Background: Breast-conserving surgery (BCS) is generally considered to be a safe treatment option for the majority of patients with T1 breast tumors (i.e., <2 cm) and a substantial part of those with T2 tumors (i.e., 2.1–5.0 cm). Breast cancer, treated in general hospitals in the southern and eastern part of the Netherlands in the period 1990–2000.

Results: Between 1990 and 2000, the proportion of patients undergoing BCS in the eastern and southern part of the country was 51% and 66% for pT1 cancers and 25% and 37% for pT2 cancers, respectively. In both regions a significant increase was observed in the use of BCS for patients of 70 years or older with T1-tumours; in the early nineties around 30% underwent BCS, whereas in 2000 64% underwent BCS in the southern part of the country and 46% of those in the eastern part. A decrease in the use of BCS was observed in patients younger than 45 years of age, especially for those with T1-tumours in the eastern part of the country (from 71% to 57%). Only in the eastern part of the Netherlands, the use of DCIS increased from 50% to 86% for patients of 50 to 70 years (screened age group) of age with T1 breast cancer and from 20% to more than 35% for those with T2 breast cancer. In-hospital variations within regions appeared to be larger than the differences between regions. In the period 1996–2000, the use of BCS for patients with T1 tumours varied between 42% (95% CI: 36–48) and 82% (95% CI: 77–86) in the southern part of the country and between 43% (95% CI: 37–48) and 61% (53–68) in the eastern part of the Netherlands. For T2 tumours these proportions were 16% (95% CI: 11–21) versus 33% (95% CI: 26–40) and 24% (95% CI: 18–29) versus 38% (95% CI: 29–49), respectively.

Conclusions: More than 20 years after the introduction of BCS in the Netherlands, large variations still exist between hospitals and regions in the use of this treatment. Differences can be partly explained by the patient’s wish, specialist’s belief in the treatment and favourable or unfavourable experiences with local recurrence after BCS. More specific guidelines and regular evaluation of adherence to these guidelines and the local recurrence rate in each hospital are needed to attain acceptable variations in the surgical treatment of breast cancer.

Background: Breast cancer treatment and 5 controls with a digital camera in four positions (front arms up and down, left and right side arms up). Previously a score (0–15) was established and the final sum was fitted into one of four classes (bad <3, medium 3–8, good >8 <13 and excellent >13). In a first round the seven observers gave each case a final score subsequently converted into one of the four classes. In a second round, the seven observers directly classified each case in one of the four classes. The individual agreement between the score classification converted in four classes and the direct classification in four groups was evaluated by the kappastatistic (k), for each of the seven observers. In order to improve the agreement and presuming that the intermediate classes were more difficult to discriminate, we recorded the two previous four classes classifications in three groups, merging the “medium” and “good” classes together and recalculated the kappastatistic (k) for each observer. A last approach was to select new boundaries between classes in order to minimize the difference between the score and the direct classifications. This classification used the difference measured by counting and weighting the mismatched results. Once again the kappastatistic (k) was calculated for the agreement between the score classification and the direct classification.

Results: The agreement between the score classification and the direct classification in four classes for each of the seven observers was very low, k coefficients between 0.37 and 0.61 for the four classes and between 0.38 and 0.54 for the three classes.

Conclusions: We found poor agreement between observers, regardless of the classification used. Even when optimised classes were used, the agreement between observers did not improve.

Background: Breast cancer surgery was introduced over the last two decades. The results were presented in uncontrolled studies using selected populations, or were based on retrospective analyses. The present study evaluates in an unselected group of patients feasibility and safety of breast cancer surgery in an ambulatory setting with or without a patient centered breast cancer care program. In order to introduce a patient centered breast cancer care program in our hospital, we have to change their attitude and behavioral trends, so their knowledge about health beliefs is an important issue to be considered.

Objective: to determine Health believes of women about mammography.

Material and Method: This was a comparative cross sectional study. Information gathering means were questionnaire.

Background: Breast cancer is one of the life threatening problem in women's life. One of its early diagnostic method is mammography which is used to detect breast cancer. For women to perform mammography, we have to change their attitude and behavioral trends, so their knowledge about health believes is an important issue to be considered.

Material and Method: This was a comparative cross sectional study. Information gathering means were questionnaire.