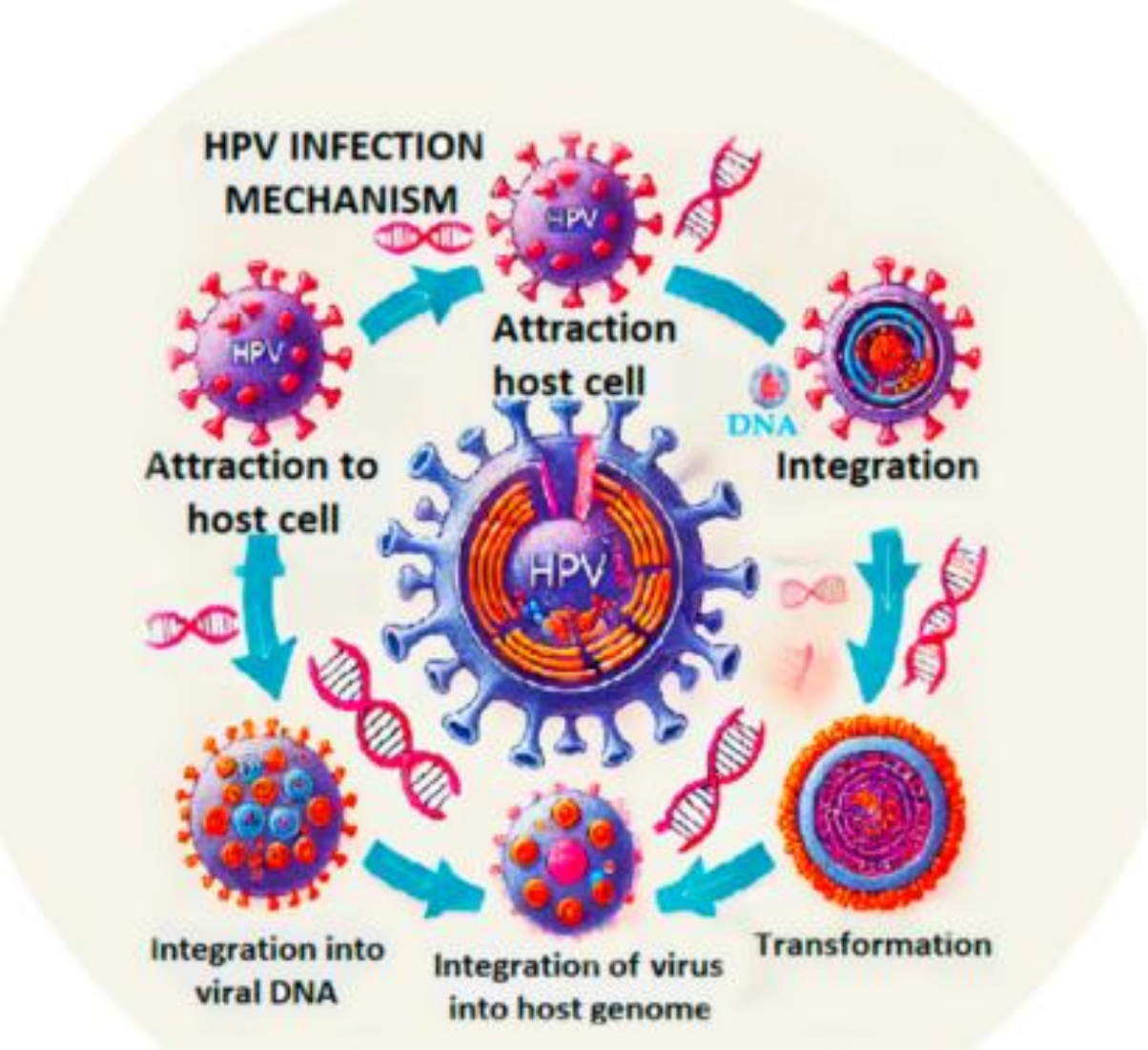
- almost all cases of genital warts and cervical cancer

BUT ALSO:

- 90% of anal cancers
- 78% of vaginal cancers
- 25% of vulval cancers
- 50% of penile cancers
- 60% of oropharyngeal cancers

