Transcript – Testimony – Feb. 26, 2008

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Representative Connor

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REP. O'CONNOR: Next speaker is Gary Griffin. Actually, could you please state your name, please.

DR. GARY GRIFFIN: I'm Doctor Gary Griffin and I'm President of Torrington Radiologists and the Director of Breast Imaging at Charlotte Hungerford Hospital in Torrington.

I had something I was just initially just read, but I think we've been through a lot of this already, so I think I can summarize.

Our practice began doing screening breast ultrasound shortly after the bill was enacted in October 1, 2005, because we felt it would be a useful examination for our patients.

I can tell you what our experience has been so far, we probably have done roughly about 1000 of these examinations each of the two years since that bill was enacted.

In those two years, we've averaged between nine and ten cancer detections per thousand ultrasound that we've done. Just putting that in perspective, the National average for detecting breast cancer with the screening mammography program is probably somewhere between four and a half cancers per 1000 mammograms done. We actually average a little bit higher than that.

In our practice we've detected about six cancers per 1,000 screens and despite that we've found another nine or ten cancers per thousand when we've done these screening breast ultrasounds and I've realized that ultrasound examination is not necessarily something that has stood the entire test of time.

There always seems to be something that is going on that makes it sound like a test that may be a little bit better.

Unfortunately, there is not anything on the horizon that is going to be perfect, but we found that the ultrasound are relatively easy to do, relatively inexpensive and pretty well-tolerated by our patients and at least in our experience have shown a pretty good detection rate and even though the ACRIN trial is not yet finished and probably wont be for another couple of years, that has shown at least a 30% increase in cancer detection by doing that examination.

So at the moment, it may not have all the data in, but it's a reasonable test to be considered as an adjunct to mammography.

What I was concerned about when I first started this, is how do we get people to get this done and part of the problem is, how do we get the patient's themselves to know and how do you get the physicians to understand what it is we are trying to accomplish.

Before we started this, we spoke with most of the major medical groups in our community and let them know that I was going to try and do this.

One of their concerns was, well gee, its going to be a lot of work for our offices in terms of trying to order these exams, who should get them, who shouldn't get them.

So there is a couple of things that we've done which I think have worked very well. First of all, it's not a big deal to put the information as far as breast density in the mammography reports. Most of these we are talking about are normal mammograms.

Most of us use, for want of a better word canned normal reports and all you need to do is put an extra line on your canned report and the information is there.

The problem is how many of these physicians actually still, despite talking with them understand what that means, so when we have someone who has a dense breast category 3 or 4, we put an extra paragraph in the bottom, saying that they might want to consider doing a breast ultrasound.

We also have modified our letter that we send to the MQSA act that requires that patients receive letters describing their mammographic findings in plain language.

We felt it would be a little bit confusing to try to go through all of this information with any particular patient as far as just a simple letter.

So in our letter in patients ho have dense breasts we have a paragraph saying, your mammogram is normal, but you have dense breasts and that may signify that additional testing might be of benefit.

If you have any questions please call our office and we put our facilities name on there for them to call, again with the idea being if they call a referring physicians office, they may not understanding what to even say and they may be a little bit angry at the fact that they have to spend their time doing that.

That's our business and we can make the explanation better than their office does. If we don't hear from the patient, we will then call them. I'm not sure that's something [Gap in testimony. Changing from Tape 3B to Tape 4A.]

--we do follow it up personally with making sure that every patient that we have given a label of dense breast understands at least that they have dense breast and hopefully what that means.

If for some reason we do not do in a hard sell in this, if for some reason the patient doesn't want the exam, that is fine with us. If they want to talk more with their doctor, that is fine with us.

If they want to go ahead and schedule it, then we actually take the initiative, we will schedule it for them, we will call their doctors office and tell them you're patient has requested an ultrasound examination as a supplement to their mammogram, could you please send us an order?

REP. O'CONNOR: Could you please conclude? Your three minutes has gone up.

DR. GARY GRIFFIN: Yes. Basically, I would like to support Senate Bill 172, I would like to support the idea of sending information that would go in the body of the report as well as to the patient that lets them know that they have dense breasts and there are other alternative test that they can use for following up on that.

REP. O'CONNOR: Thank you. And questions? Thank you very much.