

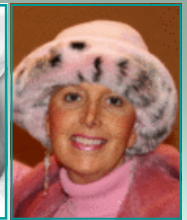


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Mammography Saves Lives

The new U.S. Preventive Services Task Force’s recommendations on screening mammography, clinical breast exam, and self-examination conflict with the facts. There has been no new evidence to justify this questionable change in breast cancer screening guidelines.

The American Society of Breast Disease continues to recommend annual mammography for all women beginning at age 40. This position is based on long standing, evidence-based studies which documents that mammography saves lives through early detection.

The fact that only 50% of American women over age 40 have had a mammogram in the past year indicates that women need to be further encouraged rather than discouraged from obtaining this simple, non-invasive test. At a time of limited healthcare resources, prevention and early detection continue to be the most cost-effective means to control the economic and human burden of breast cancer. Although it is not perfect, mammography is the best screening tool we have, in terms of overall accuracy, cost, and practicality.

Forty years of research have yielded progressively convincing evidence of the benefits of screening mammography. Long-term follow-up of randomized controlled population-based screening trials—the gold standard in medical research—prove that mammography can reduce breast cancer mortality as much as 32% among women ages 40 to 70 years at entry into screening. Some recent studies from Sweden have found that mammography can lower breast cancer deaths by nearly 50%.

As dedicated breast specialists, we agree with the multiple studies that document a reduction in breast cancer deaths due to early detection of breast cancer through regular screening. In contrast to the USPSTF recommendations, the American Society of Breast Disease continues to encourage monthly breast self-examination as an integral part of every woman’s health routine, along with an annual clinical breast examination by a trained healthcare professional.

For most women, predicting breast cancer risk on the basis of possible risk factors can be unreliable. Fully 70% of all women diagnosed with breast cancer had no known risk before the time of diagnosis.

The current flurry of media-hyped recommendations will only serve to confuse the public. To advise women age 40 and older to skip annual screening because they have no family history of the disease, is imprudent, irresponsible, and places their lives at unnecessary jeopardy.

The Gail Model

The Breast Cancer Risk Assessment Tool is based on a statistical model known as the “Gail model”, which is named after Dr. Mitchell Gail, Senior Investigator in the Biostatistics Branch of NCI’s Division of Cancer Epidemiology and Genetics. The model uses a woman’s own personal medical history (number of previous breast biopsies and the presence of atypical hyperplasia in any previous breast biopsy specimen), her own reproductive history (age at the start of menstruation and age at the first live birth of a child), and the history of breast cancer among her first-degree relatives (mother, sisters, daughters) to estimate her risk of developing invasive breast cancer over specific periods of time. Data from the Breast Cancer Detection Demonstration Project (BCDDP), which was a joint NCI and American Cancer Society breast cancer screening study that involved 280,000 women aged 35 to 74 years, and from NCI’s Surveillance, Epidemiology, and End Results (SEER) Program were used in developing the model. Estimates for African American women were based on data from the Women’s Contraceptive and Reproductive Experiences (CARE) Study and from SEER data. CARE participants included 1,607 women with invasive breast cancer and 1,637 without.

The Gail model has been tested in large populations of white women and has been shown to provide accurate estimates of breast cancer risk. In other words, the model has been “validated” for white women. It has also been tested in data from the Women’s Health Initiative for African American women, and the model performs well, but may underestimate risk in African American women and previous biopsies. The model still needs to be validated for Hispanic women, Asian women, and other subgroups, and results should be interpreted by a health care provider for women and special risk factors, such as women treated for Hodgkin’s disease with radiation to the chest and carriers of gene mutations that increase breast cancer risk. Researchers are conducting additional studies, including studies with minority populations, to gather more data and to test and improve the model.

Explaining the Results -

The Breast Cancer Risk Assessment Tool will estimate a woman’s risk of developing invasive breast cancer during the next 5-year period and up to age 90 (lifetime risk) based on the woman’s age and the risk factor information provided. For comparison, the tool will then calculate 5-year and lifetime risk estimates for a woman of the same age who is at average risk for developing breast cancer. Lifetime risk estimates are higher than 5-year estimates because breast cancer risk increases with years at risk. (Continued on back page)