



BREAST CANCER ACTION RECOMMENDATIONS AND POLICY STATEMENT: BREAST CANCER SCREENING AND EARLY DETECTION

Breast Cancer Action (BCA) believes women need access to unbiased information in order to make informed choices about the detection of breast cancer. To fill this need, BCA developed the following recommendations and policy statement on breast cancer screening. Following the presentation of BCA's recommendations, the *BCA Policy on Breast Cancer Screening and "Early Detection"* includes information on the following topics:

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Breast Cancer Action's Screening Recommendations

The recommendations that follow are for women who are *not* at elevated risk of breast cancer. Excluded from these recommendations are women with inherited genetic risk for or family history of the disease, women with a history of chest radiation treatment, and African American women. The first two these groups were specifically excluded from the 2009 U.S. Preventive Services Task Force (USPSTF) Guidelines. The complex risks facing African American women were, however, not acknowledged although many of the studies on which the new guidelines were based did include them. Because we believe these issues to be critically important, the BCA policy includes more information specifically on African American women. The specific needs of other women of color are not addressed in this policy because it is unclear at this time to what extent their needs are the same or different from those of African American or white women.

There is still a great deal we do not know about risk for breast cancer, and people need to consider their own circumstances as they review these recommendations.

BCA recommends women *not* at elevated risk for breast cancer participate in **mammography screening** for breast cancer as follows:

- Beginning at menopause (one year following cessation of menstruation)
- Every other year until age 75
- After 75, at intervals that take into consideration their other health conditions

BCA recommends that women *not* at elevated risk for breast cancer have a **clinical breast exam (CBE)** ideally annually or at least once every three years. Women should begin having CBE when they begin receiving care from a women's health provider but at least by age 21. CBE can be performed by anyone who has been formally trained to do it. The provider does not need to be a doctor.

BCA recommends that women **know their bodies** but how to go about this is entirely up to them. Even if a woman is getting regular CBE, and/or mammograms at the appropriate times, a familiarity with her own body may be her best approach, since a third of all breast cancers are found by women themselves. Any changes should, of course, be reported to a health care provider and pursued according to the wishes of the individual.

The rationale and support for this policy is explained in the accompanying Policy on Breast Cancer Screening and "Early Detection." This policy advances the overarching goals of Breast Cancer Action. BCA recognizes that dealing with breast cancer detection requires us to look beyond mammography. Focusing on mammography is not enough. Accordingly, we work to: 1) promote better tools for detecting breast cancer that are not radiation based; 2) support research to effectively distinguish between types of breast cancer; and 3) make sure that everyone has access to the best tools and care available. This is part of BCA's work to put patients first.

Policy on Breast Cancer Screening and "Early Detection"

This policy updates the prior Breast Cancer Action policy of October, 2006.

Defining Breast Cancer Screening

Breast cancer screening refers to the testing of otherwise healthy women with no symptoms of breast cancer. Screening is different from diagnostic interventions that follow the identification of something that might be breast cancer such as a lump or a finding on mammogram. Screening is performed because there are some breast cancers for which earlier detection and treatment reduce the risk of dying from the disease. However, not all cancers that are detected early need to be treated and not all cancer deaths can be prevented even if the cancer is discovered and treated early. It is also important to understand that no form of screening prevents breast cancer from occurring.

There are currently three commonly utilized methods for breast cancer screening: mammography (both digital and film), breast exam conducted by a licensed health care provider (called clinical breast exam), and breast examination conducted by a woman herself (formally called breast self exam, which BCA refers to as "know your body"). Each of these methods is useful in some women and not in others, and none is fool proof.

As with all health care interventions, breast cancer screening techniques have risks and benefits associated with their use. Breast Cancer Action therefore recommends that women be given complete, understandable information and are encouraged to make individual choices about screening based on their own values and their own evaluation of the benefits and risks involved. No two women should be expected to make the same decision but all women should have access to the same information to inform their decisions. What should not determine women's decisions about breast cancer screening is the type of health insurance coverage they do or do not have.

