

BreastScreen Australia Clinical Advisory Group (CAG) The use of Mammographically Guided Vacuum Assisted Breast Biopsy (VABB) in BreastScreen Australia

Version	<p>Date of completed advice: 12 November 2025</p> <p>Review date: November 2030</p> <p>Version number: 3</p>
Advice requested by	BreastScreen Australia National Quality Management Committee
Category	Best practice guidance
Recommendations	<ul style="list-style-type: none"> • VABB is the procedure of choice for image-guided percutaneous biopsy of microcalcifications and is also recommended for other lesion types not confidently identified on ultrasound. • In general, clients should not proceed to a surgical excisional biopsy for equivocal or inadequate core biopsy results of microcalcifications unless a VABB has been attempted, noting that multiple attempts at needle core biopsy are not best practice. • Use of marker clips The use of marker clips for needle core biopsy and VABB is the standard of care, as is specimen imaging for cases of calcification and post-clip imaging. Please see Guidance for the use of marker clips by BreastScreen Australia Screening and Assessment Services.
Discussion	<ul style="list-style-type: none"> • This advice on the use of VABB applies to tomosynthesis-guided and stereotactic mammogram-guided needle biopsies in the BreastScreen Australia program. All jurisdictions now have access to VABB. • There is clinical benefit in assessing lesions with the VABB procedure as it achieves superior results compared to a core biopsy for microcalcifications and other lesions best seen on tomosynthesis and/or mammography. For lesions visible on ultrasound, core biopsy is considered appropriate. Ultrasound-guided VABB is becoming increasingly available and may be preferred in some circumstances. • Particularly for microcalcifications, the use of VABB

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	<p>increases the likelihood of an adequate biopsy and reduces the need for repeat needle biopsies and the reliance on diagnostic open surgical biopsies. In addition, VABB is associated with fewer discordant results and lower upgrade rates compared to core biopsies, maximising the opportunity for no surgery or one-stage surgery in women undergoing treatment.</p> <ul style="list-style-type: none"> • When ductal carcinoma in situ (DCIS) is diagnosed with VABB there are fewer cases upgraded to invasive cancer at operation, compared with core biopsy. Clients whose invasive cancer has remained undetected on core biopsy, only to be found at surgery, are then likely to require additional investigations and surgery for axillary staging.
Stakeholder consultation	<p>The BreastScreen Australia CAG is grateful to stakeholders who provided input:</p> <ul style="list-style-type: none"> • BreastScreen Australia Program Management Group • BreastScreen Australia National Quality Management Committee
References	<ol style="list-style-type: none"> 1. The Royal College of Pathologists, Guidelines for non-operative diagnostic procedures and reporting in breast cancer screening, August 2021 www.rcpath.org/asset/4B16F19C-F7BD-456C-B212F557F8040F66/ 2. UK NHS Breast Screening Programme Clinical guidance for breast cancer screening assessment, November 2016. 3. Pinder SE, Shaaban A, Deb R, et al. NHS Breast Screening multidisciplinary working group guidelines for the diagnosis and management of breast lesions of uncertain malignant potential on core biopsy (B3 lesions). <i>Clinical radiology</i> 2018;73:682-92. 4. Farshid G, Sullivan T, Jones S, Roder D. Performance Indices of Needle Biopsy Procedures for the Assessment of Screen Detected Abnormalities in Services Accredited by BreastScreen Australia. <i>Asian Pac J Cancer Prev.</i> 2014;15(24):10665-73 www.ncbi.nlm.nih.gov/pubmed/25605157