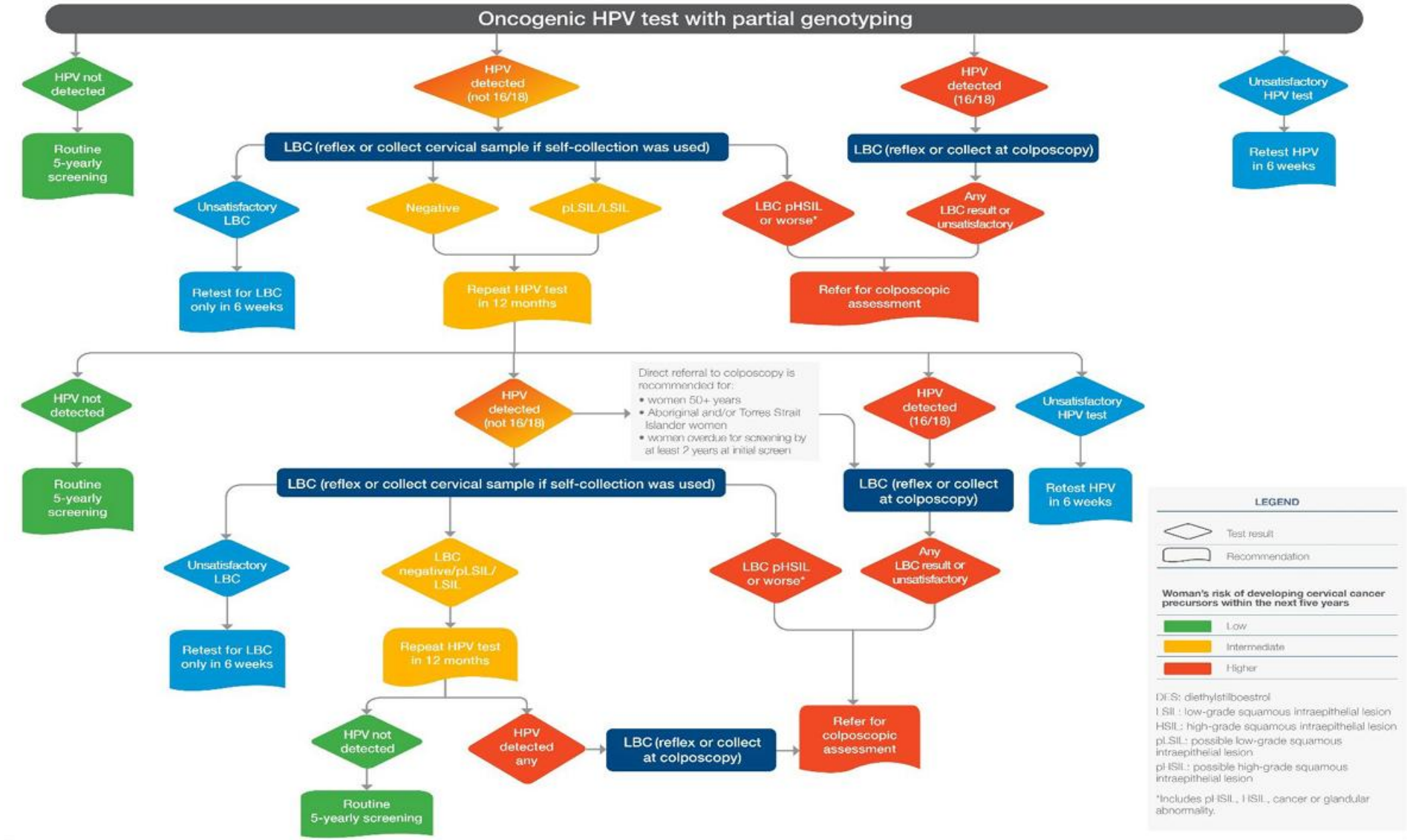
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What does HPV do?



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CERVICAL SCREENING PATHWAY (CLINICIAN COLLECTED OR SELF-COLLECTED)



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Who gets HPV

- Virtually everyone
- Sexual and possibly nonsexual transmission.
- Not necessarily more common in people with greater numbers of partners

Cancer Council

HPV types

- In total there are at least 200 strains of HPV (some say up to 400)
- **Genital Types:** At least 60 HPV strains can infect the genital area and are spread through sexual contact – or potentially close, non-sexual contact.
- **Low-Risk Strains:** These do not lead to cancer, but certain types (like HPV 6 and 11) cause about 90% of genital warts (?? Some pharyngeal cancers).
- **High-Risk Strains:** Around 12 to 14 types are classified as high-risk or oncogenic because they can cause cellular changes leading to cancer.
- **Cancer-Causing Types:** Strains **16 and 18** are responsible for the majority of HPV-related cancers, including cervical, anal, and throat cancers

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Remember:

- The most important component of the cervical cancer eradication program is HPV vaccination.
- Strain replacement: immunised people have a prevalence of non 16/18 HPV of ten percent on their first CST – many clients are disappointed by this figure.
- CST is no longer needed post hysterectomy if there was no history of dysplasia and normal histology of the resected specimen at surgery.

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HPV Non 16/18 result

Cervical Screening Test (CST)

