By the 1990’s, as incidence of all kinds of cancers increased and as treatments became variable including chemotherapy, it has become inevitably necessary to manage cancer at national level. Accordingly, our country established a ‘10-yr project for defeating cancer’ in 1996 and started a national cancer screening program to detect early cancer since 1999. At the beginning, screening was held only for stomach, cervix and breast but from 2004, it has been extended to screen for 5 leading cancers including liver and colon. For the past 10 yr, in Korea, incidence of breast cancer has increased significantly and since 2002, it has become the first leading cancer in Korean women. However, the quality of facilities in Korean medical institutions diagnosing breast cancer primarily could not keep up with the increasing rate of breast cancer. Especially, there were large gaps in standards between mammaryography instruments. The purpose of taking mammaryography is to make high contrast/high resolution images with minimum radiation exposure. Obtaining the best breast image requires a mammaryography machine with proper positioning, compression, Quality Control (QC) program, and appropriate management. The State has already passed the Mammaryography Quality Standard Act (MQSA) law in 1992 and management has been carried out legally.

Hence, Korea announced amendment pertaining to safety standards for mammaryography instruments in January 2001 as the first step. Moreover, as special law for national health insurance and financial soundness established in January 2002, regulations for special medical equipments installation and operation have been constructed. In April 2002, extensive evaluation for control concerning related equipments brought shocking results, 27.4% of CT (81/296) and 52.7% (69/131) of mammography machine had defects. Based on these results, enforcement was increased and mammography machines have been managed legally as special medical equipment, along with CT and MRI since January 2003. Regarding installation and management of special medical equipment, regular overhaul of mammography is compulsory. Documentation on inspection of manpower, testing for proper quality, and phantom image testing should be checked once a year and the clinical imaging test should be compared with the previous 3 check-up tests every three years as part of thorough examination. It was those periods when surgeons from private practice specializing in breast cancer started to form an organization. It was not until 2000 for breast cancer screening to be generalized throughout the country in private clinics although it actually started in 1992. Most of doctors performing breast cancer check-ups in private clinics were surgeons. Before that time, people preferred general hospitals for breast cancer examination, as they had more confidence in medical team and machines, even though the process was time consuming and expensive.

However, people began to change their perception when the private clinics were equipped with same facilities as general hospitals and surgeon became responsible for breast cancer evaluation. Surgeons specially trained for
breast disease performing breast cancer screening was
the principle reason to this change of mind. When regu-
lations for setting up special medical equipment for breast
disease became effective in 2002, an association consist-
ing of surgeon based breast cancer screening clinics was
established. The association set strict qualification cri-
teria surpassing government standards. It consisted
mainly of surgeons in private clinics who had over 80% of all clinic visiting patients for breast cancer screening
and with diagnostic equipment for mammography and
sonogram above standard level. Presently, there are 40
private breast clinics attached to the Korean Association
of Breast Clinics (KABC).

In 2004, analysis of patients diagnosed with breast
cancer at KABC was performed. In Korea, a total of 9,667
patients were diagnosed as breast cancer and received
operation. Among them, 1,295 patients (13%) were diag-
nosed at KABC where 28 breast clinics participated for
the analysis. Patients with in situ cancer comprise 9.6%,
and those at stage 1 comprise 35.6% of all breast cancer
patients in Korea. However, according to KABC statis-
tics, in situ accounted for 14% and stage 1 61%. The devel-
opment of trust worthy breast cancer screening hospitals
with easy accessibility seems to be the main reason for
this difference.

Private clinics are losing ground in Korea. Although
90% of medical graduates become specialist doctors, it
is not easy to practice their specialty in private clinics.
Particularly, 35% of surgeons are giving up their spe-
cialty. Doctors who want to specialize in surgery are
decreasing as surgeons are losing their identity as sur-
geons and this has become a social problem. However,
KABC members practicing breast cancer have the highest
level of professionalism and pride among various spe-
cialties. KABC have professionalism and bright future,
but for further advancement, there are assignments to
be solved.

Standardization of diagnostic tool

First, breast cancer can be diagnosed with mammo-
gram, and, if necessary, sonogram and biopsy. In the
United States, with large population of breast cancer
patients, breast cancer diagnosis has been standardized.
This was necessary since there were differences in results
based on individual experiences. Therefore, in 1992, the
American College of Radiology (ACR) imported Breast
Imaging Reporting And Data System (BI–RADS) for use
in describing mammographic findings. Category is
classified according to the degree of expected malignancy
showing guidelines if it is normal: whether follow up or
biopsy is necessary for abnormal lesions. The contents
have been revised through constant mediations of opin-
ions. Followed by the first revision in 1995, the second
revision was established in 1998, and the third revision
in 2003, including ACR–BIRADS–US, MRI. Even though
the classification of BI–RADS of sonogram is similar to
those of mammogram, they are divided in detail focusing
on the characteristics of its own.

