Responsibility of assessment teams to review and biopsy abnormal axillary lymph nodes in women with malignant lesions at assessment

Version Control	
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Background

- Even if BreastScreen Australia (BSA) services do not carry out axillary assessment, the treating surgeons usually ask for it and the client will then have to be referred for this investigation, incurring delay and cost.
- Providing the information regarding the status of the nodes does not compel the surgeon to perform axillary clearance. The decision regarding the form of axillary staging can only be addressed by integrating all of the available information, including the results of axillary assessment.
- The incremental resource cost and time commitment required from BSA services to conduct axillary assessment is not large, since the staff and equipment are already allocated for assessing the breast. The largest component would be one axillary Fine Needle Aspiration (FNA), performed in approximately 10% of the cases assessed by axillary ultrasound. By contrast the cost to the women in arranging an external an axillary ultrasound +/- FNA would be significant.
- The question has been raised as to whether axillary ultrasound at the time of breast assessment would compound the woman's anxiety. The unanimous view of the Clinical Advisory Committee (CAC) was that many women are aware that the lymph nodes under the arm are looked at when there is a suspicious breast lesion and BSA services can be trusted to approach this aspect of assessment in a low-key manner, so as not to exacerbate anxiety. The view was expressed that it would be a disservice not to provide routine axillary assessment for all women with suspicious lesions (excluding calcifications not associated with a mass).
- Is immediate access to cytology a requirement for axillary assessment? No. The BreastScreen South Australia (BSSA) data show that the value of axillary assessment was in identifying women with a large nodal burden. These are the nodes that are likely to be positive with one pass FNA. The results of the FNA are not required at the time of assessment but will be needed by the treating surgeon.
- In the setting of an abnormal axillary ultrasound (AUS), half of the women with a negative axillary FNA still had nodal disease documented in the final pathology. The point being that axillary assessment in this way is well suited to identify bulky nodes and women who would not be eligible for Z11 based management. It does not identify all women with nodal disease.

- The BSSA study noted that one of its limitations was that axillary assessment took place at the discretion of the radiologist without a prescribed uniform system for classifying the axillary ultrasound. The paper notes that Britton et al found cortical thickness >4mm constitute the morphologic feature most predictive of nodal metastases (Britton PD 2009, Eur Radiol 19(3):561-569.) Other systems, using lower thresholds for regarding nodes abnormal, may identify a larger proportion of patients with small nodal burden. The CAC considers that further investigation is needed to provide an evidence base before a particular system for axillary ultrasound can be recommended.

  Localisation of abnormal axillary nodes:

- The question of assessment of the axilla in women with screen detected highly suspicious lesions has had to be re-examined in the light of the Z11 trial outcomes. In the post Z11 era, the finding of axillary nodal disease is not necessarily an indication for axillary clearance (AC). The concern has been expressed that the documentation of any nodal involvement by BSA services may trigger over-treatment of the axilla.
- Australian data are now available from BreastScreen South Australia (BSSA) who have approached the issue from the perspective of the Z11 data (Farshid G, Kollias J, Gill PG Breast Cancer Res Treat 2015 151:34-355). The CAC reviewed the paper and discussed the findings of this Australian study of 449 lesions and noted AUS was reported as abnormal in 15.9% of the lesions. Axillary FNA was performed in 46 lesions (10.2%) with abnormal AUS and was reported as positive in 27 of those cases.
- Together AUS and FNA (when AUS was abnormal) correctly identified 26 women with nodal metastases. Of note, only 2 of these women might have been eligible for Z11 based management. One other case, assumed to be an axillary node with positive FNA, actually represented a laterally placed deposit of a multifocal carcinoma (technically false positive axillary assessment).

The CAC group also discussed a specific question raised by the PMG within the clinical issue for advice:

If the Clinical Advisory Committee determines that evaluation of the axilla is appropriate clinical practice then the CAC will need to advise as to the appropriate measurement parameters assessment services will need to use in the evaluation of node e.g. A cortical thickness of 3mm or greater etc.

The CAC group advised that that the appropriate measurement parameters should be left to a Service's clinical judgement.

Literature reviewed included Farshid G, Kollais J, Grantely Gill P, "The clinical utility of assessment of the axilla in women with suspicious screen detected lesions in the post Z0011 era", Breast Cancer Research and Treatment 2015, ISSN 0167 – 6806, Vol 151, No 2.

The CAC reviewed a clinical trial by POSNOC which is currently being implemented in the United Kingdom.

CAC decision/recommendation

The BSA CAC recommends that axilla assessment be formalised as part of a comprehensive management of women with grade 5 non-calcified lesions.

The BSA CAC recommends that appropriate measurement parameters should be left to a Service's clinical judgment.

This advice is clinical guidance for the BreastScreen Australia Program for consideration and suggested implementation within each jurisdiction.