

# Navigating the tempest over breast cancer screening

The screening recommendations of the US Preventive Services Task Force have generated considerable controversy but little practical change.

**ROSEMARY FREI, MSc**

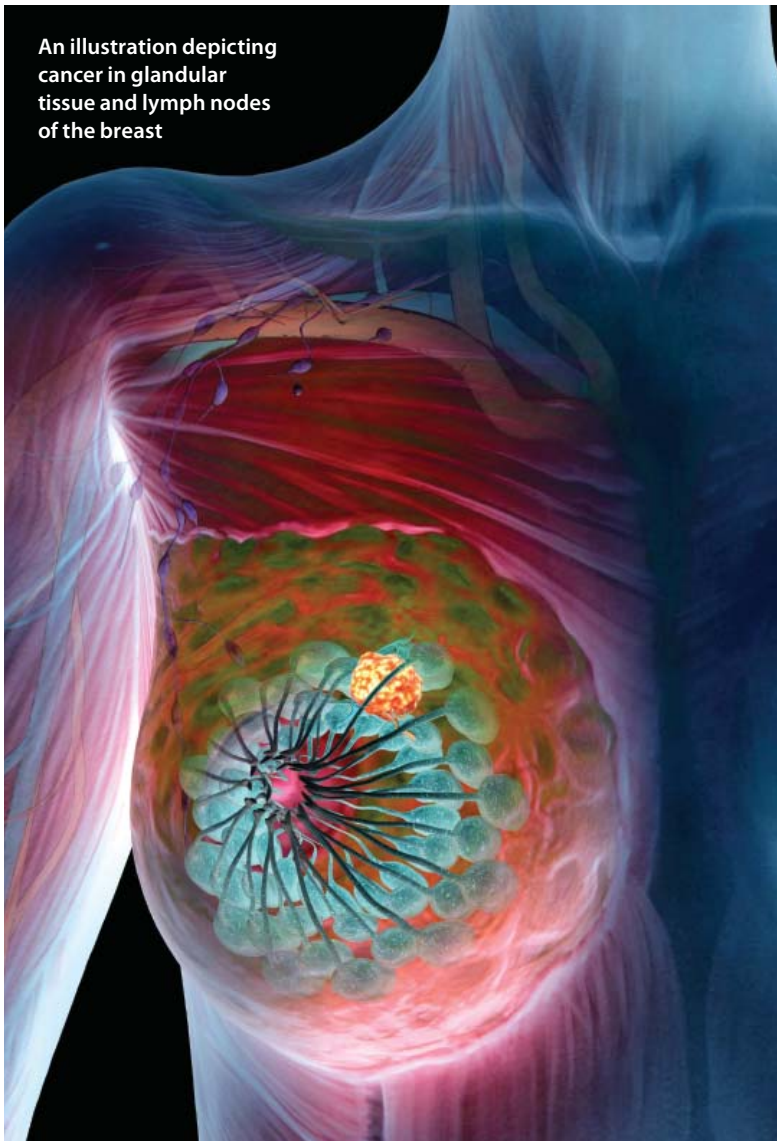
**R**arely has as much ink been spilled and as many electrons sent flying over guidelines as there were over the US Preventive Services Task Force's November 16, 2009, update and recommendations on breast-cancer screening.<sup>1</sup>

The Task Force members—primary care physicians and epidemiologists chosen and funded by the Department of Health & Human Services' (DHHS) Agency for Healthcare Research and Quality—gave a Grade C recommendation against routine screening mammography in women aged 40 to 49 years. This means clinicians advising mammography for their patients must consider additional factors, such as the woman's personal risk of breast cancer.

This recommendation was based on an accompanying literature analysis and computer modeling. The results indicated that 1,904 screening mammograms would need to be performed among women aged 39 to 49 years to prevent one breast cancer death in this age group (**Table 1**).<sup>2</sup> In contrast, 1,339 mammograms would be needed to prevent one such death in women 50 to 59 years, and just 377 would be needed in women 60 to 69 years. The analysis also pointed to the very high false-positive rate among younger women and the toll exacted by such factors as the pain and radiation exposure associated with mammography.

