



“Making of the book: the story”

DIDIER VERHOEVEN

1



ACE Hot Topic Webinar

29/1/2020, from Antwerp, Belgium



- I. The story
- II. The E-book
- III. The Content
- IV. Availability

2

1

Paris, June 2010



3



4

2

5

Aims

- A comprehensive guide to deliver high quality breast cancer care around the globe
- Focus on the highest possible care within the local resource limitations
- Multidisciplinary outlook
- Hands-on guide for developing a breast centre


6



The faculty




7



OXFORD

UNIVERSITY PRESS

- Origins back to 1478
- Largest university press in the world
- Academic and education
- Online products



8

'I first meet Didier at ESMO October 2016.
Breast cancer: Global quality care has come to fruition due to
 Didier's hard work and dedication in bringing together an
 impressive team of global experts ...



Caroline Smith, Commissioning Editor, Oxford University Press

9

The collage features several elements related to the book 'Breast Cancer Quality Measures':

- Top Left:** A purple box titled 'Measure Concept Examples for Breast Cancer' with a table of examples.
- Top Center:** A circular diagram showing a person in a yoga-like pose, surrounded by text.
- Top Right:** A 'KeyMessage' box with an orange background.
- Middle Left:** Text describing the book's focus: '1. The global cancer burden with a local solution (IARC)'. It lists co-editors: 'Ec' and 'Co-editors: -Germany (Simona Wesselmann)'. It also mentions 'Chapter 1: What happens in some individual countries? coordinator: Sabine Siesling: 5 interesting examples 30 pages (6 x 5 pages) (Europe: 2; Rest of the World/developing countries: 3)'. A 'Quality' seal is also present.
- Middle Center:** A 'FIRST DRAFT' logo for the 'European Commission Initiative on Breast Cancer' and 'Joint Research Centre: The European Commission's science and knowledge service Directorate F: Health, Consumers and Reference Materials'.
- Middle Right:** A vertical stack of text including 'CONTENT', 'in the basis of', 'ical solution (IARC)', 'struction', 'tion is a step get. mer.', 'tries)', and 'ROs'.
- Bottom Left:** '1st Alternate Title: Breast Cancer Quality Measures' and another 'CONTENT' logo.
- Bottom Center:** A 'FIRST DRAFT' logo and a 'CONTENT' logo.
- Bottom Right:** A large graphic with the text 'THERAPY CURES CANCER SAFELY today'.

10

5



- First round passed, 20/2/2017: reviewers are all six positive
- Second round, 12/3/2018: we have received five reviews for the revised proposal



- 23/4/2018: *global breast care quality* has been approved for publication by our Publishing Committee

I am very pleased to say your book provisionally entitled 'Global breast care quality' has been approved by our Delegates Committee on 8/5/2018

11

Without ...



... nothing would have been possible

12

Despite



13

More important.... Without...

- ONE GLOBAL TEAM
- A secretary
- A medical science writer



... nothing would have been possible

14

5/7/2018: signing the contract at Oxford



15

14/1/2019: deadline script submission to OUP



16

13/6/2019: final chapter: Jansi Sivaray

(project manager from Newgen)



- Pre-edit
- Art assessment
- Copy editing: Robin Watson
- Proof review
- Cover
- Indexer



17

14/11/2019: “Publishing a book is just the first step in the journey”



18

7/12/2019: Launching of the book in Antwerp



19

OXFORD MEDICINE ONLINE

Specialty Career Stage Series My Content (2) My Searches (0)

Breast cancer: Global quality care (DRAFT)
 Edited by Didier Verhoeven, Cary Kaufman, Robert Mansel, and Sabine Siesling
 Publisher: Oxford University Press Print Publication Date: Oct 2019
 Print ISBN-13: 9780198839248 Published online: Dec 2019
 DOI: 10.1093/med/9780198839248.001.0001

