

# THE ART OF COMMUNICATING WITH PATIENTS, WITH SOME THOUGHTS ABOUT THE TRANSDUCER AND PALPATION

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## Introduction

William Osler said, *“Medicine is learned by the bedside and not in the classroom. Let not your conceptions of disease come from words heard in the lecture room or read from the book. See, and then reason and compare and control. But see first.”*

This presentation on communication will offer more philosophy than science. As physicians, we have made great strides in advancing the science of our respective disciplines. After nearly 50 years in the practice of medicine, with the first seven in primary care, I feel that some of my greatest accomplishments have been made while talking with patients. Communication is a fundamental component of good medicine. Good patient care suffers when colleagues neglect or provide only the most basic communication. The radiologist, who is prepared to talk to and examine patients with an appreciation for their anxieties, embarrassment and need to hear some good news, is uniquely positioned to favorably impact the patient’s welfare. As healthcare providers, we should respect the fact that anxiety is morbidity. In the field of breast cancer diagnosis, patients’ concerns include not only mortality, but also bodily deformation. Even short delays in providing answers can compound the impact of anxiety. Every patient we see in a breast imaging practice wants to hear good news, even after receiving the bad news of a breast cancer diagnosis. This discussion will deal with personal thoughts on this subject and an approach I have applied in my practice and shared with residents, fellows and colleagues. The response from patients has been an affirmation to me that these ideas and methods of communicating pass the test for a worthy standard of care; quite simply, ***common sense and what is best for the patient.***

## Background

Direct patient communication has not been an important responsibility of the radiologist, short of “Hold your breath and “Don’t move” or “Take a mouth full, but don’t swallow until I say ‘Swallow’”. As breast imaging has matured into an important subspecialty of radiology, it has evolved into a more clinically oriented discipline. There is far greater need for direct contact and communication with the patient about procedures, diagnoses, management options and follow-up recommendations. Many breast-imaging radiologists have observed that patients are increasingly looking to them as their “primary breast care physicians”. This new identity is having an interesting, if not a profound, effect on breast-imaging practitioners. There are some who admit discomfort with a clinical role, while others embrace it as one of the more attractive, if not most attractive, aspects of breast imaging. I am encouraged to see this disparity in attitude toward accepting a strong clinical role because it distinguishes those who should from those who should not be breast-imaging radiologists. I am convinced that physicians with expertise in their field and an ability to show compassion for patients can learn to be effective communicators. The personal reward of enhanced job satisfaction can be enormous. This reward is the most logical explanation for the conspicuous passion for the discipline shown by many breast imaging radiologists.

## Basic considerations in communicating with patients

Diagnostic breast imaging studies frequently reveal the need to obtain a definitive histological diagnosis. Needle biopsy, performed by the radiologist has become the procedure of choice for tissue sampling. The radiologist interprets the mammogram, determines the need for, and performs the biopsy, receives the pathological results, determines concordance of the tissue diagnosis with the imaging concern and guides the patient toward the most appropriate disposition based on the information to date. The radiologist is clearly the best equipped to explain the imaging findings, discuss the need for biopsy and finally to present the biopsy results and appropriate options to the patient. With a small dose of compassion,

gentle and artful optimism (the good news) and a thorough address of the patient's questions and concerns, the radiologist has an opportunity to significantly reduce a patient's anxiety. The radiologist is also uniquely positioned to enhance the patient's understanding and acceptance of the pathological findings.

### **Anxiety created by screening mammography**

Those who criticize mammographic screening, repeatedly draw attention to "unnecessary" patient anxiety caused by screening- detected concerns later proven to be negative or benign. Anxiety is undeniable among women concerned about their risk for developing breast cancer. Mammography's primary purpose is to discover early breast cancer that, when appropriately treated, alters the natural history of the disease. A negative mammographic study is a happy result. The detection of a finding that requires additional imaging naturally raises the level of anxiety. There are three circumstances that worsen such anxiety. First, the lack of preparation for possible additional imaging; second, the manner in which the patient is informed of her imaging findings and need for further evaluation; and third, any delay in completing the recommended diagnostic workup. Proper address of these three circumstances can dramatically reduce patient anxiety about screening detected concerns.

