THE "HARMS" OF BREAST CANCER SCREENING

The American College of Radiology agrees that all women should be made aware of the potential results of breast cancer screening. However, radiologists have been excluded from the discussion because of a conflict of interest. Conversely, journals and the media have considered opponents of screening to be unbiased. Unfortunately, they have ignored the fact that many who oppose screening receive grant support and other funding that is based on their nihilistic conclusions. Others likely are occupied with defending their positions preventing a clear analysis of the data.

Dr. Harris has been opposed to mammography screening for women ages 40-49 for decades [1]. In 1993 he made medical recommendations to women ages 40-49 by inappropriately using retrospective unplanned subgroup analysis that lacked statistical power to conclude that there was no benefit from screening women ages 40-49 [2], when there has always been evidence of benefit from screening these women [3]. He defended the Consensus Development Conference Panel of 1997 [4] despite the fact that they had completely ignored the data that they had been called upon to review, that showed statistically significant mortality reduction for screening women ages 40-49 that was as high as 44% [5]. Dr. Harris rotated off the US Preventive Services Task Force just before they published their 2009 guidelines that were almost identical to the NCI, 1993 guidelines, despite the fact that the analysis used by the USPSTF showed that their guidelines would result in as many as 100,000 lives being lost unnecessarily that would be saved by annual mammography beginning at the age of 40 [6].

All of the arguments against screening have been raised and have been shown to be scientifically incorrect. Opponents have now returned to the "harms" of screening as a reason to deny women access yet Woolf and Harris, conveniently, neglected to define the "harms" of mammography screening. In fact, out of 100 women having a screening mammogram, approximately, 8 will be recalled for additional evaluation. These have been called false positives, and there is no question that this does cause some anxiety among many women. However, approximately, 2-3 out of the 8 will be found to have had nothing more than superimposed normal breast tissues requiring no further intervention. The others will be shown to have benign findings based on additional mammograms or ultrasound. A few of these may be asked to return in 6 months for a reevaluation. Between 1 and 2 of the 8 (15 out of 1000) will be advised to have an imaging guided needle biopsy under local anesthesia, and of these, 25-30% will be found to have breast cancer. This is a higher yield of breast cancers than when women present to the surgeon with a lump [7] and the cancers found by mammography are at a smaller size and earlier stage than those that are palpable. Using the US Preventive Services Task Force analysis, Hendrick and
Helvie have shown that among women ages 40-49 each risks a recall for diagnostic evaluation every 12 years. Each woman can expect a negative (unnecessary) biopsy every 149 years and that her cancer will be missed (false negative) every 1,000 years. Theoretically (there is no direct proof) a woman in her forties will sustain a fatal breast cancer induced by mammography every 76,000-97,000 years.

The bottom line is that the "harms" of screening have been exaggerated. Transient anxiety is not the same as dying from breast cancer

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