The Global Burden of Breast Cancer in Women [Download chapter \(pdf\)](#)
 Chapter: The Global Burden of Breast Cancer in Women
 Author(s): Isabelle Soerjomataram, Claudia Allemani, Adri Voogd, and Sabine Siesling
 DOI: 10.1093/med/9780198839248.003.0001

Introduction

The burden of cancer continues to increase as a result of both population ageing and growth as well as changes in lifestyle and exposure to cancer risk factors (1). Today, breast cancer is the most frequently diagnosed cancer in women, and it is the most common cause of cancer death in women (2). Throughout this chapter, we present the most up-to-date population-based estimates of breast cancer incidence and mortality using data compiled by the International Agency for Research on Cancer (IARC) and the World Health Organization (WHO), and breast cancer survival estimates from the CONCORD programme for global surveillance of cancer survival, led by the London School of Hygiene and Tropical Medicine. We only included primary, invasive breast cancer (International Classification of Diseases, 10th revision: C50), which we refer to as breast cancer. The global estimates for breast cancer incidence, survival and mortality, are dependent on the availability and accuracy of local data sources. Generally, there is a paucity of high-quality cancer registration in low-resource and medium-resource areas, and

Contents

- [+] Front Matter
- [+] Part 1 Epidemiology
 - 1 The Global Burden of Breast Cancer in Women
 - 2 Cancer Registries
- [+] Part 2 Quality Management of Breast Cancer: Accreditation Programmes and Quality Control

Breast cancer: Global quality care is available on OUP's online platform

Oxford Medicine Online:
<https://oxfordmedicine.com/>

Oxford Medicine Online is a digital platform hosting Oxford University Press' prestigious medical titles.

The online version is available for subscribers.

Find out more about subscribing [here](#) or speak to your librarian about access.

20

10

The chapters can be navigated via the contents menu on the left

Breast cancer: Global quality care (DRAFT)
 Edited by Didier Verhoeven, Cary Kaufman, Robert Mansel, and Sabine Siesling

Publisher: Oxford University Press Print Publication Date: Oct 2019
 Print ISBN-13: 9780198839248 Published online: Dec 2019
 DOI: 10.1093/med/9780198839248.001.0001

The Global Burden of Breast Cancer in Women Download chapter (pdf)

Chapter: The Global Burden of Breast Cancer in Women
 Author(s): Isabelle Soerjomataram, Claudia Allemani, Adri Voogd, and Sabine Siesling
 DOI: 10.1093/med/9780198839248.003.0001

Introduction

The burden of cancer continues to increase as a result of both population ageing and growth as well as changes in lifestyle and exposure to cancer risk factors (1). Today, breast cancer is the most frequently diagnosed cancer in women, and it is the most common cause of cancer death in women (2). Throughout this chapter, we present the most up-to-date population-based estimates of breast cancer incidence and mortality using data compiled by the International Agency for Research on Cancer (IARC) and the World Health Organization (WHO), and breast cancer survival estimates from the CONCORD programme for global surveillance of cancer survival, led by the London School of Hygiene and Tropical Medicine. We only included primary, invasive breast cancer (International Classification of Diseases, 10th revision C50), which we refer to as breast cancer. The global estimates for breast cancer incidence, survival and mortality, are dependent on the availability and accuracy of local data sources. Generally, there is a paucity of high-quality cancer registration in low-resource and medium-resource areas, and hence, interpretation of the estimates from these regions needs to be done with caution.

