Updated Guidelines For Mammography

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On May 9, the US Preventive Services Task Force (USPSTF) issued draft recommendations which stated that women should begin screening for breast cancer at age 40 and have mammograms every 2 years.[1] This is a revision of guidelines issued in 2009 which recommended that women start screening at age 50. Both sets of guidelines are based on the faulty hypothesis that "early detection with mammography saves lives." This was proven not to be true decades ago, but the false statement has been repeated so many times, and mammography and the treatments that result from it are so profitable that the only way this will end is for women to just say "no."

Cancer is a frightening disease and fear of getting it has driven the screening industry. Mammograms are considered the gold standard for early detection of breast cancer. While promotional programs focus on the false mantra "early detection saves lives," they deliberately do not include qualifying statements about the dangers of repeated exposure to radiation and over-diagnosis.

Over-diagnosis is the bigger concern. While missing fast-growing aggressive tumors that tend to grow between mammograms (called interval cancers), mammograms more often identify harmless abnormalities or "pseudo-cancers" such as ductal carcinoma in situ or DCIS.

DCIS is defined as the presence of precancerous cells which are localized to a single duct or ducts in the breast. DCIS only develops into cancer 20% of the time,[2] [3] [4] but almost all women are treated for it, which means the overtreatment rate is 80%. This affects about 60,000 women every year just in the U.S.

The American Cancer Society acknowledges the overdiagnosis risk, stating on its website under "Limitations of Mammograms" that "About half of the women getting annual mammograms over a 10-year period will have a false positive finding at some point."[5]

Further complicating the issue is that over 40% of women ages 40-74 have dense breasts which decreases the accuracy of mammograms even more.[6] (see detailed article in the Health Briefs Library for more information about this topic)

Overdiagnosis is serious because it usually results in overtreatment. This starts with a biopsy, which can itself increase the risk of cancer, since the procedure drags the cancer cells out of the enclosed environment and through the breast tissue.[7] (see detailed article in the Health Briefs Library for more information about this topic)

Incorrect diagnosis often follows. Even the Susan Komen Foundation, which aggressively promotes mammography, acknowledged this in a white paper in 2006 which stated that at the time that over 90,000 women who currently believed they had breast cancer had been misdiagnosed.[8]

Worst of all, the "not cancer patients" are then treated with surgery (increasingly women are opting for mastectomy since Angelina Jolie disclosed to the public her own bilateral mastectomy a few years ago), radiation, and chemotherapy. This is not warranted most of the time, and there is currently no requirement that disclosures about any of this be made to women prior to consenting to a mammogram.

So back to the new guidelines…if the old guidelines that recommended routine screening starting at age 50 were resulting in tens of thousands of overdiagnoses annually, the new guidelines will almost certainly increase that number. It is not possible to ignore the fact that there is a profit motive which keeps bad practices in place. The U.S. spends $7.8 billion on mammograms annually, and almost $30 billion on breast cancer treatment. Based on the facts stated above, it is likely that about $30 billion is invested in routine mammograms that are not warranted and overtreatment that results from mammography. There is little hope that medical institutions will voluntarily give up this cash cow. Again, the only way these bad practices stop is for women to learn more about their options and for many more to just say "no."

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[1] U.S. Preventive Services Task Force. Task Force Issues Draft Recommendation Statement on Screening for Breast Cancer. https://www.uspreventiveservicestaskforce.org/uspstf/sites/default/files/file/supporting_documents/breast-cancer-screening-draft-rec-bulletin.pdf

[2] Page D, Dupont W, Rogers L et al. "Continued Local Recurrence of Carcinoma in Situ 15-25 Years After A Diagnosis of Low-Grade Ductal Carcinoma in Situ of the Breast Treated Only by Biopsy." *Cancer* 1995 Oct 1;76(7):1197-200

[3] Eusebi V, Foschini M, Cook M et al. "Long-Term Follow-up of In Situ Carcinoma of the Breast with Special Emphasis on Clinging Carcinoma." *Semin Diagn Pathol.* 1994 Aug;11(3):223-35

[4] Calley Jones, PhD. Ductal Carcinoma in Situ: The Weight of the Word "Cancer." October 12 2022. American Association for Cancer Research https://www.aacr.org/blog/2022/10/12/ductal-carcinoma-in-situ-the-weight-of-the-word-cancer/#:~:text=The%20abnormal%20cells%20are%20confined,the%20primary%20tumor%20is%20removed.

[5] Limitations of Mammograms. American Cancer Society. https://www.cancer.org/cancer/types/breast-cancer/screening-tests-and-early-detection/mammograms/limitations-of-mammograms.html

[6] Are You Dense? Exposing the best-kept secret. https://www.areyoudense.org/files/1615/1483/5617/2018.two_page_brochure_ENGISH.pdf

[7] Hansen NM, Ye X, Grube BJ, Giuliano AE. "Manipulation of the primary breast tumor and the incidence of sentinel node metastases from invasive breast cancer." *Arch Surg* 2004 Jun;139(6):639-640

[8] Why Current Breast Pathology Practices Must Be Evaluated. Susan Komen for the Cure White Paper June 2006. https://www.komen.org/uploadedFiles/Content_Binaries/PathologyWhitePaperB2.pdf