

Letters to the editor

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Breast cancer guidelines

The guidelines by the Canadian Task Force on Preventive Health Care (CTFPHC) entitled "Recommendations on screening for breast cancer in average-risk women aged 40–74 years"¹ negated mammographic screening in women aged 40–49 years, provided weak recommendations for those aged 50–74 years and discouraged routine clinical and self-breast examinations. How will breast cancer be diagnosed in the future?

Many women aged 40–49 will not opt for screening, and the expectation that most women between 50–74 years will may not bear out given only a "weak recommendation" is denoted. Without routine clinical breast examinations, physicians may not have records for future comparison. Without routine self-examinations, patients have no baseline on which any early changes may raise concern. Only one or more of the following obvious changes might raise concern: new nipple retraction, unrelenting unilateral eczema of the nipple areola complex, reddening and swelling of the breast, rapid enlargement of the breast, visible bulge from the breast, orange peel appearance and/or retraction of breast skin, ulceration of skin overlying a breast lump, or miscellaneous symptoms suggestive of regional or systemic metastasis. This is a regressive way of diagnosing breast cancer.

In the task force's attempt to provide an evidence-based approach to mammographic screening, clinical

common sense and consequences seem to have been overlooked.

The implication on women's health is too great to be left without soliciting official position statements from the College of Family Physicians of Canada and the Royal College of Physicians and Surgeons of Canada. Clinicians working in the field as well as the general public deserve clarification. Ultimately, the quality of breast cancer prevention, early detection and treatment may be compromised.

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Reference

1. Tonelli M, Gorber SC, Joffres M; The Canadian Task Force on Preventive Health Care. Recommendations on screening for breast cancer in average-risk women aged 40–74 years. *CMAJ* 2011;183:1991-2001.

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The recent screening guidelines for breast cancer¹ by the Canadian Taskforce on Preventive Health Care (CTFPHC) have clarified the state of the science behind screening; however, many women and clinicians have expressed concerns. The new guidelines are nuanced and further discussion from the perspective of population-based screening is deserved.

The publication¹ stated that the previous guidelines advised women aged 50–69 to have mammograms annually. In fact, CTFPHC previously recommended screening every one to two years. Average-risk women aged 50–69 do not routinely receive annual mammography in Canada. The new guidelines are similar to current practice in Canada. About 70% of women aged 50–69 have had mammography within a 30-month time period.² Further, about 25% of women aged 40–49 have had annual mammography.

The new guidelines provide a "weak" level recommendation regarding routine screening with mammography for average-risk women aged 40–49 and aged 50–74.¹ A weak recommendation implies some degree of choice based on individual circumstances. Clinicians must assist women in making informed choices consistent with the woman's understanding

of harms, benefits and personal values and preferences. In consideration of informed choice, the Canadian Breast Cancer Screening Initiative (CBCSI), which includes representation from all providers of population-based breast cancer screening in Canada, has produced a decision aid (www.publichealth.gc.ca/decisionaids). An online continuing medical education course related to breast cancer screening is also in development.

In Canada, the age-standardized mortality rate for breast cancer has fallen by more than 35% since 1986.³ The most significant drop occurred after 1996, which was six to eight years after the introduction of population-based screening programs in Canada and improved quality of mammography. The decline in mortality is attributable to both the uptake in screening and the use of more effective adjuvant therapies.⁴ The age-standardized incidence rate for breast cancer in Canada has remained relatively unchanged for twenty years.

The new guidelines look at the harms and benefits of screening mammography, as well as the values and preferences of the patient. Organized, high-quality, population-based breast cancer screening programs are an important public health initiative. Screening programs with comprehensive quality assurance and evaluation of program performance have shown to be more effective than screening that is not organized.^{5,6} Early detection, in combination with appropriate treatment significantly lowers breast cancer mortality and improves the quality of life of patients with breast cancer.

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References

1. Tonelli M, Gorber SC, Joffres M; The Canadian Task Force on Preventive Health Care. Recommendations on screening for breast cancer in average-risk women aged 40–74 years. *CMAJ* 2011;183:1991-2001.
2. Doyle GP, Major D, Chu C, et al. A review of screening mammography participation and utilization in Canada. *Chronic Dis Inj Can* 2011;31:152-6.
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4. Berry DA, Cronin K, Plevritis S, et al. Effect of screening and adjuvant therapy on mortality from breast cancer. *N Engl J Med* 2005;353:1784-92.