

NWT Clinical Practice Information Notice

UPON RECEIPT: (1) PLEASE FOLLOW THE DIRECTIONS BELOW
 (2) FILE THIS NOTICE IN SECTION C, CLINICAL PRACTICE INFORMATION BINDER FOR FUTURE REFERENCE

The following clinical practice has been approved for use in the Northwest Territories Health and Social Services system, and has been distributed to:

Hospitals
 Community Health Centers
 Public Health Units
 Doctors' Offices
 Social Services Offices
 Other: _____

The information contained in this document is a Departmental:

Policy
 Standard
 Protocol
 Procedure
 Guidelines

Title: Breast Cancer Screening Program Guidelines for the NWT (2006)

Effective Date: March 23rd, 2007

Statement of approved clinical practice:

The NWT Breast Health Advisory Committee recommends the use of these 2006 Breast Cancer Screening Program Guidelines. These replace the 1997 guidelines.

Attachment:

- Breast Cancer Screening Program Guidelines for the NWT (2006)

This clinical practice is approved.  23/03/2007

 (signature & date)

Assistant Deputy Minister
 Chief Medical Officer of Health
 Director, Child & Family Services
 Director, Adoptions

**NORTHWEST TERRITORIES
BREAST CANCER
SCREENING PROGRAM
GUIDELINES**

Prepared by:
Breast Health Advisory Committee

December 2006

Table of Contents

1. PURPOSE

2. WHAT IS BREAST CANCER?

- A. Definition**
- B. Risk Factors**

3. PROGRAM FORMAT

4. DETAILS OF A SCREENING PROGRAM

- A. Breast Self-Examination**
- B. Clinical Breast Examination**
- C. Mammography Screening Program**
 - a. Criteria for Eligibility for a Mammography Screening Program**
 - b. Follow-Up Examinations**

5. DIAGNOSTIC WORK-UP OF A BREAST SCREENING ABNORMALITY

- A. Additional Mammography Views**
- B. Breast Ultrasound**
- C. Surgical Consult**

6. EDUCATION

APPENDICES

- A. NWT PROTOCOL & PROCEDURE FOR BREAST EXAMINATION (Self & Clinical)**
- B. MAMMOGRAPHY SERVICES IN THE NWT – JUNE 2005**
- C. VOLUNTEER AGENCIES & ASSOCIATED CHARITABLE GROUPS CONTACT INFORMATION**
- D. REFERENCES**

1. PURPOSE

The NWT Breast Cancer Screening Program Guidelines have been developed to aid in the earlier detection of breast cancer. The aim of these program guidelines is to reduce the number of deaths directly related to breast cancer by detecting it as early as possible. The earlier breast cancer is detected, the less likely the chance of dying from the disease.

2. WHAT IS BREAST CANCER?

A. Definition

Among Canadian women, breast cancer is the form of cancer most often diagnosed, and it ranks second after lung cancer as the leading cause of cancer deaths. It strikes more than 21,200 Canadian women each year, and is responsible for more than 5,200 deaths each year. In the NWT, breast cancer is the most commonly diagnosed cancer in women, with mortality rates similar to national rates.

Breast cancer is a malignant tumour found in the breast. Locally it spreads into the surrounding breast tissue. Like other malignant tumours, it can also spread to distant sites via the lymphatic system, and the blood stream. Common areas of metastasis from breast cancer include bone, lung, liver and brain; however any area of the body may become involved. Death usually results from the devastation of distant metastases.

B. Risk Factors

By far, the greatest risk factors for the development of breast cancer are being female (with only 1% of breast cancers occur in males), and getting older. The risk of developing breast cancer increases with each decade of life. By the time a woman reaches the age of 85, she will have a 1-in-9 chance of developing breast cancer.

According to the NWT Department of Health and Social Services document titled “Cancer in the Northwest Territories 1990-2000 – A Descriptive Report”, breast cancer accounts for 22.2% of all cancers diagnosed in the Inuit population and 23.5% of all cancers diagnosed in the Dene population. The percentage in the Non-aboriginal/Metis population is 31.4% of all cancers diagnosed.

