

# EUSOBI: State of Screening in Europe

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# EUROPE



- 50 (+6 +6) countries
- 28 EU member states/24 official languages
- 107 languages total
- 42 languages: 1 million+ speakers

The European Union has 24 official and working languages. They are:

Bulgarian	French	Maltese
Croatian	German	Polish
Czech	Greek	Portuguese
Danish	Hungarian	Romanian
Dutch	Irish	Slovak
English	Italian	Slovenian
Estonian	Latvian	Spanish
Finnish	Lithuanian	Swedish

# Epidemiology and screening programs coverage



Country	New cases	Deaths	%	Country	New cases	Deaths	%
Ukraina	16471	8123	49%	Italy	50658	12796	25%
India	144903	70218	48%	EU-28	367090	91495	25%
Pakistan	34033	16232	48%	Japan	55709	13811	25%
Greece	4934	2138	43%	Belgium	10337	2523	24%
Russia	57500	24544	43%	Brazil	67307	16412	24%
Lithuania	1479	607	41%	Ireland	2899	704	24%
Indonesia	48998	19750	40%	Spain	25215	6075	24%
Thailand	13653	4671	34%	Czech Rep	6854	1617	24%
Latvia	1145	433	38%	Germany	71623	16828	23%
Hungary	5094	1914	38%	Denmark	5224	1198	23%
Philippines	18320	6621	36%	Netherland	13895	3183	23%
Turkey	15229	5199	34%	UK	52399	11679	22%
Argentina	19386	6163	32%	France	54245	11933	22%
Poland	17259	5373	31%	Norway	2887	635	22%
Austria	5254	1512	29%	Sweden	6624	1450	22%
Europe	464202	131257	28%	Canada	23420	4924	21%
Mexico	20444	5680	28%	Switzerland	5750	1196	21%
Slovakia	2643	698	26%	Australia	14710	2968	20%
Portugal	6088	1570	26%	Finland	4477	860	19%
China	187180	47984	26%	USA	232714	43909	19%
Estonia	658	168	26%				

# History



- Two-county pilot by Tabar, Sweden, 1982
- Europe against cancer programme, 12 member states, Milan, 1985
- European Parliament – Resolution on Breast Cancer, 2003
- European Parliament - Written declaration of Breast Cancer, 2010, 2015
- European guidelines for QA in Mammography Screening, 1<sup>st</sup> ed. 1993 – 4<sup>th</sup> ed. 2006



2012

eurostat

# History and coverage

Country	Implementation of screening programmes
Austria <sup>1</sup>	2014
Belgium	2001
Bulgaria	2012
Czech Republic <sup>2</sup>	2002
Cyprus	2007
Denmark	2007
Estonia <sup>2</sup>	2002
France <sup>3</sup>	2003
Germany	2005
Greece	-
Hungary <sup>5</sup>	2001-2002
Italy	2005
Latvia	2009
Malta	2009
Poland <sup>4</sup>	2006
Slovenia <sup>7</sup>	2008
Spain	1990
Slovak Republic <sup>2</sup>	-
Romania <sup>8</sup>	-
Sweden <sup>10</sup>	1986
Turkey	1999
United Kingdom <sup>11</sup>	1988

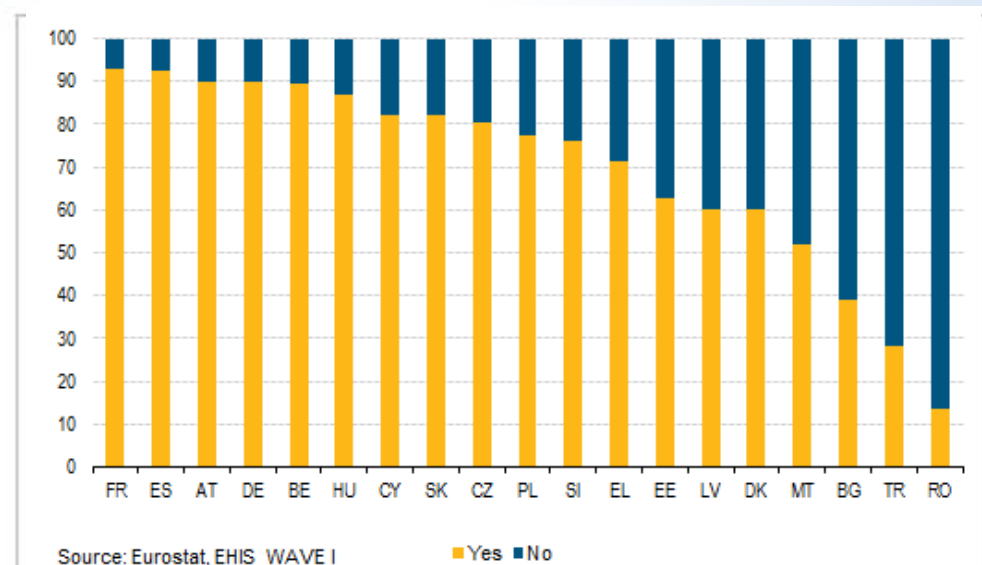


Figure 1: Mammographic screening at least once in life  
(women aged 50-69)

Source: Eurostat (hlth\_ehis\_hc2)

# Organized/opportunistic screening

- Parallel existing screening methods
- Organized: mostly at public centers
- Opportunistic: mostly at private centers
- Lot of exceptions: e.g. France – both mostly private
  
- Difficulties in data collection  
(also: tax declaration issues in some countries...)
- Sometimes the “no screening-more insurance payment” issue raised



# Organized screening



## European guidelines for quality assurance in breast cancer screening and diagnosis *Fourth Edition*

- Country or province/state-based organisation
- Invitation lists created by authorities (population, electoral registry, ZIP codes, GP registry)
- Invitation sent by:
  - screening center
  - administrative center
  - GP
- Typical attendance: 40-80%
- Centralized data collection (centers reporting is obligatory)

# QC of screening - Key performance indicators

Performance indicator	Acceptable level	Desirable level
1. Target optical density <sup>2AT4.1</sup>	1.4 - 1.9 OD	1.4 - 1.9 OD
2. Spatial resolution <sup>2AT4.1</sup>	> 12 lp/mm	> 15 lp/mm
3. Glandular dose – PMMA thickness at 4.5 cm <sup>2AT4.1</sup>	< 2.5 mGy	< 2.0 mGy
4. Threshold contrast visibility <sup>2AT4.1</sup>	< 1.5%	< 1.5%
5. Proportion of women invited that attend for screening <sup>1T32</sup>	> 70%	> 75%
6. Proportion of eligible women reinvited within the specified screening interval <sup>1T32</sup>	> 95%	100%
7. Proportion of eligible women reinvited within the specified screening interval + 6 months <sup>1T32</sup>	> 98%	100%
8. Proportion of women with a radiographically acceptable screening examination <sup>3.8, 5.4.3.1</sup>	97%	> 97%
9. Proportion of women informed of procedure and time scale of receiving results <sup>3.8, 5.4.3.1</sup>	100%	100%
10. Proportion of women undergoing a technical repeat screening examination <sup>1T32, 3.8, 4T2, 5.4.3.1</sup>	< 3%	< 1%
11. Proportion of women undergoing additional imaging at the time of the screening examination in order to further clarify the mammographic appearances <sup>1T32</sup>	< 5%	< 1%
12. Proportion of women recalled for further assessment <sup>1T32, 4T2</sup>		
• initial screening examinations	< 7%	< 5%
• subsequent screening examinations	< 5%	< 3%

