

Short Note

Eliminating Confusion Regarding Breast Cancer Screening

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Abstract

Breast cancer is the most common non-skin cancer in American women. Currently there are multiple differing recommendations regarding breast cancer screening. Unfortunately this lack of clarity causes confusion on the part of the healthcare provider and patient which may lead to suboptimal healthcare decisions. The current recommendations are reviewed and patient guidance is discussed below in a concise, organized format.

INTRODUCTION

The number and variability of recommendations regarding screening mammography for breast cancer detection has undoubtedly left even the most educated patients and physicians in a state of confusion. Unfortunately, confusion often leads to paralysis rather than conviction. In this setting it is our role to confidently guide our patients. We are accustomed to making medical decisions on a daily basis in areas without perfect data, and our guidance is especially important with the proliferation of non-medical experts issuing opinions. Here, the most recent recommendations for breast cancer screening from the most relevant groups are summarized in an easy to understand format. Also a few points of analysis and recommendations for patient guidance are discussed. All of the consensus recommendations try to balance the benefits against the harms of screening. The benefits of breast cancer screening include more early-stage cancers detected, less morbidity with earlier detection, and more breast cancer deaths prevented. Harms include increased cost, false positive exams (patients recalled for additional testing who do not have cancer), and unnecessary biopsies. Most patients prefer the inconvenience of additional testing to gain the peace of mind that comes from knowing they are cancer free.

The American Cancer Society's Breast Cancer Facts and Figures document is full of insightful data [1]. Interestingly 25% of breast cancer deaths are women diagnosed in their 40's. Unfortunately these women often develop more aggressive cancers. These women also have the most life-years to potentially lose and often still have dependents relying on them. This is significant because much of the controversy regarding breast cancer screening involves the appropriate time to begin testing. Data suggests that the minority populations are particularly disadvantaged by delaying screening [2].

Another topic that is becoming increasingly discussed is the phenomenon of "over-diagnosis" which is the concept that some cancers that are diagnosed will not be the ultimate cause of death. Are there cancer that do not need treatment? Possibly. However that is a decision best made by the patient after we offer them all the information we have about their particular case. This perceived harm is really an issue of over-treatment rather than over diagnosis and should not prevent searching for treatable disease [3,4].

Table (1) summarizes the recommendations for breast cancer screening from the most influential medical groups. Each physician who counsels patient must determine their approach to breast cancer screening and accept the medical outcomes resulting from that decision. The data clearly shows that the more screening performed, the more cancers diagnosed. However nothing comes for free, and in order to achieve additionally detected cancers there will be extra expense and unnecessary testing. It seems there is a cleavage plane based on whether the recommending body has direct face-to-face interaction with

Table 1: Summary of breast cancer screening recommendations from various medical groups.

| Organization | Begin and frequency | End |
|---|--|----------------------------|
| ACR ² , SBI ³ , ACOG ⁴ | 40: Annual | Individually decided |
| ACS ⁵ | 40-44: Optional 45-54: Annual 55: Annual or biennial | Life expectancy < 10 years |
| USPSTF ⁶ | 40-49: Individual choice 50-74: Biennial | 75 |

Abbreviations: ACR: American College of Radiology; SBI: Society of Breast Imaging; ACOG: American Congress of Obstetricians and Gynecologist; ACS: American Cancer Society; USPSTF: US Preventive Services Task Force

patients. The governmental USPSTF group contains no breast radiologists and approaches the problem from a macro level making a financially weighted argument. On the other hand subspecialty groups such as ACOG, ACR, and SBI approach the problem from an individual level with the mindset to treat each patient as if they were family [5,6].

In spite of the controversy and wherever you may fall on the spectrum of screening mammography, patient are best served by unambiguous guidance from their physicians about when to begin screening for breast cancer. We should all adopt a position and recommend it with conviction to our patients. Our expertise is especially valuable in the setting of multiple conflicting recommendations and the noise created by non-expert advice.

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