When Should Women Have a First Breast Screening? Not Everyone Agrees

BY MARY BROPHY MARCUS

This spring, during a talk at the 2019 Summit on National & Global Cancer Health Disparities in Seattle, global cancer control expert and surgical oncologist Benjamin O. Anderson, MD, told an audience of colleagues, “If you are under 45, you are on your own.”

Anderson, who is Chair and Director of the Breast Health Global Initiative—founded and led by the Fred Hutchinson Cancer Research Center and Susan G. Komen—was referring to patients whose health care providers follow the American Cancer Society’s (ACS) breast cancer screening and clinical examination guidelines. ACS recommends annual mammograms for women starting at age 45 and shifting to mammograms every 2 years for women 55 and older. The group does not recommend clinical breast exams as a breast cancer screening tool.

Anderson recently told Oncology Times that he is equally concerned about a new “guidance statement” for breast cancer screening by the American College of Physicians (ACP). The ACP’s recommendations are based on a review of national and international breast cancer screening guidelines that included breast imaging—mammography, ultrasonography, MRI, or digital breast tomosynthesis—and clinical breast examination in women.

Published in the April 16 Annals of Internal Medicine, the statement advises “average-risk women” who have no symptoms of breast cancer to wait until age 50 to get their first breast cancer screening with mammography, and then go every other year after that up until age 74 (2019;170(8):547–560). For women younger than 50, ACP advises that clinicians should discuss their patients’ preferences and the potential benefits and harms of breast cancer screening in younger women, including false positives and unnecessary biopsies.

“Women screened annually receive more abnormal results that do not represent an actual breast cancer diagnosis than women screened every other year (7.0% vs. 4.8%),” authors wrote. “These false-positive findings result in biopsies and surgeries that would otherwise not have been necessary.”

Like ACS, the ACP says clinicians do not need to perform clinical breast examination to screen for breast cancer either. The ACP noted that the recommendations aren’t aimed at women who are at a higher risk for breast cancer or those who’ve had previous abnormal screenings.

ACP President and medical oncologist Ana Maria López, MD, FACP, said in a press statement, “The evidence shows that the best balance of benefits and harms for these women, which represents the great majority of women, is to undergo breast cancer screening with mammography every other year between the ages of 50 and 74.”

But Anderson, who is also Professor of Surgery and Global Health Medicine at the University of Washington, noted there are two issues at stake with both the new ACP statement and the ACS guidelines: “One is the question of screening recommendations and the other has to do with clinical management. In particular, the clinical breast examination recommendations are something we need to discuss.” He is concerned that the statement authors only looked at mortality as an endpoint.

“When we only look at mortality, we forget about other factors that are equally important to the population, such as breast conservation,” he said. In other words, if early detection efforts in women under 50 picks up cancers at earlier points in their evolution, such that they can be removed before a mastectomy is required, then aren’t early detection efforts worth it? If cancers are detected later, such that chemotherapy is going to be required, shouldn’t this be considered?

Anderson also said removing clinical breast exam from practice is not in the best interest of patients or their physicians and will hinder clinicians from developing the skill set they need to palpate and identify a potential cancer tumor when a patient does present with a suspicious lump.

The ACP is “forgetting that their role isn’t just about screening, but that it’s also about clinical practice,” he said.

“I think their recommendation to not do a clinical exam on the basis that they don’t feel they have enough evidence to support it is inconsistent with other recommendations for clinical practice. We have never done a randomized trial of using a stethoscope versus not using a stethoscope based on lives saved [mortality]. But the ACP has never come out saying we want everyone to stop using a stethoscope because we have no randomized trials showing it saves lives,” Anderson said.

“In highly screened populations, 60 percent of cancers are found on mammography. This means that the remaining 40 percent of breast cancers are detected clinically. Allowing clinicians to become clinically incompetent in physical examination of the breast is unlikely to help women in early breast cancer diagnosis.”

A Complicated History

“When it comes to mammographic screening in average-risk women in their 30s, I think everyone is in agreement that—due to the low number of positives and because false positives are so high—we don’t need to recommend screening until age 40,” said Anderson.

But after 40, the screening question gets murky. “Do you start at 40, 45, or 50? There are shades of gray to this issue that make it very tricky. I think ACP wanted to weigh in on this challenging and contentious area of screening,” he noted.

Numerous other organizations have published breast cancer screening guidelines and recommendations, including the U.S. Preventive Services Task Force, World Health Organization, Canadian Task Force on Preventive Health Care, American College of Obstetricians and Gynecologists, American College of Radiology, International Agency for Research on Cancer, and American Academy of Family Physicians.

“Some groups look at the data and err on the side of detection while other groups say, ‘We’re going to err on the side of false positives and patient concerns,’” Anderson explained.

An editorial by Joann G. Elmore, MD, MPH, and Christoph L. Lee, MD, MS, in the same issue of Annals noted that the ACP guidance statement brings “clarity and simplicity amidst the chaos of diverging guidelines.”

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The authors wrote: “These ACP guidance statements represent convergence across differing recommendations while highlighting important points for physicians to consider in shared decision-making conversations with their patients about routine breast cancer screening.”

Dana Smetherman, MD, MPH, Chair of the American College of Radiology (ACR) Breast Imaging Commission, told Oncology Times that the ACP guidance statement doesn’t align with ACR’s recommendations.

“The American College of Radiology continues to recommend yearly mammography beginning for women at average risk at age 40,” said Smetherman, adding that her sister developed breast cancer at age 45 and they had no family history of the disease.

In April, ACR and the Society of Breast Imaging published a joint statement in response to ACP’s paper, saying, “Screening only women ages 50-74 every other year, as now recommended by the American College of Physicians and the U.S. Preventive Services Task Force, may result in up to 10,000 additional, and unnecessary, breast cancer deaths in the United States each year.”

Defining “Average Risk”
Tari King, MD, Chief of Breast Cancer Surgery at Dana-Farber/Brigham and Women’s Cancer Center in Boston, and founder of the Breast Cancer Personalized Risk Assessment, Education and Prevention (B-PREP) Program, noted, “While guidelines like this are helpful in assimilating available data and highlighting strengths and weaknesses of the available data, the challenge of these statements is that they use words like ‘average-risk women’ and assume women and PCPs understand what ‘average risk’ means. But that’s a really hard term to define.”

King said “high risk,” according to the Annals article, means a genetic mutation, but the paper does not take into account that there are many other factors involved in determining a woman’s “own risk,” such as reproductive health and history, diet, exercise, and weight changes throughout a lifetime.

There are some well-done risk assessments from a population standpoint, but not for individuals, so one-size-fits-all screening guidelines may not be realistic,” she stated.

The ACP guidelines won’t shift practice at some medical centers.
Lauren Cassell, MD, Chief of Breast Surgery at Lenox Hill Hospital in New York City, shared her thoughts. “This gets me so angry, these new guidelines. We see many women in their 40s who have been diagnosed with breast cancer. Why are we going back to the ’70s? At my institution, nothing’s going to change.”

When it comes to breast cancer screening guidelines, she said, “Sometimes they’re looking at cost and not at how many lives we are actually saving. And I don’t think everything can be put into cost and looked at through the bottom line. I think they’re ignoring the fact that, by taking two steps back, you won’t see the effect until it’s probably too late.”

Cassell believes the bottom line is that some patients’ cancers won’t be discovered early if screening begins at 50. “Truthfully, most breast cancers occur after the age of 50, but that doesn’t mean there aren’t breast cancers in women in their 40s.”

Mary Brophy Marcus is a contributing writer.