Data Sources and Methods: Incidence, Survival, Prevalence, and Mortality

Cancer Incidence

Cancer incidence is the frequency of occurrence of new cases of cancer in a defined area, for a specific population, and for a given period of time (3). It can be expressed as the absolute number of cases or as incidence rate per unit time (e.g. 300 cases per 100,000 population per year), where the number of incident cases is divided by the population at risk in a specified period of time. Comparisons of incidence rates can elucidate underlying risk factors help to, plan aid and prioritize resources for cancer control, and monitor and evaluate the impact of specific primary prevention interventions (4). Cancer incidence data are collected and classified in population-based cancer registries (PBCR, see Chapter 2), which are either national or regional in their coverage. Using these data, national cancer incidence is estimated within the GLOBOCAN project for 184 countries

Each chapter can be viewed online, or downloaded as a PDF

21

Reproduced with permission from Ferlay J, Soerjomataram I, Ervik M, Dikshit R, Eser S, Mathers C, Rebelo M, Parkin DM, Forman D, Bray, F. GLOBOCAN 2012 v1.0, Cancer Incidence and Mortality Worldwide: IARC CancerBase No. 11 [Internet]. Lyon, France: International Agency for Research on Cancer; 2013. Available from: <http://globocan.iarc.fr>

The risk of being diagnosed with breast cancer varies widely by world region (Figure 1.2). In North America, the risk of getting breast cancer before the age of 70 years is 8%, meaning that one out of 12 women in North America will be diagnosed with breast cancer before the age of 70 years. This is followed by 7% and 6% among women in the Oceania region and in Europe, respectively. The risk is lowest for women in Asia and sub-Saharan Africa, ranging from 2.5% to 3%. On the other hand, despite the diverse risks in getting breast cancer, the risk of dying from breast cancer is quite similar across the world region: on average only 1% of all women aged <70 years is expected to die from breast cancer.

Figure 1.2
 Estimated cumulative risk of being diagnosed (grey bar) and dying (dark grey bar) from breast cancer among women before 70 by world region. Data source: GLOBOCAN 2012.

Reproduced with permission from Ferlay J, Soerjomataram I, Ervik M, Dikshit R, Eser S, Mathers C, Rebelo M, Parkin DM, Forman D, Bray, F. GLOBOCAN 2012 v1.0, Cancer Incidence and Mortality Worldwide: IARC CancerBase No. 11 [Internet]. Lyon, France: International Agency for Research on Cancer; 2013. Available from: <http://globocan.iarc.fr>

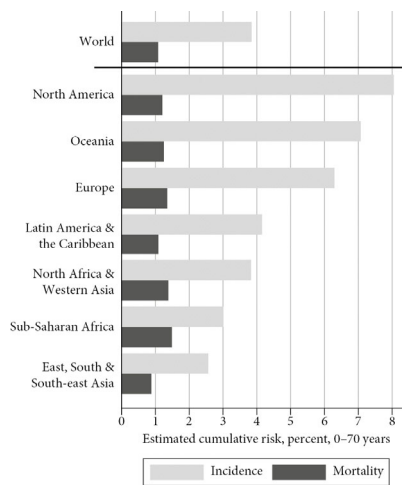
Due to differences in population size, and Asia being the most populated region with two-thirds of the total world population, the Asian continent reports the highest number of new cancer cases (36%, including 11% in China and 9% in India) followed by Europe (26%) and North America (16%). By contrast, earlier diagnosis and more effective treatment of breast cancer lead to fewer deaths in these regions, and ultimately a higher number of survivors (prevalence), with Europe and North America showing the highest proportion of prevalent breast cancers (Figure 1.3).

Figures appear within the text, and can be made larger with a click

Figures can also be downloaded as PowerPoint slides to use in lectures and presentations (see next slide)

22

Figure 1.2 Estimated cumulative risk of being diagnosed (grey bar) and dying (dark grey bar) from breast cancer among women before 70 by world region. Data source: GLOBOCAN 2012.