Although the cause(s) of breast cancer are still unknown, studies of large numbers of women with the disease have identified a number of risk factors, which seem to increase the chances of developing breast cancer.

The following table shows the risk factors from strong to weak.

Risk Factors Associated with the Development of Breast Cancer		
Strong (Risk greater than 4 x normal)	Moderate (Risk greater than 2-4x normal)	Weak (Risk greater than 1-2x normal)
Female Sex	Over 30 years old at birth of first child	First menses before the age of 12 years.
Advancing Age	Past breast biopsy: any sign of cell abnormality or hyperplasia	Menopause after the age of 54 years
Previous Cancer in one breast (especially lobular carcinoma)	Postmenopausal obesity	Family history of breast cancer: older, postmenopausal
Family history of breast cancer †: Pre-menopausal or in both breast	Diet (possibly)	Prolonged hormone use (e.g. estrogen, progesterone)
Past breast biopsy showing severely abnormal cells and hyperplasia		Moderate (3-4 drinks/day) to heavy (5 or more drinks/day) alcohol consumption
		Certain ethnic origins

† Strong family history of breast cancer in first-degree relatives, i.e. mother, sister, daughter, father, brother, son.

*This Table can be found in the following reference: “Intelligent Patient Guide to Breast Cancer – 3rd Edition” page 23.

Additional factors that may increase a woman’s risk of developing breast cancer that are not mentioned in the above table are:

- ◆ Diet, Exercise, & Obesity. Even a small degree of excess weight, 5kg. (11lbs. and greater) is associated with increased breast cancer risk, especially among post-menopausal women. Studies show that even moderate physical activity at least 30 minutes on 5 or more days of the week may reduce a woman’s risk by 30 to 40 percent.
- ◆ Family and/or personal history of ovarian, uterine, or colorectal cancer.
- ◆ Very dense breast tissue (more than 75%). Dense breast tissue is fibrous breast tissue that contains nodularities and linear densities that appear “white” on a mammogram similar to the appearance of breast cancer. The sensitivity of a mammogram and clinical breast examination can be decreased in women with this amount of dense breast tissue and therefore may require adjunctive screening tests such as ultrasound, magnetic resonance imaging, or computerized tomography imaging. Approximately 15-17% of women have more than 75 % very dense breast tissue.

- ◆ Smoking. There is some recent evidence that, at least in certain high risk groups, breast cancer incidence risk can increase up to 5 times in women who smoke.

Approximately 75% of women who develop breast cancer have NONE of the above risks, other than being female and growing older. This is why a proper breast screening program is so important.

3. PROGRAM FORMAT

In the context of enhancing women's health, a comprehensive Breast Cancer Screening Program should consist of the following:

- ◆ Breast self-examination (BSE) instructed by a specifically trained healthcare professional, beginning at adolescence and promoted throughout a woman's lifetime.
- ◆ Clinical breast examination (CBE), done by a specifically trained healthcare professional, conducted yearly from the mid-twenties onward.
- ◆ Screening mammography every two years for women aged 50 - 69, and for women ages 70 and over who wish to be screened.
- ◆ Screening mammography every year for women aged 50-69 who are in a high-risk category and have very dense breast tissue.
- ◆ Screening mammography every year for women aged 40 – 49 years who are in a higher risk category and those women who wish to begin screening in this age group.

*The ability to further investigate abnormalities detected by mammography examinations, CBE & BSE **must** be accessible.*

4. DETAILS OF A SCREENING PROGRAM

A Breast Screening Program includes three modalities, all of which are important.

A. Breast Self-Examination (BSE)

Women should be instructed to perform BSE by a specifically trained healthcare professional in accordance to the NWT Protocol (see Appendix A). BSE should be done on a regular basis, beginning in adolescence, and continuing throughout the woman's lifetime. There is not yet research data proving that BSE can reduce deaths from breast cancer, however encouraging women to be aware of their own bodies enables them to identify abnormal changes early. As many as 80% of women with breast cancer are the first to identify a breast abnormality.