The Task Force members recommended that women aged 50 to 74 undergo biennial rather than annual screening and recommended against teaching women how to perform breast self-

An illustration depicting cancer in glandular tissue and lymph nodes of the breast



© MEDICAL RF / PHOTOTAKE

examination. Amid the media uproar that followed, many members of the medical and lay communities expressed concerns about potential rationing of mammography.

### THE FUROR

Groups such as the American College of Radiology (ACR) and the Republican Party fanned the flames by charging that the recommendations were primarily geared toward such rationing. Hence, they could cause “countless” breast cancer deaths, according to the ACR.

DHHS Secretary Kathleen Sebelius issued a public statement responding to the furor by saying, “Our policies remain unchanged. Indeed, I would be very surprised if any private insurance company changed its mammography coverage decisions as a result of this action.” She also distanced herself from the recommendations and seemed to agree that they were politically motivated by telling CNN, “This panel was appointed by the prior administration, by former President George [W.] Bush.” (*Editor’s note: the Task Force has been in existence since 1984, with members appointed by all presidents since that time.*)

Meanwhile, legislation that is before the US Senate would have allowed insurance companies to use discretion on covering preventive screening or other procedures that receive a Grade C or lower recommendation—but an amendment specifically instructs insurers to disregard the Task Force’s recommendations against routine mammography in women younger than 50.

In addition, many groups are not changing their own recommendations and approach to breast cancer screening. For example, in a November 16, 2009, statement, the American Cancer Society’s chief medical officer, Otis W. Brawley, MD, said, “The American Cancer Society’s medical staff and volunteer experts overwhelmingly believe the benefits of screening women aged 40 to 49 outweigh its limitations.” The

**Because screening recommendations aren’t really “one size fits every person”, it’s important for nurses to discuss screening with every woman they see.**

American Medical Association, the National Comprehensive Cancer Network (NCCN), the American Society of Breast Surgeons, the Oncology Nursing Society (ONS), the Society of Breast Imaging, and the American College of Surgeons are among the other associations that still call for yearly screening mammography in all women starting at age 40.

One of the few medical groups defending the Task Force is the American College of Physicians (ACP). In a November 24, 2009, statement, ACP president, Joseph W. Stubbs, MD, said, “ACP urges Congress, the administration, and patient and physician advocacy groups to respect and support the importance of protecting evidence-based research by respected scientists and clinicians from being used to score political points that do not serve the public’s interest.”

### WHERE DOES THIS LEAVE NURSES AND PATIENTS?

Amid the continuing debate over the Task Force’s recommendations—including a letter by former Task Force member Steven Woolf, MD, MPH, published in the January 13, 2010, issue of *JAMA* attempting to clarify what the breast cancer screening guidelines actually said (**What do the recommendations really say?**)<sup>3</sup>—knowing what to do can be difficult for nurses and patients. This is particularly true in the face of other guidelines—such as the new guidelines for Pap tests for cervical cancer from the American College of Obstetricians and Gynecologists

**Table 1. Pooled relative risk for breast cancer mortality from mammography screening trials for all ages**

Age (y)	Trials included (n)	RR for breast cancer mortality (95% CrI)	NNI to prevent 1 breast cancer death (95% CrI)
39-49	8	0.85 (0.75-0.96)	1,904 (929-6,378)
50-59	6	0.86 (0.75-0.99)	1,339 (322-7,455)
60-69	2	0.68 (0.54-0.87)	377 (230-1,050)
70-74	1	1.12 (0.73-1.72)	Not available

Key: RR, relative risk; CrI, credible interval; NNI, number needed to invite to screening.