Performance indicator	Acceptable level	Desirable level
13. Proportion of screened women subjected to early recall following diagnostic assessment <sup>4T2</sup>	< 1%	0%
14. Breast cancer detection rate, expressed as a multiple of the underlying, expected, breast cancer incidence rate in the absence of screening (IR) <sup>1T33, 4T1</sup>		
• initial screening examinations	3 x IR	> 3 x IR
• subsequent-regular screening examinations	1.5 x IR	> 1.5 x IR
15. Interval cancer rate as a proportion of the underlying, expected, breast cancer incidence rate in the absence of screening <sup>1T33</sup>		
• within the first year (0-11 months)	30%	< 30%
• within the second year (12-23 months)	50%	< 50%
16. Proportion of screen-detected cancers that are invasive <sup>1T33, 4T1</sup>	90%	80-90%
17. Proportion of screen-detected cancers that are stage II+ <sup>1T33</sup>		
• initial screening examinations	NA	< 30%
• subsequent-regular screening examinations	25%	< 25%
18. Proportion of invasive screen-detected cancers that are node-negative <sup>1T33</sup>		
• initial screening examinations	NA	> 70%
• subsequent-regular screening examinations	75%	> 75%
19. Proportion of invasive screen-detected cancers that are ≤ 10 mm in size <sup>1T33, 4T1</sup>		
• initial screening examinations	NA	≥ 25%
• subsequent-regular screening examinations	≥ 25%	≥ 30%
20. Proportion of invasive screen-detected cancers that are < 15 mm in size <sup>7A.2</sup>	50%	> 50%
21. Proportion of invasive screen-detected cancers < 10 mm in size for which there was no frozen section <sup>5.8.2, 9T1</sup>	95%	> 95%

# QC of screening - Key performance indicators

22. Absolute sensitivity of FNAC <sup>5.5.3, 6A A1.3</sup>	> 60%	> 70%		
23. Complete sensitivity of FNAC <sup>5.5.3, 6A A1.3</sup>	> 80%	> 90%		
24. Specificity of FNAC <sup>5.5.3, 6A A1.3</sup>	> 55%	> 65%		
25. Absolute sensitivity of core biopsy <sup>5.5.3, 6A A1.3</sup>	> 70%	> 80%		
26. Complete sensitivity of core biopsy <sup>5.5.3, 6A A1.3</sup>	> 80%	> 90%		
27. Specificity of core biopsy <sup>5.5.3, 6A A1.3</sup>	> 75%	> 85%		
28. Proportion of localised impalpable lesions successfully excised at the first operation <sup>4T2, 5.8.2, 7A.3</sup>	> 90%	> 95%		
29. Proportion of image-guided FNAC procedures with insufficient result <sup>4T2, 5.5.2</sup>	< 25%	< 15%		
30. Proportion of image-guided FNAC procedures from lesions subsequently proven to be malignant, with an insufficient result <sup>4T2, 5.5.2</sup>	< 10%	< 5%		
31. Proportion of patients subsequently proven to have breast cancer with a pre-operative FNAC or core biopsy at the diagnosis of cancer <sup>7B.2</sup>	90%	> 90%		
32. Proportion of patients subsequently proven to have clinically occult breast cancer with a pre-operative FNAC or core biopsy that is diagnostic for cancer <sup>7B.2</sup>	70%	> 70%		
33. Proportion of image-guided core/vacuum procedures with an insufficient result <sup>4T2</sup>	< 20%	< 10%		
34. Benign to malignant open surgical biopsy ratio in women at initial and subsequent examinations <sup>1T32, 4T2, 5.8.2, 7A.3</sup>	≤ 1 : 2	≤ 1 : 4		
35. Proportion of wires placed within 1 cm of an impalpable lesion prior to excision <sup>4T2, 5.8.2, 7A.3</sup>	90%	> 90%		
36. Proportion of benign diagnostic biopsies on impalpable lesions weighing less than 30 grams <sup>5.8.2, 7A.3</sup>	90%	> 90%		
37. Proportion of patients where a repeat operation is needed after incomplete excision <sup>7A.4</sup>	10%	< 10%		
38. Time (in working days) between:				
• screening mammography and result <sup>4T2</sup>	15 wd	10 wd		
• symptomatic mammography and result <sup>5,9</sup>	5 wd			
• result of screening mammography and offered assessment <sup>4T2</sup>	5 wd	3 wd		
• result of diagnostic mammography and offered assessment <sup>5,9</sup>	5 wd			
• assessment and issuing of results <sup>5,9</sup>	5 wd			
• decision to operate and date offered for surgery <sup>5,9</sup>	15 wd	10 wd		
39. Time (in working days) between:				
• screening mammography and result <sup>1)</sup>				
≤ 15 wd	95%	> 95%		
≤ 10 wd	90%	> 90%		
• symptomatic mammography and result <sup>1)</sup>				
≤ 5 wd	90%	> 90%		
• result of screening mammography and offered assessment <sup>1)</sup>				
≤ 5 wd	90%	> 90%		
• result of symptomatic mammography and offered assessment <sup>1)</sup>				
≤ 5 wd	90%	> 90%		
• assessment and issuing of results <sup>1)</sup>				
≤ 5 wd	90%	> 90%		
• decision to operate and date offered for surgery <sup>1)</sup>				
≤ 15 wd	90%	> 90%		
≤ 10 wd	70%	> 70%		

# Technique

- Clinical exam (palpation)
  - None (mostly)
  - Radiographer, obligatory (*Scandinavian countries, Hungary*)
  - Radiologist, obligatory (France)
- Double reading
  - In-center (mostly)
  - Second reading centralized (France)
  - Telemammography
  - No routine use of CAD
- Ultrasound
  - only Austria

# Age range

Country	Age covered
<b>Austria<sup>1</sup></b>	40+
<b>Belgium</b>	50-69
<b>Bulgaria</b>	45-69
<b>Czech Republic<sup>2</sup></b>	45-69
<b>Cyprus</b>	50-69
<b>Denmark</b>	50-69
<b>Estonia<sup>3</sup></b>	50-69
<b>France<sup>4</sup></b>	50-74
<b>Germany</b>	50-69
<b>Greece</b>	40+
<b>Hungary<sup>5</sup></b>	45-64
<b>Italy</b>	50-69
<b>Latvia</b>	50-69
<b>Malta</b>	50-60
<b>Poland<sup>6</sup></b>	50-69
<b>Slovenia<sup>7</sup></b>	50-69
<b>Spain</b>	45-69
<b>Slovak Republic<sup>8</sup></b>	40+
<b>Romania<sup>9</sup></b>	50-69
<b>Sweden<sup>10</sup></b>	50-69
<b>Turkey</b>	50-69
<b>United Kingdom<sup>11</sup></b>	50-64