The NWT produced breast health training video, “In Your Hands” and the NWT developed BSE pamphlet, “You are Worth It” are currently available to all health centres, screening centres and physicians offices through the NWT Breast Health/Breast Cancer Action Group. Particular attention needs to be paid to having culturally-based and appropriate health promotion strategies that encourage participation of aboriginal women. Education sessions for healthcare professionals, including Train-the-Trainer programs, should be made available to teach both BSE and CBE.

B. Clinical Breast Examination (CBE)

Clinical Breast Examination (CBE) is a physical examination of the breasts, by a specifically trained healthcare professional in accordance to the NWT Protocol (see Appendix A). It should be done on a yearly basis as a part of the Well-Woman Check-up, beginning by the mid twenties, and more frequently in high-risk women (every 6 months). CBE is complementary to mammography and BSE but it is not sufficient, in itself, for the early detection of breast cancer.

C. Screening Mammography

Screening mammography is a safe, specialized x-ray examination of the breasts. It consists of two views of each breast with low dose radiation, and is used to find non-palpable abnormalities in the breast. The ideal is to find lesions while they are still less than 0.9 cm in diameter. About 90% of lesions this size will not have metastasised to the regional lymph nodes. For a screening mammography program to be effective (i.e. to reduce deaths from breast cancer) screening **MUST** be done regularly, by an accredited fixed or mobile facility. A trained mammographer takes the x-ray images of the breasts. The x-rays are then interpreted and reported by a qualified screening radiologist.

A centralized database should be maintained with reports being sent to all Health Authorities, the Department of Health & Social Services and the Cancer Registry of the NWT. These reports should reflect the participation rate of the target population and the outcomes for the clients from each Authority, yet always maintaining the clients rights to privacy.

The centralized database should also generate reports for each physician/health centre that would contain such information as the number of women they have referred for screening and the number who have named them as their family physician/health centre. A result letter and subsequent re-call letters should be sent to the women who are enrolled in a screening program. This would ensure that appropriate opportunities are taken to have regular screening done.

Mammography may not detect all breast cancers - up to 10% of breast cancers may be missed. This highlights the importance of CBE and BSE as being complementary to mammography. Any palpable lump should be subjected to a diagnostic mammographic examination.

a. Criteria for Eligibility for a Mammography Screening Program

1. **Age Eligibility:**
 - All eligible women aged between 50 and 69 years should have mammographic screening.
 - Women aged 40 to 49 years who are considered high risk for developing breast cancer or who wish to begin routine screening.
 - Women aged 70 years and older should be retained in the mammography screening program if they so desire. Re-call notices should be sent to the family physician for the women in this age group so that the benefits of screening mammography, when considering other health concerns, may be assessed on an individual basis.
 - Women under the age of 40 should be offered screening mammography only after a case-by-case review by the Medical Director of a Screening Program.
2. Women who are **asymptomatic** (women who do not have any breast symptoms).
3. Women who **do not have a personal history of breast cancer**.
4. Women who **do not have Breast Augmentation (implants)**, as these women often require more than two-view mammography.
5. Women who **have not had a mammogram within the past year**.
6. Women who are pregnant and women who are breast-feeding **are not eligible** for a mammography screening program. A woman may enter a program after 3 months cessation of breast-feeding.

b. Follow-Up Examinations

1. Frequency of follow-up examinations will be based on results from previous screening mammograms.
2. Follow up screening will be normally recommended every two years *in all women over the age of 50*.
3. Women in the 40 to 49 years age group will be recommended to have yearly screening. This recommendation is made as the majority of breast cancers are more aggressive and grow faster if the body is still producing pre-menopausal levels of estrogen. Many women aged 40 to 49 are still experiencing regular menstrual cycles therefore they have higher levels of estrogen than those women that have experienced menopause.

Thus, yearly screening is recommended in order to be able to diagnosis a breast cancer at the earliest possible stage.

Yearly screening is also recommended for women over 50 that present with high risk factors.

4. Eligible women, who have not had a screening mammogram within 2 - 3 years, should be contacted and encouraged to continue with regular screening.
5. Regular recall notices for annual/bi-annual mammography, when appropriate, should be sent to the woman and/or her family physician or health centre once enrolled in a program.