The following scenario for informing the patient of her imaging findings is not uncommon and inevitably generates needless patient anxiety. The patient has her screening mammogram; results are sent to her referring physician; she learns from that doctor's office staff that her mammogram is abnormal and that she must return for additional imaging. An appointment is made on a future date to determine the seriousness of this imaging finding. Ideally, she will have only a few days of anxiety before her diagnostic study. Fortunately, most, but regrettably not all, diagnostic study results are communicated to the patient at the conclusion of the procedure. Some patients are still told that the results will be reported to their primary care physician who will discuss the findings with them which creates yet another delay with time to incubate anxiety.

### **The challenge of balancing efficient and cost-effective medical care with what is common sense and what is best for the patient.**

Batch reading of screening mammograms has been widely accepted as an efficient method for interpreting large numbers of studies. Patients have their mammograms, knowing that the interpretation will be completed at a later time and that they must wait for (notification of) the findings by mail or telephone call. There is a strong consensus among radiologists who batch read, in high volume settings, that accuracy improves as distractions diminish. In high volume settings where the radiologists can focus on the images with minimal paper handling and where the only decisions to be made are whether the study is negative (Category 1), there is an incidental benign finding (Category 2) or additional imaging is required to properly characterize an imaging finding (Category 0.) Such screening programs, though highly efficient, can also generate anxiety as the patient waits to learn the results. If the patient is properly informed about how and when she will be notified and of the possibility of a return visit for additional imaging, the potential for anxiety can be significantly reduced. Patients must be properly informed that additional images most often reveal normal or benign findings. Often, the responsibility for informing the patient falls to the technologist who performs the screening procedure. Patients must be informed that the primary purpose of additional imaging is to enable the radiologist to understand dense tissue and to see areas of breast tissue that may be masked by overlapping structures. It is a mistake to think that technologists will instinctively complete this task in a thoughtful, supportive manner without proper instruction. In fact, this information is commonly not communicated or is poorly communicated.

### **What every screening patient needs to know**

The following information should be communicated to the patient by the technologist at the time of the screening mammogram:

- Usually 4 to 6 images (8 for women with implants) are obtained, although some breast tissue may require more images for complete evaluation. When and how the patient will be notified of the results.
- At the time the films are interpreted, the radiologist may request additional views.
- A request for additional imaging does not mean that a suspicious abnormality has been detected, but is most often made to ensure that all breast tissue is adequately visualized.

### **Delivering news – good or bad**

There are some practices that offer immediate services: interpretation of screening mammograms, results provided the patient and immediate workup of findings requiring additional imaging. Arguably, such practice is less efficient than high volume, rapid throughput practices with batch interpretations. There is no argument that immediate interpretation and workups, though less efficient, dramatically reduce the stress of waiting to learn the results and waiting for workup studies. The radiologist's availability at the time of screening to explain the need for additional imaging or the diagnostic imaging results in a sensitive and compassionate manner, to respond to questions and concerns and to provide good news probably offset any bad news.

The approach to communicating with patients discussed herein has been influenced by mentors with excellent communication skills, by observing others with poor communication skills and by experience gained through personal mistakes and successes in patient communications.

At the heart of effective patient communication, is an understanding of the patient's ability to comprehend and cope with the information to be communicated. Patients want good news. Often patients fear the worst. Anxiety, expressed or not, must never be trivialized. Respect the patient and all of her needs; for dignity, modesty, and for hopeful and helpful information. Many patients fear that they will be left to make choices for which they are unprepared. They need guidance, not dictation in decision-making. The patient with a positive diagnosis represents both a challenge and an opportunity for the breast-imaging radiologist. Few, if any, of her physicians are better equipped than the breast-imaging radiologist to help her understand the significance of imaging findings and biopsy results.

The ability to artfully deliver bad news is an important skill for any physician involved with diagnosis or management of breast disease. The need for biopsy is inescapably tied to the potential for a diagnosis of breast cancer. Cancer is bad news! Any good news is potent medicine for reducing the impact of bad news. Many lesions requiring biopsy have low or (at most) moderate risk for malignancy. Patients are relieved to learn that the majority of such lesions are (found to be) benign. When the probability for malignancy is high there are usually several elements of good news that patients should hear if they could be said honestly.

