Editorial

›› **Robert L. Barbieri, MD** Editor in Chief

Access to screening mammography: *Priceless*

One breast cancer death of a 40-year-old woman prevented by a mammogram spreads ripples of benefit beyond her life—to her family and across the community

The November 2009 recommendation of the US Preventive Services Task Force (USPSTF) against mammography screening for breast cancer in women 40 to 50 years of age[1-3] is a good example of the damage caused by a **radical, imprudent, and sudden change in strategy for disease screening**. Before I tell you why I think so, let me briefly put screening in the context of the relationship we physicians have with our patients.

Clinicians work, and continuously develop their skills, in a complex network of relationships with patients and colleagues—all committed to quality health care. Scientific evidence drives our medical recommendations and suggestions; scientific evidence is modulated and influenced by the individual patient's health needs and our professional judgment.

Screening for major diseases is built on effective patient education and standardized protocols developed by our professional societies. Radical, sudden changes in our approach to screening can weaken the trust we've built with our patients and, inadvertently, cause more harm than good. That breach of trust is just one of the dangers posed by the new USPSTF mammography screening guidelines.

Test your knowledge of age, breast cancer risk, and screening recommendations

Instant Poll

on page 11

Balancing the three-legged stool: Benefit, cost, risk

Even though the USPSTF has recommended against routine mammography screening for women 40 to 49 years old, it notes that screening mammography in that age range does save lives. Doesn't the task force seem to be talking out of both sides of its mouth?

In fact, the task force arrived at its recommendation by **overemphasizing the risks and costs associated with mammography** including:

- **anxiety** over false-positive results
- the **inconvenience and discomfort** of follow-up imaging study and biopsy
- the possibility of **overtreating** lesions that have low potential for major morbidity or death
- **undervaluing the life** of each young woman and mother whose life is saved by mammography.

The task force estimated that, among women in their 40s, one life is saved for every 1,900 women who undergo screening mammography. My question is: Who has the moral, scientific, or judicial authority to conclude that the anxiety produced by mammography is more important than preventing the unnecessary death of one young mother? **I do not think that a body appointed by the government should have final decision-making authority over such a complex question.**

What a single letter will mean for many women

The USPSTF assigned a "C" grade to screening mammography. This signifies that **1)** the task force recommends against this service and **2)** there is high certainty that the benefits of the service are small (implying low cost-effectiveness).

The impact of the "C" designation is powerful: Written rules of many health-care insurers preclude them from providing reimbursement for preventive services rated "C" by the USPSTF. The task force's imprudent decision therefore means that many women will be cut off from access to screening mammography during their 40s—an unfortunate outcome.

In the absence of strong new evidence, let's embrace evolution, not revolution

Experts should be cautious about

changing long-standing recommendations and practices unless they are acting on new data of very high quality. Science should drive our clinical recommendations; we should practice evidence-based medicine.

Experts in evidence-based medicine have reflected deeply on two key problems of evidence-based medicine:

- "How strong is the evidence?"
- "Is the evidence sufficiently strong for a recommendation that, in almost all situations, the recommendation trumps all unique patient issues, such as personal preferences and unique medical issues?"[4]

Given the long-standing recommendation that screening mammography be offered to women beginning at 40 years old, **only very strong new data should halt current practice**. The USPSTF recommendation is not credible from the perspective of many women: namely, that an annual mammogram beginning at 40 years provides far more benefit than risk.

Trust—at the heart of health care

A high level of trust, and coordinated decision-making among patients, physicians, nurses, and administrators, advances the quality of health care. **Whom do you trust to make clinical recommendations that best balance benefit, cost, and risk?** I deeply trust well-trained clinicians and highly motivated patients who are working in a collaborative relationship to make the best decisions about care.