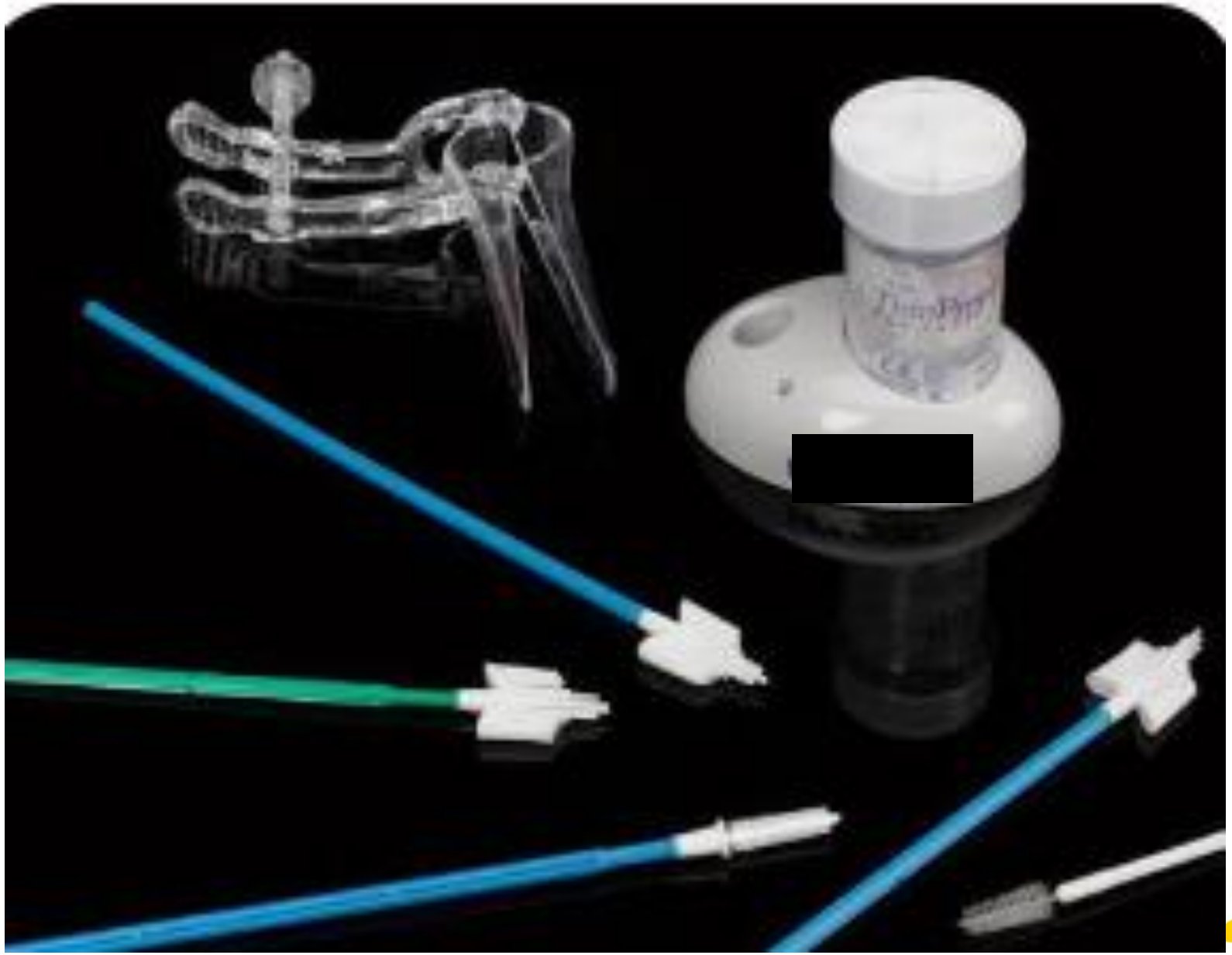
Coll Date:	**16/09/26**	05/01/24
Lab Number:	**83923716**	80111099
Site:	Cervix	Cervix
Specimen:	Thinprep	Thinprep
HPV 16/18		
HPV 16		Negative
HPV 18		Negative
HPV not 16/18		
HPV 31		Negative
HPV 33		Negative
HPV 35		Negative
HPV 39		Negative
HPV 45		Negative
HPV 51		Negative
HPV 52		DETECTED
HPV 56		Negative
HPV 58		Negative
HPV 59		Negative
HPV 66		Negative
HPV 68		DETECTED

Cytology: 83923716 Liquid Based Cytology: Manually screened

Possible low-grade squamous intraepithelial lesion (pLSIL)
Endocervical component present