The Biological Complexity of Breast Cancer and Its Impact on Early Detection

Many breast cancer awareness and education campaigns focus on the idea that "early detection is the best protection." They also carry the assurance that "breast cancer found early is almost 100% curable." But the promotion of screening in this manner obscures the actual value of "early" detection. The fact that 98% of women diagnosed at a localized stage are alive five years after diagnosis does not mean that they have been cured of breast cancer.(7) The disease can and does recur at any time, though the likelihood of recurrence is highest in the first two years after treatment, and declines over time. Being cancer-free for five years following diagnosis is accurately considered a cure for some cancers, but not for breast cancer.

Many campaigns urging women to get screened are based on the premise that breast cancer found early can always be effectively treated. This is the justification for starting regular screening as early as possible. According to this argument, the earlier we detect the disease the more likely we are to stop it from becoming a serious threat. But the complex biology of breast cancer means that women diagnosed "early" with breast cancer fall into one of three groups.(8)

- One group has very aggressive disease that, no matter how small it is when it is found, cannot be effectively treated with the therapies that are currently available. This kind of cancer will likely spread (metastasize) beyond the breast to other life-sustaining organs. There is currently no cure for metastatic breast cancer, which tragically means that many of these women will die prematurely of breast cancer. One way to think of this kind of breast cancer is that it's like a bird that flies away before it can be caught.
- Another group has a type of either non-aggressive invasive disease or a type of DCIS (ductal carcinoma in situ) that will never become life-threatening. This kind of breast cancer is like a turtle that just stays put most of the time.
- The third group has a type of breast cancer that responds to currently available treatments. This kind of breast cancer is like a bear that is not threatening until it awakes from hibernation. Finding breast cancer earlier does increase the likelihood that treatment will work for these women.

We do not know how many women historically have fallen into each of these three groups. And, while these divisions and the treatments currently available mean that "early detection" only matters for women in the third group, for the most part we still cannot tell women which group they belong to *at the time of diagnosis*. The result is that we mistreat or over-treat many women diagnosed with breast cancer. Women in the first group are likely to be mistreated—made sick by the treatments they receive, reducing the quality of their lives

without extending their lives. Women in the second group will be over-treated, undergoing chemotherapy and radiation that they do not need or from which they do not benefit. These treatments are significant and often have an impact on women's overall health and well-being.

It is the inability of the currently available methods of screening to identify those most likely to benefit from treatment—and the consequential risks of this uncertainty—that makes it essential **to examine the three methods** currently used or recommended for breast cancer detection in the United States.

Benefits and Harms of Screening

The benefits of breast cancer screening are enormous for women who are diagnosed early with the kind of breast cancer that responds positively to available treatments. The benefits include a reduced likelihood of dying of breast cancer. Screening for breast cancer by any method also involves risks.

- **False positive results.** A false positive means that the screening test indicates a possible cancer, but, on further investigation, there is no health problem. In these circumstances, women undergo additional diagnostic tests to rule out the presence of cancer. While the finding that they don't have breast cancer is of course a relief, during the work-up process women experience stress and emotional strain, as well as exposure to radiation, which may contribute to increasing their risk of breast cancer later. The contribution of radiation to breast cancer risk is discussed later in this document.(9) A work up may also trigger additional biopsies, which, for reasons not yet understood, may also increase the risk of breast cancer later.

The research that contributed to the U.S. Preventive Services Task Force recommendations discussed below found that the rate of false positives from mammography screening is related to the age at which mammography is performed as well as to how many mammograms a woman has had.(13) For example, the cumulative risk for false positives is between 29% and 49% after ten annual screenings starting at age 50 and up to 56% for women starting between ages 40 and 49.(14)

- **False negative results:** A false negative means that the screening test does not indicate the presence of cancer, when there is, in fact, cancer present. Not only do false negative results give patients an inappropriate sense of security, they may also result in a late diagnosis that increases the risk of dying from the cancer that is present for those women whose cancers can be effectively treated.
- **Overtreatment:** Overtreatment is a growing concern in the breast cancer arena. Because mammograms find many kinds of cancer that are "turtle" like in their behavior, there are increasing numbers of people being treated for breast cancers that will never be life-threatening. This overtreatment, including surgery, radiation, and drugs, can negatively affect the health of the treated person.

