Doing Mammography Right: A Specialist Speaks Out

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TOWSON, Maryland—“Mammography is still the gold standard for the screening and diagnosis of breast cancer, but that doesn’t mean it is always done right,” said Gilda Cardenosa, MD, head of breast imaging at the Cleveland Clinic. “There is a lot of bad mammography out there, even with all the regulations that are in place.”

Speaking at the Seeking Excellence in Breast Cancer Care conference sponsored by the Johns Hopkins Medical Institutions, Dr. Cardenosa described in forthright terms what she feels must be done to raise the quality of breast imaging nationwide.

One of the first steps, she said, is to keep clear the distinction between screening and diagnostic mammography. "Screening is done on asymptomatic women," Dr. Cardenosa said. If the physician is in any way concerned about patient symptoms or findings on the physical examination, then the patient should receive a diagnostic, not a screening mammogram.

"Screening is only about detection and perception," she said. If a physician receives a screening mammogram report recommending biopsy, "that is not appropriate," she said. "What is appropriate in such a situation is a simple observation that might note, for instance, a suspicious spot, apparent microcalcifications, or other manifestations."

She decried mammography "boutiques" where, for about $50, a woman can get a basic breast scan but, chances are, inadequate review or interpretation. The best way to look at screening mammograms is not while the patient is waiting on site, she said, although some centers advertise they do this. "They say, "We'll give you an answer right away!" and any responsible radiologist hearing that must wonder, Do they care if the answer is right?"

Dr. Cardenosa said that it is better for the radiology specialist to set aside several hours of quiet time, gather perhaps 50 mammograms, and go through them undisturbed. "During that time, all the viewing professional needs to ask is whether the woman appears to be normal, or if there is something in the mammogram that arouses suspicion," she said.

The interpretation of diagnostic imaging, however, calls for a different mind-frame. "In diagnostic imaging," Dr. Cardenosa said, "I am focused only on one patient, and whether that patient's findings require biopsy or another diagnostic technique."

Who Does the Call Back?

When a screening mammogram does detect something seemingly abnormal, the patient must be called back for further tests. Dr. Cardenosa believes it is better to let the radiology specialist do that directly. "That way, the radiologist can elicit information from the patient, schedule further views and tests appropriate to the situation, and do it quickly," she said.

Physicians often disagree with her. Frequently, she said, she gets a call from a doctor who protests, "You're taking over my patient." Is this the right mind frame? she asked. "If I see something suspicious," Dr. Cardenosa said, "I want to call the patient back.

A Cleveland Clinic study showed that when radiologic reports are referred back to physicians, the result is delay and lower compliance with requests for follow-up. "When the radiology program did not call patients back directly, about 70% had their studies done within a month," she said. "When patients were called directly, that rate rose to 92.2%.

Teamwork Essential

These results suggest that another way to improve mammography is teamwork. "Many institutions talk about how their providers work as a team, but for that to be true, they do actually have to work together and make sure their views of any patient's situation match up," Dr. Cardenosa commented.

She said that the Cleveland Clinic has a radiology call back program in which a secretary trained in patient communication telephones patients within 24 hours of mammogram interpretation.
the patient is reached by phone, an appointment is scheduled, and the referring physician is
e-mailed with specifics of the appointment, she said.

**Radiology and Biopsy**

Dr. Cardenosa also emphasized the importance of adequate mammography before breast biopsy. She said that too often surgeons do not have the right radiologic views or guidance to know where to sample tissue. "Blindly taking patients to surgery does not make sense," she said. She also decried the use of needle aspiration without radiology. "If we blindly aspirate, we're not going to find early breast cancer," she said. "Before we put a needle into anything, let's look at it."

She urged the same approach for nipple discharge, because negative cytology by itself does not rule out the presence of breast cancer. "If the ducts are cut to relieve the discharge, the patient may come back years later with invasive carcinoma," she said. "And if a surgeon does cut and send tissue to the pathologist, is the pathologist going to know where to find the lesion?"

Finally, Dr. Cardenosa urged health care organizations to stop treating mammography as a "loss leader" and the mammography center as an unwanted stepchild. "Nobody wants us around because we lose money," she said. "Third-party payers will also try to ratchet costs down, but like any other specialty, it's costly to do right." She also said that not all radiology centers should perform mammography. "It's a specialty and requires specialists to be done correctly."