

# “In the second screening round we are very specific.”

The Wiesestrasse Gbr screening centre at Herford, together with the Radiologischen Versorgungszentrum Minden-Löhne (Minden-Löhne radiology centre), is responsible for 75,000 women per screening round in the Herford-Minden-Lübbecke (North Rhine-Westphalia) region. There are also four gynaecologists from the region among the eight team members led by the physician in charge, Dr. Gisela Urban. For the digitalisation of image data, the screening unit in Herford relies on Carestream Health DirectView CR 975 system.



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**Dr. Gisela Urban**, Doctor in Charge of the Screening Unit Herford-Minden-Lübbecke

The Herford-Minden-Lübbecke screening unit started screening on the Herford site in February 2006 and, on the Minden site in June 2006. For this purpose, the doctor in charge, Dr. Gisela Urban, assembled half of her mammography team from the clinics taking part and half from doctors based in the region. There are also four clinic gynaecologists in the team. “This means we do not only have optimum cooperation with the team members, but also with the other practice gynaecologists. They ask their patients to come to us,” says Dr. Gisela Urban, explaining the key to the high acceptance of the screening among the women invited. It was possible to reach a participation rate of a steady 65 per cent as early as the first round. However, the data collection of the doctor in charge has also shown that a third of those 339 women in whom a carcinoma was found in the first round had no female doctor at all. Also, half of those women affected had



never before had a mammography, while, for a further quarter, their last mammography was at least five years ago. "Screening reaches women who would not otherwise go to the doctor," says Dr. Gisela Urban in this connection. "That means that we really are targeting and helping women who pay little attention to their breast health." In order to achieve wider awareness and acceptance of screening among the target group, an unusual but effective measure was taken with regards to publicity. Advertising on shopping trolleys and grocery dividers on supermarket conveyor belts establishes the everyday presence of screening in regional shopping centres. "We went to places by where women between 50 and 70 visit every day - the shops," says Gisela Urban, explaining this simple but ingenious approach. "Grocery dividers are particularly valuable because women pick them up. And then, when the invitation comes, they say, "Screening, yes I know about that. I'll go."

On the other hand, it is difficult to understand why women in the target group are not reached. "We only know which women come, not which don't," says the doctor in charge. "Among women who do not respond to the invitation there are certainly some who either do not care or are frightened of cancer, or do not want to be told what to do and do not come for this reason. But there are also those among them who are entitled to curative mammography or who are cancer patients in follow-up care." According to Dr. Urban's analysis of the data, however, the conclusion is that of those women who were in the first round, a clear majority of nine out of ten women also come back in the second screening round.

This second screening round will be completed in a few months in the Herford-Minden-Lübbecke screening unit, so that work can now be carried out entirely on prior digital images from the screening. "These images were established under absolutely identical conditions, producing the same image quality, so that we have the best possible comparison. This enhances diagnostic certainty," says Dr. Gisela Urban, explaining its significance for interpreting the findings. Among other things this enhanced diagnostic certainty becomes apparent when deciding whether a finding requires further clarification via a biopsy during the assessment. "If, in the second round, we come to the conclusion that further clarification via a biopsy is necessary, then it is relatively more certain



that the woman actually has a carcinoma, than it was in the first round without digital prior images. In the second round we are very specific." This meant that during the core needle biopsy in the first round a benign finding still resulted from two malignant specimens. This rate improved during the second round to a ratio of one (benign) to nine (malignant). It was also possible to reverse the ratio of two benign to one malignant finding for the more difficult to judge vacuum biopsies, so that in the second round only one out of three biopsies still proves to be benign. This improvement in diagnostic certainty in the second round is also evident in lobular carcinomas which are difficult to diagnose. "We were even able to find these in the screening, for instance by comparing the breast architecture and observing unspecific changes such as an increase in density of the glandular tissue and architectural distortions. Attempting to discover these occult carcinomas is one of the major topics of our internal discussions and focus. This requires great skill. Unfortunately these carcinomas

are rarely small when found. For this reason, even after the first round, there will always continue to be larger carcinomas present. One must not be disappointed if this is the case."



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**Dr. Gisela Urban**, Doctor in Charge of the Screening Unit  
Herford-Minden-Lübbecke