OPINION

Mammograms Save Lives

Criticism of breast-cancer screenings is more about rationing than rationality.

By DANIEL B. KOPANS

May 22, 2014 7:14 p.m. ET

There is a disconcerting effort afoot to reduce a woman's access to mammography screening for breast cancer by making it seem useless or even harmful. The movement dates to November 2009, during the debate over the Affordable Care Act, when the U.S. Preventive Services Task Force, which reports to Congress, dropped its recommendation for mammography screening for women in their 40s and instead recommended screening starting at age 50.

In 2009 no one on the task force had experience in caring for women with breast cancer, yet the task force decided that it would "altruistically" spare women in their 40s the "harms" associated with mammography. The main "harm," as the task force saw it, was for a woman to be recalled after a screening mammogram for additional evaluation. This was made to seem more ominous by terming every recall a "false positive" if cancer was not found.

The task force neglected to explain that, although about 10% of women are recalled (the same rate as for Pap testing), more than half will need only a few extra pictures or an ultrasound showing all is well. Some will be asked to return in six months to be careful. Only 1%-2% of women screened will be advised to have an imaging guided-needle biopsy using local anesthesia, and 20%-40% of these biopsies will reveal cancer. This is a higher yield of more-curable cancers than when a surgeon would biopsy a "lump" in the pre-mammography days.

Remarkably, this new recommendation came even though the task force's own computer models showed that as many as 100,000 women then in their 30s, whose lives could be saved by annual screening starting at 40, would eventually die from breast cancer as a result of waiting until 50.

The public outcry was immediate. Many saw the recommendation as an attempt to scale back health-care spending at the expense of women's health. The Obama administration

eventually said that it did not support the task force's recommendations, and the Affordable Care Act, signed into law in 2010, mandated insurance coverage for mammograms for women in their 40s.

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Yet efforts to reduce access to lifesaving screening tests, particularly for breast cancer, persist. A paper in the Nov. 22, 2012, New England Journal of Medicine by Drs. Archie Bleyer and Gilbert Welch concluded that mammography screening was leading to substantial "overdiagnosis" "and that screening is having "at best, only a small effect on the rate of death from breast cancer."

The Bleyer-Welch paper has had a significant impact on the advice being given to women today, yet its methods were unsound and its conclusions mistaken. The analysis was not based on direct patient data, but on summary numbers. Mammography was blamed for "overdiagnosis"—detecting cancers that would regress or even "disappear" if not detected—yet the authors had no information on which women had been screened and which cancers were detected by mammography.

All the scientific evidence to date, including large randomized, controlled trials, show that screening for breast cancer saves lives. Screening began in the U.S. in the mid-1980s. In 1990 the mortality rate from breast cancer—unchanged for 50 years—began a steady decline. Today more than 30% fewer women die each year from breast cancer than would have died had the pre-1990 death rate continued. That's about 15,000-20,000 lives saved annually, in large part due to screening.

Yes, cancer treatments (chemotherapy and radiation) have improved. But treatment saves more lives when a cancer is identified and treated earlier. Clinical studies in Sweden, Holland, Norway and Canada have shown that screening is the main reason for the decline in breast cancer deaths for women who begin screening at age 40. In one Swedish study, published in the journal Cancer (Feb. 15, 2011), researchers found that 30% fewer women in their 40s who were screened died from breast cancer compared with those who were not screened. Crucially, all had the same access to treatment.

In a study published last year, my Harvard colleagues reviewed 7,301 women diagnosed with breast cancer at major Harvard Medical School hospitals from 1990 to 1999 and the 609 women who died from these cancers (Cancer, Sept. 9, 2013). We found that 71% of the women who died from breast cancer were among the 20% of women who were not participating in screening. This relationship was particularly clear for women who were not being screened in their 40s compared with those who were being screened.

Nevertheless, a new effort to limit access to screening, called "risk-based screening," is upon us. Such screening would mean regular mammograms only for women who have a high risk of developing cancer and not bother those who are not at high risk. That may sound reasonable until one discovers that women at high risk account for only about 10%-25% of everyone diagnosed with breast cancer each year.

The American Cancer Society and the U.S. Preventive Services Task Force are currently reviewing their breast-cancer screening guidelines, particularly for women ages 40-49. These guidelines are important because they can affect what procedures will or will not be covered by insurance companies and the state and federal health-care exchanges in the future. One hopes that both groups would recommend regular screening for all women starting at age 40. Women should be informed that there is no biological, medical or scientific reason to delay screening until age 50.

Mammography is not the ultimate solution to breast cancer. Screening doesn't find all cancers and doesn't detect all cancers early enough to result in a cure, but it has been rigorously tested and proven to save thousands of women's lives each year. It would be unfortunate to deny women access to screening based on flawed analyses or rationing in the guise of altruism.

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