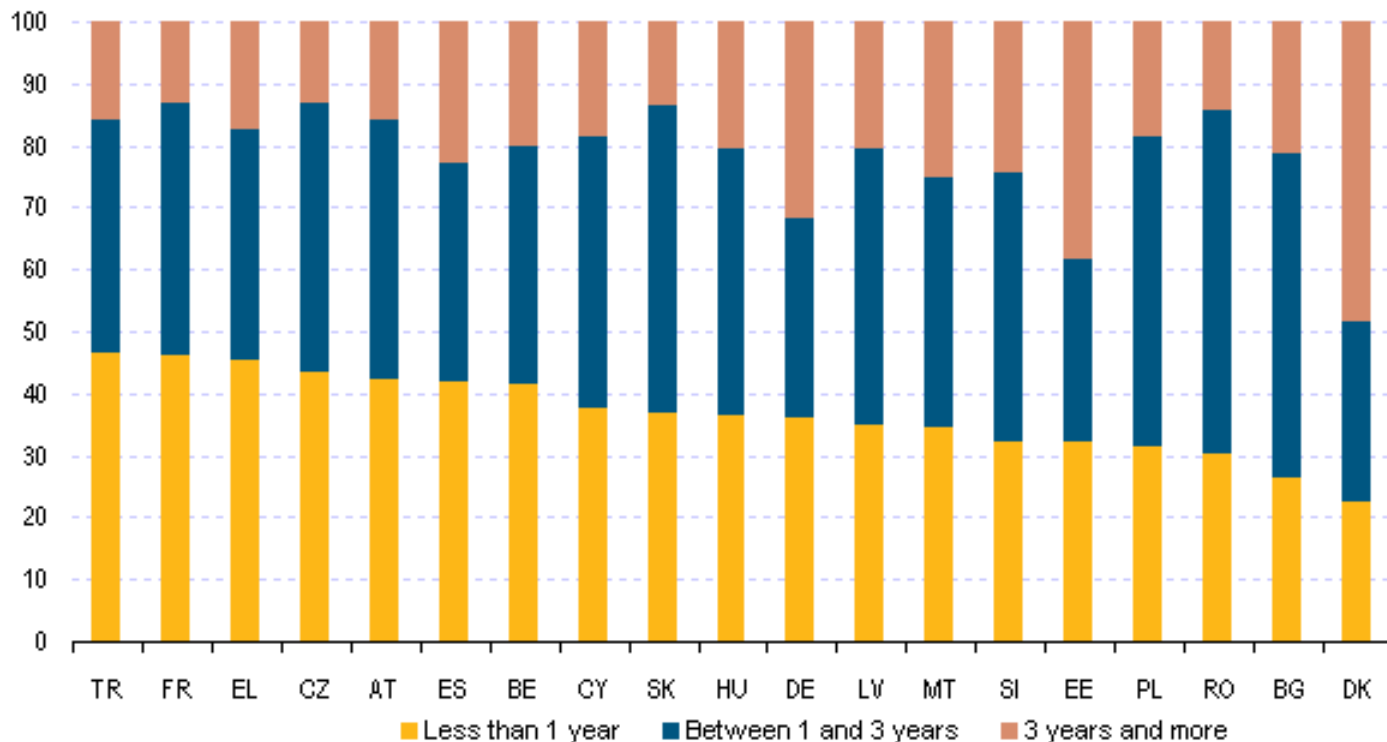


2012

eurostat



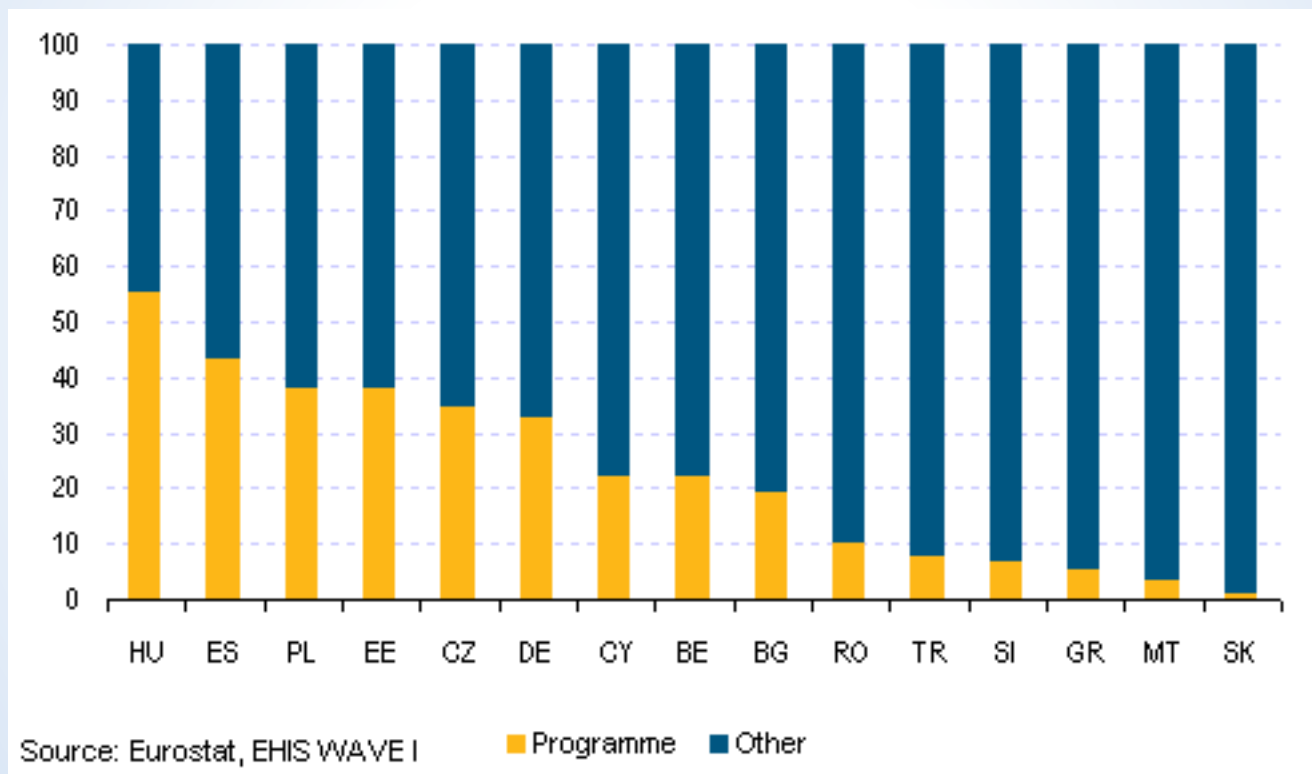
# Frequency



Source: Eurostat, EHIS WAVE I



# Participation



# Access to techniques by country

- Digital/film-screen: 50-50%
- Tomosynthesis: under 10%
- Stereotaxic bx: FNA 16%, core 31%, VAB 53%
- Ultrasound-guided bx: 20% FNA, 80% core
- MRI-guided bx: no access 32%, very low 32%, low 21%, intermediate 15%
- Technical QC: 25% none, 20% only in screening



