

Keep Getting Mammograms!

The New Recommendations are Flawed

By Robert B. Sklaroff and Robert R. Guzzardi

Healthcare bureaucrats can't take "yes" for an answer! Mammograms are so effective in reducing breast cancer mortality that they think a few more deaths are OK...to save a buck.

This startling departure from precedent, common sense, and cogent scientific analysis emanated from the United States Preventive Services Task Force (USPSTF). It served to besmirch the sterling reputation of "Public Health" and thereby presage the impact of "death panels" lying at the heart of ObamaCare.

When the recommendation cut-backs were announced, Americans recoiled in unison. Not only did they recount personal experiences that contravened these constraints, but experts were able to dramatize the disconnect between the database and how it had been misconstrued.

This forced Health and Human Services Secretary Kathleen Sebelius to retreat from her internal group's opinions. But the acute and chronic damage is immutable, for its ripple-effect has denuded how even cancer prevention could be defunded...and become rationed. That's what happens when a panel devoid of oncologists is empowered to interpret information without appreciating the need for sensitivity as to how its judgments would be applied at the bedside.

Online Resources are Easily Understood

The current issue of the Annals of Internal Medicine (<http://www.annals.org>) includes both the government's clinical guidelines (<http://www.ahrq.gov/clinic/uspstf/uspsbrca.htm>) and two articles and an editorial that attempt to place them into context. The non-physician can detect—with some guidance—both the admitted academic limitations when analyzing the six screening studies and the implied constraints on how the opinions have been synthesized.

"The USPSTF examined the evidence on the efficacy of five screening modalities in reducing mortality from breast cancer: film mammography, clinical breast examination, breast self-examination, digital mammography, and magnetic resonance imaging in order to update the 2002 recommendation. To accomplish this update, the USPSTF commissioned two studies: 1) a targeted systematic evidence review of six selected questions relating to benefits and harms of screening, and 2) a decision analysis that used population modeling techniques to compare the expected health outcomes and resource requirements of starting and ending mammography screening at different ages and using annual versus biennial screening intervals."

What this means is that clinical and imaging screening techniques were assessed at either one- or two-year intervals to determine their benefit to women of varying ages. The term “harm” was gently introduced epidemiologically, but its application was broader than is customary.

“Harms include radiation exposure, pain during procedures, patient anxiety and other psychological responses, consequences of false-positive and false-negative test results, and overdiagnosis. Overdiagnosis refers to women receiving a diagnosis of invasive or noninvasive breast cancer who had abnormal lesions that were unlikely to become clinically evident during their lifetimes in the absence of screening.” There is no evidence that radiation exposure causes any adverse sequelae and the discomfort experienced during the procedure is transient; furthermore, anxiety is eliminated when a negative biopsy is obtained, and there is no way to identify which patients with early lesions will progress and which will remain quiescent.

Therefore, the only true “harm” associated with any screening study is whether it is effective. Suggesting otherwise introduces the possibility that the underlying concern is cost-related.

“The USPSTF concluded that the current evidence was insufficient to assess additional benefits and harms of either digital mammography or magnetic resonance imaging instead of film mammography as screening modalities for breast cancer.” Thus, the debate was trained on the use of self- and/or professional-examination and the utility of routine mammography.

Physical Examination

For decades, self-examination has been heralded as a cornerstone for cancer detection, even as this advice increased awareness of the need for mammographic screening. Yet, “the USPSTF recommends against teaching breast self-examination (BSE).” Why?

Only two of the studies met this accession criterion: “We included only systematic reviews rated as good quality in the report and RCTs rated as fair or good quality in the meta-analysis.” Those addressing self-examination were both “fair,” conducted in countries that lack mass mammographic screening capacity, and detected increases in benign biopsies. Yet, this advice was self-classified as having “moderate or high evidence the service as no net benefit or that the harms outweigh the benefits.” Based on what?

The evidence was inconclusive and there were no harm. Further, some lesions are not found mammographically, and the literature dating back to the early 1970’s documented the need to perform biopsies on suspicious lesions even if they were not noted in any imaging study.

Similar concerns accompany the clinical examination: “USPSTF concludes that the current evidence is insufficient to assess the additional benefits and harms of clinical breast examination (CBE) beyond screening mammography in women 40 years or older..”

Thus, there is no reason whatsoever to abandon techniques known to be beneficial, both objectively and subjectively, based on both isolated anecdotes and integrated approaches.

Mammography

“Trials of mammography screening for women aged 39 to 49 years indicate a statistically significant 15% reduction in breast cancer mortality for women randomly assigned to screening versus those assigned to controls.” Indeed, “improvements in the relative risk for death due to breast cancer for women aged 39 to 49 years and 50 to 59 years are similar at 0.85.” So, why no recommendation for the former, yet one for the latter? Because “there is moderate evidence that the net benefit is small,” harkening back to that bug-a-boo, “harm.”

It is beyond the scope of an op-ed piece to discuss research issues related to the finding of ductal carcinoma in situ, but it is this finding that is viewed as sufficiently static to warrant acquiring biennial exams, instead of annual ones. Yet, it is conceded that new hormonal therapies (detailed in a separate article in the same issue of the Annals) are effective in this population—once such patients are identified—and there is no known methodology to predict which of these patients will develop aggressive lesions. Thus, again, there is a definable “distinction with a difference” between the information reviewed and the conclusions drawn.

Patient Advocacy Threatened

It is this type of dance between reality and elitist interpretation that is unnerving to even the most casual professional reviewer. Despite reassurances and disclaimers, the USPSTF has been a major resource for the justification of reimbursement for testing. Thus, this retrenchment carries serious implications, not only for breast cancer but as a fore-runner for how HSS panels could conceptualize other diseases.

This is why depending upon governmental whim endangers public health. This is why the debate raging on ObamaCare must yield its defeat. Otherwise, unfathomable harm looms.

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