5. DIAGNOSTIC FOLLOW UP OF A SCREEN-DETECTED ABNORMALITY

The Breast Cancer Screening Program must investigate, diagnose and refer any detected abnormality. The following is a list of possible diagnostic follow-up examinations that may be available in the NWT:

A. Additional Mammography Views – such as coned compressed views and magnification views.

Coned compressed views are used to minimize superimposition of adjacent breast tissue or to “spread out” the breast tissue by applying compression to a specific area as opposed to the entire breast and magnification views. Magnification views are used to improve the visualization of micro-calcifications and to better view borders of irregular masses.

B. Breast Ultrasound - to determine if a lesion is cystic, solid or mixed.

C. Surgical Consult - The accessibility of a specialized surgeon for consultation is imperative.

He/she will be the person who will arrange or perform a biopsy if necessary. This would be done after consultation with the screening radiologist if the abnormality were found via screening mammogram or with the patient’s family physician/healthcare provider if the abnormality is found via CBE or BSE. The surgeon would also be responsible for the follow up from any procedure.

Types of biopsies would include:

- ◆ Fine needle aspiration biopsy (F.N.A.) – procedure done for suspicious lesions, under ultrasound, mammographic stereo-tactic guidance or by palpation if the lesion is palpable.
- ◆ Large Core Needle Biopsy - procedure done on suspicious lesions under local anaesthetic by use of ultrasound, mammographic stereo-tactic guidance or by palpation if the lesion is palpable.

- ◆ Pre-open biopsy needle/wire localization - for all suspicious micro calcifications, radial scars, areas of abnormal architecture, and solid non-palpable lesions where FNA or core biopsy is not feasible or successful. This type of biopsy may also be done after a large core biopsy or FNA has confirmed that an abnormality is indeed cancerous but is not palpable. The wire localization provides a type of road map during open biopsy to enable the surgeon to remove the cancerous tissue with minimal removal of healthy breast tissue. This can be performed under ultrasound or mammographic stereo-tactic guidance, with or without local anaesthetic.

Other types of breast biopsies include Sentinel Node Biopsy, Magnetic Resonance Imaging (MRI) Guided Biopsy and Computerized Tomography (CT) Guided Biopsy. The last two modalities are used in very difficult and challenging cases. None of these three modalities are available in the NWT.

6. EDUCATION

Education is the key to a successful Breast Screening Program.

1. Healthcare professionals must be fully aware of the program, and its importance, so they can make informed recommendations to their patients. These individuals are the backbone of a successful program. Enthusiastic recommendation to be screened coming from primary care providers is a strong predictor of participation.
2. Specifically trained healthcare professionals should be teaching BSE and performing CBE and must be given the opportunity to learn or upgrade these skills through professional training.
3. Pamphlets, videos, and literature on Breast Screening must be made available in physician offices, health centres and public health units.
4. Public information sessions should be offered on a regular basis.
5. Volunteer agencies and associated charitable groups should be encouraged to become involved in the program, e.g. The Canadian Cancer Society, Canadian Breast Cancer Foundation, NWT Breast Health/Breast Cancer Action Group, Stanton Territorial Hospital Foundation and various territorial and community level women's' associations.
6. Information and educational tools for the public and healthcare professionals of the NWT should be created using these guidelines as a reference.

APPENDIX A

NWT PROTOCOL & PROCEDURE FOR BREAST EXAMINATION (Self & Clinical)

Onset:

- Clinical breast examination (CBE) offered and performed by a health professional annually beginning in the mid-twenties.¹
- Instruction in and promoting of monthly breast self examination (BSE) beginning in adolescence following menarche and coinciding with the first Well Woman Exam.²

Frequency: Yearly throughout the woman's life – that is, one year from the last visit.

