

# Breast Centres Certification Procedure

According to the Eusoma guidelines “The requirements of a specialist breast centre”



## Eusoma Quality Indicators for Breast Centre Certification

based on “Quality indicators in breast cancer care: An update from the EUSOMA working group” EJC 86 (2017): 59-81

Indicator	Recommended/ Mandatory	Minimum Standard	Target
1 Proportion of women with breast cancer (invasive or in situ) who had a pre-operative histologically or cytologically confirmed malignant diagnosis (B5 or C5)	M	85%	90%
2 Proportion of invasive cancer cases for which the following prognostic/predictive parameters have been recorded: histological type (according to WHO Classification of Tumours of the Breast), grading (according to WHO and EU Guidelines: Elston and Ellis modified Bloom and Richardson-Grading system Elston, CW et al. 1991), ER, PgR*, HER-2/neu, Proliferation index (Ki67)* *this marker is recommended but not mandatory, and does not need to be included in the calculation for compliance with the QI	M	95%	98%
<p>For patients receiving primary systemic treatment (PST), characterization on core biopsy prior to therapy is mandatory. For patients receiving primary surgery, characterization may be performed on the surgical specimen only. In addition to the above parameters, the following parameters must be recorded after surgery: Pathological stage (pT and pN, or ypT and ypN in case of PST), Size in mm for the invasive component, Peritumoral vascular invasion (L,V), Distance to nearest radial margin</p>			
3 Proportion of non-invasive cancer cases for which the following prognostic/predictive parameters have been recorded: Grading (according to WHO Classification of Tumours of the Breast), dominant histologic pattern, size in mm (best pathology or radiology estimate if 2 stage pathology), distance to nearest radial margin, ER.	M	95%	98%
4 Proportion of patients with invasive breast cancer (Mo) who received post-operative radiation therapy (RT) after surgical resection of the primary tumor and appropriate axillary staging/surgery in the framework of BCT	M	90 %	95 %
5 Proportion of patients (BRCA1 and BRCA2 patients excluded) with invasive breast cancer not greater than 3 cm (total size, including DCIS component) who underwent BCT as primary treatment.	M	70%	85%
6 Proportion of patients with non-invasive breast cancer not greater than 2cm who underwent BCT	M	80%	90%

7	Proportion of patients with DCIS only who do not undergo axillary clearance	M	97%	99%
8	Proportion of patients with endocrine sensitive invasive cancer who received endocrine therapy	M	85%	90%
9	Proportion of patients with ER- (T > 1 cm or Node+) invasive carcinoma who received adjuvant chemotherapy	M	85%	95%
10	Proportion of patients (invasive cancer only) who received a single (breast) operation for the primary tumor (excluding reconstruction)	M	80%	90%
11	Proportion of patients (DCIS only) who received just one operation (excluding reconstruction)	M	70%	90%
12	Proportion of patients with invasive cancer and clinically negative axilla who underwent sentinel lymph-node biopsy (excluding patients who received PST)	M	90%	95%
13	Proportion of patients receiving immediate reconstruction after mastectomy (at the same time)	R	40%	NA
14	Proportion of patients with invasive cancer who underwent sentinel lymph-node biopsy with no more than 5 nodes excised	R	90%	95%
15	Proportion of patients with HER2 positive (IHC 3+ or in situ hybridisation positive FISH +) invasive carcinoma (T > 1 cm or N+) treated with chemotherapy who received adjuvant trastuzumab	M	85%	95%
16	Proportion of treated patients for which the breast centre collects data on life status and recurrence rate (for at least 5 years)	R	80%	90%
17*	Ratio of benign to malignant diagnoses based on definitive pathology report (surgery only, non-operative biopsies excluded) –	M	1:4	1:5

**\*For this indicator, the procedure foresees a check onsite**

For the complete description of each of the above indicators, please refer to the Eusoma document “Quality indicators in breast cancer care: An update from the EUSOMA working group” EJC 86 (2017): 59-81, available at [www.eusoma.org](http://www.eusoma.org)