"The good news is,

- This is less than 1 cm in size."
- Cancers this size have better than a 90% cure rate."
- If this is malignant, it is most probably contained within the ducts or non-invasive."
- We see no abnormal appearing lymph nodes."

The setting for communicating bad news should be a distraction-free place where the patient can be comfortable and not left to feel isolated or defenseless. Sitting alone and across a desk from the physician can make a patient feel isolated, if not threatened. The further the physician is from the patient, the less empathetic or caring the physician will appear to her. Communication must be with words that are clearly understandable. This is not the time for medical jargon. The physician should invite the patient to ask questions as often as necessary.

There are both appropriate and inappropriate ways for delivering good or bad news. There is no place for calloused indifference, condescension or lighthearted trivialization when communicating the need for biopsy, let alone the diagnosis of breast cancer. Careless or clumsy delivery of bad news may contribute to the patient's anxiety and invite distrust of the physician. If a physician is uncomfortable in reporting bad news, it is important to avoid communicating a sense of detachment, or his or her own emotional distress in discussing the news. If a physician is unable to deliver bad news with appropriate compassion and support, it is best to delegate this communication and reconsider one's continuing role in breast imaging.

The patient must never be made to feel that she is being abandoned to make difficult choices on her own or that she is being left out of the decision-making process.

The following principles have been well tested and have proven to be worthy guides to effective patient communication:

- When delivering good news, be prompt and clear.
- Avoid verbiage that allows or promotes the feeling you are preparing the patient for bad news.
- When delivering bad news, be truthful and gentle.
- Avoid initial use of words such as "I am sorry to tell you...", "bad news," "cancer" or "malignant."
- Keep eye contact with the patient, preferably at the same level.
- Apply a gentle touch, not before, but immediately or very soon after delivery good or bad news.
- Follow bad news with an offering of good news.

The first words heard by a patient being informed of negative or benign results of a diagnostic workup or biopsy, should be, "Good news!" Any pleasantries regarded as appropriate or traditional in most social communication can be instantly interpreted as "preparation for the bad news." It is better for her to hear the good news before any introductions or pleasantries.

Bad news may vary from the need for additional views, scheduling of additional diagnostic imaging, need for a needle biopsy to reporting positive biopsy results. In any case, the first announcement should be promptly delivered. For example, "Mrs. Jones, we still do not have the information we need about this "finding." I think an MRI study will help us determine whether this is normal tissue or something benign that we can forget about." It is preferable to phrase recommendations for additional imaging or biopsy as a means of determining *normal* or *benign* rather than *malignant* features.

The bad news, "You have breast cancer", is commonly perceived by many patients as a death sentence. Many years of practice and countless occasions requiring delivery of such news, have led to a preference for phrases like, "The pathologists found abnormal (or malignant) cells in the biopsy tissue, so the next step is to get you into the hands of the surgeon to have this area removed." I try to avoid the term "cancer" or "malignant" unless specifically asked, "Does that mean I have cancer?"

The meaning of what we say to patients can be lost or misunderstood by a poor choice of words. Avoiding terms such as "cancer," "malignant," "...sorry to tell you..." etc., is usually not difficult. When challenged as to whether the findings mean cancer or malignancy, we must be truthful; however, truth can be gently revealed and laced with the additional truth of good news in most cases. The following examples illustrate bad and good news delivered with compassionate, truthful reporting.

Bad news:

- There is a dense area in the upper breast that could be normal tissue or something perfectly benign, but I think we should sample the tissue with a needle biopsy and have the pathologist tell us exactly what it is. There is also some good news, ...
- This is most probably a benign finding, but I recommend we confirm it with a needle biopsy. Now, some good news....

- The pathologist found some abnormal cells in the tissue sample, so we need to have the surgeon take that area out. That is the bad news, but here is the good news.....
- The pathologist says this is not benign. We need to arrange an appointment with the surgeon to take the lump out. Now, lets talk about the good news.....