Mammography

Historical Context of Approaches to Mammography Screening

Since the early 1980s, the United States' public campaign to control breast cancer has focused largely on efforts that promote mammography screening. Mammography is routinely referred

to as “prevention for breast cancer” although it does not prevent the disease but rather detects the condition, reducing the likelihood that some women will die from it. In recent years, mammography screening has been the subject of considerable debate within the health care community, particularly with respect to its use among premenopausal women, and, increasingly, with respect to its optimal use as a screening tool for women of any age.

The most highly debated aspect of mammography surrounds the recommendation that all women begin having annual mammograms after age 40. While debate regarding the scientific basis for this recommendation has existed for over two decades, political and advocacy forces have ensured that the women aged 40 to 49 hear only one side of the issue: the message encouraging routine screening.

Access to mammography for women from traditionally underserved populations, particularly African American women, has been a focus of significant advocacy and outreach efforts over the last two decades. In many ways, women have gained access to the larger health care system through the door of mammography. Thus, the revised guidelines may come as a blow to communities that have historically struggled for access to mammograms and health care in general. While higher screening rates with mammography in these populations have not led to the anticipated significant decline in mortality, mammography has been an important community empowerment tool. In light of the new guidelines, renewed advocacy efforts in traditionally underserved and African American communities must take into consideration these complex histories. Attention must be paid to promoting replacement activities to support these communities and to strategize ways to work for equitable health care access when mammography is not the focus.

United States Preventive Services Task Force Guidelines

In late 2009, the [U.S. Preventive Services Task Force](#) (USPSTF) revised its 2002 breast cancer screening recommendations, downgrading the recommendation of mammography for women age 40 to 49 from a “B” to a “C” rating.(10) (See box below for more information on this rating scheme.) The USPSTF is a government-appointed independent body charged with reviewing the science of preventive health care interventions. Their job is to assess the balance between risks and benefits and to make recommendations to health care providers about preventive health care interventions. The USPSTF does not evaluate or consider the financial costs of these interventions.

The USPSTF does not recommend that everyone in the 40 to 49 age range be routinely encouraged to have a mammogram. Instead, every woman in this age group should consider the risks and benefits of screening as they apply *to her* (her particular circumstances, temperament, tolerance for uncertainty, feelings about cancer treatment, and/or medical and family history). The USPSTF also does not categorically reject screening for women in their 40s. Instead, it legitimizes the decision to delay it until age 50. In other words, it provides scientific support for an alternative choice.

The second change proposed by the USPSTF involves the frequency of routine mammography for post-menopausal women. The Task Force now recommends that post-menopausal women undergo mammography every other year rather than annually. The rationale for this change is that there is no improved reduction in mortality from annual (as compared to biennial) mammography, but there are additional risks associated with increased frequency of mammography. This is a “B” recommendation for women aged 50 to 74.

Why 50?

Age 50 is used as a surrogate for menopause. The average age at which women stop menstruating in the U.S. is 51.(11) Following menopause, breast tissue often becomes less dense, making it is easier to see meaningful changes on mammograms. Women who start menopause earlier may want to consider starting mammography earlier.

In addition, the USPSTF concluded that there was insufficient evidence to assess the additional benefits and harms of screening for women over 75. As women over 75 may have a more complicated health status, BCA recommends that decisions about mammography include an assessment of other ongoing health conditions.

These recommendations do not apply universally to all women. The USPSTF explicitly excludes women with a prior history of chest radiation (for an earlier cancer or for any other condition, see discussion below for more information) and women with a family history of breast cancer and/or known genetic mutations.

Chest Radiation

An estimated 50,000 to 55,000 women in the United States have been treated with moderate to high dose chest radiation for pediatric or young adult cancer. These women are at clinically significantly increased risk for breast cancer and breast cancer mortality after cure of their primary cancer. Breast cancer risk is greatest among women treated with high-dose mantle radiation for Hodgkin lymphoma, but it is also elevated among women who received moderate-dose chest radiation.(1) One research team has estimated that among women aged 35 to 39, mammography itself in this group of women induces 82 cases of cancer for every million women screened.(5)

Nor does the USPSTF have any advice to offer African American women who may be susceptible to more life-threatening forms of breast cancer before age 40 (see "African American Women: The Limbo of Not Enough Information," p. 11).