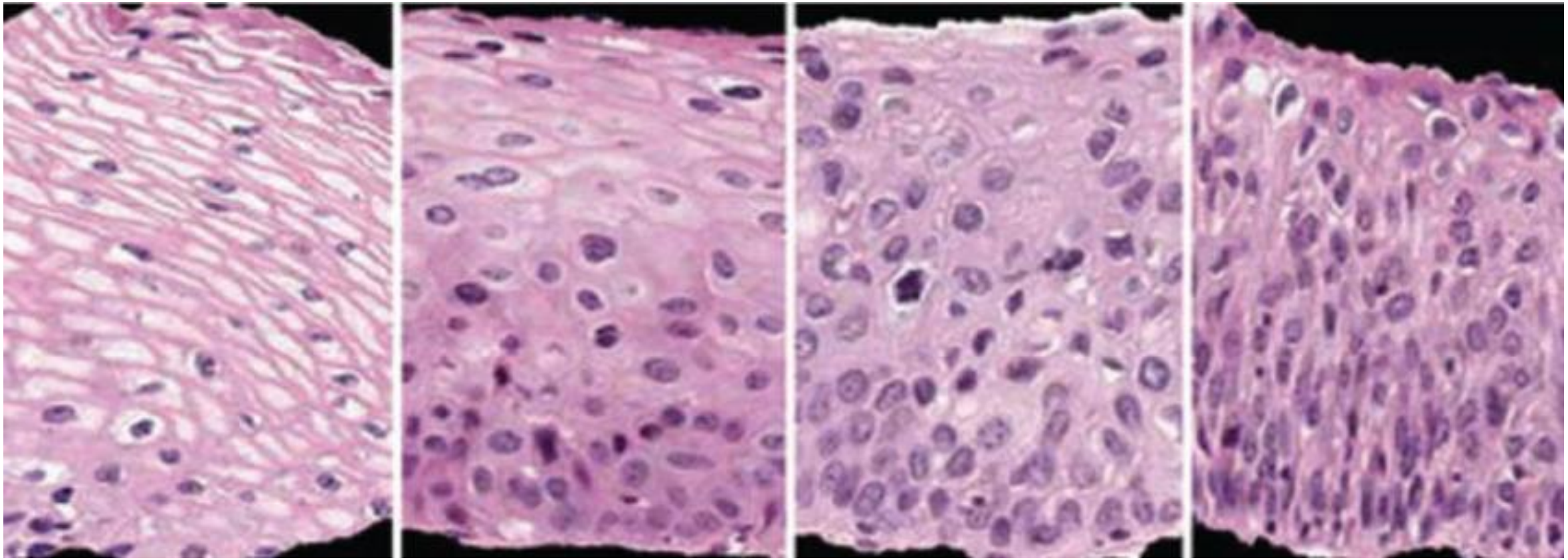


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Cancer Council



Cancer Council

Okay, so how should we do this?

- ACCCURATE MEDICAL RECORDS – with the CORRECT gender, preferred name and pronouns.
- The client WANTS cervical screening
- Client choice about everything – person to accompany, level of lighting, level and nature of interaction during the procedure, client options such as being the one to insert the speculum.
- Do they want a curtain (RACGP standard), or not?
- Self taken tests can be in the office, or at home, and by the client, a partner, or health professional.
- Level of follow up desired.
- NO MEDICAL BLACKMAIL ….

Cancer Council

Remember:

- Cervical screening is an unpleasant, intrusive and potentially highly traumatizing procedure.
- Do not assume that simply because CST is medically logical and highly evidence based and all of that that this is necessarily the priority of your client.
- There can be work-arounds, for example delaying a practitioner taken cytology test in the setting of non16/18 HPV on PCR testing.

Cancer Council

Clinical scenario 1: screening after a difficult experience

A trans man with a cervix has avoided screening following a previous distressing examination.

DISCUSS

- How would you open the conversation?
- What options and adjustments could you offer?
- How would you agree on next steps without pressure? (Hint – it is the client's decision to have the screen, not the health professional's)

Cancer Council

CCV inclusive cervical screening projects

Cancer Council Victoria and Thorne Harbour Health, supported by Victorian Department of Health, are running a new LGBTIQA+ cervical screening campaign in early 2027.

The campaign will raise awareness and encourage appointment booking or LGBTIQA+ people with a cervix.

Free resources will be available to prime your clinic (e.g. posters, postcards); you may experience possible increased demand from LGBITQA+ people.



An image from the previous combined organisations' "Public Cervix Announcement" campaign

Cancer Council

Cervical Screening Clinic at Thorne Harbour Health

- Dedicated, peer-led service for LBQIA+ women and TGDNB people with a cervix.
- Available on Fridays from 2 October 2026 to 29 January 2027
- Located within the Equinox Gender Diverse Health Centre: *200 Hoddle Street*



Scan QR code for more information or to book

Cancer Council

Publicity for Thorne Harbour Health project

- Free cervical screening for LBQIA+ women and TGDNB people with a cervix. Our peer-led team won’t ask you to justify your body or your identity, and self-collection means it’s quick, private and on your terms.

- If you have a cervix and you’re aged 25–74, a screen is recommended every five years. It tests for HPV, the virus that causes most cervical cancers. People in our communities are less likely to screen, so if you’re due (or not sure), this is your sign.

Cancer Council

Three changes clinicians can make tomorrow

1 Ask, don’t assume: eligibility, language and preferences

2 Offer informed choice: self-collection, comfort and ongoing consent

3 Close the loop: results, recalls, referrals and respectful follow-up

Please visit the Cancer Screening Hub for resources:

Cancer Council

Ensuring adequate specimens

- PCR reagents can be inactivated by gel-based lubricants so use the minimum.

