

December 15, 2009

## An Open Letter to our Community

RE: Detailed Statement by Mohave Desert Radiology on the III Advised and Dangerous USPSTF Mammography Recommendations

As confusion continues to grow over the recent U.S. Preventive Services Task Force recommendations in regards to mammography screening, women of course are wondering if their mammograms will not be covered by their insurance company and Radiology practices have begun to receive calls from women about their yearly mammograms. In order to clear up some of the confusion about screening mammography, let us first state that the USPSTF recommendations against screening mammography for women in the ages of 40-49 are just that, they are recommendations. The task force does not set federal policy and they do not determine what services are covered by the federal government. The American Cancer Society and the American College of Radiology continue to urge women to follow the current American Cancer Society and the ACR practice guidelines as posted on the ACR web site.

According to the American College of Radiology, the USPSTF recommendations are a step backward and represent a significant harm to women's health. To tell women that they should not get regular mammograms at the age of 40 when this approach has overwhelmingly been shown to save lives is shocking to say the least. If these cost cutting recommendations were to be adopted, two-decades of decline in breast cancer mortality could be reversed and countless American women may die needlessly from breast cancer each year.

Over the last two decades, numerous trials of mammography screening have provided conclusive evidence that the policy of offering screening mammography has reduced the breast cancer mortality rate by 30%. Eight major controlled studies over the last two decades particularly in women age 40-49 have shown a 15% reduction in mortality rate from breast cancer directly attributed to screening mammography.

The basis of the recommendations not to screen women in their forties is one of a risk-benefit analysis. As even acknowledged in the research of the task force, if regular mammography screening does not begin until the age of 50 more women will die of breast cancer. Likewise, the research cited by the task force acknowledged that lives will be lost if screening becomes biannual versus annual.

The USPSTF selectively reviewed literature ignoring hundreds of well-regarded studies on the subject. The task force commissioned its own computer models that were never subject to critical peer review, ignoring previously published scientific data from large clinical trials. The fact that hundreds of respected journal articles were ignored

while a trial translated from Russian to English for consideration by the task force makes the entire literature review subject to lack of credibility. The task force also ignored the fact that screening mammography not only detects cancers, which is the point of screening, but also prevents progression to large or node-positive cancers from occurring.

The task force made their recommendations without allowing for public input or involving anyone with expertise in breast cancer detection and diagnosis. They rejected randomized controlled trials and already-existing model studies. They instead commissioned their own modeling study and made recommendations in reliance on this study before the study had ever been published and made public or held to critical peer review.

For women who are concerned about over-diagnosis it should be reassuring to learn that on their first screening a woman is 19 times more likely to be diagnosed with a progressive ductal carcinoma insitu and on subsequent screenings, she is 164 times more likely to be diagnosed with a progressive tumor. Because the benefit-to-risk ratio overwhelmingly favors the value of screening for detecting most lesions that are progressive, concerns about over-treatment of smaller number of non-aggressive lesions probably should be directed at choices about therapy, not about screening.

In conclusion, since the onset of regular mammography screening began in 1990, the mortality rate from breast cancer which had been unchanged for the preceding 50 years has decreased 30%. Ignoring direct scientific evidence from large clinical trials, the USPSTF based their recommendations to reduce breast cancer screening on conflicting computer models and the unsupported and discredited idea that the parameters of mammography screening change abruptly at age 50. In truth, there is no data to support this premise. The USPSTF is an independent panel of primary care physicians funded and staffed by the HHS agency for Healthcare Research and Quality (AHQR).

It is our advice and that of the American College of Radiology to continue following the American Cancer society guidelines in regards to mammography screening which is that yearly mammograms are recommended starting at the age of 40 and continued for as long as the woman is in good health. The clinical breast exams should be a part of periodic healthcare. Women at high-risk, which is greater than 20% lifetime risk, should get a MRI and mammogram every year.

Respectfully submitted,

William Kelley M.D.  
Mohave Desert Radiology

Bobby Shah M.D.  
Mohave Desert Radiology

Rawn Emig M.D.  
Mohave Desert Radiology