Adapted from Nelson HD et al. Screening for breast cancer: systematic evidence review update for the US Preventive Services Task Force. Evidence Review Update No. 74. AHRQ Publication No. 10-05142-EF-1. Rockville, MD: Agency for Healthcare Research and Quality; 2009.



**“One effect of the Task Force recommendations could be that fewer disadvantaged women will be screened.”**

—Brenda Nevidjon, RN, MSN

that recommend more restrictive criteria for treatment or screening (**Cervical cytology screening**).<sup>4</sup>

*Oncology Nurse Advisor* turned to several experts and nurses in the trenches to learn what sources of authority and information they are relying on and what stance they and their institutions are taking. All say that it is business as usual, with annual screening mammography for women aged 40 and older. This is because, they note, every woman is at some risk of developing breast cancer.

“The ONS position has been and continues to be that mammography has to be dealt with on an individual basis. Because screening recommendations aren’t really ‘one size fits every person’, they still have to be individualized,” said Brenda Nevidjon, RN, MSN, president of the ONS and Clinical Professor and Director, Nursing & Healthcare Leadership, School of Nursing,

Duke University, Durham, NC. “So it’s very important for nurses to discuss this with every patient, to talk about her specific risk level and explain the importance of screening mammography after age 40. This is one of our responsibilities as nurses, as providers of patient education and patient support.”

She added that one possible unintended side effect of the Task Force recommendations could be a reduction in the number of disadvantaged women getting mammograms. “We’re still not fully screening all women who should be screened and even have insurance coverage to be screened. And the concern is, will the new recommendations lead to more women saying, ‘Why bother?’” wondered Ms Nevidjon.

Therese Bevers, MD, also takes this approach rather than supporting the Task Force’s recommendations. Dr Bevers chairs the NCCN’s breast cancer screening and diagnosis guideline panel. She also is the medical director of the Cancer Prevention Center at the M.D. Anderson Cancer Center, Houston, Texas, and a professor of clinical cancer prevention there.

“I asked women in my clinic for about a week and a half after the guidelines came out, ‘Would you be willing to undergo an unnecessary biopsy so that fewer women will die of breast cancer—[even though] it may not be you, it may be other women [who die of breast cancer]?’” said Dr Bevers. “And there was never a hesitation [among any of the women]. They all said, ‘Absolutely, if it means that fewer women are dying from it.’”

## What do the recommendations really say, and why did the Task Force make them?

*Oncology Nurse Advisor* approached the chair of the Task Force, Ned Calonge, MD, MPH, for a comment on the controversy. He declined, saying that the fate of the Task Force itself is now in the balance and he wishes to wait until a decision is made on that front before he speaks to the media. Instead, he deferred to a letter by former Task Force member and senior advisor Steven Woolf, MD, MPH, that was recently published in *qJAMA*.<sup>3</sup> Dr Woolf was unavailable for further comment.

The key points in Dr Woolf’s letter are these:

- The Task Force did not oppose mammography in women aged 40-49 years “but recommended against automatic (‘routine’) imaging, without informing women about potential harms,” wrote Dr Woolf. It did so because in the Task Force’s last set of breast cancer screening guidelines, published in 2002, it gave the nod to mammography screening starting at age 40 but “urged clinicians to inform patients about the reduced net benefit at this younger age.” Since this was “largely ignored in practice,” the Task Force

members opted for “the blunter language of [their Grade] C recommendation” in the guidelines.

- “Advocates of mammography and cancer survivors often belittle these harms [including false-positive findings, unnecessary biopsies, overdiagnosis, and treatment of latent disease], but a moral duty exists [to examine the evidence for this approach] when subjecting millions of asymptomatic women to a procedure that benefits relatively few,” continued Dr Woolf.
- “Scientific panels on controversial topics should gauge public sensibilities and communicate clearly when releasing recommendations,” he noted in the Lessons Learned section of his letter.
- “Today’s health care crisis demands efforts to curtail overutilization and maximize the health benefits of spending,” he concluded. “Independent commissions are proposed to find solutions, but lawmakers who fear rationing have barred them from examining costs, even as costs threaten health care and the economy.... The nation cannot afford this approach to decision-making.”

