in the symptomatic service, we noted that requests for imaging after normal examination appeared to be significantly increasing. It was our impression that this had not led to an improvement in cancer detection. We aimed to identify demand for imaging following normal clinical examination and the incidence of cancer in this group.

Methods
In February 2014, our unit underwent a staffing structural reorganisation, with Consultant Surgeon as primary clinical assessor in the one stop symptomatic service. We carried out a retrospective audit, choosing a month post service reorganisation and a comparable month from 2013, prior to restructuring. All patients included were referred to imaging with normal clinical examinations (P=1 or P=1/2). All other clinical groups (P=2 to P=5) were excluded. Patient demographics, presenting complaint, profession of referrer (eg, Consultant Surgeon, Advanced Nurse Practitioner), imaging findings and biopsy outcomes were recorded.

Results
Pre consultant involvement, 576 patients were seen and 175 referred with P=1 (30%). A total of 5 biopsies (3% of referred) were performed. There was no significant difference in failure of malignancy detection by clinical professional group (2013; Consultant n=1, Nurse Specialist n=2. 2014; Consultant n=1, Nurse specialist n=2).

Post reorganisation, 771 patients were seen and 308 referred with P=1 (40%). A total of 32 biopsies were performed (10% of referred) with 3 malignancies (<1% of referred). In this group only one patient was <40 years old. All malignancies identified had an invasive component (B5b). All symptomatic malignancies were in the areas of presenting concern with only one incidental contralateral identified in this series. All of the patient detected symptomatic malignancies had suspicious imaging features (IC=4 and IC=5).

There was no significant difference in cancer detection (Chi squared is 0.031 (p= 0.86)) between the pre consultant involvement and post reorganisation despite work load increase.

In both study periods, the imaging classification in all of the benign biopsy cases was either IC=2 or IC=2/3. There was only exception in 2014, of a U4 axillary node in a patient with a known lymphoproliferative disorder where biopsy was performed and confirmed atypical reactive changes only. The commonest reason cited in reports for performing biopsy in 2014 was to 'confirm benignity'. All biopsies performed yielded expected or benign results in both study periods. The commonest benign lesion identified was fibroadenoma, for both study periods and for all imaging classification subgroups.

There was a significant increase in workload with decreasing sensitivity of radiology and clinical examination post reorganisation for malignant masses. The background incidence of malignancy was low and stable.

This short study has identified a change in clinical practice. We feel, further study is required to evaluate the service evolution of symptomatic Breast one stop clinics. Utilisation of tertiary professional expertise needs to be balanced within a framework of escalating demand with relatively fixed resources of capacity, cost, staff and space whilst giving due consideration to external service concerns, including litigation and not least patient expectation.

There is increasing demand on imaging for patients with normal clinical examination unrelated to clinical seniority. Cancers are present even with normal clinical examination and patient's initial clinical concern proved to be an important predictor. Careful scrutiny of patient's presenting symptom should allow detection of symptomatic cancers and avoid unnecessary referral for biopsy of benign disease.