The USPSTF has updated its definitions of the grades it assigns to recommendations and now includes "suggestions for practice" associated with each grade. The USPSTF has also defined levels of certainty regarding net benefit. These definitions apply to USPSTF recommendations voted on after May 2007.

Grade	Definition	Suggestions for Practice
A	The USPSTF recommends the service. There is high certainty that the net benefit is substantial.	Offer or provide this service.
B	The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.	Offer or provide this service.
C	The USPSTF recommends against routinely providing the service. There may be considerations that support providing the service in an individual patient. There is at least moderate certainty that the net benefit is small.	Offer or provide this service only if other considerations support the offering or providing the service in an individual patient.
D	The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.	Discourage the use of this service.
I	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.	Read the clinical considerations section of USPSTF Recommendation Statement. If the service is offered, patients should understand the uncertainty about the balance of benefits and harms.

Risks and Benefits from Mammography Screening

Based on the best available data, screening mammography has led to a 15% relative risk reduction in mortality from breast cancer.(10) However what this means to women on an individual level is best understood as the reduction in absolute risk (see *discussion below on Absolute v. Relative Risk*).

Absolute v. Relative Risk

Figuring out the benefits and risks for any medical intervention is often confusing, and that certainly is the case with mammography screening. Both benefits and harms vary by age at the time of screening, as well as by family and medical history, race, previous experience with mammography, proficiency of the screening technicians and radiologists who interpret the results, and the reliability of the equipment, not to mention other unknown factors.

The USPSTF's review of the literature describes what is known about the effects of mammography screening for healthy women without known increased risk of breast cancer. To understand their work, it's helpful to know the statistical meaning of absolute risk and relative risk.

A group of researchers at the University of California, San Francisco, who train advocates to critically appraise biomedical research, uses a good example to explain the difference.⁽³⁾ If you went to Las Vegas with \$50, and you came home with \$100, you could say:

1. You won \$50 (the absolute increase in dollars),
2. You doubled your money (% change in dollars, a relative increase).

WOW! You doubled your money!

If you went to Las Vegas with \$500, and you came home with \$550, you could say:

1. You won \$50 (the absolute increase in dollars), or
2. You increased your money by 10% (% change in dollars, a relative increase).

At least you didn't lose money.

Proponents of various medical interventions sometime use both relative risk *and* absolute risk to describe benefits or harms to either maximize the seeming benefits or to minimize the apparent harms.

For example, best research estimates of the benefits of screening mammography every one to two years for women age 40 to 49 are a 15% relative reduction in breast cancer mortality (after 14 years of follow-up). That is, you have a 15% smaller chance of dying from breast cancer if your tumor was found by mammography rather than in some other way. This is a way of expressing the relative risk of dying from breast cancer in pre-menopausal women.

Wow! A 15% smaller risk of dying!

But very few women without symptoms, thankfully, are found to have breast cancer in their early 40s. And even fewer, thankfully again, die from the disease.

The five year breast cancer risk for a 40 year old woman with no known risk factors is 0.4% (that is, forty women out of 10,000 this age would develop breast cancer over five years). The five-year survival rate for women 45 years old and younger is 81%.⁽⁶⁾

This means that approximately 8 of the 40 women diagnosed with disease (or 8 out of 10,000 screened) would die within five years. A 15% reduction in that number is slightly over one (1.2). In other words screening 10,000 healthy women for five years would result in about one less death. This is an expression of screening mammography's benefits in terms of absolute risk of mortality.

Or: A little more than one life saved in 10,000 women screened.

Human life is very, very precious, and some would understandably argue that having 10,000 healthy women undergo mammography annually for five years would be worth the saving of a single life. However, we know that screening's harms in this age group include a high percentage of false-positive results, increased radiation to the chest (a known cause of breast cancer), false reassurance, and the ill effects and expense of treatment of lesions that would not threaten a person's life.