Good news:

- Most findings of this type are benign on biopsy
- I believe this is most likely benign, but I would be uncomfortable following it.
- I believe this is most likely benign, but since we have no prior films, we cannot assume it is stable. A biopsy can prove it is benign.
- Atypical means it is still benign
- If it proves not to be benign, the good news is that over 90% of such small findings are curable.
- Even though it is not benign, I see no other abnormalities in the same or opposite breast.
- Even though the pathologist says it is not benign, I see no suspicious lymph nodes.
- This is called a low grade.... This is much better news than....
- This is still contained within the duct. They found no sign of invasion.
- There was only a microscopic area of invasion.
- ER and PR receptors were positive.
- New treatments for findings like this are showing excellent results.

### **The power of a gentle touch**

In my family practice days, I could put my arm around a patient as an expression of condolence after delivering bad news. Regrettably, we are in an era that calls for extreme discretion and caution; however, the power of a timely, gentle touch cannot be overstated. I have heard colleagues say they avoid any physical contact with a patient, even a handshake, except when performing a physical examination. I am convinced that placing my hand on the patient's hand, forearm or shoulder is a powerful way to convey empathy and genuine appreciation for her anxiety and dignity. Timing in applying the gentle touch is critical. The duration of the touch should be brief. Taking the patient's hand or placing a hand on her shoulder before she hears the good or bad news can have the same negative impact as offering pleasantries before getting the news out. Initiating the contact, immediately after delivering the news, creates a bond of appreciation, empathy and concern.

### **Eye-to-eye contact**

Eye-to-eye contact is another powerful communication tool. Consistent use of eye contact is difficult because some patients are disinclined to maintain eye contact while speaking or listening; however, keeping our eyes on those of the patient, even when she does not maintain eye contact, is still important. When her eyes return to yours, she will experience a positive effect from the eye contact and not a sense that you are avoiding her eye contact. Eye contact is most effective when kept on the same horizontal plane. Eye contact may be intimidating when someone is looking down at you. Eye-to-eye contact is best achieved when seated in front of the patient, when your posture can be adjusted to bring your eyes to the same level. It is unfortunate that much of our most valuable interaction with patients in the diagnostic setting occurs in the ultrasound room, where the physician in the position of looking down on the recumbent patient. It is less distracting, if not less intimidating, to be seated when talking to the recumbent patient than to be looking down at her from a standing position. Once no further scanning or pointing to the monitor is required, it is helpful to have the patient sit up as findings are discussed.

### **Being available and accessible to respond to the patients' questions and concerns:**

Patients often become preoccupied or distracted once they hear bad news. It is incumbent on physicians to be alert to the patient's ability to comprehend and to repeat or rephrase important information. I usually remind the patient and others who are with her that it is common for a patient to think of two or

three questions after leaving the office. I encourage them to call me if they have questions they forgot to ask. They seldom call, but often express appreciation for my invitation to call if they have questions. The most important benefit of this invitation to call with questions is the reduction in anxiety. It is helpful to develop a list of resources patients can be referred to for the more common questions. Patients are told that a particular member of the treatment management team will cover specific questions about surgery, radiation or chemotherapy. They are encouraged to write questions and bring them to their various appointments.

**“Where is the primary care physician in all of this communication?”**

An important and provocative question arises at this point. *“Where is the primary care physician in all of this communication?”* The procedure for communication described above is not intended to leave the primary care physician (PCP) out of the picture. On the contrary, the PCP should play an important role in supporting and guiding the patient through the process of entering and navigating the treatment phase of her breast cancer. We have established excellent rapport with most of our referring physicians. We have cultivated their support and appreciation for our efficient, informative, compassionate and stress-minimizing protocol for managing patients with positive clinical or screening-detected concerns. To accomplish this level of collaboration and appreciation of each other’s role we began with the premise that our approach must meet the test of what is common sense and what is best for the patient. We began with mutually respected and accepted axioms:

- The primary care physicians should refer to consultants in whom s/he has confidence.
- The primary care physician should be promptly notified of the consultant’s findings and recommendations.
- The primary care physician should prepare the patient for what she should expect from the consultant.
- The primary care physician and patient should collaborate in deciding what other physicians will be consulted.
- The primary care physician usually has an established rapport with the patient and is the most knowledgeable about her medical and psychosocial needs.
- A clinically or screening-detected breast abnormality should be resolved as quickly as possible.
- The radiologist who performs the diagnostic work up or tissue sampling procedure is best equipped to explain the meaning of the results from these diagnostic procedures.
- The breast imaging radiologist who reports the findings to the patient can significantly reduce delays in scheduling additional consultations by collaborating with the referring physician, and developing an agreed upon referral, prior to the radiologist speaking to the patient.
- It is in the best interest of patient care for the patient to understand that the radiologist and the PCP have collaborated in developing an action plan, for her approval, that will minimize delays in implementing further care.
- The patient should be encouraged to contact the PCP if she has any questions or concerns.

The following scenario illustrates this interaction and collaboration, using the key elements discussed above: A patient has undergone a diagnostic procedure to evaluate a screening or clinically detected concern. An abnormality requiring needle biopsy is detected. The patient has been advised by the referring physician or provided information explaining that if an abnormality were detected, the radiologist may recommend a needle biopsy. The radiologist discusses the findings and options for obtaining a definitive diagnosis. This is the opportunity for the patient to be properly informed with unambiguous answers and whatever good news can be offered. The biopsy procedure is described and the patient is reassured that making the procedure as nearly painless as possible, is of the highest priority. The radiologist offers to schedule the biopsy when it is convenient for the patient, avoiding an unjustified implication of urgency. She is provided written information about the procedure, addressing the most common questions and concerns with specific instructions regarding how she should prepare, when and where she should report. We also include instructions regarding her return visit to have the biopsy site

checked and to discuss the pathology findings. She is advised that if “abnormal cells” are found in the tissue sample, we will arrange, in collaboration with her PCP, an appointment with a surgeon to remove the area of concern. At this point, many patients ask specific questions about what the surgeon will do. I find it helpful to reassure the patient that the surgeon will cover the answers to all such questions.

An appointment for the biopsy is made. The importance of prompt reporting of findings and recommendations and of scheduling biopsies cannot be overstated. The PCP must never be left to think that he or she is being left out of the loop.

When the patient returns for her biopsy, the entire procedure is explained again, she is asked if she has any questions. Members of the technical staff who are preparing her for the biopsy provide answers. If needed, the radiologist is brought in to discuss to answers to her questions. Before the radiologist proceeds with the biopsy, the procedure is again reviewed. The patient is reminded that she is to return in two days for a brief inspection of the biopsy site and to discuss the pathology findings. She is informed that we may obtain two images to confirm the location of the biopsy marker that was placed the biopsy site. She is also reminded that if “abnormal cells” are found in the tissue sample, we will work, with her PCP, to secure an appointment with a surgeon to remove the area of concern. We firmly believe, as emphasized above, it is in the best interest of the patient for her to learn the results of the biopsy from the physician who has prepared her for the biopsy, performed the biopsy and is most qualified to interpret the results in the context of the imaging findings.

In our practice, pathology results are usually available within 48 hours. If the results are not available shortly before the patient is expected to return, the pathology lab is contacted and requested to expedite interpretation and reporting. A good rapport with the pathologist is the best assurance that reports are received promptly. If histology reveals malignant tissue, the PCP, the PCP assistant or physician covering is notified of the results. If there is no precedent regarding the preferred surgeon, we ask for the name of the surgeon the PCP would like the patient to see. It is our practice to contact the office of that surgeon to schedule an appointment for the patient as soon as possible, providing contact information for the patient, indicating the pathology findings and the name of the PCP and informing them that the imaging studies and reports will be sent to the surgeon’s office.

When the patient returns for her wound check and results, she and her spouse or companion are taken to our consultation room. When the patient is gowned, the radiologist is notified that she is ready. Every effort is made to minimize the time the patient waits in the consultation room before the radiologist enters.

If the pathology results are negative or benign, I announce, “Good news!” as I enter the room. After that, there is time for introductions and pleasantries. If the results are malignant, I proceed immediately to the side of the patient as I announce, “The pathologist found some abnormal cells in the biopsy tissue, so we need to have a surgeon remove some more tissue.” This is the moment that I take the patient’s hand or place a hand on her shoulder or forearm to announce, “But there is some good news.”

