Practical Approaches to the New Guidelines on Breast Cancer Screening - Frankly Speaking EP 29

Transcript Details

This is a transcript of an episode from the podcast series "Frankly Speaking" accessible at Pri-Med.com. Additional media formats for this podcast are available by visiting www.pri-med.com/online-education/Podcast/breast-cancer-screening-frankly-speaking-ep-29

Dr. Frank Domino:

So, poor Mary has quite the quandary, she has both friends who are telling her one thing, and family members who are suffering with breast cancer. We received a new guideline for the American College of Obstetricians and Gynecologists that stands in some degree of contrast to what the other large organizations say. So, what I'd like to do is begin by looking at these new guidelines from ACOG, and then let's compare it to the the US Preventive Services Task Force and the American Cancer Society.

Susan Feeney:

The American College of OBGYN or ACOG, their recent guidelines are very thoughtful and they really talked about, strongly about, shared informed decision making, working with your patients to come up... Look at the evidence, look at their risk factors for breast cancer, and come up with a plan as sort of individualized. But all of the agencies that we mentioned talk about clinical breast exam, mammography, when do you start, how often do you do them, and then when do you stop. ACOG basically said that as far as the clinical breast exam, they still advocate for it, and they say it may be offered every one to three years for women 25 to 39. And then they agree that it should be annually for women 40 years and older. So that would be the exam that the provider does. Mammography, they believe that it should start at 40, and that between 40 and 49, as if the patient desires. So that if someone, for some reason or they're low risk, wants to wait until later on in their 40s, that might be something that might be reasonable for them. But they say absolutely no later than age 50, if they have not had their mammogram already. And then they

believe that it can be yearly or every other year. Again, based on risk and your just informed decision making. And then they believe that you can stop at 75; and to continue beyond that would be based on longevity, the activity of the woman, and again, really intense, informed decision making with your patient.

Dr. Frank Domino:

Great. Jill tell us about the US Preventive Services Task Force.

Jill Terrien:

Sure Frank. So I think in just listening to Susan talk about ACOG, these guidelines have a little bit different things to say but they're also a little bit the same. So, as far as a clinical breast exam goes, they say that's insufficient evidence for or against, so that really leaves it up to the provider and the patient and their shared decision making. As far as mammography initiation, they recommend at age 50 to start screening. However, between ages of 40 and 49, you may start screening mammography earlier, and it should be done on an individual nature; so again, assessing their risk factors for that. As far as mammography screening interval, they say every other year; they don't go on to say anything further about that. And then as far as a stop age for mammography, they really don't find sufficient evidence to say stop at 75. They're really looking at the person as an individual. If they're a healthy 75, because we all know that as your age increases, your risk of getting cancer does increase as well.

Dr. Frank Domino:

I'm going to cover the American Cancer Society recommendations, and I wanna remind the audience that the American Cancer Society, unlike ACOG or the US Preventive Services Task Force, is an agency that does a great deal of community outreach as well as funds a great deal of research. And so they have a bit of a different take on the data that's present, and maybe one that I think we should have a slightly... A curious mind, but not necessarily one that drives my care. They do not recommend clinical breast exam, which I find surprising. Now the reason they don't, is that there isn't data that shows it's beneficial and there's a tiny bit of data that shows it can be harmful. They do recommend that you initiate mammography screening, or at least offering it to

patients beginning at age 40, and through age 40 to 45, recommend it and offer it, but don't necessarily push it.

After age 45, they recommend it to be done on a yearly basis 'til age 54. And then at age 55 they recommend doing a mammogram every other year and not stopping until you believe the patient's life expectancy is less than 10 years. So they've got a very, very broad range, probably the most aggressive range, with regard to mammographic screening, and certainly a very strong view that finding a cancer and addressing it is going to lead to improved outcomes; which we know may or may not be true. Well thank you for that comparison and contrast. Can you tell me a little bit about what makes a person at high risk and how we use that in our informed consent, decision making with our patients, Susan?

Susan Feeney:
Sure, the ACOG guidelines talk about women of average risk and then women of high risk. And women of high risk, that would be someone you'd wanna screen more regularly, maybe annually. And so they have quite a exhaustive list, but the ones that we think of most sort of importantly would be nulliparity, or a woman who's never been pregnant, or has never breastfed, we know that those are risk factors as women age. And 98% of cancers are... Breast cancers are found in women, so being a woman and having increasing age are the greatest risk factors. Higher body mass, we know is associated with that, alcohol consumption, although they really haven't given us an amount of alcohol that makes you at greater risk. We know smoking, and then there is a little bit of the hormonal therapy with estrogen and progesterone for menopausal women, women who are just on estrogen alone actually have a decreased risk. Which was interesting, it was the combination of estrogen and progesterone.