Mammograms use low-dose X-rays to examine the breast. X-rays are ionizing radiation, a known carcinogen which has a cumulative effect on the body. The greater the radiation exposure/dosage over a lifetime, the greater the risk of radiation-induced cancer.(4) This risk is highest in tissue in which cells are rapidly changing, such as the breast tissue of adolescent females (12) or potentially women in menopausal transition (no research has yet examined this question).

Radiation Exposure Facts

- All sources of radiation affect us the same way, whether from natural sources (radon, cosmic rays) or man-made (from occupational and medical exposures or consumer products).
- Americans were exposed to more than seven times as much ionizing radiation from medical procedures in 2006 than they were in the 1980s. Medical exposures have more than tripled and now account for almost half the total annual exposure to radiation in the United States.(2)
- No regulatory agency has ever set a limit on an individual's annual exposure to medical radiation although even the very small doses of radiation from screening mammography can exceed an individual's average annual exposure from all other sources combined.
- A typical radiation dose associated with a course of radiotherapy is about 10,000 times the mammogram dose.(4)

Because mammography is less accurate in finding cancers in premenopausal breasts, clinical Breast Exam may be a more useful screening tool in younger women. (See Clinical Breast Exam section below on page 10 for a discussion of the limitations of existing data on CBE.)

Film vs. Digital Mammography

Over the last few years digital mammography has begun to replace film mammography. The driving force behind this change is increased efficiency (the images can be easily shared electronically). But the newer technology is significantly more expensive than film mammography. Early evidence regarding digital mammography suggests that, on the whole, it is no more accurate than film mammography and that the probability of false-positive results is similar for the two techniques.(10) One study, however, has found that digital mammography was better at detecting lesions in women who were younger than fifty years or premenopausal, or who had dense breast tissue.(16)

Breast Cancer Action's Recommendation

Given the available information, BCA recommends that women *not* at elevated risk for breast cancer participate in mammography screening at menopause (one year following cessation of menstruation), continue thereafter every other year until age 75, and after 75, at intervals that take into consideration other health concerns.

Clinical Breast Exam

Clinical breast exams (CBE) are done by licensed health care professionals who periodically examine a woman's breasts for any palpable masses (masses that can be felt). There is wide variation in the training health care providers receive in CBE and an equal amount of variation in how well they are performed in clinical practice.(17, 18) The data are inadequate to determine whether routine performance of a CBE results in reduced mortality from breast cancer.(19) Reflecting the lack of sufficient evidence, the USPSTF did not make a recommendation related to CBE. Several large clinical trials are ongoing internationally (20, 21) and new evidence will continue to inform recommendations related to this screening method. What evidence there is suggests that a quality CBE cannot be performed quickly or without sufficient training.

Women should understand the limitations of CBE and not assume that a lack of a finding means that they do not have breast cancer. Conversely a positive finding on CBE may not be cancer and a false positive result may lead to unnecessary and potentially harmful interventions. Women relying on CBE as a means of breast cancer screening should know that not all breast exams are the same and are highly dependent on the skill of the clinician performing the exam. Different people conducting CBE will find different things, and not all people trained to do CBE are trained in the same way.

Breast Cancer Action's Recommendation

Recognizing the limitations of current knowledge, BCA recommends that women obtain CBE ideally annually or at least every three years from a health care provider trained to do the exam.

Breast Self Exam

For years, advocates and clinicians have told stories of the many women who found their own breast cancers. In response, research began to study whether women could be taught techniques that would increase the likelihood of self identification and reduce the risk of dying of breast cancer. This formalized process became known as breast self examination or BSE. Clinicians and health educators routinely encouraged women to perform BSEs on a monthly basis. But the procedure was not without its critics who argued that the recommendation to perform BSEs, while not a mandate, had the effect of alienating women from their own bodies.(22)