Across many centuries, the patient–physician relationship has been the foundation of health care. But as our civilization grows more complex, other entities increasingly intervene to exert influence over that relationship: professional societies (ACOG, the American College of Radiology), disease-focused organizations (such as the American Cancer Society), insurance companies, government agencies, and the legal profession. To amplify my perspective on trust: It's our professional societies and disease-focused organizations that I trust to make recommendations that, to the best extent possible, balance those three factors that often exist in tension: benefit, risk, cost.

As for insurers and the government? They often have unconscious, hidden agendas that undermine optimal functioning of the patient–physician relationship. And tort attorneys? Through an adversarial legal process, they work to fully rend the trust inherent in the patient–physician relationship. I trust the recommendations of our professional societies more than I trust the recommendations of insurance companies, government agencies, and tort attorneys.

What will I do in my practice?

With regard to screening mammography, **I plan to continue to heed the long-standing recommendations of ACOG while I await publication of additional high-quality data and analysis.**

ACOG's recommendations[5] are:

- screening mammography every 1 to 2 years for women 40 to 49 years old
- screening mammography annually for women 50 years and older
- breast self-exam can be recommended because it has the potential to detect palpable breast cancer.

In the end, preventing the unnecessary death of one 40-year-old woman with screening mammogra-

Instant Poll

TAKE THESE TWO TESTS

Match a woman's age and her 10-year risk of breast cancer

Age (yr)	Risk
40	1.5%
50	4.2%
60	3.8%
70	2.7%

TRUE OR FALSE?

The American Cancer Society recommends:

a. an annual mammogram starting at 40 years of age

b. no mammograms after 75 years of age

c. a clinical breast exam annually for women 40 years and older

d. not performing a breast self exam

e. a threshold of >20% lifetime risk of breast cancer to warrant an annual magnetic resonance imaging (MRI) scan plus a mammogram

The answers are on page 12

phy has many positive—even priceless—benefits for her family and for her community.

OBG@DOWDENHEALTH.COM

References

1. U.S. Preventive Services Task Force. Screening for breast cancer: U.S. Preventive Services Task Force recommendation statement. Ann Intern Med. 2009;151:716–726.

2. Nelson HD, Tyne K, Naik A, Bougatsos C, Chan BK, Humphrey L; U.S. Preventive Services Task Force. Screening for breast cancer: an update for the U.S. Preventive Services Task Force. Ann Intern Med. 2009;151:727–737.

3. Mandelblatt JS, Cronin KA, Bailey S, et al; Breast Cancer Working Group of the Cancer Intervention and Surveillance Modeling Network. Effects of mammography screening under different screening schedules: model estimates of potential benefits and harms. Ann Intern Med. 2009;151:738–747.

4. Guyatt GH, Oxman AD, Vist GE, et al; GRADE Working Group. GRADE: an emerging consensus on rating quality of evidence and strength of recommendations. BMJ. 2008;336:924–926.

5. American College of Obstetricians and Gynecologists. ACOG Practice Bulletin. Clinical management guidelines for obstetrician-gynecologists. Number 42, April 2003. Breast Cancer Screening. Obstet Gynecol. 2003;101:821–831.

Instant Poll Results

Age and risk of breast cancer

40 years: 1.5%; 50 years: 2.7%; 60 years: 3.8%; 70 years, 4.2%

Source: American Cancer Society Breast Cancer Facts and Figures, 2005 to 2006.

What the ACS recommends

a. true

b. false—the ACS recommends an annual mammogram as long as a woman is in good health

c. true—a clinical breast exam should be part of the periodic health exam: every 3 years for women in their 20s and 30s and annually for women 40 years and older

d. false—the ACS recommends that women should have knowledge about their own breast exam and report any changes to a health provider. Breast self-exam is an option for women starting in their 20s.

e. true—the ACS recommends that women who have a lifetime risk of breast cancer >20% should have an annual MRI scan and a mammogram. For women whose lifetime risk is 15% to 20%, the pros and cons of MRI screening should be discussed with their physician. Annual MRI screening is not recommended for women whose lifetime risk of breast cancer is <15%.