Dr. Daniel Kopans: On the draft USPSTF breast screening guidelines
By Dr. Daniel Kopans, AuntMinnie.com contributing writer

April 21, 2015 -- It is encouraging that the U.S. Preventive Services Task Force (USPSTF) has finally acknowledged what has been clear for years -- namely, that lives are saved by breast cancer screening beginning at the age of 40. The statistical models that were used in its analysis all show that the most lives are saved by annual screening beginning at the age of 40.

Unfortunately, once again, the USPSTF panel contains no one with any expertise in breast cancer care, and no experts in breast cancer screening, so that many of the other observations they have made are not supported by the scientific evidence. Because insurance coverage is based on USPSTF recommendations, unless Congress intervenes, women will be denied access to annual screening based on the new 2015 guidelines.

Informed decisions

The panel legitimately argues that women should be given information to allow them to make informed decisions. But the panel guidelines will actually take the decision away from women, based on its subjective value judgment that the "harms" of mammography (which they overestimate) outweigh the benefits for women in their 40s.

The task force also made the value judgment that although lives will be lost by screening every two years, women should allow cancers to grow and spread while being screened biennially instead of annually.

Women over age 74

USPSTF understood that since the randomized controlled trials (RCTs) did not include anyone older than the age of 74, there is no direct proof that screening women older than the age of 74 will save lives.

However, there is also no reason to expect that early detection suddenly stops reducing deaths at the age of 74. If a woman has a life expectancy of more than five to 10 years and does not have any major competing causes of morbidity and mortality, she should be supported if she wishes to continue screening after the age of 74.

USPSTF should reconsider its recommendation so that women ages 40 and older can make
their own decisions as to whether or not to participate in screening. Women should be provided with accurate information about the so called "harms" of screening (mostly anxiety and inconvenience from recalls for additional evaluation) as well as the benefits.

Clearly, any woman may choose not to participate, but those who choose to be screened should be supported in that decision.

**Age 50 as threshold**

The inexperienced task force panel has once again used the age of 50 as if it is a legitimate threshold for screening. Yet there are absolutely no data that show that any of the parameters of screening change abruptly at the age of 50 -- or at any other age. There is no scientific or biological reason to use age 50 as a threshold.

All of the scientific evidence shows that lives are saved by screening starting at the age of 40 (which is the youngest age studied in the randomized controlled trials of screening). With regard to screening, there is no demonstrable difference between a woman in her late 40s and a woman in her early 50s. The only scientifically supportable threshold is age 40.

The previous USPSTF chairperson, Dr. Michael LeFevre, who oversaw the development of the guidelines, left the panel a short time ago. He has mistakenly claimed that breast cancer is a disease of older women.

In the U.S., there are more than 30,000 women diagnosed with breast cancer each year while in their 40s. The panel also seemed to be unaware that more than 40% of the years of life lost to breast cancer are among women diagnosed while in their 40s.

The panel also did not seem to understand that there have been no randomized controlled trials of screening high-risk women, so no one actually knows whether screening limited to these women will save any lives.

Perhaps of greater importance is the fact that the vast majority of women (75%) who are diagnosed with breast cancer each year have no definable excess risk. The RCTs involved women from the general population. If only high-risk women are screened, most women who will be diagnosed with breast cancer will not have the opportunity afforded by early detection.

**Overdiagnosis**

The lack of in-depth knowledge by panel members was evident by their failure to understand that the studies that claim massive "overdiagnosis" of invasive breast cancer are scientifically flawed. The scientific evidence shows little if any "overdiagnosis" of invasive breast cancer.

The management of ductal carcinoma in situ (DCIS) is a legitimate area that needs to be addressed, but efforts to better understand these lesions have been ongoing for decades. The panel was misinformed in its analysis of DCIS. Invasive breast cancers are "real" cancers, and given enough time, they will be just as lethal as palpable cancers (which they will grow to become).

Women should not be denied access to screening simply because pathologists are not yet able to be certain that any cancer, even the largest, will be lethal. They should not be denied access to screening simply because medicine is far from an exact science, and it is not yet possible for oncologists to determine precisely which women with cancer of any size will
benefit from therapy. What is clear is that therapy saves the most lives when breast cancers are treated early.

The inexperienced panel also relied on results from the Canadian National Breast Screening Studies (CNBSS), which were shown years ago (in the 1990s) to have used poor-quality mammography and a nonblinded allocation process that compromised the results, making them unreliable.

The task force was also swayed by the claim that the Canadian trial showed a 22% rate of "overdiagnosis." Data actually show that it was less than 4%. Even the Canadians have ignored CNBSS, and a recent analysis of breast cancer deaths in multiple provinces in Canada showed there has been a major decline in mortality related to mammography screening for women ages 40 and older.

The USPSTF guidelines ignore their own findings and are based on the panel's subjective value judgments. The task force should support what is confirmed by the scientific evidence. It should support screening annually beginning at the age of 40, while providing women with accurate, scientifically derived information so that each woman (not the panel) can decide for herself whether or not to participate in screening.

In the future, "inexpert" panels should not be deciding guidelines. Panels should include actual experts, and all deliberations should be open to the public. Minority reports should be issued if there is not unanimity in the recommendations.

Dr. Kopans is a professor of radiology at Harvard Medical School and a senior radiologist in the department of radiology, breast imaging division, at Massachusetts General Hospital.

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4/21/2015 8:03:44 AM
Michael Dowe
In screening programs such as in the UK where women are invited to screening between 50 and 70 for a mammogram every 3 years, is there a difference in stage at diagnosis and overall morbidity and mortality compared to countries with more aggressive screening such as the US?

4/21/2015 9:04:20 PM
wisdom
They do not do as well

4/23/2015 10:06:19 AM
Thor
We are middle of the pack when it comes to breast cancer mortality better than some and worse than some European countries. Of course this is a multifactorial problem since a low breast cancer death rate may be brought on by short life expectancy (Africa for example). None the less the frequency of breast cancer screening recommended does not correlate particularly well with worldwide breast cancer mortality

4/23/2015 10:20:40 AM
Thor

Can someone show me the stage shift?
Can someone point out the change in incidence of larger tumors?
Can someone show where an increase in the diagnosis in DCIS correlates to a drop in invasive cancers?

All these should be evident if mammography screening is efficacious. This is why screening should be a conversation and not a prescription

4/23/2015 10:53:44 AM
TheFlash
+1

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