Chapter: The Global Burden of Breast Cancer in Women Author(s): Isabelle Soerjomataram, Claudia Allemani, Adri Voogd, and Sabine Siesling From: Breast cancer: Global quality care (DRAFT)

Downloaded from [Global Medicine Online](http://dx.doi.org/10.1002/9781118445111.ch11). Reproduced with permission from Ferlay J, Soerjomataram I, Ervik M, Dikshit R, Eser S, Mathers C, Rebelo M, Parkin DM, Forman D, Bray F. GLOBOCAN 2012 v1.0, Cancer Incidence and Mortality Worldwide: IARC CancerBase No. 11 [Internet]. Lyon, France: International Agency for Research on Cancer; 2013. Available from: <http://gobocan.iarc.fr>

23

effects including an emphasis on health promotion, and information concerning who will be responsible for, or who to contact regarding, all of the above (Box 20.1) (17). Ideally, the SCP is generated and discussed as part of a transition meeting with the cancer survivor and treating staff. While the document itself is useful for cancer survivors to have as part of their medical record and to share with future healthcare providers responsible for their care, more important is the conversation that accompanies its completion.

Box 20.1 Survivorship Care Plan (SCP) contents per the Institute of Medicine

1. Surveillance for recurrence or new cancer
2. Assessment and treatment or referral for persistent effects (e.g. pain, fatigue, sexual dysfunction, functional impairment, depression, employment issues)
3. Evaluation of risk for and prevention of late effects (e.g. second cancers, cardiac problems, osteoporosis), health promotion
4. Coordination of care (e.g. including frequency of visits, tests and who is performing these)

Source: based on Hewitt ME et al. *From Cancer Patient to Cancer Survivor: Lost in Transition*. Washington DC: The National Academies Press; 2006 (17).

Participants in the 5th Breast Health Global Initiative Global Summit outlined a set of recommendations for delivery of supportive care after curative treatment for breast cancer that might be reasonable to provide, depending on the resources available in a certain country. These use breast cancer care as the model, but the content of the recommendations is readily generalizable to survivorship care for cancer more broadly (see Tables 20.1 and 20.2) (18).

Table 20.1 Healthcare delivery issues: health education, community adaptation, and patient support following curative treatment

	Basic	Limited	Enhanced	Maximal
Health professional education ^a	BC recurrence, second primary cancer Long-term TX complications Women's health Psychosocial (survivorship) consideration ^b Lifestyle modifications	Psychosocial risk assessments Psychosocial complications of survivorship Sexual health	Psychosocial screening methods	
Patient and family education ^b	BC recurrence or new cancers; symptoms to report Long-term and late TX complications Appropriate use of	Follow-up schedules Adherence to endocrine therapy Sexual health		

Here is an example of what boxes and a tables look like

24

All websites are hyperlinked so the reader can click straight through to the web page

Cross-references within the text are hyperlinked to the relevant chapter, heading, or figure

Peer-to-Peer Support

As patients are becoming experts in their own disease, they are often seeking out their peers for information. Online discussion forums such as breastcancer.org are popular sources of information and support. Both open and closed (private) Facebook groups exist for many different breast cancer subpopulations, including BRCA gene carriers ([see Chapter 22](#)), ductal carcinoma in situ, metastatic breast cancer, reconstruction type, and lack of reconstruction. Twitter is home to two robust breast cancer support communities: #BCSM (Breast Cancer Social Media) and #BCCWW (Breast Cancer Chat Worldwide). These Twitter communities were founded by breast cancer patient advocates as sites for patients to gather and discuss evidence-based information and issues related to breast cancer diagnosis, treatment, and survivorship. Both communities benefit from regular physician participation, and, in the case of #BCSM, participation in the group chats has been shown to improve patient education and decrease anxiety (9).

However, there are some cautions in directing patients to online information sources. Newly diagnosed patients need to understand that accessing information, especially in a peer-to-peer setting, does not ensure that the information is evidence-based or even applicable to themselves. This situation may be exacerbated by individuals (media, medical, or other) who drive traffic to their websites in order to sell or to promote ideas or thoughts that may not be well-researched or credible. Patients should be encouraged to bring information found online to the attention of their physician and to discuss whether the information actually pertains to them.

