Mixed Reviews for New Mammography Recommendations

Kerri Reeves

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In May, the United States Preventive Services Task Force (USPSTF) released a recommendation for all women to get screened for breast cancer every two years starting at age 40. The recommendation represents a significant change from the USPSTF's prior recommendation for women to begin routine mammograms by age 50. While the radiology community is relieved that women in their 40s will experience increased detection and reduced mortality from the disease, the "how often" piece has frustrated many experts.

"The best way to summarize my reaction to the guidelines is mixed. I was so pleased to see they're finally recommending that women start having screening mammography at age 40, but disappointed that they didn't go farther in a number of areas, particularly to recommend annual mammography rather than biennial," says Nina Vincoff, MD, chief of breast imaging at Northwell Health in Lake Success, NY.

The task force did not take a separate stance on screening guidelines for women with dense breasts, other at-risk groups including Black women, or those age 75 and older, which is problematic, says Kemi Babagbemi, MD, FACR, vice chair for diversity, equity, and inclusion and associate professor of clinical radiology at Weill Cornell Medicine, New York City.

"The USPSTF is still not recognizing that 'one size does not fit all' when it comes to screening for breast cancer," Dr Babagbemi says. "What they say sets the tone, impacting policy and advocacy. They missed the chance to really set us on the right track."

While breast imagers and imaging societies are speaking out about the need for earlier risk assessments, clearer guidance for specific populations, and the benefits of yearly screening, the USPSTF, an independent panel of non-federal experts on prevention and evidence-based medicine, emphasizes that the recommendations for average-risk women are based on a balance of benefits and harms and available evidence.

"We still need more scientific evidence to help us understand whether and how additional screening could help the 40 percent of women in the US with dense breasts," says Carol Mangione, MD, MSPH, immediate past chair of the USPSTF. "We also need more information to better understand how to address health disparities…and about the benefits and harms of screening in women over the age of 75. We do not endorse a 'one-size-fits-all' approach, but rather have identified evidence gaps and called for additional research."

Dr Mangione is also chief of the division of general internal medicine and health services research, and the Barbara A. Levey, MD, and Gerald S. Levey, MD, endowed chair in medicine at the David Geffen School of Medicine at the University of California, Los Angeles.

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Stamatia Destounis, MD, FACR, managing partner of Elizabeth Wende Breast Care LLC in Rochester, NY and chair of the ACR Breast Commission.

"For now, the most important thing for women to know is to begin screening at age 40," she says, noting that the change from age 50 could result in 19% more lives saved, and will have significant benefit for Black women, who are 40% more likely to die from breast cancer.[1]

As the USPSTF evaluates public comments received through June 5, Dr Mangione summarizes the statement's impact as "good for women."

"It's going to lead to a lot more women getting screened, diagnosed, and treated. The predicted mortality reduction from this change is significant," she says.

How Often to Screen? That Is the Question

Previous USPSTF guidelines recommended that women in their 40s make an individual decision about when to start screening based on their health history and preference, and for all women to start by age 50. Stamatia Destounis, MD, FACR, managing partner of Elizabeth Wende Breast Care LLC in Rochester, NY, says the change was long overdue.

"We have been lobbying with women, with providers, with everyone who would listen how important it is to have early detection for women in their 40s. We are encouraged that we moved the needle," says Dr Destounis, who is also chair of the American College of Radiology (ACR) Breast Commission.

While there's generally a consensus for screening to begin at age 40, the interval strategy is up for debate. The USPSTF weighs the potential harms of screening, including false-positive results—and their potential for psychological impact—along with the need for additional imaging and biopsy, overdiagnosis, and radiation exposure. Dr Mangione says they "looked hard" to determine if annual mammograms would save more lives than every-other-year screens and determined that every two years is optimal for now, while calling for more evidence.

"We worry about harms, with the main benefit of saving lives from breast cancer. So we balance that, and the majority of benefit in reducing mortality can occur if you go every other year and you have a much lower rate of false positives," Dr Mangione says. She adds that the "B recommendation" means there's "moderate benefit" to starting screening at 40 every other year, but "we can't really say exactly how much better or worse annual would be because there isn't a lot of data."

While the task force considers various mammography risks, breast imagers generally prioritize early cancer detection, notes Dr Destounis.

"Our goal is to find every tumor at its smallest. The ACR, SBI [Society of Breast Imaging], RSNA [Radiological Society of North America]—we're all in agreement, recommending annual screening beginning at age 40. The USPSTF looks at other

things such as callbacks, and considers those more important. Essentially they're putting the risk of getting a callback higher than finding a cancer," she says.

Dr Babagbemi concurs. "We have data that says if you're screening annually starting at age 40, that has the greatest reduction in mortality," she says. "The USPSTF needs to look very carefully at that data." She adds that annual mammograms for Black women could significantly reduce disparities in their survival rates compared to other groups.