# Cost for patients

- In most countries: social security covers it (free)
- Co-payment (some)
- Full fee payment (rare)

# BIRADS in EU countries

COUNTRY	BI-RADS YES	BI-RADS NO
Austria	X	
Bulgaria		X
Cyprus		X
Czech Republic	X	
France	x	
Germany	X	
Greece	X	
Hungary		X
Ireland	X	
Italy		X
Netherlands	X	
Poland		
Portugal	X	
Romania	X	
Slovakia		
Slovenia	X	
Spain	X	
Sweden		X
United Kingdom		X
Turkey	X	
Croatia	X	
Andorra	X	
Norway		X

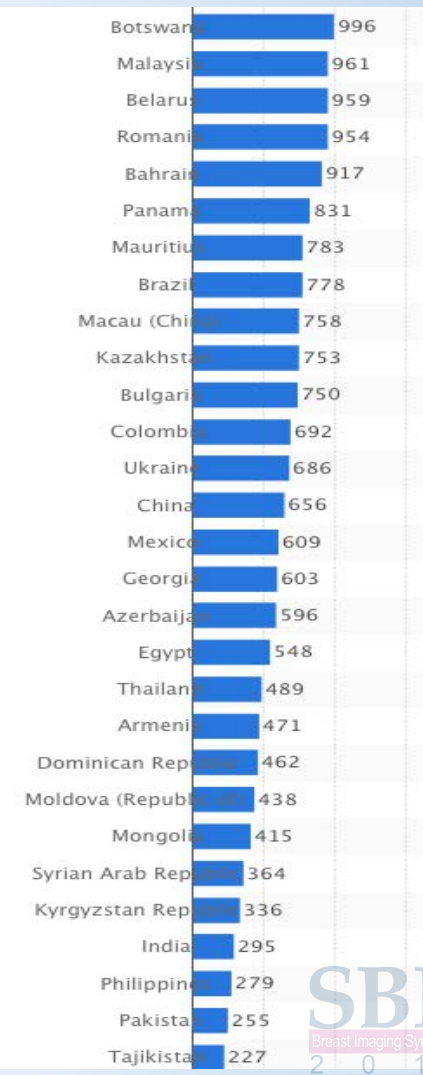
- No 0, 4abc in UK
- No 0, 3, in screening, no 4abc in clinical in Germany
- etc.

To do		RKU	BI-RADS		To do
			0		FURTHER ASSESSMENT
<b>NO CLINICAL EXAM CODE IN BIRADS</b>					
		1	→	1	N/A
N/A					
	benign + prob.benign	2	→	2	benign → N/A
F/U			→	3	prob.benign → ASSESSMENT
	indeterminate	3	→	4	
BIOPSY			→	4	indeterminate + suspicious → BIOPSY
	suspicious	4	→	5	
TREATMENT		5	→	5	malignant → BIOPSY
				6	proven malignancy → TREATMENT

Rank	Country	USD NET
1	Luxembourg	3,495
2	Denmark	2,831
3	Sweden	2,560
4	United Kingdom	2,553
5	Finland	2,500
6	Ireland	2,419
7	Netherlands	2,395
8	France	2,392
9	Austria	2,363
10	Germany	2,357
11	Belgium	2,321
12	Italy	2,256
13	Cyprus	1,924
14	Spain	1,747
15	Malta	1,212
16	Slovenia	1,133
17	Portugal	1,114
18	Estonia	1,111
19	Greece	923
20	Croatia	849
21	Czech Republic	815
22	Slovakia	782
23	Poland	781
24	Latvia	713
25	Lithuania	667
26	Hungary	603
27	Romania	462
28	Bulgaria	395

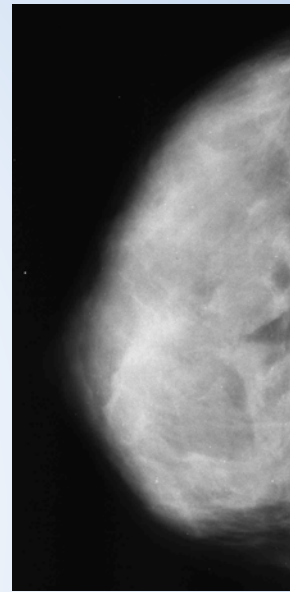


- Native language reporting using BIRADS wording?
- Translation of BIRADS?
- Accessibility of BIRADS



# Dense breasts

- No EU regulation about additional methods @ dense breasts
- Masking effect of density is accepted, but
- Discussion ongoing regarding density as separate risk factor
- Seems to be overestimated, especially in communication
- 2014, New Guidelines of French High Health Authorities
- 2016, EUSOBI Statement on Screening, in press
- Colin C, Prince V, Valette PJ. Can mammographic assessments lead to consider density as a risk factor for breast cancer? Eur J Radiol. 2013 Mar;82(3):404-11.
- Colin C, Schott AM, Valette PJ. Mammographic density is not a worthwhile examination to distinguish high cancer risk women in screening. Eur Radiol. 2014 Oct;24(10):2412-6.
- Brandt KR, Scott CG, Ma L, Mahmoudzadeh AP, et al. Comparison of clinical and automated breast density measurements: Implications for risk Prediction and supplemental screening. Radiology. 2015 Dec 22:151261. [Epub ahead of print]
- McCormack VA, dos Santos Silva I. Breast density and parenchymal patterns as markers of breast cancer risk: a meta-analysis. Cancer Epidemiol Biomarkers Prev. 2006 Jun;15(6):1159-69.



# Ultrasound use in Europe

- Ultrasound is widely offered in the clinical practice (more than half of visits)
- Performed by radiologists
- No sonographers in breast diagnostics/screening
- Automated ultrasound not is routine use
- Practical observations:
  - Kind of an “extended palpation” - solves patient anxiety related to palpable lesions (lipoma, etc)
  - Good for patient-radiologist relation
  - High number of only US-only lesions in (not only dense!) breasts, but:
  - Lot of false positives
  - Lot of “unnecessary” biopsies
  - Boosts the diagnosis of non-calcified DCIS (10-30 percent?!) and lobular cancer

# CAD use in Europe

- Standard EU practice is double reading
- CAD not implemented in European screening programmes
- No reimbursement for CAD
- Costs
  
- “The scientific evidence is insufficient to determine whether the accuracy of single reading + CAD is at least equivalent to that obtained in standard practice, i.e. double reading where two breast radiologists independently read the mammographic images.”

Is single reading with computer-aided detection (CAD) as good as double reading in mammography screening? A systematic review (53 full-text articles). Edward Azavedo, Sophia Zackrisson, BMC Medical Imaging 2012, 12:22

- “CAD showed the potential to increase the cancer detection rate for FFDM and for screen-film mammography in breast cancer screening performed with independent double reading.”

Effect of computer-aided detection on independent double reading of paired screen-film and full-field digital screening mammograms. Skaane P, Kshirsagar A, Stapleton S et al. AJR Am J Roentgenol. 2007 Feb;188(2):377-84.