- Atrophic vaginitis, whether through post menopausal changes or linked to gender affirming testosterone therapy may make vaginal examination substantially more uncomfortable and may interfere with cytological analysis. Consider three weeks of intravaginal estriol or estradiol prior to the appointment

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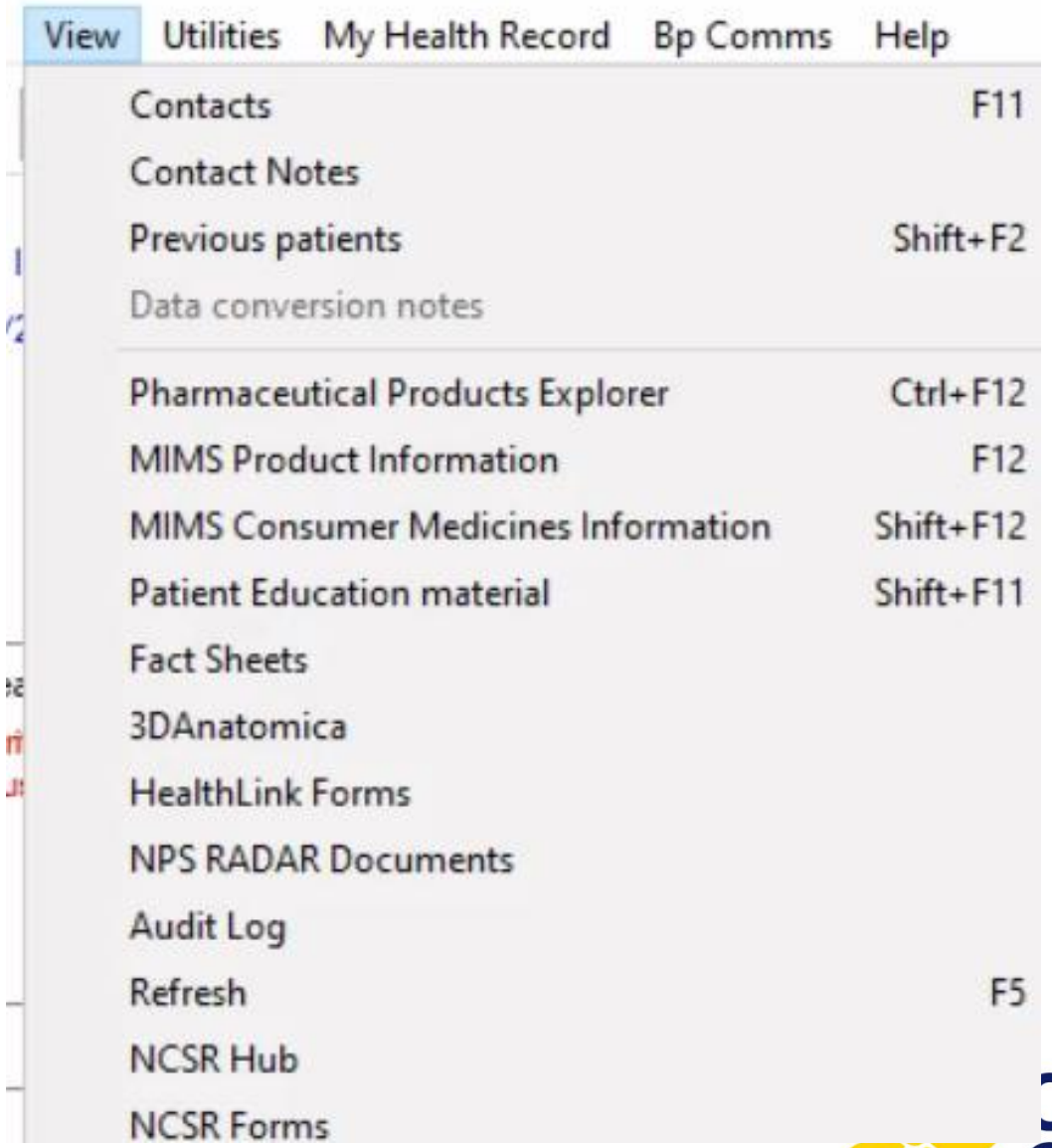
A final note on recall:

- Victorian Cytology Service currently recalls all people within the 25 – 74-year age range with a female gender marker at the prescribed intervals, unless a health practitioner or client has specifically submitted notification to remove the person from the register.

- This means that people may be inappropriately included into or excluded from the register. It can be difficult to add trans-men to the register. Scrupulous maintenance of general practice recall systems is essential.

Cancer Council

To remove someone from CST reminders from the National Cancer Screening Registry, choose NCSR Forms from the view menu of the client file front page.



Cancer Council

Cancer Council

Thank you.

HealthPathways Melbourne

Breast density, risk management and inclusive cervical screening: a primary care update