## Cervical cytology screening also recommended for fewer women

The American College of Obstetricians and Gynecologists (ACOG) released new Pap testing recommendations in November 2009. These were published the following month in *Obstetrics & Gynecology*.<sup>4</sup>

The main changes from the association's last set of recommendations on this topic, published in 2004, are that cervical cancer screening should begin at age 21 years and continue every 2 years until age 30, followed by check-ups every 3 years in women with negative results. ACOG had previously recommended that women should be tested initially after having sex for the first time, or no later than age 21, with annual Pap tests thereafter.

The rationale for the changes is the uncovering of new evidence that more frequent screening is not any more effective than less frequent screening. Reduced screening is also associated with decreased costs and avoidance of unnecessary interventions that could be harmful, according to the ACOG members who performed the review.

Robin Coyne, RN, MSN, a family nurse practitioner who works with Dr Bevers, says it would be taking a “step back” to change practice. “We’ve been telling women in their 40s to get a yearly mammogram for years now, and our guideline is still to initiate mammography [at] age 40 because we feel enough data support that practice,” Ms Coyne told *Oncology Nurse Advisor*. “When women know that it’s been the guideline for a long time, to tell them, ‘No, we’re not going to give you a mammogram’—that’s hard for them to hear.”

These sentiments supporting continued early mammography are echoed by Susan Boolbol, MD, a surgical oncologist at the Beth Israel Medical Center in New York City. “There are many studies showing a survival advantage with early detection [based on routine mammographic screening starting at age 40],” said Dr Boolbol. “If breast cancer is diagnosed at its earliest stage, chemotherapy is not needed. At larger sizes and later stages, chemotherapy frequently is part of the treatment plan. This addition of chemotherapy has an enormous impact on quality of life. Having mammograms every 2 years instead of annually may potentially increase the number of women who will require chemotherapy.”

Mary Cahill, RN, a staff nurse who works with Dr Boolbol, relays this decision to stick to the status quo to the patients treated at the hospital. “We get a lot of women asking us about the new guidelines; they’re very confused because they’re hearing and reading conflicting information,” said Ms Cahill. “We tell them that we have not changed our guidelines because the evidence is not compelling enough to support a change.”

### BREAST CANCER-SCREENING CONTROVERSY LIKELY WON'T GO AWAY SOON

The currents that have been stirred up by this debate are too deep and too strong to dissipate overnight. Patients, nurses,

and the rest of the nation will continue to watch, wait, and worry about which way the winds will blow—and whether safeguarding a high standard of health care, including prevention, is still possible in the face of growing pressures to be able to balance the budget some time in the decades to come.



A lot of women are going to say, “I think my life is worth more than 1,900 biopsies.”

—Therese Bevers, MD

“I don’t know what you think your life is worth, but a lot of women are going to say, ‘My life is worth more than 1,900 biopsies,’” says Dr Bevers in summing up the prevalent attitude. So stay tuned... ■

Rosemary Frei is a medical writer in Toronto, Ontario.

### REFERENCES

1. US Preventive Services Task Force. Screening for breast cancer: US Preventive Services Task Force recommendation statement. *Ann Intern Med*. 2009;151(10):716-726.
2. Nelson HD, Tyne K, Naik A, et al, for the US Preventive Services Task Force. Screening for breast cancer: an update for the US Preventive Services Task Force. *Ann Intern Med*. 2009;151(10):727-737.
3. Woolf SH. The 2009 breast cancer screening recommendations of the US Preventive Services Task Force [letter]. *JAMA*. 2010;303(2):162-163.
4. ACOG Practice Bulletin No. 109: Cervical Cytology Screening. *Obstet Gynecol*. 2009;114(6):1409-1420.