



Wake Radiology's Response to Recently Revised USPSTF Guidelines

Late last year, the U.S. Preventive Services Task Force (USPSTF) published new recommendations for performing breast cancer screening in the *Annals of Internal Medicine*. In their recommendations, the task force recommended against performing screening mammography at all in the 40- to 49-year-old female population. They also recommended screening mammography every two years for women between ages 50 and 74 instead of the currently accepted protocol of annual screening mammography in this age group. Lastly, they recommended that women stop performing monthly self-breast examinations completely.

We at Wake Radiology join the American Cancer Society (ACS), the American College of Radiology (ACR), the American Congress of Obstetricians and Gynecologists, the Susan G. Komen Foundation, and other professional societies or patient advocacy groups in strongly disagreeing with these new proposed guidelines. We fiercely support the current standards since we think that the scientific evidence supporting the country's current guidelines is clear and indisputable.

In the late 1970s, multiple prospective randomized controlled trials were performed including studies in Sweden that followed 134,867 women and demonstrated a 30% reduction in mortality from breast cancer among the women who were screened vs. the control group. Later randomized controlled trials performed in Gothenburg, Sweden, with almost 50,000 women in the 39- to 49-year-old age group found a 44% reduction in mortality from breast cancer among those screened vs. those who were not screened. These trials proved that regular screening at intervals of less than two years were most efficacious in finding breast cancer at an early stage. In fact, the data were so convincing that these studies could not be again performed, since it is not justifiable to randomize any women into the no screen control group. The USPSTF did not consider these studies at all in making their recent recommendations. Indeed, the USPSTF did not consider any new data in coming to their conclusions. Instead, they have relied on various computer models that do not consider real patient data. Since they did not evaluate the overwhelming evidence supporting current ACS/ACR screening guidelines, it is hardly surprising that they came to the conclusions they did. However, Wake Radiology breast imagers and the objective data strongly support yearly screening mammography beginning at age 40 and ending at ages 75–80.

The task force has also made their recommendations based on their opinions about what the "harms of mammography" are, and the desire of the task force to limit these "harms." Included in the USPSTF list was patient discomfort during a mammogram, although the USPSTF themselves thought that this problem had little effect on the use of mammography. The breast

imagers at Wake Radiology are baffled about including this issue at all in the discussion, since to our knowledge minor patient discomfort during collection of blood or stool samples has never been cited or even considered as a reason not to perform an otherwise efficacious screening test.

The USPSTF dismissed radiation exposure as a significant harm of mammography, but again we are perplexed why this issue was brought into the USPSTF discussion if the task force agrees with most radiation experts that radiation exposure during yearly mammography is not creating significant risk. Indeed, in subsequent discussions in the media, radiation exposure is being cited as a reason the USPSTF has made its recommendations, and the task force members have done little to correct this perception.

The USPSTF has also cited patient anxiety regarding positive results and overdiagnosis and overtreatment as reasons to curtail current screening guidelines. Wake Radiology thinks the anxiety of dealing with the treatment of an advanced breast cancer that could have been diagnosed and treated at an earlier stage greatly outweighs patient anxiety incurred during the workup of a finding finally found to be negative. We also believe that medicine has just begun to understand the spectrum of the disease we call “breast cancer.” Greater understanding of the pathophysiology of breast cancer including subtypes that require little or no treatment and implementation of new diagnosis and treatment guidelines to evaluate the results of screening mammography is the answer to this problem—not eliminating clinically proven screening protocols. The data also support the fact that most women agree wholeheartedly with the breast imagers at Wake Radiology, and are willing to accept the risks of unnecessary intervention associated with current clinically acceptable levels of false positive results including negative biopsies in order to save lives.

Saving lives by diagnosing and treating breast cancer at an earlier stage is the whole reason to perform screening mammography. Indeed, breast cancer mortality has decreased 30% in this country since 1990 when widespread screening became commonplace. The USPSTF agrees that screening in the 40- to 49-year-old age group saves lives just as it does in the 50-to 70-year-old age group (the USPSTF cites the most conservative estimates of 15% reduction in breast cancer mortality in both these age groups), but the task force believes that the absolute number of lives saved does not justify screening in the 40- to 49-year-old age group. Since 17% of women diagnosed with breast cancer are in the 40- to 49-year-old age group, Wake Radiology breast imagers respectfully, but strongly, disagree with this conclusion. We also disagree with increasing the interval between screening mammograms for women 50 years old or older since adopting the USPSTF recommendations would result in significantly increased morbidity and mortality for these women. We strongly recommend that our patients and their physicians adhere to the protocols in place currently that are still endorsed by imaging experts and professional societies in spite of recent USPSTF publications.