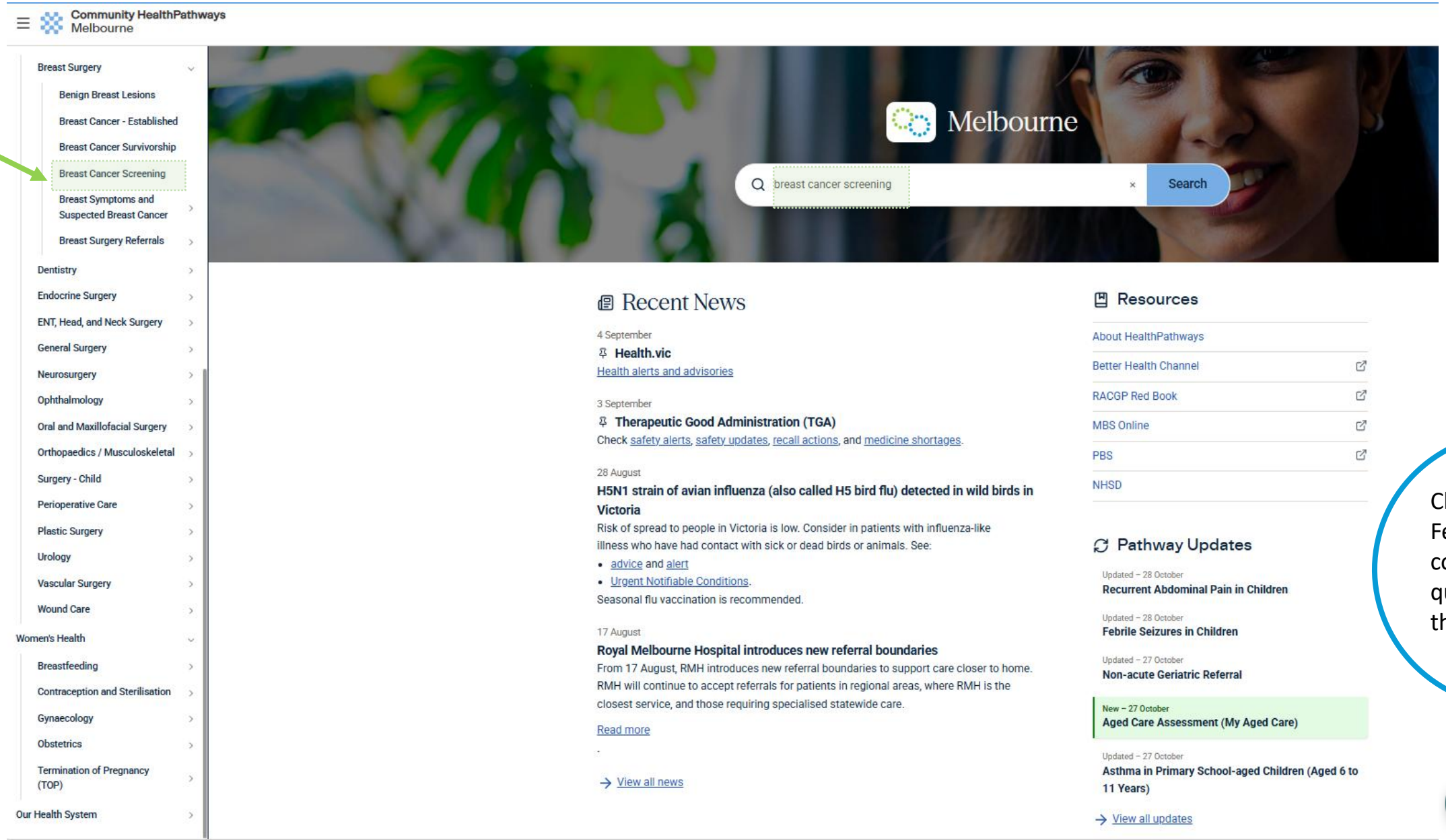
4th November 2026

Pathways are written by GP clinical editors with support from local GPs, hospital-based specialists and other subject matter experts



- clear and concise, evidence-based medical advice
- Reduce variation in care
- how to refer to the most appropriate hospital, community health service or allied health provider.
- what services are available to my patients

HealthPathways- Cancer Screening Pathways



Click 'Send Feedback' to add comments and questions about this pathway.

Cervical Screening

Red flags

- Visible suspicious cervical mass

Background

About cervical screening

About cervical screening

- Nearly all cases of cervical cancer are caused by persistent infection with oncogenic subtypes of human papillomavirus (HPV).
- 70 to 80% of cases are associated with HPV 16 and 18.
- The majority of HPV infections are spontaneously cleared but, if persistent, may cause cancerous change over an extended period (usually 10 to 15 years.)
- Cervical cancer is the third most common gynaecological malignancy in Australia, after uterine and ovarian cancer, with an estimated 1030 women diagnosed in 2024. [1]
- More than 70% of women diagnosed with invasive cervical cancer have never been screened or were underscreened. [2]
- The National Cervical Screening Program (NCSP) invites women and people with a cervix aged 25 to 74 years to have a Cervical Screening Test (a primary HPV DNA test with partial genotyping and liquid-based cytology (LBC) triage) every 5 years. HPV testing with partial genotyping allows separate detection of certain high-risk HPV genotypes.
- Patients are managed according to their risk of developing significant cervical abnormalities, which is determined by their HPV test result and subsequent LBC result, if indicated.
- The National Cancer Screening Register has replaced state and territory registers.

Assessment

Breast Cancer Screening

This pathway is about breast screening of asymptomatic patients. See also Breast Symptoms and Suspected Breast Cancer.

Background

About breast cancer screening

About breast cancer screening

Breast cancer is the most common cancer diagnosed in women in Australia (approximately 20,000 new cases per year). One in seven women will be diagnosed with breast cancer in their lifetime.

Breast cancer screening aims to detect cancers early and to improve survival.