Nowadays, in Korea, BI–RADS classification from the
United States is being used and biopsies are performed
accordingly. However, it has never been studied if the
classification is applicable for breast evaluation in Korea.
For example, in Japan, meetings of Japan Association
Breast Thyroid Sonogram (JABTS) are held twice a year
to set standardization fitting their actual state by exam-
ination and revision of the category. As a matter of fact,
since I have patients in my own practice, I often person-
ally thought BI–RADS classification revision should be
done to suit Korean society. To achieve more professional
aspects in our meetings, we need constant revision and
compensation on the BI–RADS classification of Koreans.

Second, data of breast screening should be collected. In
the United States, after basic mammogram is taken in
women under 40s, mammogram is recommended every
1–2 yr between 40 and 50 yr of age depending on risk
factors and annually for women over 50 yr of age. Since
2003, ACR recommends sonogram for high risk groups.
In Korea, self–examination if recommended for women
under 35: women between the age of 35 and 40 need to
be checked by a doctor, and those over 40 need an annual
mammogram unless they belong to a high risk group.

However, according to clinical experience, there are
inconsistencies following these guidelines. Considering
that incidence of breast cancer occurs in younger age in
Korea and that unlike American women, many Korean women have dense breasts, limitations of mammography should be assessed. Although fewer American women have dense breasts, a great deal of research has been done on the limitations of mammography. As a result of comparative analysis of palpable breast cancer with 132 cases by Stavros(4) in 2004, lesions were not observed in 34 cases (26%), lesions were considered benign in 5 cases (4%). Korean women have much more dense breasts: it has been reported that 50–90% of women have dense breasts, depending on the hospital. However, data on the limitations of mammogram are few. Therefore, KABC has a great deal of task to fulfill. Data needs to be collected and revised constantly regarding starting period, interval, ending period, examination tools of breast cancer screening and guidelines for high risk group.

Third, after diagnosis of breast image, biopsy is performed for confirmation. There are various methods for confirmation such as fine needle aspiration, core needle biopsy, incisional biopsy, excisional biopsy and vacuum-assisted biopsy device. These days, biopsy method is selected depending on each hospital and personal experience. It is important to establish guidelines to select the most appropriate procedures according to images of the lesion.

**Concerning benign breast disease**

The first aim of the breast clinic is early detection of breast cancer. The clinic focuses on this primary aim, and general hospitals are also focused on breast cancer diagnosis and treatment. It is obvious that KBCS has the same interest. Therefore, it is natural that there is less concern for benign breast disease. In fact, many patients visit breast clinics for symptoms such as breast pain, inflammation or for benign mass in addition to breast cancer. Even KBCS has few approach methods for benign disease. Moreover, the Journal of KBCS does not include research articles on benign breast disease. KBCS should be more concerned than ever about benign breast disease and provide opportunities to discuss, share opinions and give presentations about treatments.

**Extension of specialization**

In current medical practice, it is rare for a disease to be limited to a specific department. As boundaries are collapsing, conflicts are fostered between departments. However, this trend will not change, only worsen in the future. It is actually predicted that doctors with same interest of disease of an organ, concerning treatment to management will gather together regardless of their specialties. In other words, surgeons should be able to practice all kinds as a primary physician relating to disease of the breast. This includes breast cancer diagnosis, breast reconstruction and especially management after breast cancer surgery.

In the present state, patients have been highly satisfied with cancer treatment due to the remarkable system but in cases of care after treatment, they have been unsatisfied. Following cancer diagnosis, anxieties of patient and families have been endless: patients want to know what the survival rate is, which treatment is better, and where they should receive medical attention. Anxiety about nutrition, stress, and exercise is extreme.(5) The most frequent question is about diet. Most of the time, the answer is to eat well. If you think of food accounting for 35% of cancer development and treatment, nutrition education and awareness are extremely important. Stress is known as a root cause of all current diseases, and one of the factors in development of cancer. Patients feel uneasy when they undergo cancer surgery and chemotherapy. Advising them to take it easy is not enough to reduce their anxiety. Approach to soothe their anxiety should be administered after the patients’ mental state has been evaluated. Cancer patients tire easily as a result of surgery and the side effects of chemotherapy. However, exercise for cancer patients is important.

According to cancer prevention guidelines from the United State cancer association, exercise could reduce cancer risk by as much as 35% if people exercised more than 30 min a day and more than 5 days per week. New access to exercise, including aerobic exercise, rather than just body movement, is necessary. Numerous patients pay attention to exercise, stress management, nutrition and complementary medicine while there are only few
hospitals and doctors who actually address these needs. Surgeons should be concerned about this problem. Surgeons who, make diagnosis, operate on, give medication, observe patients regularly should feel responsible to resolve a patients’ curiosity. This is especially appropriate for surgeons working at KABC clinics.

Although KABC has a short history of its own, it has become the most successful and specialized group among many primary clinics in Korea. There is a possibility that breast cancer incidence may increase in the future and many problems remain to be solved. That is why many more young doctors specializing in surgery is required to participate. I hope young breast cancer surgeons build professional knowledge of breast cancer surgery in university hospitals and as emerge as primary clinicians, giving efforts to approach breast cancer from diagnosis to surgery, chemotherapy, cancer care and complementary medicine, and to collect experimental data.

REFERENCES