

DIE NEUEN EMPFEHLUNGEN ZUM BRUSTKREBS-SCREENING AUS AMERIKA (Oktober2015)

Zusammenfassung:

- Mammografie-Screening ab 45. Lebensjahr
- Zwischen 45 und 54 jährliches Screening empfohlen (USA!)
- Ab 55 alle 2 Jahre
- Klinische Untersuchung nicht nötig
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ACS Updates Screening Mammography Guidelines

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For the first time since 2003, the American Cancer Society (ACS) has updated its breast cancer screening guidelines for women at an average risk of developing the disease. The guidance [is published](#) in the October 20 issue of *JAMA*.

"The biggest change in the guidelines and the one that will be noticed the most is that we now recommend women start annual screening at age 45," said guideline author Elizabeth T.H. Fontham, MPH, DrPH, professor of epidemiology and founding dean of Louisiana State University Health Sciences Center School of Public Health, New Orleans.

"Previously we recommended that women start screening with mammography at age 40, but the guideline development group has carefully examined the data and the burden of disease among women ages 40 to 54 is not uniform," she said in a *JAMA* audio interview. "The group concluded that the risk of cancer is lower for women aged 40 to 44 in terms of incidence and the risk of a false positive is somewhat higher. So a direct recommendation to begin screening at 40 was no longer warranted."

While annual screening is recommended for women aged 45 to 54 years, the new guidelines recommend that at age 55, women should transition to screening every 2 years instead of annually.

Women should also continue screening mammography as long as their overall health is good and they have a life expectancy of 10 years or longer. "Previously we didn't discuss screening after age 75," explained Dr Fontham. "These recommendations offer a more tailored guidance rather than a 'one-size-fits-all,' based on a woman's age, health personal preferences, and so on."

The ACS also does not recommend clinical breast examination for breast cancer screening among average-risk women at any age.

These recommendations represent guidance from the ACS for women at average risk for breast cancer, which includes women without a personal history of breast cancer, a suspected or confirmed genetic mutation known to increase risk for breast cancer, or a history of previous radiotherapy to the chest at a young age.

The ACS also recommends that all women should become familiar with the potential benefits, limitations, and harms associated with breast cancer screening.

Recommendations:

- Women with an average risk for breast cancer should undergo regular screening mammography starting at age 45 years (strong recommendation).
- Women aged 45 to 54 years should be screened annually (qualified recommendation).
- Women 55 years and older should transition to biennial screening or have the opportunity to continue screening annually (qualified recommendation).
- Women should have the opportunity to begin annual screening between the ages of 40 and 44 years (qualified recommendation).
- Women should continue screening mammography as long as their overall health is good and they have a life expectancy of 10 years or longer (qualified recommendation).
- The ACS does not recommend clinical breast examination for breast cancer screening among average-risk women at any age (qualified recommendation).

Guidelines Becoming More Consistent

Multiple studies have attempted to evaluate the mortality benefit and associated harms of breast cancer screening with mammography, but it remains a highly debated topic. Fueling the controversy were the 2009 [screening guidelines](#) issued by the US Preventive Services Task Force (USPSTF), which were in opposition to other existing breast cancer screening recommendations and were met with criticism from many experts.

The USPSTF guidelines recommended screening mammography every 2 years for women aged 50 to 74 years of age and that women 40 to 49 years should make individual decisions about screening in partnership with their doctors. They also felt that the evidence was insufficient to assess the benefits and harms of screening mammography in women older than 75 years of age.

The furor was primarily directed at the recommendation against routine screening mammography for women aged 40 to 49 years. Many organizations, including the ACS, American College of Radiology, and American College of Obstetricians and Gynecologists, were critical of the new recommendations and advised physicians and patients to ignore them. The USPSTF updated the guidelines earlier this year, but they remained [largely unchanged](#).

"There has been a lot of discussion about screening in recent years since the task force [USPSTF] has updated its guidelines in 2009, when they recommended biennial screening for women 50 years and older," commented Nancy L. Keating, MD, MPH, professor of health care policy and medicine at Harvard Medical School and a physician at Brigham and Women's Hospital in Boston, Massachusetts.

Dr Keating, who along with Lydia E. Pace, MD, MPH, also from Brigham and Women's Hospital, authored [an editorial](#) that accompanies the guidelines, pointed out in the *JAMA* audio interview that in some ways, the USPSTF and ACS guidelines are now more consistent.

Dr Keating and Dr Pace have previously conducted research looking at the risk for false-positive mammography results leading to unnecessary biopsies. They have been proponents of stopping the "[one-size-fits-all](#)" screening strategies and instead moving to optimize the balance between benefits and harms of mammography.

"Both guidelines agree that for average risk women under the age of 45, the harms of mammography may outweigh the benefits," she said. "Both guidelines actually encourage individualized decisions about screening."