Examples of various bits of good news have already been discussed above. The patient is informed that we have reported the findings to her PCP and that we would like her to see the surgeon that her PCP feels will be best for her. If she expresses any concern about the choice of surgeons, she is encouraged to discuss the matter with her PCP. From this point, the discussion becomes unique to the patient and the circumstance. Her questions are invited and an attempt is made to answer them. If she has questions that are better answered by the surgeon, she is reminded that the surgeon will have specific answers that will help her understand all her concerns. Patients are invited to call me if they have additional questions. I am rarely called but often thanked for this effort to be available.

The benefit of this protocol for proceeding from detection, through workup, biopsy, discussion of findings and referral for surgical management is an efficient, compassionate, stress-reducing mechanism for

prompt and appropriate patient care. The primary care providers with whom we have established an excellent rapport and who send us patients who have been properly prepared for our management protocol have been enthusiastic supporters. Regrettably, some PCPs have expressed concern that this protocol deprives them of control over management of their patients and that they are better equipped to communicate results. Our experience contradicts this position and has repeatedly shown how grateful patients are for being referred to our facility and, more often than not, express appreciation for the manner in which their procedures and scheduling were managed. The recurring positive responses from referring physicians and patients has been an ongoing affirmation that our protocol meets the test of common sense and what is best for the patient.

### **THOUGHTS ABOUT THE TRANSDUCER AND PALPATION**

This is not a presentation about breast ultrasound. Breast ultrasound has unique features that make it a powerful tool for communicating findings and providing information and can be a valuable educational tool in reassuring the patient and minimizing unnecessary anxiety. Breast ultrasound is a commonly performed imaging procedure that has become an invaluable technology for discriminating solid from cystic lesions. Advances in ultrasound technology have brought ultra high resolution technology, elastography, Doppler and harmonics into the breast ultrasound room and have transformed breast ultrasound from a tool for solid vs. cystic differentiation to a powerful analytic tool for critical tissue characterization. Ambiguous clinical or mammographic findings are often resolved with breast ultrasound. Ultrasound is commonly the diagnostic tool that determines whether a clinical or mammographic concern is benign or of sufficient concern to require histological sampling.

Most breast ultrasound is performed by certified ultrasound technologists or by mammographic technologists with special training in ultrasound. Many radiologists are uncomfortable with the technologic aspects of operating ultrasound equipment or performing sonographic procedures. In busy practices, the convenience of delegating the performance of sonographic studies and depending on the judgment of the technologist in characterizing lesions diminishes the radiologist's involvement in both the performance and real time assessment of sonographic studies. Unlike mammography, performing breast ultrasound and recording meaningful images requires an understanding of normal and abnormal sonographic features, application of appropriate image optimization techniques and capture of specific images to memorialize the mammographer's real time experience and understanding of what is seen. Optimal breast ultrasound technique should also include an understanding of the clinical and/or mammographic concern that prompts the study and, palpation as part of the scanning technique.

The importance of breast palpation as part of a breast ultrasound study cannot be overstated. High quality breast ultrasound is *palpation-guided sonography* and *sonography-guided palpation*. Radiologists who do not palpate the breast while performing breast ultrasound studies and, technologists who have not been taught or have not learned the importance of palpation as an integral part of acquiring and interpreting breast ultrasound images; are limited in what they can gain from breast ultrasound procedures. Regrettably, expediency and insecurity in performing breast palpation or breast ultrasound are all too common explanations for why radiologists defer to technologists and depend solely on static images and the technologist's impressions of the studies. Only those with experience in performing breast palpation with breast ultrasound can fully appreciate the symbiotic relationship of the transducer and fingers in discovering and understanding subtle abnormalities.

With the transducer held in one hand, the index, middle and fourth fingers of the opposite hand should be placed along the broad edge of the transducer head. The fingers and transducer should move in concert, with one guiding and the other following to discover and share information that leads to a common understanding of the underlying tissue.