PROCEDURE FOR CLINICAL BREAST EXAMINATION (CBE)³:

- If the woman presents with a breast health concern, have the woman complete a breast health screening form (sample of form attached).
- In reviewing the history, health professional specifically asks:
 1. Do you examine your breasts regularly? If so, have you found any changes in your breasts that you are concerned about today?
 2. Have you experienced any previous breast health concerns or disease? Obtain specific details of significant symptoms, severity, duration and influence of menstrual cycle.
 3. Have you or any member of your immediate family (mother, daughter, sister) been diagnosed with breast or ovarian cancer?
- Note: The breast health screening form may be useful for teaching purposes.
- Offer to examine the client's breasts as part of health assessment. If she refuses, explain the importance of having a nurse or family physician perform annual clinical breast exams. The exam may be done prior to the pelvic exam or immediately following it.
- The area to be examined includes from top of clavicle to 2 fingerbreadths below breast from mid-chest to mid-axillary line on each side.

<p>1. Sitting Position, middle of exam table, disrobed to waist.</p>

Procedure/Techniques

- **Inspect breast, areola, and nipple and chest area**, both sides from front and side.
 - **Inspect axillae.**
 - **Palpate axillary lymph nodes.**
 - **Palpate infraclavicular lymph nodes.**
 - **Palpate supraclavicular lymph notes.**
- Observe for abnormalities from front & then both sides:
 1. With arms at side, both hands placed on thighs.
 2. With arms raised above head and both hands placed at the back of her head.
 3. With palms pressed against hips OR with hands squeezed together at chin level.
 - With arms raised above head, inspect skin of axillae.
 - With arms lowered, support client's left hand and wrist with left hand to examine left axilla. Cup fingers together. Reach as high as possible into axilla and make small circular movements. Repeat using reverse procedure for right axilla.
 1. Bring fingers down over ribs; feel for central nodes.
 2. Feel inside anterior axillary folds for pectoral nodes.
 3. Feel inside posterior axillary folds for subscapular nodes.
 4. Feel against humerus for lateral nodes.
 - Palpate 1st interspace with finger pads bilaterally.
 - Palpate above clavicle with finger pads bilaterally.

Sitting Position, continued

- Palpate breasts:
 - a) **glandular tissue**
 - b) **areaolar tissue**
 - c) **nipple**
 - d) **Tail of Spence**

Procedure/Techniques

- Palpate using Grid Method bilaterally:
 1. Ask client to move arm away from chest on side being examined & place arm on thigh on same side.
 2. Use flats of middle 3 fingers, in a circular motion to compress breast tissue against chest wall.
 3. Flex from the wrist, not the fingers.
 4. Apply moderate pressure, keeping constant contact with skin.
 5. Starting at the top midline, move back and forth across the breast in straight lines, making constant small circles.
 6. Slide hand down 1 finger width for each pass.
 7. Cover from top of clavicle to 2 fingerbreadths below breast from mid-chest to mid-axillary line.

Supine Position, with small pillow under client's shoulder on the side being examined.

- Arm on side being examined raised with arm placed behind her head.
- Repeat palpation as for sitting position

Explain the results of examination to client, and remind of next recall examination in accordance with NWT Breast Cancer Screening Guidelines.

PROCEDURE FOR TEACHING BREAST SELF-EXAMINATION (BSE)

Teach BSE while performing a clinical breast exam. If not possible, have the client examine herself in your presence as you direct her through the following steps:

Lying Down Check:

Procedure/Techniques

- With arm raised above head, place a pillow under that shoulder and use the opposite hand to examine with finger pads, not fingertips.
- Instruct in the Grid Method, steps 1-7 above.
- Using the opposite hand, repeat on other breast.

Visual Check:

- Stand in front of the mirror, arms at sides and look at each breast carefully. Lift arms above head and behind ears, looking for changes. Large breasts may need to be lifted up.
- Turn slowly and look at side view of the breast; slowly turn to other side and look at side view of the other breast.
- With hands outstretched overhead, bend forward at the waist and observe both breasts to see if they fall easily away from the chest.
- Lower hands to chin level and squeeze palms together.

Sitting Check: Palpation of Axillary Lymph Nodes

- Put left hand on left hip and relax the arm, place fingers of right hand in armpit and make smaller circular movements across the entire area under the armpit. Repeat for the right side.

- **Provide BSE pamphlet for reference.**
- **Remind woman to do BSE on the same day once a month if menopausal, OR one week after the monthly period begins, if menstruating.**

Documentation and Referral

If no abnormalities are found:

- Document findings on the progress notes.
- Refer for screening mammogram according to eligibility criteria for screening program and follow-up examinations in the NWT Breast Cancer Screening Guidelines.