The USPSTF agrees. In a statement, the Task Force commended the ACS on their use of an evidence-based approach to updating its mammography screening guidelines and noted that they planned to examine the evidence that the ACS has developed as their own recommendations on mammography are finalized.

"There are many similarities between our draft recommendation and the new ACS guidelines," the USPSTF noted. "Importantly, both identify strategies that help women, together with their doctors, identify and treat this serious disease."

Their own draft recommendations and the new ACS guidelines both recognize that mammography is a "good test, but not a perfect one, and that there are health benefits to beginning mammography screening for women in their 40s."

Challenges Remain

But while the two sets of recommendations may have become more consistent, Dr Keating pointed out that differences remain, and this can be challenging to patients — particularly those aged 40 to 54, the group for which the guidelines diverge.

"I think some patients and doctors may just throw up their hands and ask, 'What am I supposed to do?' But I also think this is an opportunity for doctors to engage patients in discussions about their risk of breast cancer and to think about their own values and preferences," Dr Keating said.

She added that the biggest challenge is that there is still "so much we don't know about how to quantify benefits and harms of screening, particularly for women in these age groups."

Dr Keating and Dr Pace also highlight that "the vast majority of women who are diagnosed with breast cancer will do well regardless of whether their cancer was found by mammography." Data from randomized controlled trials suggest that for women in their 40s and 50s, screening mammography modestly decreases breast cancer mortality by approximately 15%.

Thus, "about 85% of women in their 40s and 50s who die of breast cancer would have died regardless of mammography screening," they write.

Because the risk for breast cancer is low for women in their 40s and to some extent for those in their 50s, the editorialists point out that the relative benefit of 15% "translates to a very

small absolute benefit." This extrapolates to screening mammography being able to prevent breast cancer in approximately 5 of 10,000 women in their 40s and 10 of 10,000 women in their 50s.

The absolute benefit is greater for women with a higher risk for breast cancer, and this underscores the importance of identifying higher-risk women, they say.

The bottom line is that there isn't a single answer to the question, "Should I have a mammogram?", Dr. Keating pointed out. "We physicians need to do a better job of explaining the benefits and risk and the uncertainties surrounding those things, and really try to talk with our patients and understand what their worries and fears are, what their values and preferences are and goals are and helping them make a decision that is right for them."

Dr Keating also noted that the ACS recommendation to stop screening women with a life expectancy of under 10 years is "consistent with an increasing emphasis on functional rather than chronological age."

"I have been having that discussion with my older patients, and I find it helpful to talk to patients about their life expectancy and to use the talk about screening and other goals of care," said Dr Keating. "I hope that this may stimulate more of these types of discussions."

Updating the Evidence

The impetus for the ACS's updating their breast cancer screening guidelines was that new evidence has accumulated during the past decade, from long-term follow-up of randomized controlled trials and observational studies of organized, population-based screening programs.

As part of the ACS guidelines development process, Evan R. Myers, MD, MPH, from the Duke Evidence Synthesis Group, Duke Clinical Research Institute, Durham, North Carolina, and colleagues conducted a systematic review of the evidence on specific benefits and harms of mammography and clinical breast examination, which in turn was considered by the ACS Guidelines Development Group. The results of the review were [also published](#) in the same issue of *JAMA*.

The authors concluded that for women of all ages who fall within the population deemed at "average risk," screening was associated with a reduction in breast cancer–related mortality of approximately 20%. However, there was uncertainty about quantitative estimates of the association of different breast cancer screening strategies in the United States.

Dr Myers and his colleagues note that other "uncertainties" about screening remain. There is still uncertainty about the magnitude of associated mortality reduction in the entire US population, among women 40 to 49 years, and with annual screening compared with biennial screening. There is uncertainty about the magnitude of overdiagnosis associated with different screening strategies, which are probably attributable, at least in part, to a lack of consensus on methods of estimation and the importance of ductal carcinoma in situ in overdiagnosis.

"There isn't much direct evidence on the impact of screening frequency among age groups as far as breast cancer mortality goes," said Dr Myers during the *JAMA* interview. "There is some indirect evidence comparing age groups in randomized trials, and some suggestions from observational trials that more frequent screening has some degree of benefit in younger premenopausal women."

"From what we know about the biology of the disease, breast cancer tends to be more aggressive in younger women," he added, "But the tradeoff is that more frequent screening leads to more false-positives."

The authors noted that when a woman has her first mammography screening at age 40 years, the estimated 10-year cumulative risk for a false-positive biopsy result was higher (7.0% [95% confidence interval (CI), 6.1% - 7.8%]) for annual vs biennial (4.8% [95% CI, 4.4% - 5.2%]) screening. Also, even though the 10-year probabilities of having false-positive biopsy results were similar for women who began screening at age 50 years, indirect estimates of lifetime probability of false-positive results were lower.

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JAMA. 2015;314:1599-1611, 1569-1571, 1615-1634. [Guideline](#) [Editorial](#) [Review](#)

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