The most common presenting palpable concern in the breast, whether detected by the patient or her examining clinician, is loculated fatty or glandular tissue. These palpable areas may present as definable

soft or firm movable nodules or as ill-defined areas of induration. Palpable loculations of fatty or glandular tissue are sonographically recognizable and easily characterized with the fingers guiding the transducer. Mammographic findings are typically negative. Unless there is dense glandular tissue in the area of concern, ultrasound is rarely considered and more often than not, the area of concern is not palpated by anyone in the breast imaging facility. A negative report is generated, often with a disclaimer that reminds the clinician of the fallibility of mammography and the need for clinical correlation. Clinical literature is full of admonitions to seek surgical consultation for an unexplained persistent palpable concern. Such palpable findings are often excised with the pathologist providing a benevolent offering "fibrocystic change." The patient is happy for a benign result that has brought her three weeks of anxiety to an end. Neither she nor her primary care provider is aware of the more reasonable alternative to her experience. Clinicians are unlikely to appreciate the importance of clinical correlation as an integral part of the breast imaging practice, especially in cases where there is no mammographic explanation for the palpable concern. Because loculated fatty and glandular tissue may be indistinguishable from normal parenchyma, the combination of palpation to locate and ultrasound to "see" the palpable concern provides the only means of identification and characterization. Palpation-guided sonography and sonography-guided palpation, especially in the hands of the radiologist who has interpreted the mammographic images, is a convenient and reliable means for providing the patient with an immediate and definitive explanation of her palpable concern.

Patients appreciate being able to see and understand the imaging findings that are the topic of consideration, whether demonstrating normal, benign or suspicious features.

Breast ultrasound studies are performed as a follow up to a mammographically or clinically detected concern. The breast-imaging radiologist is responsible for correlating the concerns and imaging findings and for formulating a final assessment with appropriate recommendations. Common sense should dictate that the radiologist must understand the clinical or mammographic concern leading to ultrasound evaluation. Common sense should also dictate that meaningful interpretation requires assessment of the concordance between the clinical, mammographic and sonographic findings. This is clinical correlation at its best, provided by the radiologist, not abdicated to the clinician. It is a rare clinician that has sufficient understanding of mammographic and sonographic findings to properly correlate them with clinical findings.

Patients are usually able to see the screen or may specifically ask to see the screen as the breast is scanned. Anxiety is created when patients are aware that the technologist has identified something that requires measurements and multiple images for documentation. Anxiety is compounded when the technologist is unable to provide a satisfactory explanation for what is seen and being recorded. When the radiologist participates in the scanning, he or she is able to explain findings in a context that can significantly reduce patient anxiety while establishing rapport with the patient.

The opportunity to show the patient what the scan shows provides an invaluable opportunity to explain the significance of findings. When a patient asks how we can be sure her palpable mass, seen now on the screen, is a cyst, she can be shown the appearance of a rib in contrast to her anechoic cyst. She can be shown how the fatty hilum of a lymph node and its smooth cortex enable us to determine a nodule is a normal lymph node.

It is easier for patients to accept the explanation of loculated fatty or glandular tissue, if they can be shown how normal tissue could feel like a discrete lump or mass. It is helpful to describe the breast as a honeycomb structure with Cooper's ligaments forming the walls of the honeycomb pockets, containing fatty or glandular tissue that may tightly fill the space and present as a palpable lump. Patients are reassured when the radiologist confirms that he or she can feel the lump and demonstrate it sonographically on the monitor

Breast ultrasound is often the defining or final study that establishes either the need for biopsy or the benign character of a clinical or a mammographic finding of concern. During breast ultrasound, the

radiologist is in a unique position to reduce or relieve anxiety by providing immediate results to the patient. At the same time, providing answers to questions and offering information that may help the patient avoid needless anxiety or speculations.

The patient wants to know that her breast-related concerns are understood, explained and acted upon in an efficient, competent and timely manner. She is relieved to know that the radiologist is there to help her and those who will be caring for her as she moves through managing her diagnosis. The radiologist, willing and able to help women with breast related issues, is uniquely able to minimize needless anxiety and help in developing a more healthy understanding of breast imaging or biopsy findings and the need for additional intervention. Artful delivery of reasonable good news, when challenged to report bad news, may be the most important contribution to enhancement of the patient's coping skills.

**Suggested reading:**

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