Mammography Experts Assail USPSTF Stance

BY KERRI WACHTER

New mammography screening recommendations from the U.S. Preventive Services Task Force will cost women's lives and essentially take the breast cancer death rate back to 1950s levels, a panel of mammography experts said at the annual meeting of the Radiological Society of North America.

The net effect of the recommendations is that "screening would begin too late and would be too little. We would save money but we would lose lives," said Dr. Stephen A. Feig, a professor of radiology at the University of California, Irvine, and president-elect of the American Society of Breast Disease.

'What does this tell women in their 40s? It tells them basically that they can go back to the 1950s, when they waited until a cancer was too large to ignore any more.'

The task force now recommends that women aged 50-74 years need only get biennial exams instead of annual screenings and that routine mammographic screening is not necessary for women aged 40-49 years.

"What does this tell women in their 40s? It tells them basically that they can go back to the 1950s, when they waited until a cancer was too large to ignore any more and then bring it to their doctor's attention," said Dr. Daniel B. Kopans, who is senior radiologist in the breast imaging division at Massachusetts General Hospital and a professor of radiology at Harvard Medical School, both in Boston. "They're basically saying, 'Ignore your breasts until there's an obvious cancer.' "

The recommendations—released in November (Ann. Intern. Med. 2009;151:716-26)—triggered a controversy among physicians, patients, and politicians. The recommendations were the subject of a Dec. 1 hearing before the Health subcommittee of the House Energy and Commerce Committee, at which task force members were put on the defensive.

The USPSTF guidelines were updated using evidence from two studies commissioned by the task force. One study, funded by the Agency for Healthcare Research and Quality, is an updated systematic review of screening mammography randomized, controlled trials (Ann. Intern. Med. 2009;151:727-37). It concludes that mammography screening reduces breast cancer mortality by 15% for women aged 39-69 years and that both false-positive results and additional imaging are common.

The other study, by the Cancer Intervention and Surveillance Modeling Network, used estimates of screening outcomes for a range of screening strategies at different frequencies and ages of initiation and cessation (Ann. Intern. Med. 2009;151:738-47). This study concluded that "biennial intervals are more efficient and provide a better balance of benefits and harms than annual intervals."

The use of these studies as the basis of the new recommendations angered experts on the RSNA panel. "They used selective science and they also used computer modeling as the major new analysis that they put forth," Dr. Kopans said. "There were direct studies that were actually ignored by the task force." These studies show that most of the decrease in breast cancer deaths is because of screening and not therapy.

Dr. Feig agreed and cited several randomized studies. "We know from these studies that women who are screened may have their risk of death from breast cancer reduced by as much as 40%-50%."

In the Swedish Two-County trial (Lancet 1985;1:829-32), a 31% reduction in mortality was seen in women aged 40-74 years who were offered screening. "These randomized trials underestimate the benefits of screening" because the results include all women who were offered screening, not just those who underwent screening, Dr. Feig said.

In the Swedish seven-county service screening study (Cancer 2002;95:458-69), there was a 44% reduction in mortality among women who were screened.

"In the United States—where many women are being screened—the average woman with invasive breast cancer today is almost 40% less likely to die from her disease, compared with her counterpart in the 1980s," Dr. Feig said (Cancer 2002;95:451-7).

"About 20% of all breast cancer deaths in our country are found in women in their 40s. Because they're younger, they have longer life expectancies. About 40% of the years of life lost to breast cancer are linked to those that are found in their 40s," he said. The new recommendations would put these younger women at risk.

The RSNA panelists also expressed concern that the recommendations could prompt insurers to stop paying for screening mammography not recommended by the task force. ■

Disclosures: *Dr. Feig and Dr. Kopans reported that they have no relevant conflicts of interest.*

USPSTF Members Defend Report on Mammography

BY ALICIA AULT

WASHINGTON — Updated screening mammography recommendations issued in November by the U.S. Preventive Services Task Force became politicized in part because they were released during Congressional action on health care reform, Rep. Frank Pallone (D-N.J.) said at a Dec. 2 hearing he called on the issue.

"The controversy that was ignited by the report may be eclipsing what the report actually says," said Rep. Pallone, chair of the health subcommittee of the House Energy and Commerce Committee.

The recommendations became fodder for Republicans seeking to bolster their argument that the House-passed health reform plan would give too much power to government-appointed boards and could result in the rationing of health care. The argument was played out again at the hearing.

After more than 4 hours of wrangling, Rep. Pallone said to Dr. Ned Calonge, USPSTF chair, and Dr. Diana Petitti, the group's vice chair, "I really want to apologize to you, maybe on behalf of Congress." He added: "This has been totally politicized."

Rep. Marsha Blackburn (R-Tenn.) expressed sympathy for Dr. Calonge and Dr. Petitti, and said "you probably stepped into a quagmire that you did not expect." Dr. Petitti said that when she found out the report would be released within a few days of the House vote, "I was sort of stunned and then also terrified. And I think my being terrified was exactly the right reaction."

Eleven health organizations, including the American College of Physicians, sent a letter to Rep. Pallone and the health subcommittee's ranking minority member Joe Barton (R-Tex.) supporting the recommendations.

Testifying for the ACP, Dr. Donna E. Sweet said the college is concerned that politicization of clinical effectiveness findings "could lead to efforts to eliminate the Task Force, cut its funding, or result in politically driven changes so that future evaluations are influenced by political or stakeholder interests—instead of science."

Dr. Sweet, professor of internal medicine at the University of Kansas, Wichita, added that the ACP "urges Congress, the administration, and patient and physician advocacy groups to respect and support the importance of protecting evidence-based research by respected scientists and clinicians from being used to score political points that do not serve the public's interest." ■

Analgesics Underused by Breast Cancer Patients, Despite Pain

BY SHERRY BOSCHERT

SAN FRANCISCO — Pain is common in breast cancer patients—painkillers less so, according to results of an online survey.

In all, 65% of 335 breast cancer patients reported they suffered from pain during the course of their disease or treatment, yet 28% of the 218 patients reporting pain did not use an analgesic.

Acute or inconsistent analgesic use may be inadequate.

DR. SIMONE

The top reasons given for lack of analgesic use were not having a recommendation for analgesic use from their health care provider (83%), fear of addiction or dependency (77%), and inability to pay for medication (74%), Dr. Charles B. Simone II and his associates reported in an award-winning poster at a breast cancer symposium sponsored by the American Society of Clinical Oncology.

Some of those who reported pain but no analgesic use tried physical therapy (86%), massage therapy (8%), or other alternative measures for pain control, but still reported having pain on a regular basis, said Dr. Simone, a clinical fellow at the National Cancer Institute's Radiation Oncology Branch.

The findings highlight a need for additional education of health care providers on cancer pain evaluation and management, the investigators said. Clinicians should make pain management a priority, perform a standardized assessment of pain at every visit, and regularly discuss pain symptoms and pain treatment with breast cancer patients in order to break down the barriers to pain management, they suggested.

The survey was posted on the University of Pennsylvania's OncoLink Web site, the oldest and one of the largest online cancer information sources. Respondents were 97% female, 77% white, and predominantly educated beyond high school (82%). Of the entire cohort, 92% had undergone surgery, 74% had been treated with chemotherapy, and 62% underwent radiation therapy.

Acute or inconsistent analgesic use may be inadequate. Many breast cancer patients could benefit from analgesic use throughout the course of their disease and treatment, Dr. Simone and his associates suggested.

The researchers reported having no conflicts of interest related to the survey. ■