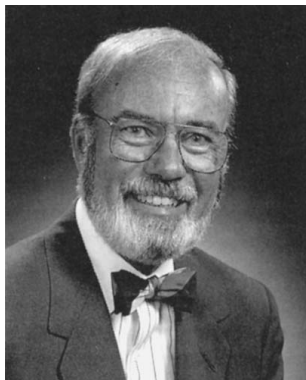


## PREFACE



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During the past 30 years, I have had the privilege of establishing two Breast Health Centers. The first in Boston, Massachusetts and the second more recently in Providence, Rhode Island at Women & Infants' Hospital.

The Breast Health Center is a concept rather than an office practice. In each center we have provided a multidisciplinary approach in a comfortable and nonthreatening environment. More than 100,000 patients have been evaluated and treated during this period, attesting to the acceptance of this approach. The majority of our patients are referred by primary care physicians, in many cases, the obstetrician/gynecologist. They are referred because of pain, nipple discharge and the discovery of a mass, and increasingly because of a family history of breast cancer and for a second opinion regarding the diagnosis and treatment of breast cancer. Given the large number of patients, especially during their reproductive years, who will complain of breast symptoms, and the relative scarcity of dedicated breast centers to deal with these problems, it is appropriate to provide the primary care physician with sufficient knowledge to manage most of these patients. Ideally, patients would be referred only when refractory to standard treatment, for a second opinion, or for additional diagnostic studies to confirm or to rule out breast cancer.

Many European countries and South America have long recognized the special role of the obstetrician/gynecologist in the evaluation and treatment of breast disease. The American Board of Obstetrics and Gynecology and the American College of Obstetrics and Gynecology were slow to acknowledge this responsibility. However, in a Bulletin published by the Board, it was stated that a knowledge of breast disease would be required in its certification process, and questions related to breast cancer appeared on the Board examinations.<sup>1</sup> The American College of Obstetricians and Gynecologists also increased its efforts to more clearly define the role of the obstetrician and gynecologist in this area and published a number of Committee Opinions and Technical and Practice Bulletins dealing with both benign breast disease and breast cancer.<sup>2, 3, 4, 10</sup>

At a meeting of the Study Group on Breast Disease of the American College of Obstetricians and Gynecologists, the following was recommended: "Basic

teaching in breast management should begin early in residency and should include instruction in adequate history taking, physical examination, breast examination, requisite ancillary tests, management of benign breast disease, performance of needle aspiration and needle biopsies and referrals when appropriate. Medical institutions should be urged to develop this teaching through residency review committee mandate, CREOG objectives, and ABOG requirements. CREOG consultation, outside programs, and an Education for Educators Program should be considered for institutions unable to implement such a program."<sup>5</sup> At this meeting, it was recommended that CREOG develop a program for educating educators to train residents and to provide routine breast care similar to the now established urogynecology program.

In order to implement this concept, CREOG established four centers throughout the United States. It was anticipated that during a two week training period, faculty responsible for resident training in diagnosis and treatment of breast diseases would be provided with the latest information and diagnostic techniques. This information would then be incorporated into the residency program at their own institutions. The Breast Health Center at Women & Infants Hospital in Rhode Island was chosen as one of these centers. Unfortunately, the response was less than enthusiastic, and few institutions took advantage of this opportunity, probably because of competing pressures to establish new programs in primary care.

For many women, the obstetrician/gynecologist is the only physician who provides them with regular health care; however, primary care residency training requirements implemented in 1996 significantly affected the obstetrics and gynecology curriculum content.<sup>6, 7, 8, 9</sup> Obstetrics and gynecology residents found themselves under increased pressure to participate in the required primary care educational programs and rotations, and little time was available for additional training in breast disease.

In my experience, the most valuable educational experience is that associated with participation in a clinical setting such as a multidisciplinary Breast Health Center. Unfortunately, very few obstetrics and gynecology programs have access to these facilities, and even when they are available attendance is sporadic because of competing obstetrics, gynecology and primary care responsibilities. Traditionally, residents evaluate their educational experience based upon the number of operative procedures performed and not on the number of patients seen in the "clinic."

Given the complexities of the contemporary management of breast cancer including the role of the image guided biopsy, the indications for breast conservation therapy including sentinel node biopsy, and the increasing acceptance of the prospective multidisciplinary Tumor Board, few residents are equipped to participate in the evaluation and management of breast cancer patients.

Obstetricians and gynecologists in their expanded role as the primary physician to women, however, are the first physicians to see the patient with breast complaints. They are the patient's last best hope in overcoming the indifference and inadequacy of our present health care dilemma. Patients increasingly rely on their primary care physician not only for relief of symptoms but also as a source for appropriate and expert referral. These physicians bear the double burden of making the correct diagnosis and recommendations appropriate to referral, unfortunately often associated with litigation.

The American Cancer Society has predicted that there will be 192,200 new breast cancer cases in the United States in 2001.<sup>11</sup> In contrast, several million women will have symptoms and signs related to benign breast disease. They are the under-served and in many cases, inadequately managed patients. Unfor-

tunately, the diagnosis of benign breast disease frequently is associated with inaccurate clinical descriptions, an incomplete pathology diagnosis, and the treatment in many cases is unsupported by scientific evidence. The evaluation and treatment of the dominant mass, because of its litigious implications is managed in a more structured and effective setting. The general surgeon seldom sees patients with pain and fibrocystic changes and even nipple discharge since these are not considered operative cases. The result is that except for the patients with breast cancer for which there are formal treatment guidelines, patients either receive inappropriate treatment or are shuffled between their primary care physician and the emergency room.

The previous editions of the *Obstetrics and Gynecology Clinics of North America* devoted to diseases of the breasts were published in two volumes in September and December of 1994. This single volume combines the best of the previous *Clinics* with appropriate updates and recommendations for the primary care physician. The first section deals with the evaluation and treatment of benign breast disease, and the second section discusses the contemporary management of breast cancer. They have been prepared with the primary care physician in mind, including an emphasis on screening, diagnostic evaluations and contemporary management strategies.

Two areas, in my opinion, benefit from additional comment—inflammations of the breast, because in our experience at the Breast Health Center they are frequently incompletely evaluated and incorrectly treated, and duct cancer in situ (DCIS) for which treatment is controversial.

The material provided represents, in my opinion, the latest and best information on the subject. I would like to thank the contributors for sharing their expertise and in doing so with enthusiasm and an eye toward the inevitable publication deadline. I would also like to thank the staff of Saunders, particularly Carin Davis, Clinics Acquisition Manager, who presided over the birth of this project and very patiently anticipated the completion of the several manuscripts. Finally, I would like to thank my staff at the Breast Health Center, Gwen La Riviere and Eleanor Hall, who have cheerfully labored through the many drafts of my articles.

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