For years, women were encouraged to get breast cancer screenings at 40. Now, the U.S. Preventive Services Task Force has issued new guidelines saying that the average woman can wait until 50. The guidelines also discourage the teaching of self breast examinations. Experts explain how the study was conducted, and how to interpret the new recommendations.
49 years. The decision to start regular biennial screening mammography before the age of 50s should be an individual one and take into account patient context, including the patient's values regarding specific benefits and harm. It goes on to say that's a Grade C recommendation. What does that mean?

WILSON: Grade C means it's not their strongest recommendation, and the point here and the thing that needs to be underscored is routine, and average. We're talking about the average American woman. We're not talking about a women whose family has had a history of breast cancer. We're not talking about African-American women, some of whom have been shown to have very aggressive breast cancers when they've been diagnosed. We're not talking about any woman who comes from a group that has been identified as high risk.

And essentially what they are saying, they - it's kind of curious because they are saying even though the recommendation says, you know, we're not advising or recommending routine screenings starting at age 40, but they are not against screening.

They keep emphasizing this. This is a conversation. What they want women to do instead of just sort of automatically, without thinking about it, I've hit the age of 40, that's when I'm going to kind of be struck down in my prime, so I'm heading off to get a mammogram. Instead of doing it that way, what they want women to do is talk to their doctor. What are - what are the things I need to think about? Is this something I should do? Do I have - I mean, you know, do I have any of the potential risk factors? Are there some things that would put me more at risk?

Have the conversation with your doctor, don't automatically go off. And what they're also saying: you can wait until you're 50. I mean, this is - you don't have to do it before you're 50. The risk shows - I mean, the benefits of doing it when you're 40, it seems, are small compared to - keep in mind - compared to, in a larger public policy sense, waiting until you're 50, and then after you reach the age of six - no, 74, there doesn't appear to be any benefit to continue doing it.

ROBERTS: Right. So they go on to recommend biennial screening mammography for women between the ages of 50 and 74, and then say there is insufficient evidence to assess the additional benefits and harms of screening mammography in women 75 years or older.

WILSON: And I - you know, essentially when you get to be 74, you know, breast cancer, as in some cancers, many cancers become - they're slow growing. And you might develop something or something might be identified through the procedure that will not have any effect on you within your lifetime.

ROBERTS: Here's another recommendation that has gotten some press: the task force recommends against clinicians teaching women how to perform breast self-examination. That's a Grade D recommendation. Okay.

WILSON: And part of the problem even with doing this, both with the mammographies at an early age and with breast self-exams, is that they lead to further screening. And because, you know, they are not the best method. They have - and this is based upon studies. It's not just sort of somebody deciding this. There - yes, women have found things and you can find things, but then in order to determine whether it's something that you're going to need to have a procedure done, you're going to have to be screened, you may have to go through repeated screening or biopsies.

The other thing that they said about all of this, if you would prefer, you know, if you can deal with the anxiety, you know, of going through the repeated screenings, that's a woman's individual decision. It's not - but for some women the whole process of thinking that they're about to die or being subjected to multiple screenings - and there are a fairly high number of women who've had to undergo this process, and it's not as simple as we think and it's not as painless and it's not just psychological anxiety. It's the choice of the woman.

ROBERTS: Let's take a call from Tanya in Redding, California. Tanya, welcome to TALK OF THE NATION.

TANYA (Caller): Thank you. My question is: Why are American women being given recommendations on studies that have been conducted overseas, when clearly historically health differences between women in America and women overseas are much different, and why wasn't there a study done on American women?

WILSON: There - some of this information was based upon studies that were done upon American women as well. They were using the latest data, I'm told, that's available, and beyond that we are now entering into something that's above my pay grade. But it's not that they were not looking at the evidence and the information here in the United States. There were six U.S. cancer centers also involved in, you know, providing information that this decision was based upon.
ROBERTS: Tanya, thanks for your call. Brenda, in 1997 there was a different federal committee of medical experts recommending that women in their 40s should not get routine mammograms. There was a big political outcry, and we're seeing - it ended up being voted on and challenged in the Senate. We're seeing the brewings of something similar now. Why does this get politicized? What do you think that that's about?

WILSON: I actually think that when people hear this, they're thinking of their own individual circumstances, but when you're talking about public agencies or, you know, administrative divisions within the government - the government has to make policy not just for one person. It has to consider the societal cost, the larger cost, and I think it's very difficult for an individual or person who's facing the potential of a life-threatening illness.

