Breast Cancer is the commonest cancer in Hong Kong. According to data from the Hong Kong Cancer Registry in 2006, the lifetime risk of developing invasive breast cancer was 1 in 20 Hong Kong women. Breast cancer screening is of paramount importance in health maintenance. As stated by the National Cancer Institute in 2007, breast screening has significantly contributed to the 23.5% decline in breast cancer mortality from 1990 to 2000.1

However, controversy remains about some aspects of breast cancer screening. Recent studies and recommendations have questioned the appropriate age group to screen, the best interval between examinations, and the usefulness of other screening tools, e.g., MRI, digital mammography, etc.

Self Breast Examination

Women are often advised to perform self breast examination (SBE), but most do not perform it regularly or in the correct way. A Cochrane review concluded that SBE has no beneficial effect and actually increases the number of biopsies.2 The US Preventive Services Task Force (USPSTF) also found insufficient evidence to support SBE. Therefore, women should be informed of the facts about SBE. If women choose to perform SBE, a physician should provide training in the appropriate technique and timing of SBE to improve the chance of finding a breast lesion.

Clinical Breast Examination

Clinical breast examination (CBE) is generally recommended as part of regular health checks. A systematic review concluded that the overall sensitivity of CBE was approximately 54% (95% CI 48%–60%) and the specificity was 94% (95% CI 90%–97%).3 The American Cancer Society published a comprehensive review of the literature on CBE and provided a detailed recommendation on the best method. They stated that it should take between 6 to 8 minutes to perform a CBE for the average woman.4 Although some randomized trials found the combination of mammography and CBE did not reduce breast cancer mortality compared with mammography alone,4 the independent contribution of CBE is difficult to determine because of the lack of standardization of the technique. Physicians are encouraged to follow the latest guidelines and recommendations regarding technique when performing the breast screening examination to maximize the potential of finding any lesions.

Screening Mammogram

The primary method used to screen for breast cancer is mammography. Nine large clinical trials have established the efficacy of the screening mammogram after 10 to 20 years follow-up.6

<table>
<thead>
<tr>
<th>Study</th>
<th>Location</th>
<th>Year Initiated</th>
<th>Age at Entry, Years</th>
<th>Screening Interval, Months</th>
<th>CBE Follow-up, Years</th>
<th>RR (95% CI) for BC Mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIP</td>
<td>New York</td>
<td>1963</td>
<td>40-64</td>
<td>12</td>
<td>Yes</td>
<td>18</td>
</tr>
<tr>
<td>Malmö</td>
<td>Sweden</td>
<td>1976</td>
<td>63-70</td>
<td>18-24</td>
<td>No</td>
<td>19</td>
</tr>
<tr>
<td>Two County</td>
<td>Sweden</td>
<td>1976</td>
<td>40-74</td>
<td>24</td>
<td>No</td>
<td>20</td>
</tr>
<tr>
<td>Edinburgh</td>
<td>Scotland</td>
<td>1978</td>
<td>65-64</td>
<td>24</td>
<td>Yes</td>
<td>14</td>
</tr>
<tr>
<td>CNBSS 1</td>
<td>Canada</td>
<td>1980</td>
<td>50-59</td>
<td>12</td>
<td>Yes</td>
<td>13</td>
</tr>
<tr>
<td>CNBSS 2</td>
<td>Canada</td>
<td>1980</td>
<td>40-49</td>
<td>12</td>
<td>Yes</td>
<td>13</td>
</tr>
<tr>
<td>Stockholms</td>
<td>Sweden</td>
<td>1991</td>
<td>40-64</td>
<td>12-20</td>
<td>No</td>
<td>15</td>
</tr>
<tr>
<td>Age trial</td>
<td>United Kingdom</td>
<td>1991</td>
<td>39-59</td>
<td>10</td>
<td>No</td>
<td>11</td>
</tr>
</tbody>
</table>

BC, breast cancer; CBE, clinical breast examination; CI, confidence interval; CNBSS, Canadian National Breast Screening Study; HIP, Health Insurance Plan of New York; RR, relative risk.
(Table 1). The results have been summarized in systematic reviews and meta-analyses. Recent meta-analyses estimate that the reduction in breast cancer mortality 10 to 15 years after initiation of mammography screening is 23%. Many major organizations still recommended mammography screening to the public, although there are variations in the target age group and the time interval recommended. In general, women aged between 50 to 69 years are advised to have a mammogram every 1 to 2 years (Table 2).

