erlanger
Cancer Institute

Institutional Recommendations Regarding

Screening Mammography

October 2022

Screening mammograms are done in asymptomatic women to diagnose breast cancer prior to becoming palpable for earlier diagnosis and treatment. This is done on a regularly scheduled basis. Mammography is the only imaging test that has been found to decrease breast cancer mortality. The National Comprehensive Cancer Centers (NCCN) guidelines have been updated for screening mammograms, recommending annual mammograms for average risk women over age 40. This is to clarify varying recommendations through the U.S. Preventive Services Task Force and the American Cancer Society (ACS) that recommend screening biennially at age 50 and continue through age 75. The American Society of Breast Surgeons (ASBrS) has mirrored ACS but said for providers to discuss with patients their priorities to decide on a screening protocol. The American Society of Clinical Oncology (ASCO) and American Society of Therapeutic Radiology and Oncology (ASTRO) did not issue updated recommendations. Finally, the American College of Radiology (ACR) has always recommended annual screening for women over age 40. These different recommendations have been confusing for both patients and providers.

NCCN has specifically discussed that pregnant women age 40 and over should still undergo screening mammograms with shielding. NCCN guidelines also call for all women starting at age 25 to have lifetime risk assessments done. This will typically be done by their primary care provider or gynecologist at their yearly physical/clinical breast exams. If patients have an elevated risk of breast cancer of greater than 20% lifetime risk, a history of whole chest radiation, atypia or lobular carcinoma in situ, or a prior chest biopsy, this would qualify for additional screening most commonly by breast MRI, ultrasound and physical exam or a combination. Screening mammograms should not start prior to age 30 in these patients. Patients with family history of breast, ovarian, or pancreatic cancer should also be seen by a healthcare professional with the opportunity for genetic testing.

These recommendations were generated by a subcommittee of physicians involved in breast program leadership and the care of breast patients at Erlanger. Approval of all physicians attending our weekly multidisciplinary conference and representing multiple specialties was obtained by acclamation. We acknowledge that our recommendations weigh more heavily toward reducing breast cancer mortality, even at the cost of false positive findings, unnecessary biopsies and possibility of "overtreatment."

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Recommendations

It is inherent in our mission to identify and treat breast cancer early in order to save lives. We acknowledge that patients and providers may view risks and benefits of screening mammography in a different light. These recommendations allow latitude based on those preferences. The goal, however, was to generate a rational set of recommendations which would be relatively easy to explain, follow and track within a practice.

1. Women at baseline risk should undergo annual mammography starting at age 40. There is a reduction in breast cancer mortality with screening even in women age 40 45. False positive findings are more likely in this age group and can lead to added healthcare costs and anxiety associated with biopsy as well as increased frequency of imaging.

2. Women should undergo annual mammography from ages 40 75 or expected life expectancy of 10 years.

3. Screening should be reassessed at age 75. Women who remain in good health and have a life expectancy of at least 10 years should continue screening.

4. There is no role for screening earlier than age 40 in women at baseline risk who are asymptomatic.

5. These recommendations apply only to women at baseline population risk of breast cancer. Women who have a lifetime calculated risk of greater than 20% due to personal or family risk factors will have altered personal screening recommendations.

6. There are no national guidelines on the issue of imaging for dense breasts other than screening mammography. 3D tomosynthesis has an increased sensitivity in dense breasts and may be useful for these patients. Screening ultrasound and/or MRI can be considered.

7. Mammography screening should continue in pregnant and breast feeding women based on age and risk factors with abdominal shielding. Breast MRI is not recommended during pregnancy as gadolinium contrast cannot be administered. Nursing or pumping prior to mammography is recommended.

8. All women should have lifetime risk assessment at age 25 to determine appropriate screening recommendations. If patients have an elevated risk of breast cancer of greater than 20% lifetime risk, a history of whole chest radiation, atypia or lobular carcinoma in situ, or a prior breast biopsy, this would qualify for additional screening most commonly by breast MRI, ultrasound and physical exam or a combination. Screening mammograms should not start prior to age 30 in these patients. Patients with family history of breast, ovarian, or pancreatic cancer should also be seen by a healthcare professional with the opportunity for genetic testing.

References

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5 – NCCN Guidelines Version 1.2022. Breast Cancer Screening and Diagnosis. National Cancer Center Network.

6 – Consensus Statement on Screening Mammography. The American Society of Breast Surgeons. October 29, 2015. https://www.breastsurgeons.org/ new layout/about/statements/PDF Statements/Screening Mammography.pdf

7 – ACR and SBI Continue to Recommend Regular Mammography Starting at Age 40. The American College of Radio style is called List Bullet.]

CANC0001 1022