# High risk MRI screening

- Long tradition: many European studies
- Different regulations and accessibility in European countries
- Access to breast MRI:
  - 20% low, 45% intermediate, 35% high
- Access to breast MRI-guided biopsy:
  - no access 32%, very low 32%, low 21%, intermediate 15%
- Social security coverage:
  - yes in most developed European countries
  - no separation from diagnostic MRI in less developed countries
  - Romania stopped all breast MRI reimbursement in 2014 for financial reasons...



# Regulations

- Licence exams for breast radiologists
  - France (FORCOMED) – course+test+reading
  - UK (Performs) 2x per year - reading
  - Hungary (5-step exam incl.practical and interventional knowledge)
  - No breast licence in most countries
- If applicable, licence is obligatory for:
  - screening only (mostly)
  - screening + diagnostics (rare)
  - incl.+/- breast MRI (exceptional)

# Recommendations/certification

- EUREF

(European Reference Organisation  
for Quality Assured Breast Screening and Diagnostic Services)

- Certification of breast centers

- Diagnostic Breast Assessment Unit (1000 procedure/yr, radiologist: 500 read/yr)
- Diagnostic Breast Imaging Unit (2000 proc/yr, rad: 1000 read/yr)
- Loco-regional Breast Screening Programme (5000 proc/yr, rad: 5000 read/yr)
- European Reference Centre for Screening (10000 proc/yr, rad: 5000/yr)

- (very few centers are EUREF certified...)

# Malpractice in Europe

- Underdeveloped issue 😊
- No EU-harmonized legislation on medical liability
- No valid EU data
- Much less cases as in USA
- **“Europeans accept restrictions on their ability to sue doctors for malpractice is that they have guaranteed health insurance. It's part of the social contract: doctors accept limited salaries in exchange for limited liability; patients accept that they cannot sue doctors for millions of dollars in exchange for a guarantee of access to decent health care.”**
- Lawyer fee also limited in some countries (UK)

*Malpractice and the social contract, The Economist, Feb 9th 2010*

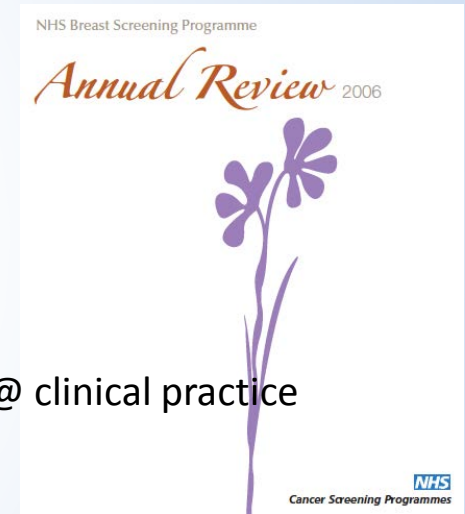
# Malpractice in Europe - National differences

- Regarding standard of care and the cases where a reversal of the burden of proof for the patient's benefit is accepted under civil law
  - grave fault (Germany)
  - easy medical treatment (Italy)
  - when lack of informed consent is invoked (France)
  - the bodily injury is a typical consequence of medical malpractice (UK )
  - In Germany and France there is also a specific duty to document all relevant steps of medical treatment
  - Nordic countries – Denmark, Finland, Norway and Sweden – the patient insurance system is the central point of contact of the claims

# Examples - UK



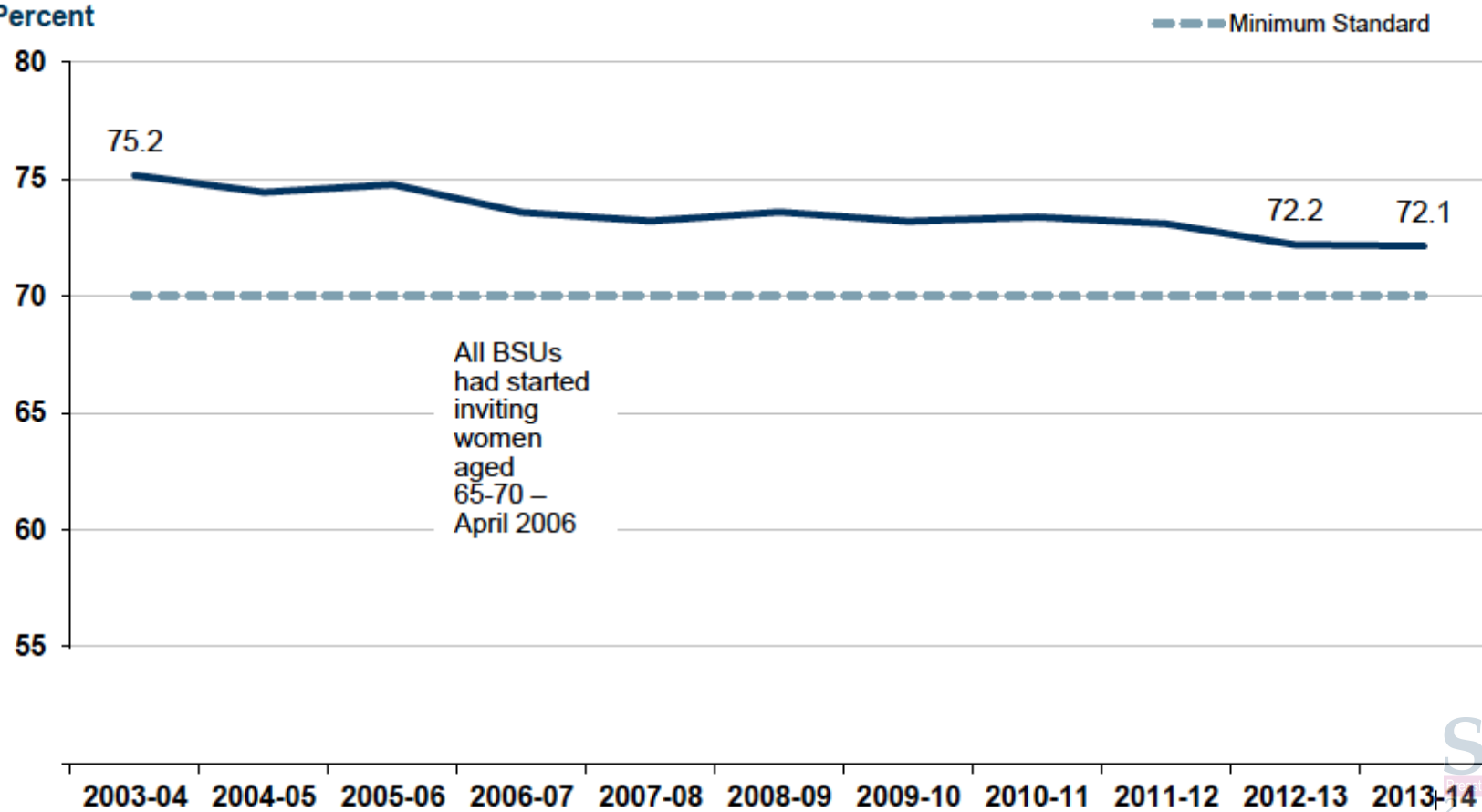
- Started 1988
- Screening cycle: 3 years (!)
- 47-73 years age range (was 50-64 before 2001, 50-70 after 2001)
- Separated protocol for high risk women (MRI screening, etc)
- Public – free of charge (day off not provided by employer)
- Centralized data evaluation by country
- The center sends out individual letter invitations
- No clinical exam @ screening, varies @ recalls, radiologist/surgeon/nurse @ clinical practice
- 95% digital (2014)
- Double reading by the center
- Center and radiologist accreditation, breast licence (Performs)
- Radiographers and “breast clinicians” (excl surgeon) also read films (!) (*Netherlands: gynecologists*)
- No BIRADS