Reference numbers are linked to the reference list at the end of the chapter

25

The book is fully searchable

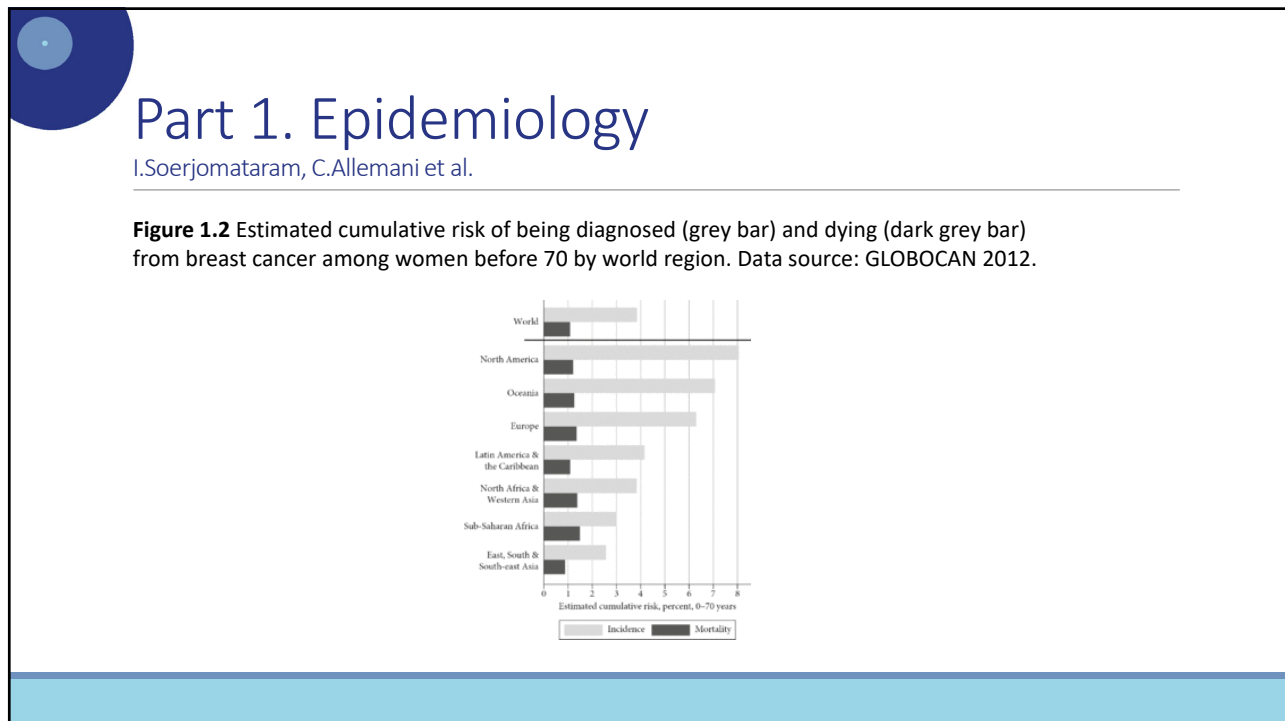
The screenshot shows the Oxford University Press search interface. On the left is a navigation menu with 'Contents' and 'Part 1 Epidemiology'. The main search area shows the search term 'technology' and various filters like 'By Availability' and 'By Date'. On the right, search results are displayed for two chapters: 'Improving Treatment Value Using Health Information Technology' and 'The Status of Breast Pathology around the Globe'. Each result includes the authors, publication year, and a snippet of the text.

Returning the chapters most relevant to your search term

26



27



28

14

Part 2. Quality Management / NAPBC Vision

C.Kaufman et al.