Erik Anderson, division president of breast and skeletal health solutions at Hologic, based in Marlborough, MA, which manufactures mammography scanners, agrees with Dr Babagbemi.

"Every two years is inconsistent with the position of leading voices in the breast cancer community. This creates confusion for patients and providers and puts women's lives at risk by giving cancers time to grow undetected. Early detection through annual screening is especially important for Black women and Jewish women, who are at higher risk for developing more aggressive breast cancer at earlier ages," Anderson says.

Saving lives isn't the only goal of early detection; more favorable treatment courses impact quality of life, Dr Vincoff adds.

"If you wait two years instead of one [to screen], you increase the chances that your cancer will be larger and require more aggressive treatment like mastectomy and chemotherapy," Dr Vincoff says.

At-risk Considerations

The new USPSTF guidelines are for average-risk women. African Americans, women of Ashkenazi Jewish descent, and those with dense breasts all benefit from earlier and more frequent screening, Dr Babagbemi says. Without recommendations for risk assessments, however, women may not know which category they're in. In May, the ACR called for *all* women to have risk assessments by age 25 to determine if they should be screened before they turn 40.[2]

"Most people fail to recognize Black women as being in a high-risk category. So we fail to screen them early, and we fail to genetically test them," Dr Babagbemi explains, arguing that radiologists have a responsibility to educate providers and patients about the higher risks Black women carry for breast cancer.

"One of the reasons the task force lowered the age was in recognition that the old guidelines weren't serving Black women well enough," Dr Vincoff adds. "But even these guidelines may not be serving them well enough."

The USPSTF underscored the importance of equitable follow-up and treatment after screening, and urgently called for more research on how to improve the health of Black women. Similarly, the task force called for more research on the benefits and risks of screening women 75 and older.

"For women expected to live into their 80s and 90s with a high quality of life, there's no guidance for them about screening. That's unfortunate," says Dr Vincoff.

Dr Destounis adds there should be no screening upper limit, which she calls a "disservice" to older women. "What should define if a woman over 75 gets mammograms is not her age but her comorbidities—her ability to come back in for additional views, tests, or procedures. Most patients in this group do return to have additional workup," she says.

The task force acknowledges that women with dense breasts are at higher risk for breast cancer and that their mammograms are less effective. However, the USPSTF failed to make a recommendation on supplemental screening strategies as part of the new guidelines, instead calling for more research.

"We don't know the best testing strategies for women with dense breasts in terms of supplemental testing," says Dr Mangione. "Is it better to do an ultrasound? MRI? We don't know at what age, or how often. We have an urgent call for research to help us answer all those questions."

On a related note, the US Food and Drug Administration recently updated its mammography guidelines to require patient reporting of breast density, which will be enforced by next year.

"It's disappointing that women are now going to get these notifications, but then be unable to look to the task force for guidelines about what to do next," Dr Vincoff says.

Patient Education

As the incidence of breast cancer evolves over time, the body of evidence on screening will grow, leading to adjustments to guidelines by stakeholder organizations across primary care, the cancer community, and medical imaging. To patients, the

recommendations can seem like a "moving target," observes Dr Destounis, who explains that while various organizations often consider the same data and research, they approach the information differently. Educating patients and referring physicians is critical, Dr Babagbemi says.

"Empowering patients is one of the key things when it comes to care of patients. We need to provide them with the best scientific evidence we have, and allow them to make their decisions with the aid of their PCPs," she says.

Dr Vincoff agrees. "As radiologists, a big part of our job has always been educating the community. Patients and referring physicians need to know that the guidelines proposed are not the ones that will save the most lives. We're going to need to tell that story."

This includes educating patients about potential false positives, says Dr Babagbemi, who notes that many patients are less alarmed by callbacks than they are by a missed cancer.

"I'm not insensitive to the idea of the anxiety. I'm a breast imager, but I'm also a woman who has mammograms and understands the fear and anxiety associated with callbacks. Women need better education about what they involve," Dr Babagbemi says. "With this information, some of the anxiety can be reduced and women may be better able to make decisions about screening with their doctors."

Dr Mangione summarizes that the task force, across more than 100 recommendations—ranging from preventive medications to hormone therapy to autism screening—tries to strike the balance between benefit and risk to keep Americans as healthy as possible.

"Our whole decision-making is based solely on net health benefit," she says.

References

1) McDowell S. Breast cancer death rates are highest for Black women—again. American Cancer Society. October 3, 2022. . https://www.cancer.org/research/acs-research-news/breast-cancer-death-rates-are-highest-for-black-women-again.html. Accessed May 25, 2023

2) Monticciolo D, Newell M, Moy L, Lee C, Destounis S. Breast cancer screening for women at higher-than-average risk: updated recommendations from the ACR. *JACR.* Published May 5, 2023. DOI: https://doi.org/10.1016/j.jacr.2023.04.002