**KEY CONCERNS WITH THE 2018 BREAST SCREENING GUIDELINES**

**No experts on the Task Force Committee**

* The Canadian Task Force (CTF) has no breast cancer screening experts in its membership by design. Public Health states they have done this to prevent expert bias. As such, CTF members have no experience in reading screening mammograms and treating patients with breast cancer. Of the five doctors on the breast cancer screening working group, two are nephrologists, one is a gastroenterologist and two are family doctors. The chair of the CTF is a psychologist.

**Lack of an Accountability Structure**

* The CTF is an arm’s length body and the Public Health Agency of Canada has not created an accountability structure that would allow recommendations to be evaluated for harm.
* The CTF membership changes before each round of guidelines, so without other internal structures in place, there is minimal learning from the failings of one round to the next as we see from the similarities in recommendations in 2011 and 2018.

**Reliance on old data and lack of consideration of current data, resulting in a significant understatement of the benefits of mammography**

* The CTF relies on outdated, flawed data, utilizing data that is 25-50 years old. The equipment used in the Randomized Control Trials (RCTs) was analogous to basing current telecommunications policy on performance of a rotary dial phone, compared to a current day cellphone.
* The guidelines have ignored Canadian research that incorporates the use of current technology that shows that women who have screening mammograms are 40-44% less likely to die of breast cancer than women who do not. [[1]](#endnote-1) The CTF underestimates the percentage to be 15% - 20%.

**Ignoring the importance of screening for women in their 40s**

* The CTF recommends against screening women 40-49, but this ignores that these women have the most years of life to lose: 24 to 30 percent of the life-years lost from breast cancer are due to cancers in women in their 40s. Science has proven that lives are saved when mammograms are done annually starting at age 40.
* With 1 in 5 women being diagnosed with breast cancer under the age of 50, the logical outcome of these guidelines is that more younger women will die unnecessarily because of the methodology failures and lack of consideration for current research.

**The CTF only considers the benefit of screening in terms of reduction of mortality**

* The CTF only uses RCTs which are focused on mortality reduction and as such, the CTF considers mortality reduction as the only benefit of early detection. The CTF does not consider other significant health benefits of early detection of cancer: avoiding chemotherapy, mastectomy and lymphedema. Studies in well-respected journals demonstrate that when breast cancers are found smaller and earlier stage, mastectomies and toxic chemotherapy can be avoided.

**Ignoring the risks of breast density**

* Breast cancer risk increases with increasing breast density, but the greatest risk associated with high density is cancer being hidden because cancer and normal dense tissue both appear white on a mammogram. There is ample data demonstrating the ability of supplementary ultrasound to detect cancers missed by mammography in women with very dense breasts. If the CTF recommendations are followed, women with dense breasts will lose the opportunity to receive appropriate enhanced screening.
* Women with the highest category of breast density are at elevated risk for breast cancer, but the CTF included them with average risk women. The information was in the evidence report to the committee but was ignored.
* The CTF advises against breast self-exams and clinical exams by doctors but for women with dense breasts who have a higher chance of a cancer being missed on their mammogram, these are essential. Although breast cancer is much less common in women under 40, for these women, breast self examination is really the only way in which they can improve their chances of finding a breast cancer earlier.

**Exaggeration of the harms of screening**

The CTF exaggerates the “harms” of screening: 1. overdiagnosis and 2. false positives

* **Overdiagnosis** is the possibility that a woman will be diagnosed with breast cancer and treated for it but die of something else before she would have died of her cancer. The likelihood of overdiagnosis is uncertain; it is not known which cancers would result in overdiagnosis. The guideline methodology markedly exaggerates overdiagnosis. Wide variations of overdiagnosis of 0-58% are reported, whereas the most scientifically reasoned estimate is 10% or less. The CTF used one of the highest values based on a single study that was not designed to study overdiagnosis.
* **False Positives:** The CTF fails to explain that “false positives” do not mean a woman is told she has breast cancer when she does not. It is merely a recall from screening for a few extra pictures or an ultrasound that almost all show everything is fine. About 10% of women need additional tests after screening. A small fraction need a needle biopsy which is less painful than a blood test from the arm. That’ s a small price to pay to determine whether cancer is present. The CTF stresses the harm of anxiety. Being recalled can cause anxiety, but studies show it’s transient and doesn’t harm women in the long-term.

**The guise of shared decision making**

* Shared decision making is encouraged by the CTF and suggested as empowering women. The decision on whether to participate in screening is up to individual women with advice from their health care providers. However, women and their physicians are not being given the most accurate information on which to have the discussion. With the exaggeration of harms and the understatement of benefits, it is possible many women will choose not to be screened.
1. Coldman et al, JNCI 10/2014 and Tabar et al, Cancer 11/2018 [↑](#endnote-ref-1)