They want all amount of money to be spent. They don't care what the cost is going to be because it's their lives, it's the lives of their family members, and they don't understand why cost should be a factor in this. But in fact, the government has to look at whether a lot of these procedures that are being done that do cost, that are going to end up costing billions of dollars, is this the best way to spend the money to in fact aid all of its citizens when you look at the potential risk to the individuals, when you look at how many women are at risk of breast cancer. And for women in their 40s, it's hard to realize if you're looking at the total population of women, you know, it's like about 1.44 percent, starting at age 40, for the - for you, you know, the next 10 years of that woman's life. That's the potential risk for her.

But the government has to take that in consideration when, you know, it's going to make decisions on how money for health care should be spent.

ROBERTS: And from a science point of view, having read these recommendations and done some reporting on them, in the hoopla that has resulted in the last couple of days, do you think these recommendations are being represented accurately?

WILSON: I think they are, at least by the media. I think that it doesn't matter how they're being, you know, presented. I'm not sure the task force has done the best job in explaining its position. I mean, I think it says it, but I don't think people hear it because all they are thinking of is that something's being taken away that's going to protect them, and the task force keeps repeating and keeps emphasizing: no, you can still go be screened if you want to, but understand you are going to possibly be subjected to any number of mammograms that may show that there's something there when in fact you don't have cancer, and then you're going to have to be re-screened, and then you may have to go - undergo a surgical procedure.

So I think people are saying, well, I don't really care. Why are they saying not to do this? And I think we're facing - we're coming out of 10 years of being told we should do this, and that's a difficult message to turn around.

ROBERTS: Brenda Wilson, thank you so much.

WILSON: Okay.

ROBERTS: Brenda Wilson is NPR's science desk correspondent. She joined me here in Studio 3A. If you're confused about the new - and frankly, the old - guidelines for mammograms, you're not alone. Stay with us. We'll have more in a moment. And we want to hear from you, particularly if you're a breast cancer survivor. Do you support or oppose the new recommendations? Our number here in Washington is 800-989 - 255 - 8255. Our email address is talk@npr.org. I'm Rebecca Roberts. It's TALK OF THE NATION from NPR News.

(Soundbite of music)

ROBERTS: This is TALK OF THE NATION, I'm Rebecca Roberts in Washington. Earlier this week, the U.S. Preventive Services Task Force issued new guidelines suggesting women should hold off on mammograms until they reach 50, causing some understandable confusion.

We will, in a few moments, talk to Jeffrey Tice. He's an assistant professor of medicine at University of California, San Francisco, and also to Constance Lehman, medical director of radiology and director of breast imaging at the Seattle Cancer Care Alliance. But first, Health and Human Services Secretary Kathleen Sibelius acknowledged that the new guidelines have caused some anxiety. Here's what she had to say. I quote: There is no question that the U.S. Preventive Services Task Force recommendations have caused a great deal of confusion and worry among women and their families across this country. I want to address that confusion head on. The U.S. Preventive Task Force is an outside, independent panel of doctors and scientists who make recommendations. They do not set federal policy and they don't determine what services are covered by the federal government.
Secretary Sibelius continued: There has been debate in this country for years about the age at which routine screening mammograms should begin and how often they should be given. The task force has presented some new evidence for consideration, but 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 went on to say that women should talk to their doctors about their individual histories and ask questions and make the decision that is right for them.

So we want to hear from you, particularly if you're a breast cancer survivor. Are you opposed to or for the new recommendations? Will the new guidelines change the way you view routine mammograms? Tell us your story by calling 800-989-8255. Our email address is talk@npr.org, and you can join the conversation on our Web site - go to npr.org and click on TALK OF THE NATION.

Joining me now to talk more about the task force recommendations are Jeffrey Tice, assistant professor of medicine at the University of California, San Francisco. He supports the new task force guidelines and joins us by phone from his office in San Francisco. Thanks so much for being here.

Dr. JEFFREY TICE (University of California, San Francisco): My pleasure.

ROBERTS: Also with us is Constance Lehman. She's medical director of radiology and director of breast imaging at Seattle Cancer Care Alliance. She opposes the new guidelines and joins us by phone from her office in Seattle. Welcome to you.

Dr. CONSTANCE LEHMAN (Seattle Cancer Care Alliance): Thanks so much.

ROBERTS: I want to get right to the phones because there are so many personal stories involved in this. Let's hear from Jennifer in Sarasota. Jennifer, welcome to TALK OF THE NATION. We're having problems with that button. Let's hear from Mary Jo in Columbus, Ohio.

MARY JO (Caller): Yes. I have heard that it's not necessarily the mammograms that are ineffective but human error in reading them, more so in the United States than in Europe, in fact. Can you comment on this? And I have relatives who are - many relatives who are survivors.

