



**SOCIETY OF BREAST IMAGING TALKING POINTS  
RE: USPSTF SCREENING GUIDELINES  
NOVEMBER 16, 2009**

1. Since 1990, the breast cancer death rate in the U.S, that had been unchanged for the preceding 50 years, has decreased by 30% primarily due to screening mammography. There has been little impact from newer therapies.
2. There is universal agreement that screening mammography saves lives. The disagreement lies in the estimates of how many lives are saved. The USPSTF considered only old data in its analysis and ignored more modern data that provides compelling evidence of a greater benefit from screening. This data from service screening in Sweden shows that the death rate can be reduced on the order of 40%.
3. The USPSTF seems overly concerned with the harms of screening such as discomfort from mammography, anxiety from recall, ultrasound, and needle biopsy. The public understands that mammography is not a perfect test, and is willing to accept minor inconveniences in order to maximize the opportunity of finding a cancer earlier by screening.
4. The USPSTF estimates that the mortality reduction for screened women aged 40-49 is 15% and for women 50-59 is also 15%. However, approximately 1900 women need to be screened to save one woman in her 40's, 1300 women need to be screened to save one woman in her 50's, and 600 women need to be screened to save one woman in her 60's. They reason that because more women aged 40-49 are needed to save one life than in the other age groups, the harms are too great to justify screening beginning at 40, despite a similar mortality reduction. We would argue that the earlier in her life that a woman's life is saved by screening, the better.
5. The USPSTF wants to lengthen the time between screening to two years for women ages 50 and over. The likelihood that annual screening is better than biennial has been shown in other computer models (Michaelson J et al). Other studies show that cancers are smaller and found at an earlier stage when screening is annual. Would you rather give a breast cancer 2 years to grow, and possibly metastasize before you looked for it, or would you rather give it only one year?

6. The potential for mammography to save lives is seriously underestimated by the USPSTF for a variety of reasons. They used a meta-analysis of many RCT's, including some that were not as well executed as others. In addition, it is the nature of RCT's to underestimate the benefit, because there is comparison of the study and control groups as a whole, whether women participated in screening or not. So, for example, women who were assigned to the screening group but never had a mammogram were counted as having been screened, even if they were not, and even if they developed breast cancer. The magnitude of the benefit is further diluted in RCT's because some women assigned to the control group may have gone for mammography and had their breast cancer detected; these women would have still been counted as not screened.

7. The USPSTF conclusions are based on different mathematical models which do not agree with each other. Evidenced based RCT's clearly show a major benefit for all populations in the trials including the 40-49 year group except for the seriously flawed Canadian National Breast Screening trial.

8. Swedish trials showed decrease in mortality of greater than 40% for 40-49 year group in 1/3 of the country. Malmo trial had a 35% mortality reduction for women 40-49 and 44% reduction in the Gothenberg trial.

9. It is unscientific to compare 40-49 year old age group to women 50-74. No magical biological changes happen at 50 therefore picking 40-49 as an age group has little benefit and comparing it to a group of women over a much larger age span (50-74) is pure data manipulation. Breast cancer incidence increases per decade and the incidence in women in their 40's is very similar to those in their 50's.

10. USPSTF recommends screening based on risk. Only 10-25% of breast cancers occur in high risk women. Not screening the others would miss 75-90% of breast cancers. Furthermore none of the RCT's were designed to examine risk as a variable.

11. Combined U.S data is not population based. Most American women included do not undergo REGULAR PERIODIC screening therefore the benefits of screening are diminished.

12. Women should rely on the ACS to advise them on the best screening regimen to reduce their risk of dying of breast cancer. The ACS considers all the evidence in making screening recommendations.