If there are concerns from the history or physical exam, document the following:

- A description of all significant findings: size, shape of discrete masses, location (e.g., 2 o'clock position, R breast), consistency and mobility.
- Complete a referral form and refer:
 - a) for mammogram, and
 - b) to a family physician or surgeon for further follow up.

Note: Any woman with a family history of more than two first-degree relatives with breast cancer, or a woman who has had previous breast surgery or procedures will be referred to a physician or community health nurse if not already being followed.

References and Explanation Notes

1. This is in accordance with the NWT Breast Cancer Screening Guidelines (December 1997).
2. This is in accordance with the NWT Breast Cancer Screening Guidelines (December 1997).
3. Adapted from Alberta Medical Association, Clinical Practice Guideline for Early Detection of Breast Cancer, Appendix 2, Clinical Breast Examination. Retrieved June 12, 2001 from <http://www.amda.ab.ca/cpg/>

APPENDIX B

MAMMOGRAPHY SERVICES IN THE NWT – SEPTEMBER 2005

- Stanton Territorial Hospital (STH) in Yellowknife offers screening services and diagnostic follow-up services that include additional mammographic views, breast ultrasound, ultrasound-guided and mammography-guided large core biopsy and fine needle aspiration biopsy, and open or surgical biopsy.
- The Inuvik Regional Hospital provides screening mammograms on a limited basis. The facility has the capability of performing additional mammographic views and breast ultrasound.
- Screen Test Alberta provides mobile mammography screening service to the communities of Hay River and Ft. Smith on a year-to-year contract basis. All follow-up examinations post-screen are referred to Yellowknife.

APPENDIX C

VOLUNTEER AGENCIES / CHARITIBLE GROUPS CONTACT INFORMATION

Canadian Cancer Society
Alberta/NWT Division
3rd Floor, Graham Bromley Bldg.,
Box 2007, Yellowknife, N.T.
X1A 2P5
Local Number: (867) 920-4428
Toll Free Number: 1-888-939-3333
Aboriginal Languages
Information Service: 1-888-261-4673
Website: www.cancer.ca

Canadian Breast Cancer Foundation
Alberta/NWT Chapter
#345, 10909 Jasper Avenue
Edmonton, AB
T5J 3L9
Number: (780) 451-1166
Toll Free Number: 1-866-302-2223
Website: www.cbcbalberta.org

NWT Breast Health/
Breast Cancer Action Group
2 Heal Ct.
Yellowknife, NT
X1A 3H6
Number: (867) 873-8221
Email: trudel2@internorth.com
Website: www.breasthealthnwt.ca

Stanton Territorial Hospital Foundation
Main Floor, Diamond Plaza
#102-5204 50th Ave.
Yellowknife, NT X1A 1E2
Number: (867) 669-7382
Website: www.srhb.org

Canadian Breast Cancer Network (CBCN)
602-331 Cooper St.
Ottawa, ON K2P 0G5
Number: (613) 230-3044
Fax: (613) 230-4424
E-mail: cbcn@cbcn.ca
Website: www.cbcn.ca

Willow Breast Cancer Support
& Resource Services
785 Queen St. East,
Toronto, ON
M4M 1H5
Toll Free Number: 1-888-778-3100
Website: www.willow.org