## Figure 4: Uptake\* by women aged 50-70 of invitations to screen

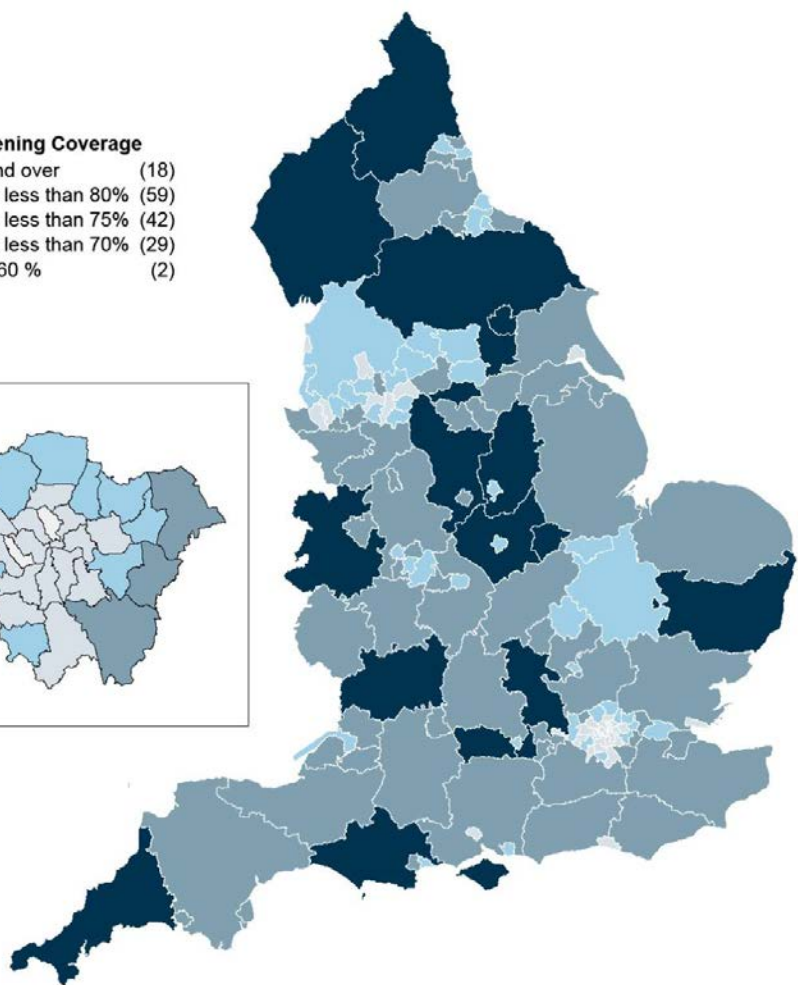
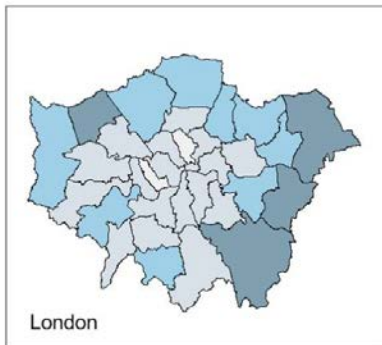
England, 2003-04 to 2013-14

Percent



**Breast Screening Coverage**

- 80% and over (18)
- 75% to less than 80% (59)
- 70% to less than 75% (42)
- 60% to less than 70% (29)
- Under 60 % (2)



- Recall rate:
  - 7,9% (1<sup>st</sup> round-prevalent)
  - 3% (subsequent-incident)

Age group	2013-14		
	Number screened	Cancers detected	
		Women with cancer	Rate per 1,000 women screened
45 and over	2,079,271	17,961	8.6
45 - 49	184,743	1,198	6.5
50 - 70	1,770,435	14,821	8.4
71 - 74	82,584	1,130	13.7
75 and over	41,509	812	19.6

# Examples - Sweden



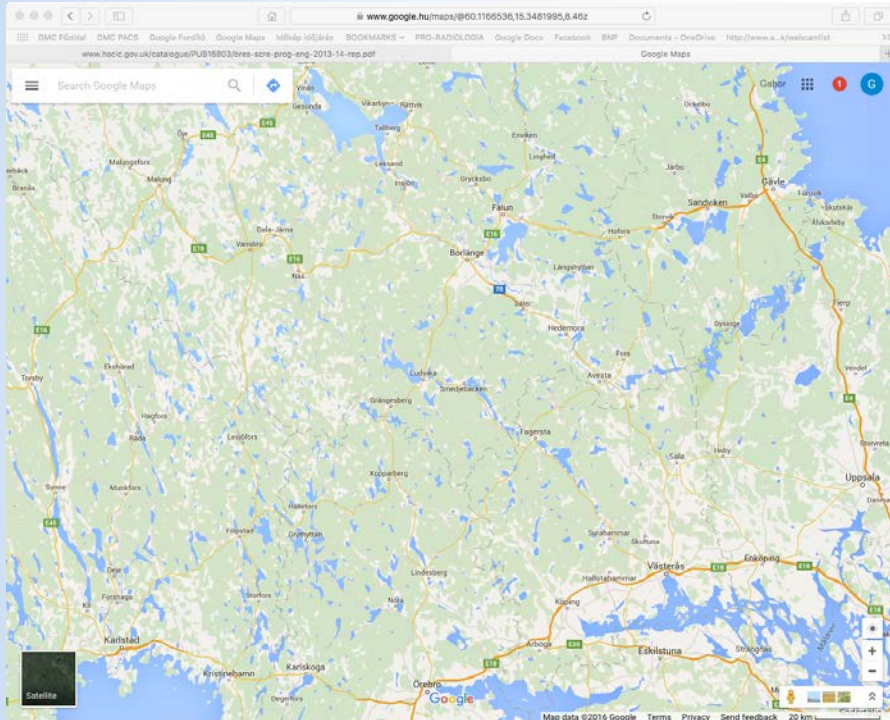
- Started 1986
- Screening cycle: 2 years
- 40-74 years age range – free of charge (75+ population is struggling for free screening)
- Public centers, 30 in the whole country (10 million)
- Decentralized (regional) data evaluation
- Data from other specialities (oncology, surgery) also collected
- The center sends out individual invitations
- Attendance over 80% (lot of rural areas, disciplined population)
- Clinical exam @ screening – by radiographer
- Mostly digital
- Double reading by the center or by telemammography
- No breast licence exam - nor radiologist speciality exam
- No systematic accreditation of centers (like MQSA)
- No BIRADS (RKU)