Researchers have been unable to demonstrate any survival benefit that BSEs offer over other forms of routine screening. Two large randomized clinical trials in Russia and China found that the harms from having clinicians teach women to perform BSE outweighed the benefits.(23, 24) Critics of these studies argue that the availability of different intervention options for women in the United States make the findings from these trials inapplicable in the U.S. context. The USPSTF, nevertheless, recommends against clinicians teaching women how to perform BSE.(10)

Breast Cancer Action's Recommendation

Rather than focus on a standardized monthly form of self examination, BCA recommends that women know their bodies, and be aware of their breasts (size, shape, feel), examining themselves for changes on a periodic basis, using whatever technique and interval makes them comfortable. Many women will continue to find changes in their breast that are meaningful. Women need to know, however, that not all lumps are cancer and that finding a lump may lead to the same unnecessary interventions that follow a positive result on a mammogram or CBE, namely additional mammograms and biopsies that may, in the long run, increase their risk of cancer. BCA, however, believes that familiarity with one's body, including one's breasts, is an important part of overall health.

African American Women: The Limbo of Not Enough Information

African American women are at higher risk of dying from breast cancer than white women, even though they have an overall lower incidence of the disease. The available data suggest that African American women are more likely to be diagnosed with breast cancer before they reach the age of 40 and to die from the disease at a rate that is approximately 37% higher than the death rate for Caucasian women.(7) In addition, there are substantial differences in tumor characteristics across racial/ethnic groups in the United States, though aggressive tumor characteristics are not unique to any particular ethnic or racial group.(25) The reasons for these differences are not fully understood but include differential environmental exposures, increased stress, and discrimination as well as numerous other structural inequalities.(26) Initially thought to be the result of lower breast screening rates among African American women, the differences in mortality have not declined despite high rates of mammography in many African American communities.

The USPSTF did not, however, address the situation confronted by African American women, or an aspect of ethnic or racial inequities in its analysis of mammography. More recent research looking at women under 40 suggests that African American women undergoing screening are more likely than their white counterparts to be recalled for additional workup and to receive both false positive *and* true positive results (that is, both false alarms and diagnoses of breast cancer).(27)

Mammography is also a tool that is less accurate in finding cancers in dense breast tissue. Consequently, it is less effective at diagnosing breast cancer in women under 50, who are more likely to have dense breast tissue. Thus the risks from mammography are greater and the benefits significantly lower for premenopausal women. For this reason, it is important that pre-menopausal African American women have information about all screening methods, and access to the most useful interventions – including CBE and Know Your Body at the appropriate ages. Admittedly, these options do not offer a satisfactory solution. Taken together, these options expose both the weakness of a “one size fits all” approach that fails to address the needs of those who may be at greater risk of dying from the disease, as well as the limitations of our screening methods.

Premenopausal Women

Mammography is less useful in women prior to menopause because premenopausal women tend to have dense breasts. Mammography has difficulty distinguishing tumors, which are also dense, from the normal tissue in women with dense breasts. Evidence does not yet exist for

the value of CBE in reducing the risk of breast cancer mortality for this group. And while knowing one's body may help identify changes, there is no evidence to date that such findings reduce one's chance of dying of cancer. As such, premenopausal women concerned about the risk of breast cancer have limited choices. Women in this category may benefit from the use of other technologies used in the breast cancer field but which have yet to be studied as screening tools. These include interventions such as thermography, ultrasound, and magnetic resonance imaging (MRI). Ultrasound has been studied in conjunction with mammography in women at elevated risks for breast cancer and found to be useful for women with dense breasts. In conjunction with mammography, more cases of breast cancer are found using ultrasound, but false positives also significantly increase (28). Ultrasound has not yet been studied as a screening tool.

Readers of this policy may wish to explore what is known, and not yet known about these options (see separate [BCA policy on screening technologies](#), currently being updated). Women deciding to use these tools should be aware that they suffer from the same limitations as existing tools: false positives necessitating additional procedures, over treatment resulting from identifying cancers that do not need treatment, mistreatment of people whose cancers cannot be effectively treated, and false negative results.

