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"Rethink" of Cancer Screening Triggers Comments and Controversy

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October 23, 2009 — In a comment that has triggered widespread media coverage, the chief medical officer of the American Cancer Society (ACS) admitted that the benefits of cancer screening, especially for prostate and breast cancer, have been oversold.

The advantages to screening have been exaggerated.

"I'm admitting that American medicine has overpromised when it comes to screening. The advantages to screening have been exaggerated," the ACS's Otis Brawley, MD, told the *New York Times* in an October 21 article.

With this statement, a long-simmering controversy — about how the benefits of prostate and breast cancer screenings are emphasized at the expense of discussion of the harms — seems to have boiled over, at least momentarily. The story has been covered by many major media outlets, including ABC News, NBC Nightly News, CNN, the Jim Lehrer News Hour, and National Public Radio.

Hours after Dr. Brawley's comments were published, the ACS released an official press statement from Dr. Brawley that shifted focus back to the benefits of screening — and away from his earlier candid interview about the downsides of screening.

"While the advantages of screening for some cancers have been overstated, there are advantages, especially in the case of breast, colon, and cervical cancers. Mammography is effective — mammograms work and women should continue get them," reads Dr. Brawley's statement.

The statement also reiterated the ACS's stand that men should make an "informed decision" about whether prostate cancer screening is "right for them."

Dr. Brawley's original comments apparently arose in an interview with the *Times* about an essay published in the October 21 issue of the *Journal of the American Medical Association* about the need to rethink prostate and breast cancer screening.

The essay argues that new approaches to screening for breast and prostate cancer are needed, because the current methods have not led to a "significant reduction in deaths" from the 2 diseases.

Explaining the Case for a Rethink

The essay, written Laura Esserman, MD, MBA, and Yiwey Shieh, AB, both from the University of California, San Francisco, and Ian Thompson, MD, from the University of Texas Health Science Center, San Antonio, calls for a rethink on cancer screening and offers a 4-pronged program for improvement.

They decided to write the essay when they realized how similar prostate and breast cancers and their screening problems are.

A central problem with the screenings for both of these cancers seems to be that they have increased the burden of low-risk cancers without reducing the burden of more aggressive cancers, the essayists write.

Mammography and prostate-specific antigen (PSA) testing, although having "some effect," have led to the well-documented overdiagnosis and overtreatment of breast and prostate cancers, they note.

We need to refocus and figure out how to tailor screening.

"We are not saying that screening is bad. It's what you do with the information that makes it good or bad," Dr. Esserman told *Medscape Oncology*. "We need to refocus and figure out how to tailor screening," she summarized.

The American Cancer Society should not be afraid of Otis's message.

She supports Dr. Brawley for speaking out on this issue. "Otis had a lot of courage. The American Cancer Society should not be afraid of Otis's message."

The messages about cancer screening need to evolve, suggested Dr. Esserman.

"I think people like the simple message that screening is good and are uncomfortable with complexity. I understand that. However, cancer is a complicated disease. We need to expand our messages to say, among other things, that many screen-detected cancers are slow growing and may not need treatment," she said.

Other messages should include the mention of harm and the fact that screening will not find all cancers early, Dr. Esserman added.

With regard to the latter, Dr. Esserman said that a recent study indicates that most stage II and III breast cancers actually turn up clinically, between normal planned screens.

"It's just not true to say that 'if you get a mammogram, all will be well'," she explained.

Problems With Prostate and Breast Cancer Screening

It is estimated that more than 1 million men have been overtreated for prostate cancer since the advent of widespread PSA testing in the mid-1980s.

Furthermore, as the essayists point out, the intensive PSA screening has not resulted in a significant difference in prostate cancer mortality between the United States and the United Kingdom, where PSA screening was not widely adopted.

The essayists also note that although evidence indicates that breast cancer screening saves lives, 838 women, aged 50 to 70 years, must undergo screening for 6 years to avert 1 death. However, this 1 life saved generates "thousands of screens, hundreds of biopsies, and many cancers treated as if they were life-threatening when they were not," they write.

A critic of mammography recently told *Medscape Oncology* that such mammography facts are in stark contrast with what is most publicized about the screening, namely that "mammography saves lives."

While Dr. Brawley's comments have garnered great attention, another ACS official recently suggested to *Medscape Oncology* that public education about breast cancer screening is in need of improvement. "We all have to do a better job to best inform the public about the benefits and harms of screening mammography," said Bob Smith, PhD, director of cancer screening at the ACS.

Dr. Esserman believes the time is right to improve both patients' and clinicians' understanding of screening. "If you don't take a hard critical look, then you miss the opportunity to improve things," she said.

A Plan for Improved Screening

In their essay, the authors chart a new 4-point course for breast and prostate cancer screening that will "significantly reduce death and morbidity" from the cancers.

First, more powerful markers that identify and differentiate cancers with significant risk from those with minimal risk are needed.

Second, the treatment burden for minimal-risk disease must be reduced. Methods currently exist to identify low- and high-risk cancers in both the breast and prostate, they emphasize. For instance, in prostate cancer, low-volume lesions with low Gleason scores have a low-risk for death. Minimal-risk disease should not be called cancer; it should be called indolent lesions of epithelial origin (IDLE), they say.

Third, improved tools to support informed decisions are needed. "Information about risks of screening and biopsy should be shared with patients before screening," they write. Currently, an estimated one third of PSA tests take place without even the most basic doctor–patient discussion, as reported by *Medscape Oncology*.

Finally, a greater emphasis on prevention, including the use of proven cancer preventive agents, such as finasteride for preventing prostate cancer and tamoxifen and raloxifene for preventing breast cancer, is needed.

An estimated $20 billion is spent to screen for prostate and breast cancer in the United States. The essayists call for 10% to 20% of that amount to be invested in an effort to improve screening.

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