### Screening for Women Aged 40 to 49 Years
There is no consensus on the value of mammography screening for women aged between 40 and 49 years. The incidence of breast cancer is lower and mammograms are less sensitive in this age group. The AGE trial randomized 160,291 women aged 39 to 41 years to annual mammography until the age of 48 years. The overall compliance with mammography was about 70%. After more than 10 years of follow-up, the relative risk for breast cancer mortality was 0.83 (95% CI 0.66–1.04), which was a statistically insignificant reduction in mortality. People argue that given the available data and the potential harm from false-positive results, radiation exposure and pain during the mammogram, we should tailor the decision on the basis of women’s preferences and their risk for breast cancer.

### Digital Mammography
Full-field digital mammography captures the image of the breast digitally. It may improve the signal to noise ratio of radiographic detection and their risk for breast cancer. Radiation exposure and pain during the mammogram, we should tailor the decision to screen women on the basis of women’s preferences and their risk for breast cancer.

### Magnetic Resonance Imaging
MRI has been studied extensively as a breast cancer screening tool for high-risk patients. However, there is no study demonstrating that MRI can reduce the risk of death from breast cancer or improve survival. The sensitivity of MRI is at least double that of mammography, ranging from 32% to 40%. However the specificity of MRI ranges from 81–97%, which is lower than mammography (93% to 99%). The lower specificity means more false-positive results and more biopsy procedures. Before further data become available, screening by MRI should be limited to high-risk patients, such as BRCA mutation carriers.

### Ultrasonography
At this time, there is no major study to support the use of ultrasound screening. One large prospective trial in high-risk women with dense breasts showed that the sensitivity of breast ultrasound was identical to mammography, but the specificity was lower.

### Summary
Mammography screening does reduce breast cancer mortality. Because of the variation in benefits and harms associated with mammography screening, we should tailor the decision on the basis of women’s preferences and their risk of breast cancer.

### Recommendations for Breast Cancer Screening in Average Risk Women

<table>
<thead>
<tr>
<th>Screening Modality</th>
<th>US Preventive Services Task Force (USPSTF)</th>
<th>Canadian Task Force on the Periodic Health Examination (CTFPH)</th>
<th>American Cancer Society (ACS)</th>
<th>National Cancer Institute (NCI)</th>
<th>International Agency for Research on Cancer (IARC)</th>
<th>United Kingdom</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mammography</td>
<td>40–49 years: Every 1–2 years, insufficient evidence</td>
<td>Annual</td>
<td>Every 1–2 years</td>
<td>Insufficient evidence</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>50–69 years</td>
<td>Every 1–2 years</td>
<td>Annual</td>
<td>Annual</td>
<td>Every 1–2 years</td>
<td>Every 1–2 years</td>
<td>Every 3 years</td>
</tr>
<tr>
<td>70 years or older</td>
<td>Every 1–2 years (with mammography)</td>
<td>Annual</td>
<td>Annual</td>
<td>Every 1–2 years</td>
<td>Insufficient evidence</td>
<td>0</td>
</tr>
<tr>
<td>Clinical breast examination</td>
<td>Optional every 1–2 years (with mammography)</td>
<td>Annual</td>
<td>Annual</td>
<td>Every 1–2 years</td>
<td>Insufficient evidence</td>
<td>0</td>
</tr>
<tr>
<td>Breast self-examination</td>
<td>Optional</td>
<td>Recommended against</td>
<td>Optional</td>
<td>No recommendation</td>
<td>Insufficient evidence</td>
<td>Recommended against</td>
</tr>
</tbody>
</table>

References
In this issue, I wish to share with you the story of our EEU. If endoscopy is one of the most rapidly growing services in HKBH, endosonography is one of the leading among private hospitals in Hong Kong.

**Workload**

The number of endoscopic procedures performed in the HKBH increased by nearly threefold in 6 years, from just over 9,000 in 2003 to nearly 26,000 in 2009.

**Facilities and Equipment**

The new EEU at 1/F Block A opened in December 2008 has 8 procedure rooms, including one with negative pressure for bronchoscopy, and one that is lead lined for ERCP and procedures requiring X-ray screening. The equipment is also notable:

- All rooms are equipped with the latest model of high-definition video endoscopy system and advanced narrow band imaging (NBI) system for detection of early gastrointestinal cancer.
- We have a single balloon enteroscopy system for difficult small bowel diseases, and the latest capsule endoscopy system for non-invasive oesophageal, small bowel and colonic examination.
- Our Endoscopic Ultrasonography System (EUS) is probably the most advanced in Asia.
- The Endocapture Reporting System, the first in Asia, is one of the best in Hong Kong.