Making Sense of the Recommendation to "Talk with Your Doctor"

Because of the controversy surrounding breast cancer screening, many organizations—including the USPSTF—encourage patients to "talk to your doctor." This approach is insufficient to help women make informed choices. Physicians as well as other health care providers may be concerned about liability resulting from their failure to recommend screening. Additionally, many health care providers may not be aware of the most recent science related to breast cancer screening, or they may have entrenched attitudes of their own about the risks and benefits of screening. Still others may have a financial interest in promoting screening services for women—many practices own their screening and/or diagnostic equipment. For all these reasons, BCA encourages women to learn about the benefits and risks of breast cancer screening and to be sure that they are making a personal decision whether or not to undergo screening. The most important aspect of the discussion with a health care provider is that the individual woman should feel that her decision is respected and supported:

Talking to your doctor

The following questions may help a woman initiate a conversation about breast cancer screening with her health care provider.

- ✓ I am interested in your opinion but I am going to make my own decisions. Can you work with me?
- ✓ How do you evaluate my personal risk for breast cancer and what do you consider in evaluating that risk?
- ✓ Do you recommend I get a mammogram? Why?
- ✓ At what age do you recommend that all women get a mammogram?
- ✓ What do you see as the risks and benefits of a mammogram for me at my age?
- ✓ What alternatives might be available to me if I don't want to get a mammogram?

BCA Recommendations Explained

For women with no family history of breast cancer, no prior history of significant chest radiation, and who do not have an elevated risk for breast cancer, BCA recommends initiating screening mammography at the time of menopause (for most women this will be at age 50) and having a mammogram every other year until age 75. Women who are younger than age 50 and particularly concerned about breast cancer may wish to consider earlier mammography but should be aware of the higher risks of false positives, the reality that mammography is less effective in pre-menopausal women, and the risks of radiation from both screening and unnecessary treatment. These women may want to consider other forms of breast cancer screening including quality clinical breast exam. Regardless of the age of initiation, mammography is best performed every other year, rather than every year, unless there is a clinical reason for more frequent mammography.

BCA believes that all women should receive a clinical breast exam from a qualified provider in the course of their regular women's health care, preferably annually but at least once every three years.

Finally, women should be encouraged to know the size, shape and feel of their breasts. In all cases, women who identify an abnormality should seek care as soon possible and be sure that they are followed until they believe the issue has been satisfactorily resolved.

Summary

BCA believes that once a woman is fully informed about the pros and cons of each breast cancer screening method, she should make her own decision about whether or not to make use of the tool. Informed consent, in this case, presents women with difficult choices. Those who choose to have screening mammograms should have ready access to the best available technology, with the expense covered by their health insurance provider, whether private or public. Similarly, women who choose to have CBE should have access to properly trained clinicians with appropriately allotted time to complete a thorough exam.

Women should be informed that mammograms—whether film or digital—as well as CBEs and self examination do not always detect breast cancer— thereby yielding “false negative” results (when a detection method fails to find a breast cancer that is present). Conversely, mammography, CBE, and self examination yield false positive results which lead to additional interventions and occasionally unnecessary and harmful treatments. The tools can also detect cancers that can be treated and thus reduce a woman's risk of dying from the disease. How women make decisions about the balance between risks and benefits is based on individual values and preferences.

The care a woman receives, however, should not be based on the type of insurance or financial resources to which a woman has or does not have access. Breast Cancer Action believes all women should have access to the same choices about breast cancer screening (please see our [policy on universal access to care](#)).

BCA believes that attention and resources should be focused on improving screening methods for both younger and older women, understanding and addressing the experiences of populations with unequal distribution of disease, developing better treatments for the kinds of breast cancer that we are currently unable to treat effectively, and developing techniques for distinguishing, at the time of diagnosis, between those cancers that require—and respond to—treatment and those that do not.

Breast Cancer Action is a national grassroots organization whose mission is to carry the voices of people affected by breast cancer to inspire and compel the changes necessary to end the breast cancer epidemic. We recognize that fundamental social changes are necessary to accomplish our mission, and we are dedicated to organizing people to work toward those changes. As a matter of policy, BCA does not accept funding from any company that is profiting from or contributing to cancer, including pharmaceutical and other health care corporations.

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