Breast programme leadership with local authority	A small leadership team of the breast centre with authority to direct actions and direction of the breast centre.
Multidisciplinary providers of care	A team of dedicated clinical professionals with speciality expertise with regards to breast disorders.
Regular multidisciplinary breast conferences	Regularly scheduled multidisciplinary meetings of the breast centre clinical team with pretreatment discussion of all patients.
Set of approved treatment guidelines	An agreed upon set of standards, guidelines or treatment schemes that guide the initial approach for each unique clinical situation.
Concurrent database management	Ongoing real-time monitoring of clinical care facilitated by maintaining a database on all patients.
Maintained equipment for diagnosis and treatment	A fully equipped breast centre with up-to-date supplies and functioning equipment within the practical restrictions of the region.
Quality improvement programmes	Regular quality improvement projects initiated and completed by the multidisciplinary team and reported to the breast centre leadership. This may often include clinical research projects.
Clinical research opportunities	Provide patients with opportunities to participate in clinical research.
Community outreach and awareness programmes	Outreach efforts to provide and inform the local community of the need for screening as defined by your region.

29

Part 3. The Guidelines

B. Anderson et al.

NCCN	<ul style="list-style-type: none"> • Annual institutional review of guidelines by clinical cancer experts at NCCN member institutions of new data/evidence. • NCCN Headquarters Guidelines team identify important clinical issues/topics for deliberation at the annual Panel meetings. • Literature Review: Prior to the annual update of the Guidelines, an electronic search of the PubMed Database, provided by the US National Library of Medicine, is performed to obtain key literature published since the previous Guidelines update. • See https://www.nccn.org/professionals/development.aspx 	<ul style="list-style-type: none"> • Evidence weighting: • Category I, high level of evidence with uniform consensus; • Category IIA, lower level of evidence with uniform consensus; • Category IIB, lower level of evidence without a uniform consensus but with no major disagreement; • Category III, any level of evidence but with major disagreement. 	Annual	US/global
------	---	--	--------	-----------

30

15

The Guidelines

Key Messages

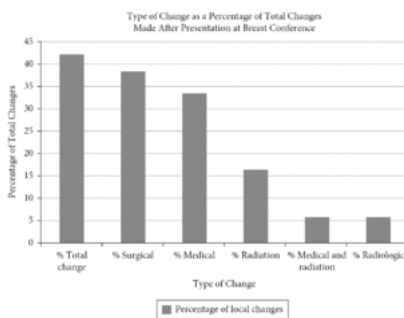
- The development and use of guidelines for the management of breast cancer in HICs has led to extensive evidence to support their widespread use.
- Adherence to evidence-based guidelines is associated with improved patient outcomes.
- In resource-rich environments, there is relatively little variation between CPGs themselves, although uptake and compliance vary widely between, and in some cases between and within, institutions.
- As CPGs appropriate for use in LMICs are developed, attention to barriers that may prevent or reduce their implementation efficacy should be assessed.
- Resource-stratified guidelines provide an approach, whereby evidence-based treatment approaches can be adapted to existing practice environments in LMICs.
- Since the implementation of resource-stratified guidelines has not yet been shown to improve cancer outcomes in LMICs, implementation research methodology will need to be developed to assess how improved guideline adherence in LMIC correlates, or fails to correlate, with improved breast cancer outcomes.

31

Part 4. The multidisciplinary meeting

T. Sarantou et al.

Figure 10.1 Type of treatment modification as a percentage of total change made following discussion at MBC. A total 42% of all cases presented received changes to treatment following discussion at MBC (38.2% surgical, 33.3% medical, 16.6% radiation, 6.8% both medical and radiation, and 4.9% radiologic).



32

16

Part 5. Quality Control / Radiology

H. Junkermann et al.

Table 11.1 Comparative utility of imaging methods according to tasks

Method	Symptomatic disease	Screening average risk	Screening high risk	Assessment of detected lesions
Mammogram	+++	+++	++	+++
Tomogram	+++	++	–	++
Ultrasound	+++	–	–	+++
MRI	+	–	+++	+

MRI, magnetic resonance imaging.
 +++, essential; ++, useful; +, not mandatory; –, no role.