**Recent Improvement**

- Normal service and normal charge extended to cover Sunday since March 2004.
- Offered 24-hour emergency on-call service since January 2008.
- Provide experienced endoscopy nurse to assist colonoscopy and therapeutic endoscopy procedures in main Operating Theatre.
- Revised information pamphlets on seven common endoscopic procedures to facilitate patients’ understanding of the procedures and the signing of informed consent.
- A Forum with Doctor-Endoscopists was held on November 4, 2009 to enhance communication and collect feedback for service improvement.

**Development and Continuous Improvement Plan**

- New equipment in the planning includes Endobronchial Ultrasound (EBUS) for detection and staging of lung cancer; and CO2 Regulator and AFI Bronchovideoscope for quality improvement.
- Produce educational video for patients’ viewing before the procedure.
- Set up reporting mechanism for complications.
- Put up posters with tips on good practice to maintain standard of service and promote quality of care.
- Conduct the Second Doctor-Endoscopists Forum, and a Patients Forum, in 2Q-3Q 2010 to collect feedback for improvement.

We will continue to maintain and upgrade our high-quality EEU service to meet the continuously increasing demand. We hope our state-of-the-art endosonography service will be better utilized as appropriate for quality patient service.

*Dr. Raymond CHEN Chung I*  
Chief Executive Officer
Physicians

Session A: Management of Community-Acquired Pneumonia
Session B: Updates on MRSA

Treatment Guideline
Director of Programme: Dr. Peter WONG C.Y.
Chairman: Dr. Peter WONG C.Y.
Speakers: Dr. Jane CHAN (Session A)
            Dr. LAI Wai Man (Session B)
Date: March 1, 2010
Time: 8:00 – 10:00 pm
Venue: The Chapel, D9, HKBH
Enquiries: 2339 8873 (Ms. Polly TAM)
Coming Meetings: April 12, 2010
                May 3, 2010
                June 7, 2010

Anaesthesiology

Session A: DVT Prophylaxis
Session B: Optimal Anticoagulation Therapy for Atrial Fibrillation

Chairman: Dr. NG Tse Choi
Speaker: Dr. LEUNG Chung Cheung (Session A)
         Dr. David SIU Chung Wah (Session B)
Date: March 7, 2010
Time: 8:00 – 10:00 am
Venue: The Chapel, D9, HKBH
Enquiries: 2339 8873 (Ms. Polly TAM)

Surgeons

Breast Reconstruction

Director of Programme: Dr. YUNG Leung Tung
Chairman: Dr. CHUNG Chi Kin
Speaker: Dr. HO Chiu Ming
Date: March 5, 2010
Time: 8:00 – 9:30 am
Venue: The Chapel, D9, HKBH
Enquiries: 2339 8872 (Ms. Connie LOK)
Coming Meetings: April 9, 2010
                May 7, 2010
                June 4, 2010

Rhesus Iso-immunization

Speaker: Dr. Steven LO
Date: March 9, 2010
Time: 7:30 – 8:30 pm
Venue: The Chapel, D9, HKBH
Enquiries: 2339 8873 (Ms. Polly TAM)
Coming Meetings: April 13, 2010
                May 11, 2010
                June 8, 2010

Obstetricians & Gynaecologists

Rhesus Iso-immunization

Speaker: Dr. Steven LO
Date: March 9, 2010
Time: 7:30 – 8:30 pm
Venue: The Chapel, D9, HKBH
Enquiries: 2339 8873 (Ms. Polly TAM)
Coming Meetings: April 13, 2010
                May 11, 2010
                June 8, 2010

Surgical Pathology

Joint Surgical Pathology Meeting

Date: March 19, 2010
Time: 8:00 – 9:00 am
Venue: The Chapel, D9, HKBH
Enquiries: 2339 8872 (Ms. Connie LOK)
Coming Meetings: April 16, 2010
                June 18, 2010

What’s ON

Commencement of Practice of Dr. Wilson CHAN Wai Man & Dr. KWONG Shu Keung
Cocktail reception on March 6, 2010 (Saturday), 1:00 – 3:00 pm, Chiu Hin Kwong Heart Centre
RSVP on 2339 8977

Who’s NEW

Dr. Wilson CHAN Wai Man
Director, Chiu Hin Kwong Heart Centre

Editorial Enquiry
We would like to hear from you! Any questions, comments or suggestions are always welcome. Please email us at pr@hkbh.org.hk

Blessed are the pure in heart, for they will see God. (Matt 5:8)