ROBERTS: Constance Lehman?

Dr. LEHMAN: Great question, and I also appreciate the earlier caller who was saying, why do we look at Europe when we're trying to figure out what to do in the United States? There are different methods that have been compared for European sites and for U.S. sites, but I want to make it really clear that while there is a diversity of performance across the country, I think the U.S. should be really proud of the Mammography Quality Standard Act and the work that our government has put into making sure women have access to high-quality centers.

But there is variation even with that. When we address the changes between the U.S. and Europe, we see some patterns. We are better at detecting ductal carcinoma in situ in earlier-stage cancers. We do across the country - this isn't at all centers by any stretch - but we do across the country have higher callback rates. We will do more additional imaging than European sites.

So there are differences in the practices, but the performance as far as cancer detection and lives saved is as good or higher in the U.S. So it's - I don't think it's a situation where we're performing worse in the U.S.

ROBERTS: Mary Jo, thanks so much for your call. Let's hear from Jennifer in Sarasota. Jennifer, welcome to TALK OF THE NATION.

JENNIFER (Caller): Thanks. I'm a survivor. I was diagnosed at age 41, had had my mammogram at age 40, and it was clean, perfectly clean, and they looked at it again after I was diagnosed. And yet at 41 I was diagnosed with a five-centimeter tumor and inflammatory breast cancer and a whole bunch of ductal carcinoma in situ. So the mammogram didn't really - didn't help.

ROBERTS: And how was your cancer picked up, Jennifer?

JENNIFER: I found it.

ROBERTS: Through a self-exam, or just accidentally?

JENNIFER: Uh-huh. Both. I mean, my tumor became so big so fast, it was kind of hard to miss, and then I had inflammatory breast cancer, which is on the skin, and so you see differences and you feel
differences on the skin.

ROBERTS: And Dr. Tice, is there a difference in the cancer that is detected for women in their 40s? Is that part of this conversation?

Dr. TICE: I mean, there is. I mean, Dr. Lehman probably has more expertise than I have in this, but in general, younger women are diagnosed with more aggressive more fast-growing tumors, like our caller, unfortunately, and they are more likely to - or they're less likely to express hormone receptors, estrogen and progestin receptors, which we know are good clinical markers for outcome, and we have targeted therapy for those. Perhaps Dr. Lehman would want to expand on my comments.

Dr. LEHMAN: I'm glad the caller made these comments because I think a lot of women want to hear that while mammography is the best tool we have for early detection, it's not perfect. If a woman feels something in her breast, sees changes on her skin, absolutely go to her doctor. A negative mammogram isn't perfect. These cancers, such as the one that the caller has, do grow quickly and can occur very rapidly. And again, we can have what we call false-negative mammograms. So the cancer is there but the mammogram doesn't identify it. It's not a perfect tool, and it's why it's so important that women not only get the mammogram but always talk to their doctor if they find a change in their breast or they're concerned about a lump.

Dr. TICE: Absolutely. I'd like to echo that. That's essential. But it also points out, you know, starting routine mammography at age 40 would not have helped our caller. In this case she found it herself, brought it to her doctor's attention and hopefully will live a long, happy life having done so.

ROBERTS: Let's hear from Nina in Buffalo. Nina, welcome to TALK OF THE NATION.

NINA (Caller): Thank you.

ROBERTS: Hi, you're on the air.

NINA: Yes, I'm calling because I'm concerned about the self-exams, recommend that women don't do self-exams, and they're not helpful. I'm 47 years old and I caught my cancer. I have invasive lobular carcinoma. I had a bilateral mastectomy and I caught it from self-exam. And what's the harm of doing the self-exam? It's free. Women should know their breasts, be educated about them. I find that that's very reckless.

Dr. LEHMAN: I agree with you completely. You know, the studies that were performed, that ended up to so many people saying, gosh, we shouldn't teach self-breast exam - one of the largest studies was in China and then went in and they taught women in certain areas of work to do self-breast exam, and they didn't offer those training programs to other women.

So it's an interesting study, and it sort of guided some of the areas where they were saying if we go into a country and we want to improve the situation of breast cancer, should we put funding into developing self-breast exam training programs? And the answer from that study was probably not.

I think it's a really different question for women in America to say, should I exam my breast tissue? What I say to women is if you're comfortable examining your breast tissue, you've always been comfortable with it and you feel like if there's a change you'll go and talk to your doctor, that is terrific, because many, many women, especially young women, the only reason why their cancer was diagnosed is because they noticed a lump in the breast.