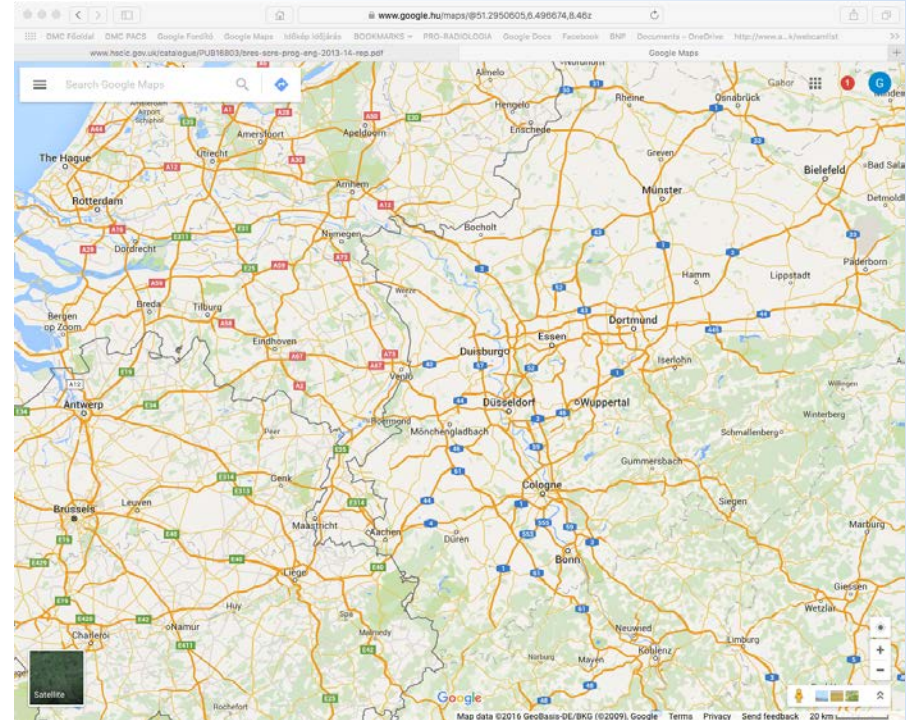
# Sweden

-

# W-Europe

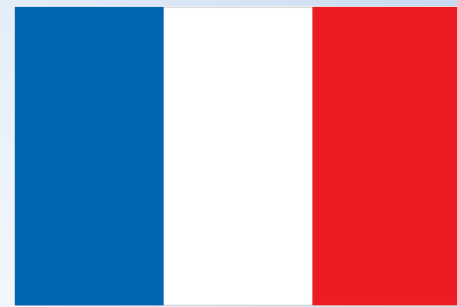


fixed + mobile units



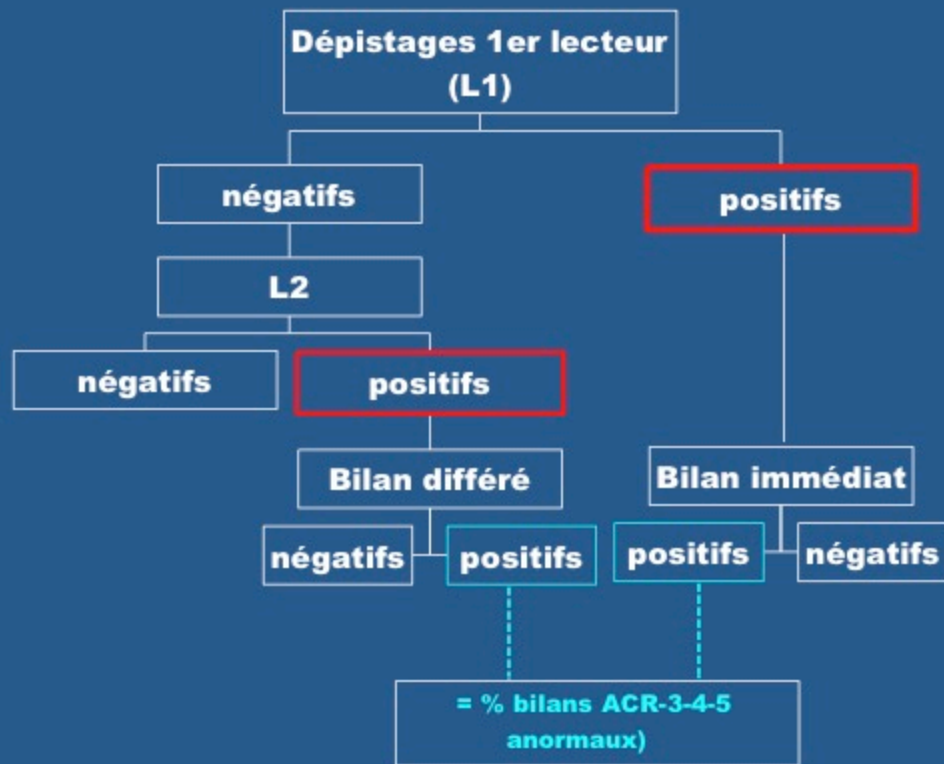
- mostly fixed

# Examples - France



- Started 2003
- Screening cycle: 2 years
- 50-74 years age range – free of charge (ultrasound payable)
- Nearly all are private centers, very high number
- Coverage over 95%
- Data collected by the centers, also from other specialities (pathology, surgery)
- No national cancer registry
- Patients get individual invitations by letter, they can choose the radiologist
- Clinical exam @ screening – by the radiologist
- More than 90% digital – CR and DM
- Second reading centralized, patients get results in 2 weeks
- Breast licence exam (FORCOMED)
- BIRADS in use

# prescriptions de bilans de diagnostic



+ 6-8 % cancers  
by second reading

by Dr. I.Brault

# Examples - Hungary



- Started 2001
- Screening cycle: 2 years
- 45-65 years age range – free of charge
- No organized separate track for high risk women
- Public and private centers - 70:30 – 52 in the country (10 mio)
- Centralized data evaluation (reports monthly/quarterly) – problems with frequent reorganization of authorities
- Data from other specialties (oncology, surgery, pathology) also collected
- Nationwide cancer register is not able to follow the requirements
- The center sends out individual letter invitations
- Attendance 47% - individual screenings not recorded – overall 65%
- Clinical exam @ screening – by radiographer
- Digital/analogue – 75:25
- Double reading by the center
- Accreditation by the center, but F/U not strong
- Breast specialist licence exam, most serious of EU
- No BIRADS (RKU)