33

Quality Control / Pathology

S. Masood et al.

Table 12.2 summarizes the guidelines, process, and quality indicators related to the possibility of offering breast conservation in countries of limited resources. As previously indicated, detailed information about the tumour as well as the status of surgical margins and sentinel lymph nodes are essential to the report.

Table 12.2 Special considerations for breast conservation and sentinel lymph node biopsy

Guideline	Process	Quality indicator
Pathology report should include the status of margins, the presence and extent of ductal carcinoma in situ, and the presence of lymphovascular invasion	Adopt standardized methods of orienting specimen, and inking and sampling the surgical margins	% of pathology reports include margin status, ductal carcinoma in situ, and lymphovascular invasion
Measures in place to provide intraoperative evaluation of sentinel lymph nodes	Adopt standardized methods for determination of the presence and quantification of ductal carcinoma in situ and lymphovascular invasion	% of diagnostic discordance between intraoperative and final pathologic diagnosis for sentinel lymph nodes
	Adopt standardized methods for processing and reporting of sentinel lymph nodes	

Reproduced with permission from Masood S, Vas L, Ibarra JA, et al. 'Breast Pathology Guideline Implementation in Low- and Middle-Income Countries'. *Cancer*. Volume 113 Volume 8 (Suppl). pp. 2297–304. Copyright © 2008 John Wiley & Sons. DOI: <https://doi.org/10.1002/cncr.23833>

34

17

Quality Control / Reconstructive surgery

M. Magelhaes Costa et al.

Oncoplastic surgery has four levels of competence:

- Level 1: unilateral and displacement techniques, aesthetic skin incisions, de-epithelialization of areola margins, glandular mobilization and reshaping techniques, and purse string suture of central quadrant reconstruction;
- Level 2: bilateral and replacement techniques, breast reduction, mastopexy, Grisotti flap, and nipple and areolar reconstruction;
- Level 3: expander and implant techniques, immediate breast reconstruction with temporary expanders or implants, and contralateral symmetry procedures;
- Level 4: autologous flap techniques, either pedicle or free tissue transfer or a combination of both techniques.

Breast surgeons should be prepared to work with levels 1 and 2, but the ideal is to have a full training to manage all case scenarios.

35

Quality Control / Radiation Therapy

P. Poortmans et al.

Table 15.1 Requirements for infrastructure, staffing, and workload, as defined by the Radiation Oncology Group of the European Organisation for Research and Treatment of Cancer

	Before 2009	Since 2009
Human resources: workload		
FTE radiation oncologists per department	Minimum 2.5	Minimum 3
Patients treated per year/FTE radiation oncologist	Maximum 300	Maximum 250
FTE qualified radiation physicists per department	Minimum 1.3	Minimum 2
Patients treated per year/FTE radiation physicist	Maximum 500	Maximum 500
Radiation technologists per treatment unit	Minimum 2	Minimum 2
Equipment: numbers		
Simulator (classical and/or CT scanner)	Minimum 1	Minimum 1 [*]
Megavoltage treatment units [†]	Minimum 2	Minimum 2
Equipment: workload		
Patients per year/megavoltage unit	Maximum 700	Maximum 600
Patients per year/conventional simulator	Maximum 1500	Maximum 1200
Patients per year/CT simulator	–	Maximum 2400

CT, computed tomography; FTE, full-time equivalent.

^{*} Including access to a CT scanner.

[†] Preferably aged <10 years.

[‡] Based on normal working hours.

36

18

Part 6. HIT

R.Maguire et al.

Figure 22.2 The quantified self.



37

HIT

G.Parham et al.

Table 23.1 Major challenges related to teleoncology in sub-Saharan Africa

- Local technical expertise remains essential even to process specimens
- Resources to train personnel and establish and maintain equipment and servers
- Strong commitments by participating pathologists, clinicians, and IT collaborators
- Minimum computing and image capture technologies
- Stable source of funding to maintain and replace equipment over time as required
- Insufficient bandwidth for smooth communication and timely loading of scanned slides
- Unpredictable Internet service provider outages
- High cost of Internet service

38

19

Part 7. Research

D. Verhoeven, F Cardoso et al.

Figure 25.2 World map with the number of performed clinical breast cancer studies.