Now, that noticing might have been from incidental finding, they were taking a shower, they brushed against something. But being comfortable with your breast tissue, not being sensitive or worried about touching your breast and bringing something to your doctor's attention, I think that's a great thing. And so I think of it more as really important to promote self-awareness and breast self-awareness.

Whether or not we, you know, put a lot of government funding, for example, into training self-breast exam is another question, but we really want women to be aware of their breast tissue and to be comfortable with their breast tissue exam.

Dr. TICE: I'd like to expand on that as well. There were two big, what we call the best kind of study, the randomized trials, of self-breast exam, but as Dr. Lehman said, neither one was in a country like the United States. One was in China. The other was in Russia. And they found no benefit at all, not even a trend towards fewer deaths from breast cancer in those who were instructed in self-breast exam.

They did, however, find that women had 50 percent more biopsies. So that's why some organizations have come out against it. The best data that we have is of no benefit and in fact a trend towards more deaths from breast cancer paradoxically. And there were clearly more biopsies. So there's no evidence
of benefit, some evidence of harm.

There are data from England, where it wasn't a randomized trial, it was a very carefully done observational trial, where they trained women at a couple of centers in self-breast exam - several hundred thousand women - and followed them for 16 years and then compared them to expected death from breast cancer. And they also saw no difference in rates of breast cancer overall in that study. So that's the closest to the United States.

So, the real question is whether we should be promoting this and potentially finding lots more lumps leading to biopsies and potential harm when there's no evidence of any benefit.

ROBERTS: Well, that brings up an email from Martha(ph) in St. Louis, who says, I heard the task force said the risks outweigh the benefits. What risks have been shown with mammograms or self-exams?

Dr. LEHMAN: I think that's a really important question, because one of the biggest criticisms I have of this whole process has been - it was an opportunity for women to be less confused and this really have confused them, because the message has been so unclear and some of the language has just been too loose. So, when I read headlines and it says, harms of mammography, most of my friends are saying, what do they mean? What does that mean?

And I think we need to address that really carefully when they say a lot of women are at risk for harms. So the harms or the downside is the woman is called back for additional imaging. And we have very clear data showing the risk at which a woman might be called back to have another X-ray or to have an ultrasound of the breast. It's going to be less than 10 percent. So, women may come back and have additional imaging.

A much smaller percent of even that group are going to actually need to undergo a biopsy. And this is if we're performing our breast imaging programs at quality centers that are good at doing what they do. So, I think women need to be able to have much more of a voice when they say, well, women don't want to go through the anxiety. Our friends and my patients are saying, what are they talking about? I mean, I think that we have really made this a very emotional situation of the anxiety and the harms and over diagnosis of cancer so there are a lot of people walking around now thinking that their breast cancer that was treated two years ago, we could have left it alone - there was no reason they needed to go to treatment.

ROBERTS: Well, let me push back on that a little bit because we have some emails that say, that anxiety is nothing small. We've got Sallie(ph) in Denver who says, I wish the study have been done years ago. I had mammograms all through my 40's. I ended up having three needle biopsies, each of which cost a week of anguished waiting for results.

I also had a surgical biopsy which was painful for weeks and permanently disfiguring. And all the biopsies were negative. Added to the physical and emotional burden was the financial one. All of this was not cheap. Since I've turned 50, I haven't had another biopsy. Thank goodness.

Dr. TICE: I'd love to address it from a primary care perspective because I think I see the flipside. I think the oncologist, the treating doctors see all the cancers and all the bad outcomes. But myself, as a primary care physician, I see more the anxiety. And some women become severely depressed in response to the fear or anxiety around a false positive result.

And it's not uncommon. You know, if we're talking about a thousand women ages 40 to 49 getting annual mammograms, we expect somewhere between 500 and 1,000 false positives, somewhere between 75 and 100 biopsies to find 14 breast cancers, invasive breast cancers and four ductal carcinoma in situ. All of that will prevent about a third of a death. So it actually takes 3,000 women screened for 10 years, in this age range, to prevent one death from breast cancer.

And that's a lot of false positives. A few of those women will have really severe emotional responses to those false positives. And there's a lot of harm in that.

ROBERTS: You're listening to TALK OF THE NATION from NPR News.

On the cost question that was brought up in that former email, there's a tweet from Mighty Casey(ph) who says, screening mammograms cost less than $150 in all U.S. States. Women must make the decision based on their health, not federal guidelines. Do either of you know if that $150 number is accurate?

