Mammography Controversy

Yearly mammogram screening has been scientifically demonstrated to reduce breast cancer mortality. The most dramatic reduction in mortality occurs in women over 50 years of age, but women between the ages of 40 and 50 also receive significant benefit from screening. The risk of radiation exposure in women over 40 years is insignificant. Women younger than 40 years should discuss the relative advantage of receiving screening mammography with their physician.

Women with breast symptoms such as a new lump should be evaluated by their physician. In most cases the physician will order a diagnostic mammogram which includes special focused views and potentially an ultra-sound to evaluate the symptoms. In women less than 30 years old, we begin the evaluation with an ultra-sound and only consider mammography if needed to make an accurate diagnosis. We find that in most cases a mammogram is not required for this age group.

If you have questions on mammography or other breast related issues, visit our website www.beawarefoundation.org and click on the ask the doctor section.

The following is an editorial that appeared in The Orange County Register in response to the mammography controversy:

I was stunned when I read the recent announcement from U.S. Preventive Services Task Force (USPSTF) stating that they would no longer recommend routine screening mammography for women under the age of 50 years, no longer recommend that doctors teach Breast Self-Examination (BSE), and no longer recommend yearly clinical breast examinations.

The panel seems to be suggesting that women in this age group simply wait until a tumor grows to the point where it becomes so obvious that it will likely be incurable. This is a major step backward. It is well known that studies from Sweden demonstrate a 40% mortality reduction in association with yearly mammography screening in the 40-50 year age group.

The task force actually admits that screening mammography saves lives in young women, but concludes that there is insufficient data to justify the emotional distress and costs associated with screening. They point out that screening leads to a large number of negative biopsies which are costly and of no medical benefit.

The American Cancer Society (ACS) has a panel of experts who also reviewed the literature. The ACS concludes that screening mammography is appropriate in the 40-50 year age groups. Both panels indicate they propose guidelines that are designed to insure best value, which is defined as achieving the best medical outcome at the lowest cost. To achieve best value, the panel from the ACS put more weight on the issue of outcome, and the panel from USPSTF put more weight on the issue of cost. Such differences in interpretation are predictable in a system of care in which third parties rather than individuals pay for services.

The reason a government panel would emphasize cost-containment is readily understandable. Costs of medical care are spiraling out of control. The government will be unable to meet its objective of providing universal access to reasonably priced medical care unless the costs of care are brought under control.

The panel does make one important point on the issue of cost-containment. They correctly state that there is no published data that demonstrates a survival advantage for screening women over 74 years of age. There are undoubtedly some women in this age group who would benefit from screening. Physicians should share this information with their patients to assist them in making informed decisions.

The behavior of breast cancers in younger women is much different than it is for seniors. Many of the cancers that develop in women over 74 years of age are slow growing and if left untreated would not influence survival. Cancers in young women tend to be aggressive. If left untreated or diagnosed late, these cancers will kill.

Early mammographic detection of breast cancers in the under-50 age group is complicated by the fact that these women tend to have dense breasts making early detection more challenging. Also, younger women are more likely to have rapidly growing cancers that are either not detected on mammograms or show up as new lumps between yearly mammograms. However, despite a multitude of challenges, numerous studies from both the U.S.A. and abroad demonstrate the life-saving value of screening in the 40-50 year age group.

There are also other early detection strategies that provide additional layers of protection. Women who do BSE with confidence are often able to perceive small and potentially curable cancers that are not detected on mammograms. Physicians who inspire women to perform proper BSE and support them when they do detect subtle changes on self-exam, add an additional layer of protection.

In the bigger picture, the guidelines as proposed may offer a glimpse into what is in store for the public as the government attempts to achieve budget neutrality while providing universal access to care. Their recommendation to restrict life-

saving care to young women is an indicator of how far government panels may be willing to go to achieve their cost-containment objectives. Fortunately, the new guidelines have for the most part been rejected, but pressures for cost-containment will continue to mount and other approaches to rationing of care will be advanced. The alternative to rationing is to restructure the healthcare system to improve efficiencies, eliminate marginally beneficial procedures, and provide incentives for physicians to compete for best value of services. It will take an informed and energized public to insure that the focus of our evolving health care system is on creating value rather than controlling costs.