

AAMC's Message to the Public

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It has been an interesting week in the once-quiet world of cancer screening. The U.S. Preventive Service Task Force (USPSTF), a group of outside scientists, who have an advisory role, set off a firestorm with new recommendations regarding mammography. They commissioned a re-review of data on screening mammography and recommended delaying the onset of screening until 50 years and reducing the frequency of mammography to every other year.

The public, understandably, was left confused and even enraged. Congress weighed in demonstrating no less confusion and outrage. Anecdote and invective replaced judgment and discourse. Opponents of health care reform found an opening and used it to land some jabs and uppercuts on the jaws of health care reform. The Secretary of Health and Human Services attempted to distance herself from her own task force, leading to a counter coup wave of criticism that she was putting politics above science.

An onlooker can only observe "Wow!" But perhaps some benefit can be derived after all, if we can refocus away from diatribe and into a debate. The latter is healthy, the former is not.

The USPSTF re-review of the data concluded that mammography is helpful in preventing breast cancer deaths, though perhaps less helpful than is widely assumed. But, among age groups where breast cancer incidence is lower, mammography -- like any screening test -- is likely to result in a large number of false positives. The authors of the scientific study were careful to note that, "Mammography screening at any age is a tradeoff of a continuum of benefits and harms. The age at which this tradeoff becomes acceptable to individuals and society are not clearly resolved by the available evidence."

But the USPSTF itself didn't have the same trouble seeing with clear resolution. The task force made its own value judgment on that tradeoff, determining that screening between 40-49 should not be done because a lot of false alarms will be generated, meaning up to five women will need to undergo biopsy for every cancer detected. Screening in the 40- to 49-year-old range should be reserved for "high risk" patients, the panel said.

This is a bad call, because breast cancer is *not* rare in the 40-49 age groups, being diagnosed in one of every 69 women by the end of their 40s. Indeed, it causes about 5,000 deaths

among women 40-49, annually. The USPSTF's concern about harms such as false positives and resulting anxiety smacks of paternalism. Indeed, previous research has demonstrated that most women *can* deal with the anxiety resulting from false positives without lasting harm.

In addition, the idea of limiting screening to high-risk groups is ill-advised. While such a policy would help reduce false positives, this recommendation will not detect enough cancers, since most breast cancer occurs in women who are not known to be at high risk.

It must be recognized that mammography is an imperfect test, especially in younger women. Part of that is inherent in the technology; even when expertly performed and interpreted, there are going to be false positives. In addition, the data provides a sobering recognition that some cancers are biologically aggressive and that screening at any interval may not alter their course. But it is worth remembering that a "positive" mammogram, i.e. one that requires additional studies or even a biopsy, is not necessarily evidence of cancer.

We will continue to recommend starting screening at 40. Insurers should not change coverage policy, either. At a time when the public is being urged to take responsibility for their own health, it would be foolish to reduce access to an early-detection program that enjoys widespread support *and* a documented record of success.

What else can the public learn from this debate? First, recognize that all mammography is not the same. Make sure the mammographic facility has the latest in technology such as digital mammography and that the studies are interpreted by radiologists who do it full time, or nearly so. Better technology, expertise and experience reduce the need for call backs and biopsies. If you are visiting a facility for the first time, bring your old studies; they help interpret the new studies.

Finally, advocate for scientific advancement. Those of us entrusted with advising the public and individuals need better tools, such as biologic markers, that help to detect cancers and predict its behavior. At the AAMC Breast Center, we are participating in studies to develop these biologic predictors that will one day compliment the use of imaging and help to direct therapy. When those tools arrive, I hope it will also make the front pages because that is what we really need: more light and less heat.

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