

New and Improved? Breast care task force recommendations come under scrutiny

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When the United States Preventive Services Task Force (USPSTF) published updated recommendations on using mammography screenings, experts immediately began to weigh in. And the response was not complimentary.

The recommendations sought to evaluate the efficacy of commonly used techniques for breast cancer screening, ranging from clinical and self-breast exams to different imaging modalities. The Task Force then used established statistical models to evaluate the efficiencies of different screening strategies with respect to their ability to affect mortality.

The new recommendations discourage teaching and applying a self-breast exam, question the efficacy of clinical breast exams, and support a biennial screening mammography schedule for average-risk women to begin at age 50 and continue until age 74. In addition, they indicate incorporating mammography at ages outside the recommended screening interval, and state that self breast exams and clinical breast exams should be individualized for each patient based on personal risk for breast cancer and perception of potential harms.

The comprehensive breast care team at Hollings Cancer Center, an NAPBC- and NCI-designated cancer center, is strongly opposed to these screening mammography recommendations. The American Cancer Society, the National Comprehensive Cancer Network, the American College of Radiology, the American Society of Breast Disease, the American Society of Breast Surgeons, the Susan B. Komen Foundation, and the American College of Obstetricians and Gynecologists have all voiced opposition to these new recommendations.

The data are not compelling enough to abandon evidence based validated screening mammography guidelines. This current analysis demonstrates that mammography screenings reduce mortality in every age group, including women age 40 to 49 and women over 74. Admittedly, this comes at the cost of false positive results and additional procedures.

In the 40 to 49 age group that's most at risk, five women will undergo an additional biopsy procedure for every breast cancer that is detected. This screening schedule, however, will reduce breast cancer-related mortality in that same age group by 15 percent. Breast cancer survival rates are lower for women of color in nearly every age

group, even when you account for access to healthcare and economic status. These facts imply that the biology of breast cancer, particularly for African-American women, is more aggressive. The difference is more pronounced in the 40 to 49 age group and could be worse if screening is not implemented until age 50. However, these types of demographic variables are not well accounted for in the USPSTF analysis.

Assessing Risk

In an attempt to be efficient with resources, the USPSTF deemed it acceptable to lower the sensitivity of a national screening mammography program from the current detection rates of 90 percent of all breast cancers to 70 percent of those in the future. In an era of limited resources, when early detection and prevention are paramount and critical for cost savings, this recommendation is ill advised. Furthermore, the Task Force recommends that women undergo annual risk assessment to evaluate their need for a mammogram. This risk assessment is rarely performed and a significant gap in healthcare provider education also remains.

In addition, even with advanced statistical risk modeling, researchers can't identify most women who will develop breast cancer. The Task Force did not account for the predicted shift in disease progression that will occur.

The Task Force analysis focused on mortality and life years gained as the main endpoints, when in fact much of the recent success in breast cancer therapy has been focused on quality of life issues. For example, with earlier detection, clinicians have made tremendous strides preserving women's breasts, decreasing the need for mastectomy by more than 40 percent in the last 20 years. If breast cancer is allowed to grow undetected, the rates of mastectomy, breast reconstruction, and chemotherapy will clearly rise.

Unlike other healthcare systems that currently use screening models included in this analysis, the U.S. healthcare system is not structured to ensure that women will be encouraged or compliant with these recommendations. Unlike the statistical analysis, clinicians cannot hold compliance with recommendations constant. Instead, women are faced with inconsistent, disparate, and intermittent access to healthcare that underscores the reality of many of their lives. Much of the success of current screening recommendations lies in their elegant simplicity for patients, providers, and the health insurance industry.

Exams Questioned

With respect to recommendations against self breast exam or the equivocal support for clinical breast exams, the Task Force cites issues of cost and anxiety related to false positive results. However, the notion that women should be discouraged from being familiar with their body is perplexing.

Approximately 5 percent of all breast cancers cannot be visualized on imaging and must

be detected through a physical exam. Although the number of mammographically occult breast cancers may be a small portion of the overall breast cancer population, in the absence of any other diagnostic modalities, the “laying of hands” on the patients not only allows for diagnosis, but underscores the importance of fundamental physical exam techniques.

Many cancers behave differently, and patient attitudes toward surveillance are equally diverse. When considering patient anxiety, it is inappropriate to evaluate and model the effects of testing, examining, and imaging, and not consider the behavioral impact of the omission of these screening elements.

Women must continue to speak to their healthcare provider and understand their personal breast cancer risk, and develop appropriate and individualized screening strategies. In the meantime, women should adhere to previous screening recommendations.

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