- Mammography is proven to be effective in reducing morbidity and mortality in women aged 50 to 74. The efficacy of mammography in other age groups is not proven and there are different risks and benefits of mammography for women aged 40 to 49 and 75 and over.
- Ultrasound is not recommended for breast screening as it has not been proven to reduce breast cancer morbidity and mortality.
- MRI is not recommended as a population screening tool due to its high false positive rate.

BreastScreen: [1]

- provides free 2-yearly screening mammograms for women aged ≥ 40 years with no breast symptoms.
- provides free annual screening for women with increased risk factors.
- does not offer diagnostic mammograms for women with breast symptoms.

For every 1000 women who have a mammogram through BreastScreen, only 6 women will be found to have breast cancer.

For every 1000 women aged 50 to 74 years who attend for a screening mammogram at BreastScreen, 45 will be called back for further tests.

Assessment

HealthPathways – Relevant and Related Pathways

Cervical cancer screening relevant and related pathways

- Cervical Screening
- Women's Health
- Cervical Cancer
- Cervical Polyps
- Gynaecology
- Endometrial Cancer
- Ovarian Cancer – Established
- Ovarian Cancer Follow-up
- Colposcopy Referral

Breast screening

- Benign Breast Lesions
- Breast Cancer - Established
- Breast Cancer Survivorship
- Breast Cancer Screening
- Breast Symptoms and Suspected Breast Cancer

LGBTIQA+ Health

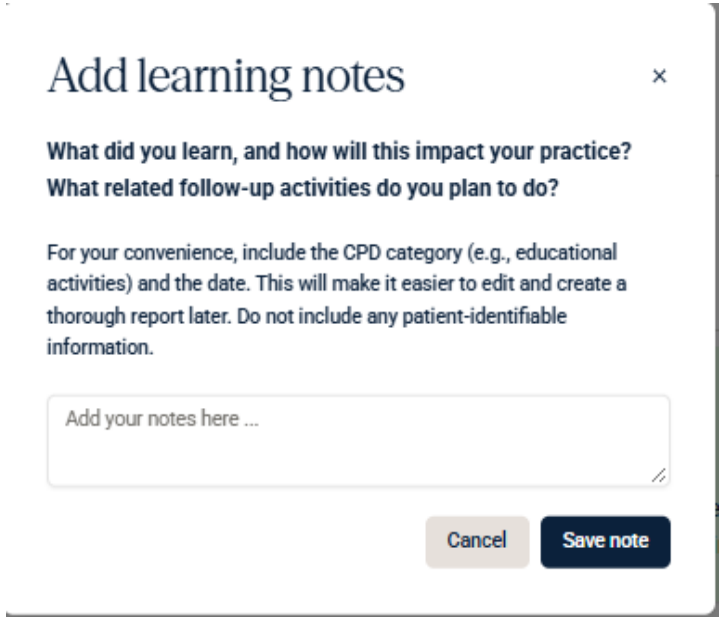
- LGBTIQA+ Overview
- LGBTIQA+ Sexual Health
- LGBTIQA+ Referral
- Transgender Health and Gender Diversity

Record Your CPD Today: Start with HealthPathways



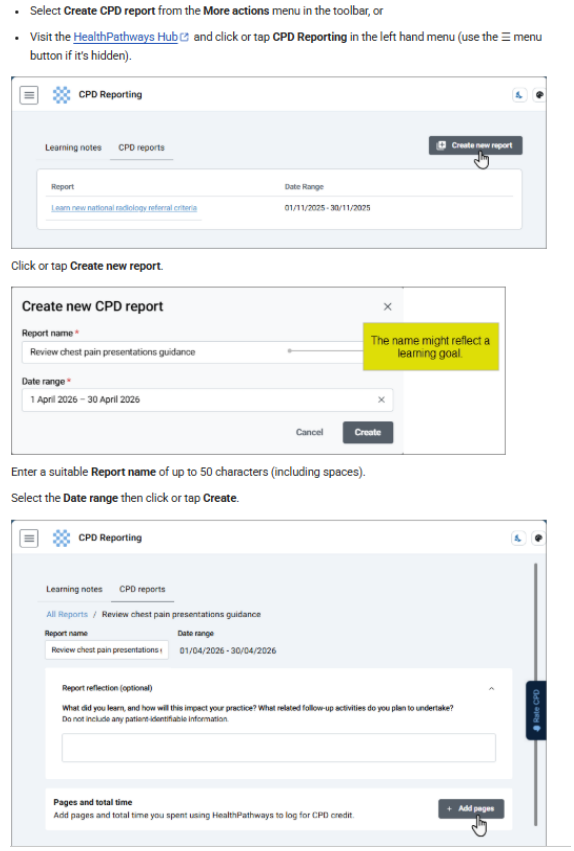
Step 1: Access a Pathway Page

- Navigate to a clinical pathway (e.g., *Psychosis – Established*).
- Click **“Add CPD note”** to begin tracking your CPD activity.



Step 2: Add Learning Notes

- Reflect on what you learned and how it will impact your practice.
- Include any planned follow-up activities.
- These notes are saved to your CPD record.