APPENDIX D

REFERENCES

1. “Quality Determinants of Organized Breast Cancer Screening Programs in Canada”, Canadian Breast Cancer Screening Initiative (CBCSI): Report of the Quality Determinants Working Group. Health Canada. 2003
2. Internet Sites:
<http://www.mtsinai.on.ca/FamMedGen/Disorders/breastcancer.htm>
http://www.med.umich.edu/1libr/aha/aha_resect_crs.htm
<http://www.medscape.com/server-jav> (breast cancer and smoking)
http://opd.od.nih.gov/consensus/st...ts/ede/103/103_stmt.html
(Breast Screening for Women Ages 40 - 49)
http://www.hc-sc.gc.ca/english/iyh/diseases/breast_cancer.html
<http://www.ahrq.gov/clinic/3rduspstf/breastcancer/brcanrr.htm>
<http://www.cancer.ca/ccs/internet>
<http://www.uptodate.com> “Screening for Breast Cancer”. Suzanne W. Fletcher, MD:
UpToDate: Vol.12 No.1 pgs. 1-7 and “Screening for Breast Cancer-II”.
Suzanne W. Fletcher, MD: UpToDate: Vol.12 No.1 pgs.1-7
3. “Cancer in the Northwest Territories 1990-2000 – A Descriptive Report”. Department of Health and Social Services. Yellowknife, NT. February 2004.
4. “Organized Breast Cancer Screening Programs in Canada: 1999-2000 Report”. Canadian Breast Cancer Screening Initiative (CBCSI). Health Canada. Ottawa. 2003
5. “Canadian Cancer Statistics 2004”. Canadian Cancer Society, National Cancer Institute of Canada, Statistics Canada, Provincial/Territorial Cancer Registries, Health Canada. April 2004.
6. “Guidelines for Monitoring Breast Cancer Screening Program Performance”, Canadian Breast Cancer Screening Initiative (CBCSI): Report from the Evaluation Indicators Working Group. Health Canada. 2002.
7. “Mammography service screening and mortality in breast cancer patients: a 20-year follow-up before and after introduction of screening”. Laslo Tabar, Ming-Fang Yen, Berich Vitak, Hsiu-His Tony Chen, Robert A. Smith, Stephen W. Duffy. *Lancet*. 2003; **361**: 1405-10.

8. "Screening Mammography Under Age 50". Karen Antman, MD, Steven Shea, MD. The Journal of American Medical Association. 1999; **281**: 1470-1472.
9. "Continuing Screening Mammography in Women Aged 70 to 70 Years-Impact on Life Expectancy and Cost-effectiveness". Karla Kerlikowske, MD, Peter Salzman, MD, Kathryn A. Phillips, PhD, Jane A. Cauley, DrPH, Steve R. Cummings, MD. The Journal of American Medical Association. 1999;**282**: 2156-2163.
10. "Breast Self-Examination – Does not prevent deaths due to breast cancer, but breast awareness is still important". Joan Austoker. British Medical Journal-USA. 2003: **Volume 3**: 167-169.
11. "Preventative health care, 2001 update: Should women be routinely taught breast self-examination to screen for breast cancer?". Nancy Baxter & The Canadian Task Force on Preventative Health Care. Canadian Medical Association Journal. 2001: **164(13)**: 1837-1845.
12. "Balancing Mammography's Benefits and Harms – Are we over-diagnosing breast cancer?". Joshua J. Fenton, Joann G. Elmore. British Medical Journal. 2004: **328**: 301-305.
13. "The Canadian Consensus Conference on Menopause and Osteoporosis 2000-2001". Journal of the Society of Obstetricians and Gynaecologists of Canada. 2001: 1-86.
14. "Breast patterns as an index of risk of developing breast cancer". J. N. Wolfe. American Journal of Roentgenol. 1976: **126**: 1130-1139.
15. "Quantitative classification of mammographic densities and breast cancer risk: results from the Canadian National Breast Screening Study". N. F. Boyd, J. W. Byng, E.K.Fishell et al. Journal of National Cancer Institute. 1995: **87**: 670-675.
16. "The Handbook of Mammography 3rd Edition". Shirley M. Long. Edmonton, Canada. 1994.
17. "Teaching Course in Diagnostic Breast Imaging – Diagnosis and In-depth Differential Diagnosis of Breast Diseases". Laszlo Tabar, M.D. Falun, Sweden. 2002.
18. "Intelligent Patient Guide to Breast Cancer - 3rd Edition". Ivo Olivotto, MD, Karen Gelmon, MD, & Urve Kuusk, MD. Vancouver, Canada. 2001.
19. "Randomised controlled trial of mammographic screening in women from age 40: predicted mortality based on surrogate outcome measures". S. Moss, M. Waller, TJ Anderson and H. Cuckle (writing committee) for the Trial Management Group. British Journal of Cancer 2005: **92**: 955-960.