"WHAT YOU SHOULD KNOW ABOUT THE LATEST CHANGE IN MAMMOGRAPHY SCREENING GUIDELINES"
JANELLE YATES, SENIOR EDITOR (OCTOBER 2015)

"ACOG PLANS CONSENSUS CONFERENCE ON UNIFORM GUIDELINES FOR BREAST CANCER SCREENING"
LUCIA DIVENERE, MA (NOVEMBER 2015)

"ANNUAL SCREENING MAMMOGRAPHY BEGINNING AT AGE 40 SAVES THE MOST LIVES"
DANIEL B. KOPANS, MD (DECEMBER 2015)

Why is ACOG so late?

I am quite dismayed that the American College of Obstetricians and Gynecologists (ACOG), again, is the last kid on the block to accept data on a major recommendation like mammography. (ACOG was late to respond to cervical cancer screening changes.) There are growing data supporting the concept that we have over-done mammography and ignored the warnings that mammograms do not meet usual criteria for a good screening test, especially for those aged younger than 50 years. In the 70s and 80s, Dr. John Bailar of the National Cancer Institute warned of the dangers of radiation in "breast x-rays".[1,2] We must move forward and develop a more unified approach for this deadly disease.

James Kolter, MD
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References

1. Bailar JC 3rd. Mammography: a time for caution. JAMA. 1977;237(10):997–998.
2. Bailar JC 3rd. Mammography before age 50 years? JAMA. 1988;259(10):1548–1549.

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Help me accept that we must let these women die

I have been a frontline gynecologist for about 40 years. When I was trained, the goal was to screen everyone. We sought to find diseases early enough to successfully treat and cure before they were too far advanced. In my years thus far I have seen it work: early breast cancers have been found on mammography and during clinical breast examinations. Many lives saved.

I have known most of my patients for 25 to 35 years. I am embarrassed to send an academic journal these experiential and anecdotal stories without numbers and percentages, but I treat individual people and not populations. I cannot get it into my brain that it is not worth saving these women.

Janet, a 37-year-old woman, had just lost her husband to a sudden heart attack, leaving her with 5- and 7-year-old daughters. At that time, baseline mammograms were ordered between ages 35 and 40 years. We were shocked when her mammography revealed breast cancer; she had no family history of breast cancer. Five years later it recurred, and 5 years after that, she was found to have something no one had known about earlier: the BRCA gene mutation. She has since had bilateral mastectomies and bilateral oophorectomies. Last week, at her annual check-up at age 62, she showed me pictures of her grandchildren.

I cannot help but feel that Janet would not be here today if we had not done that screening mammography years ago. But now I am asked to let someone like her go, so that the system does not have to pay for all the "normals." There are many stories of lumps found during routine examination, of an aggressive cancer found on mammogram 1 year (not 2) after a perfectly normal mammogram.

Help me accept that we must let these people die, or identify their disease at a much more advanced state given these new guidelines. I cannot be the only bread-and-butter gynecologist who is having trouble agreeing with this new approach.

Are there not other ways to cut medical costs? Can we eliminate the "middlemen" in the system? Is there any way other than *not* screening to save women's lives?

If a patient gets breast cancer before age 45 or within the 2-year interval between mammograms, would she sue their doctor for not recommending annual screening? We all know cases of women who have died of cervical cancer after having normal Papanicolaou (Pap) test results 2 years before. (Their survivors sued, and won). But if they had had a Pap after only 1 year, would their disease have been discovered and successfully treated?

Perhaps I reveal myself as politically incorrect or not "cost-effective" in this letter. But rest assured, many of my colleagues are retiring (as will I in time), so those trained in my era will disappear. The younger crop is thoroughly trained in this new way. I wonder what the pendulum will do, if after these guidelines sink in, advanced cancers that cannot be treated successfully reveal themselves.

Lois S. Goodman, MD
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Prevent rather than detect

Early detection is not prevention. Until medicine actually wants to work on prevention, the American Cancer Society guidelines are just more of the same old story, focusing on the symptoms rather than on the root causes. Using genomics and personalized, functional medicine in combination with breast thermography, many more breast cancers can potentially be prevented in the first place, with mammography (and ultrasonography) used as a diagnostic tool. This would be much more powerful than focusing only on early detection. ObGyns need to learn how to apply these new skills and help women get much more value from their preventive care. Until physicians reclaim their ability to think and evaluate critically with open, curious minds, they will continue to fail the very people they aim to serve—their patients.