Step 3: Generate Your CPD Report

- Go to the **CPD Reporting** section.
- Add reflections, review pages, and confirm time spent.
- Export your report as a **PDF for submission**.

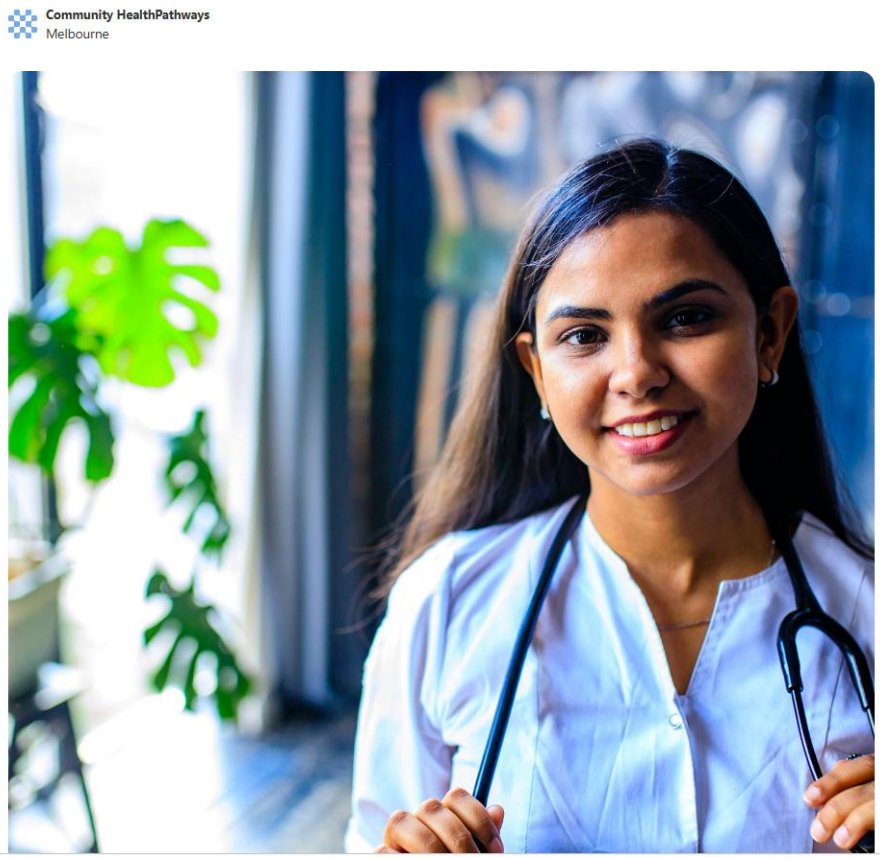
For further information on the CPD reporting tool, please see these videos:

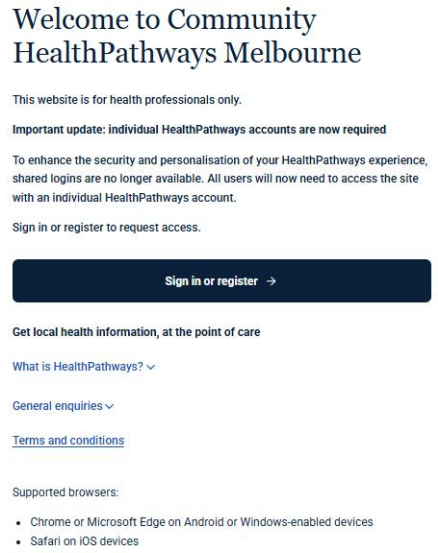
- How to create a CPD report
- How to add learning notes

Access Now: Sign In or Scan to Register

Please click on the **Sign in or register** button to create your individual account or scan the QR code below.

If you have any questions, please email the team info@healthpathwaysmelbourne.org.au





Clinical referral pathways across Southern Alliance PHNs

PHN region	Clinical referral pathway platform	Link
Eastern Melbourne PHN + North Western Melbourne PHN	HealthPathways Melbourne	Open platform
Gippsland PHN	Gippsland Pathways	Open platform
Murray PHN	HealthPathways Murray	Open platform
South Eastern Melbourne PHN	The Clinical and Referral Guidance Hub (the Hub)	Open the Hub
Tasmania PHN (Primary Health Tasmania)	HealthPathways Tasmania	Open platform
Western Victoria PHN	HealthPathways Western Victoria	Open platform
Country SA PHN + Adelaide PHN	HealthPathways South Australia	Open platform

Not sure which PHN applies? Use the Australian Government PHN locator map

HealthPathways Melbourne



melbourne.healthpathways.org.au

Thank you for attending. What's next?

After this session you will receive:

1. *Slides, resources and the recording of this session within the week*
2. *RACGP CPD hours will be uploaded within 14 days.*
3. *Attendance certificate will be received within 4-6 weeks.*

- ***Register for more education sessions here:***
  nwmphn.org.au/resources-events/events
- ***Past education sessions can be found here:***
  nwmphn.org.au/resources-events/resources

Feedback - QR code

We welcome your feedback. Let us know if you got what you needed from this session.