

American College of Preventive Medicine
USPSTF Breast Cancer Screening Talking Points

Who sits on the Task Force?

Most Task Force members are primary care doctors. Many have prestigious academic appointments.

- They are 4 family physicians, 4 general internists, 2 obstetrician/gynecologists, 2 pediatricians, 2 nurse practitioners, 1 preventive medicine physician and 1 PhD researcher.

Isn't the Task Force a government panel?

None of the panelists are federal employees or members of the Obama administration. The Task Force is an independent panel of experts that receives only administrative support from a small federal agency.

Doesn't the insurance industry carry a lot of influence on the Task Force?

What about the two insurance industry representatives on the panel?

2 doctors on the panel serve as medical directors for non-profit health plans. They are accountable to the plans' patients - not to shareholders.

- George Isham, MD, MS is an internist at Partners Health. He served as a committee chair for the prestigious Institute of Medicine.
- David Grossman, MD, MPH is a pediatrician at Group Health Cooperative of Puget Sound. He is professor at the University of Washington.

Why are there no breast cancer specialists on the task force?

Specialists see patients with more advanced disease and require more aggressive therapy. The Task Force considers patients who are healthy or do not have symptoms.

- The Task Force receives ample input from specialty experts. All evidence summaries and draft recommendations undergo extensive peer review by the nation's leading experts. Their input is incorporated into USPSTF documents.
- Family Physician, Joy Melnikow, MD, MPH, serves on the Task Force. She has published numerous articles on breast and cervical cancer preventive services.

The Task Force says mammography for women in their 40's reduces breast cancer mortality by 15% then says that the net benefit is small. 15% doesn't seem small to me.

The background breast cancer mortality is relatively low. 15% less mortality is about 4 per 100,000 women.¹ To put that into context, car accidents claimed about 7 lives per 100,000 women² in that age group last year.

¹ American Cancer Society. Breast Cancer Facts & Figures 2009-2010. Atlanta: American Cancer Society, Inc., p4. From table 2 calculate 6070 deaths estimated in 2009 for women 45-54. Divide by census denominator from reference 2 (22,519,000). Use as upper bound for breast cancer mortality for women age 40-49. Multiply by 15% (RR).

² National Highway Traffic Safety Administration, *Traffic Safety Facts 2008*, Early Edition, DOT HS 811 170, US Department of Transportation, P. 106, table 57. Use the average of fatality rates for women age 35-44 and 45-54.

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- A 45-year-old woman might get the same survival benefit by telecommuting instead of driving to work.³

If the Task Force agrees that screening mammography in this age group saves lives, why does it recommend against mammography?

The Task Force is NOT against mammograms for women in their 40's. It favors them having mammograms after discussing the pros and cons with their doctors.

- The Task Force recommends against *routine* mammography – such as a postcard that says you need a mammogram because you just turned 40. It does not permit women to make an informed decision.
- Information about the pros and cons of mammograms becomes more important for women in their 40s than for older women. Women in their 40s are less likely to have breast cancer and are more likely to have a test that is falsely positive. The balance of benefits and harms improves as women get older.

Regardless of the subtle wording, the message that is getting out there is that women in their forties should not get mammograms.

Yes, that is exactly why we need to use opportunities like these to set the record straight.

- The current health reform debate creates a charged political environment. We shouldn't ignore the scientific evidence and bow to political pressure. Instead, partisans should quit twisting the facts for political gain.

What harm can result from doing extra mammograms that may not be necessary?

False positives can lead to unnecessary biopsies. Screening can detect indolent cancers that would never have created problems. That situation leads to unnecessary treatment.

- Every breast cancer detected requires 5 biopsies for women in their 40s compared to 3 for women in their 50s and 2 for women in their 60s.⁴
- A recent study suggested that one-third of screening-detected breast cancers lead to unnecessary surgery, chemotherapy, and/or radiation therapy.⁵

Why does the Task Force want to deprive women of the Breast Self Exam – a helpful tool in detecting breast cancer?

The Task Force did not tell women to stop examining their breasts. It recommended against doctors *teaching them* a standard protocol for doing so – because studies have shown this instruction to be ineffective.

³ Assuming that the vast majority of the woman's driving time is spent commuting. Please note: this calculation is not published in a peer review journal and is not meant as a true recommendation. It a way to put the approximate magnitude of screening mammography in terms understandable to the general public.

⁴ Nelson HD, Tyne K, Naik A, Bougatsos C, Chan BK, Humphrey L, Screening for Breast Cancer: An Update for the U.S. Preventive Services Task Force, *Ann Intern Med.* 2009;151:727-737.

⁵ Jørgensen KJ, Gøtzsche PC. Overdiagnosis in publicly organised mammography screening programmes: systematic review of incidence trends. *BMJ* 2009;339:b2587.

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- All women should be conscious of their breast health and seek clinical attention if a lump or any other abnormality is detected.
- The recommendation serves only to help the busy primary care physician prioritize a lot of needed preventive care within a very short office visit. These include screening all adults for tobacco and alcohol use, depression, obesity and hypertension.

Isn't this recommendation about paving the way for health reform?

No, the Task Force voted on this recommendation over a year ago – long before the current health reform debate started.

- The vote occurred in July 2008.
- Extensive peer review caused the announcement to occur more than a year after the vote.

Won't the Task Force recommendations cause insurers to deny coverage of mammograms?

The Task Force does not make insurance coverage decisions. As far as the Task Force is concerned, women in their 40s who make an informed decision to have mammograms should have full coverage for the test.

How can you say this recommendation has nothing to do with costs?

The Task Force does not consider cost in its recommendations. It weighs the scientific evidence of benefits against medical harms, NOT costs.

- The Task Force did not use cost-effectiveness analysis in reaching its conclusions.