Dr. LEHMAN: It's in the ball park. It's fairly accurate. The range from site to site is going to vary and what insurers will compensate or CMS or Medicare or Medicaid, but that's definitely within the range, around 100, $250 is a reasonable estimate. It will vary from site to site.
ROBERTS: We have an email from Melissa in California who says, in 2007 at age 48, I found a lump in my breast from self-exam. Down the path of specialists I went, starting at my primary care doctor and moving to an ultrasound doctor, then onto a breast surgeon who all led me to believe it was probably nothing. After a biopsy confirmed it was stage three invasive ductal carcinoma, I was put on the route to surgery, radiation, drug treatment therapy.

I hope to bounce the future children of my teenagers on my knee and celebrate my 25th anniversary with him next year and my 50th with him in the future, yet I wonder if I wouldn't even be here today if these new guidelines were in place. I feel women with stories like mine are being treated as dispensable or collateral damage in the health care debate and I'm furious.

Dr. LEHMAN: We've had a lot of patients have very, very similar reactions. You know, when we hear a group saying, we know and the science proves and the data proves that the death rate has been decreased by 30 percent. We know that. But you know what, we've decided that the anxiety that the screening programs raise isn't worth saving those women's lives. And that's just a perspective that's not acceptable to many of us.

ROBERTS: Well, so does this come down to, like so many of these do, that, you know, trust your own instincts and your own tolerance for risk and reward and have a conversation with your doctor?

Dr. TICE: Absolutely. I think that's what the recommendation said. You know, I think on a population basis, this very close balance between the risks and benefits of mammography come down in favor for the general population at about age 50. Between 40 and 50, it really is patient values and patient risk that makes the decision; higher risk women or women who are risk averse would really, you know, should opt for screening mammography. And I think the guidelines support that there's nothing saying women should not get a mammogram at age 40. They just recommended that it not be routine, and for younger than 40, that it be a thoughtful discussion.

ROBERTS: Well, also, it seems to me that if one of the risks is all these false positive, what we need is a better mammogram. I mean, Constance Lehman, is there a better screening technology on the horizon?

Dr. LEHMAN: Well, I love it that you're bringing this up. But even before we get to a better mammogram and new technology, which we absolutely need to aggressively pursue in our research, we also need to continue to push so had on better education - higher levels of expertise. The variation across the country is not acceptable. Mammography, and especially digital mammography in women in their 40's, can perform at a very high level and the variation is just not acceptable.

So there's a lot of work we can do right now with the technology we have and better training and higher standards. They can do a lot of good. And in the meantime, absolutely pursuing better methods of early breast cancer detection is just - is so important.

ROBERTS: That's Constance Lehman, medical director of radiology and director of breast imaging at Seattle Cancer Care Alliance.

Thank you so much for joining us.

Dr. TICE: I would like to add one other thing. One of the other areas

ROBERTS: We're almost out of time, so I'm going to have to say goodbye to you. That's Jeffrey Tice. He joined us from his office in San Francisco, California. He's the assistant professor of medicine at the University of California, San Francisco.

Thank you to both of you.

Dr. TICE: All right. Thank you.

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comments

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Conness Thompson (Conness) wrote:

Wednesday, November 18, 2009 3:33:17 PM

I find the logic of the first speaker's comment about not doing self-exams flawed - and concerning: The rationale against women doing self-exams is that they might find a lump and this will result in all sorts of tests and cause all sorts of anxiety when it is likely the lump is nothing . . . so is it better for women not to self-exam and miss a lump that is cancerous?!

Cheryl McGinnis (cfmc) wrote:

Wednesday, November 18, 2009 2:01:43 PM

The primary principle I taught my 7th and 8th grade health students was to PLAN to position themselves to take the percentage shot in life. What were those attitudes, basic scientific knowledge, self-understanding insights, and the literacy skills needed to recognize the heads-up/pay attention cues that would come from new research that might suggest needed change in their health game plan.

These new studies are a perfect example. Evidence bases research findings are important to include in all those factors affecting one’s health care choices. If it is already known that you have a low breast cancer risk then this information will be helpful in scheduling a regime that would be effective in personal health management which does include cost considerations. If on the other hand your family has a history of cancer then your health care planning should be tweaked to cover the increased risk.

One thing to note is that these new findings are RECOMMENDATIONS. I do realize that nothing remains pure science for long. Insurance companies might see these recommendations as a way to trim costs. Mammogram suppliers will see their business and bottom lines affected. Some may grasp a false security. One thing that will result from the pull and tug caused by these recommendations will be a broader conversation. Hopefully this will mean that more women will rethink the way they approach their health care.

As in any sport, strategy is important. A personal health care strategy is crucial.

Contessa Thompson (Contessa) wrote:

Wednesday, November 18, 2009 3:33:17 PM

Recent First

Cheryl McGinnis (cfmc) wrote:

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