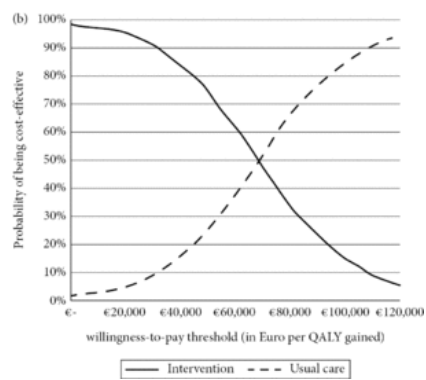


39

Part 8. The economics

M. Joore et al.

Figure 27.4 The incremental cost-effectiveness plane and cost-effectiveness acceptability curve.

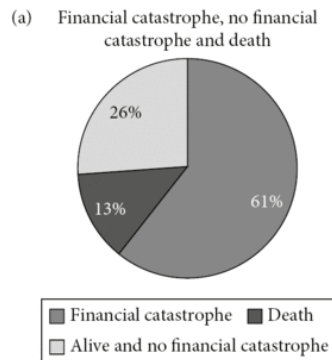


40

20

The economics

Figure 28.1 Financial catastrophe, economic hardship, and death at 12 months after diagnosis among breast cancer patients. OOP, out-of-pocket.



41

Part 9 . Patients, physicians and the media

D. Attai et al.

Figure 30.1 The cry: US and UK version.



"I stumbled upon conversations among women trying to find answers to very basic questions that I felt should have been answered by their physicians. Some women were truly uninformed, but many were simply overwhelmed."

Deanna Attai MD

42

21

Patients and physicians

R. Mansel

Figure 31.1 How 17,338 claims were settled in 2016/17.

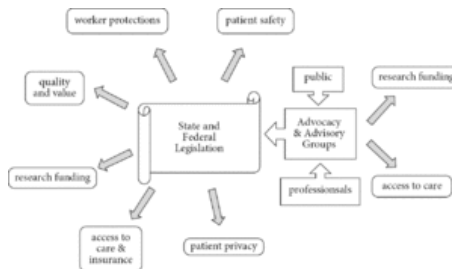


43

Part 10. Governments and executives - US

L. Tucker and T. Heckel

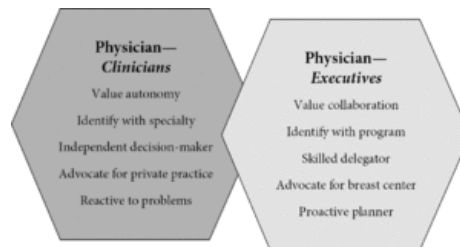
Figure 33.1 Relationship between government and advocacy in the development of health policy, access, and funding in the USA.



44

Governments and executives

Figure 33.2 Attributes of physicians versus leaders.

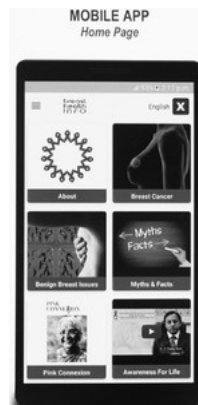


45

Governments and executives – India

Raghu Ram

Figure 35.2 The world's first mobile phone breast app.



46

23

Availability of the book / E-book

Online

- Oxford University Press

<https://global.oup.com/academic/product/breast-cancer-global-quality-care-9780198839248?cc=be&lang=en&>

- Amazon

<https://www.amazon.com/Breast-cancer-Global-quality-care-ebook/dp/B081566JLD>

47

Questions? didier.verhoeven@KLINA.be



48

24