# Licence exam from 2008



LVIII. ÉVFOLYAM 10. SZÁM 2881-3112. OLDAL 2008. május 28.

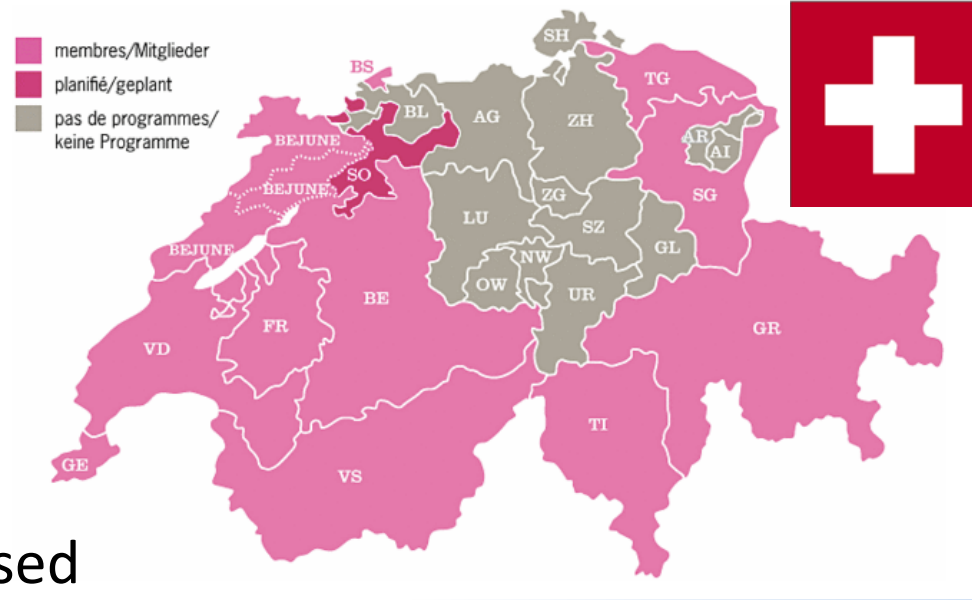
**EGÉSZSÉGÜGYI KÖZLÖNY**  
AZ EGÉSZSÉGÜGYI MINISZTERIUM HIVATALOS LAPJA

# Examples - Switzerland

- No screening in some cantons
- No clinical exam
- Age range: 50-70
- Patient pays 10%, 90% reimbursed

- **Scandal in 2014**

- Abolishing mammography screening programs? A view from the Swiss Medical Board. Biller-Andorno N1, Jüni P. N Engl J Med. 2014 May 22;370(21):1965-7.
- The Swiss Medical Board had managed to stop the plans of a new program that was supposed to start in Luzern and Zürich



**EUSOBI**  
european society of breast imaging



# activities



# Executive Board (term of office: 2015-2018)



**President:** G. Forrai, Budapest/HU  
**Vice President:** J. Camps Herrero, Alzira/ES  
**Past President:** F. Sardanelli, Milan/IT

**Secretary General:** F. Gilbert, Cambridge/UK  
**Treasurer:** R. Pijnappel, Utrecht/NL

**Chairperson of Educational Committee:** F. Pediconi, Rome/IT  
**Chairperson of Scientific Committee:** U. Bick, Berlin/DE  
**Chairperson of International Relations Committee:** M. Fuchsjäger, Graz/AT

**Ordinary Member:** E. Cornford, Nottingham/UK  
**Ordinary Member:** T. Helbich, Vienna/AT  
**Ordinary Member:** C. Kuhl, Aachen/DE  
**Ordinary Member:** R. Mann, Nijmegen/NL  
**Ordinary Member:** P. Panizza, Milan/IT  
**Ordinary Member:** K. Pinker-Domenig, Vienna/AT



# Aims and focus of the Society



- To promote high quality breast imaging across Europe by developing **education and training** initiatives, by encouraging **research** and by promoting **guidelines and standards**.
- Promotion of a **uniform training** programme based on the **ESR curriculum for breast imaging** (EUSOBI is actively participating in its creation and continuous update)
- Organisation of **courses, conferences, forums, symposia, workshops**
- To define and promote **scientific and technical standards**, defining place of **new modalities** (e.g. DBT)
- Producing **detailed patient information** on the key imaging modalities involved in breast imaging. ("EUSOBI recommendations for women's information - mammography, breast MRI, ultrasound, intervention")
- Publishing "**Statement in favor of breast screening**" (in press) organizing press conferences, participation at civil movements etc.

# NATIONAL SOCIETIES NETWORK



## 30 COUNTRIES

Germany

Norway

Czech Republic

Slovak Republic

Turkey

Bosnia And Herzegovina

Moldova

Italy

Switzerland

Estonia

Sweden

Romania

Bulgaria

Serbia

Spain

Austria

Finland

Belgium

Netherlands

Russia

United Kingdom

Greece

Croatia

Hungary

France

Portugal

Slovenia

Lithuania

Israel

Denmark

## European Society of Breast Imaging Scientific and educational activities

- ✓ EUSOBI Annual Meeting
  
- ✓ EUSOBI Breast MRI Training Course
- ✓ EUSOBI Digital Breast Tomosynthesis Course
- ✓ EUSOBI Screening Course
- ✓ EUSOBI Ultrasound Course
  
- ✓ European Diploma in Breast Imaging
  
- ✓ Education
  - Exchange Programme for Breast Imaging Fellowships
  - Breast Imaging Scholarship

# European Diploma in Breast Imaging

- Common European qualification for breast imagers
- Help to standardise training and expertise in breast imaging across Europe
- The EDBI confirms specific competence of radiologists to perform, interpret and report mammography, ultrasound, MRI and breast intervention.
  
- Written and oral components (practical)
  
- **The EDBI will assist breast imagers in the promotion of their skills and experience in breast imaging when dealing with other clinical colleagues and with the general public.**

# SBI-EUSOBI cooperation

- Scientific
- Educational
- IDOR
- BIRADS
- ...hopefully further



# International Day Of Radiology (IDOR)

- Nov 8, 2016, discovery of X-rays by Wilhelm Konrad Röntgen
- This year's subject: Breast
- EUSOBI-SBI common publication, under construction
- Target: public



# IDOR publication chapters

## EUSOBI

1. EUSOBI 'Women info' papers:
  - Mammo (with the addendum contrast and tomo),
  - MRI (with Gadolinium deposition issue addendum)
  - Ultrasound
  - Interventions
2. EUSOBI Statement on Screening
3. Interview with the President of EUSOBI
4. Patient info papers from Europa Donna
5. "Beautiful" radiological images for the public (from all modalities)
6. Informative drawings, self-exam, etc

# IDOR publication chapters

## SBI

1. History of Breast Imaging – Bonnie Joe and Ed Sickles
2. Screening controversies in the USA – Dan Kopans
3. Dense Breasts – Jennifer Harvey and Wendie Berg
4. BI-RADS: Why it is so important and how it paved the way for standardized reporting – Carol Lee
5. The importance of MQSA – Penny Butler
6. Media advocacy by the SBI - Murray Rebner and Joy Burwell
7. FB posts and tweets - Murray Rebner and Joy Burwell
8. Interview with the President of SBI



EUSOBI is about to create  
a highly professional node  
for breast radiologists  
both within and outside Europe



**We are looking  
forward to  
welcoming  
you to Paris!**

**Annual Scientific Meeting 2016**  
European Society of Breast Imaging



**BREAST IMAGING**

In cooperation with the  
Société d'Imagerie de la Femme