Roberta Kline, MD
Santa Fe, New Mexico

Guidelines written by statisticians, not ObGyns

I was happy to see Dr. Kopan's article, as well as others about the new American Cancer Society (ACS) screening mammography guidelines. Initially, I was infuriated when I read the guidelines. Looking at the composition of the ACS committee, I can understand some of the conclusions: I believe there were 4 statisticians among the members.

Statisticians look at mammography statistics as numbers and significant figures. They do not consider that these numbers represent lives. In the guidelines it was stated that earlier and more frequent screening, as well as discontinuing screening after the age of 74, only saved the lives of 10 women out of 100,000. That would certainly be significant for the 10 women who are saved. What if one of them was a relative of one of the committee members?

Another silly recommendation was that women no longer have clinical breast examinations. The committee obviously does not realize how frequently cancers are found by clinical exam.

Norman D. Lindley, MD
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"MANUAL VACUUM ASPIRATION: A SAFE AND EFFECTIVE TREATMENT FOR EARLY MISCARRIAGE"
PIYAPA PRADITPAN, MD, MPH, AND ANNE R. DAVIS, MD, MPH (NOVEMBER 2015)

Which antibiotic for prophylaxis at vacuum aspiration for miscarriage?

Thank you to Drs. Praditpan and Davis for a great article. I think, however, there is more evidence for azithromycin 1 g PO (than doxycycline as the authors recommend) as prophylaxis for surgical abortion and *no* antibiotic prophylaxis for medical abortion.

Tirun (Ty) Gopal, MD
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›› Drs. Praditpan and Davis respond

Thank you for your comment and for allowing us to provide clarification on the topic of antibiotic prophylaxis at the time of vacuum aspiration for miscarriage management. Few studies address the question of antibiotic prophylaxis at the time of surgical management of miscarriage, and a meta-analysis found insufficient data to yield a conclusion.[1] Recommendations for infection prophylaxis in miscarriage management have been extrapolated from the abundance of data for induced abortion, since the surgical procedure is the same for both.

The 2011 Society of Family Planning (SFP) clinical guidelines on prevention of infection after induced abortion identified 14 randomized trials that examined the efficacy of antibiotic regimens administered preoperatively to prevent upper genital tract infection after first trimester surgical procedures.[2] Five studies (involving a total of 5,380 patients) examined tetracyclines, while only 1 study (N = 378) examined macrolides. The trials comparing tetracycline prophylaxis with placebo showed significant risk reduction in upper genital tract infection in tetracycline users (up to 88%), with an overall postinfection rate similar to that reported in the United States (<1%). Regardless of antibiotic choice or duration, the risk of infection was lower in women who received any prophylactic antibiotics compared with women who received placebo.

Based on these data and doxycycline's cost effectiveness and its minimal adverse effects, the SFP recommends doxycycline as the antibiotic of choice for prevention of infection after induced abortion. Antibiotics should be administered on the day of the procedure and, if clinicians prefer, for no more than 3 days afterwards. Azithromycin is a macrolide that can be used for presumptive treatment of chlamydia at the time of surgical abortion.[3] No trials compare azithromycin to doxycycline for prevention of infection after vacuum aspiration.

References

1. May W, Gulmezoglu AM, Ba-Thike K. Antibiotics for incomplete abortion. Cochrane Database Syst Rev. 2007;(4):CD001779.
2. Achilles SL, Reeve MF; Society of Family Planning. Prevention of infection after induced abortion: release date October 2010: SFP Guideline 2010. Contraception. 2011;83(4):295–309.
3. Royal College of Obstetricians and Gynaecologists. The care of women requesting induced abortion: Evidence-based clinical guideline number 7. https://www.rcog.org.uk/globalassets/documents/guidelines/abortion-guideline_web_1.pdf. Published November 2011. Accessed December 18, 2015.