So women who have these risks would need more regular mammography and women of low risk would be someone who had none of these risk factors. Which is tough because these are quite... It's quite an expansive list and as people age they're gonna start risking in to this list.

Dr. Frank Domino:

Sure.

Susan Feeney:

But it's important... I think what it makes us do is we really have to have this conversation with our patients on what are their risk factors and what are the harms and benefits of mammography.

Dr. Frank Domino:

Well we certainly know one in three US citizens have a BMI that's over 30. So now we're talking about at least one in three women are gonna be at high risk and then we add in the smoking, the alcohol consumption, the risks get very concerning. Jill and Susan both, two of the risk factors of concern are having dense breast tissue on mammography and women who are of African-American descent. Can you talk a little bit about those as risk factors and why they're different than some of the other issues?

Susan Feeney:

Okay, I'll talk about the dense breasts and I think as a primary provider, this is one of the most frustrating things you see on mammography, right? That having a dense breast makes it less sensitive, the mammography. And it's not that I... My understanding is it's not that the dense breast itself puts someone at risk, is that it's hard to get a sensitive mammogram with that. And so women who have dense breasts, and I think the recommendation, at least locally from various surgeons, is that this might be someone who would be monitored by a breast specialist to have their mammography done in a structured exam. But that they might need an MRI or something like that to have a better sensitivity in examination.

Jill Terrien:

Yes, and so in regards to African-American descent, so you have to look to a social determinance of health. When do these women have access to healthcare and screening mechanisms? And

that might lead them to a later diagnosis at a later age, which can be concerning.

Dr. Frank Domino:

Yeah, I think the delay in diagnosis is the big issue. And we know it's related to the health disparities that come from decreased access to care. Well, I wanna end this discussion with our personal thoughts. Jill certainly lets start with you, what do you think about clinical breast exam and when do you normally start screening women?

Jill Terrien:

So, I usually talk about breast self-exam in my college health population, which is where I'm currently working. And actually if I'm talking about birth control and I'm talking about women's health in general with them and knowing their body, I'm talking about them knowing their breasts and being aware. So, certainly clinical breast exam I do with my Pap smears and so which is the recommended age of 21 or older, depending on their risk factors.

Susan Feeney:

And I agree with Jill, I usually start breast exams in the early adolescent to young women. And part of it is also it's a modeling behavior that you can make them that they're not afraid of their breasts, that they understand that they will change with the cycle and change as they age. And one thing that ACOG did point out is even though they said that clinical breast exams, the evidence is a little bit not as clear and they do recommend every one to three years. They talk about breast self-awareness and I think that comes from looking in the mirror and understanding how it looks, so if they see something. The thing that we do need to be aware of is that 50% of lesions in women over the age of 50 and 71 or more percent of lesions in women under 50 are found by the woman with an exam. So I think it is important that we, at least from my personal standpoint, that we at least talk to them about that self-awareness.

Dr. Frank Domino:

Well, I practice very similarly; especially if I'm starting an oral contraceptive. I teach a self-breast exam and I tell them it's their responsibility, that they're gonna be better than any test we can do.

And I recommend the week after their menses to go ahead and do the exam. And I do start screening, or at least having a discussion with women, in their mid to late 40's about when to initiate mammography. But, I encourage them that unless they're at high risk to try to wait 'til age 50. Well, I thank the both of you for this really timely and important discussion. And I'm sure we're gonna come back to revisit it again in the not too distant future. Thank you both.

Susan Feeney:

Thank you.

Jill Terrien:

Thank you Frank.

Dr. Frank Domino:

Practice pointer: The ACOG US Preventive Services Task Force and the American Cancer Society's recommendations on breast cancer prevention through screening have some differences, but for the most part, many similarities. The most important thing that all agree upon is an informed consent discussion that's very patient-focused on the risks and benefits of screening. Keep in mind the risk factors that are commonly associated with making a woman high risk for breast cancer: Nulliparity; not breastfeeding; high body mass index; alcohol consumption; tobacco abuse; and possibly having dense breasts; or being of African-American descent, which may be related to access to healthcare. Join us next week as we investigate headache, especially migraine, and talk about new treatments.