

## 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"<sup>1</sup> 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.

**Wah Ting Wong MD**

General surgeon (retired), Victoria, BC

## 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 cancer<sup>1</sup> 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 publication<sup>1</sup> 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.<sup>2</sup> 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.<sup>1</sup> 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](http://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.<sup>3</sup> 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.<sup>4</sup> 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.<sup>5,6</sup> Early detection, in combination with appropriate treatment significantly lowers breast cancer mortality and improves the quality of life of patients with breast cancer.

**Gregory Doyle BSC MBA**

Chair, National Committee, Canadian Breast Cancer Screening Initiative, Ottawa, Ont.

## 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.

5. Duffy SW, Tabár L, Chen HH, et al. The impact of organized mammography service screening on breast carcinoma mortality in seven Swedish counties. *Cancer* 2002;95:458-69.
6. Jonsson H, Nyström L, Törnberg S, et al. Service screening with mammography of women aged 50-69 years in Sweden: effects on mortality from breast cancer. *J Med Screen* 2001;8:152-60.

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### The authors respond

In response to the letter by Wong,<sup>1</sup> our recommendations do not represent a substantial departure from previous guidance.<sup>2</sup> Independent Canadian national guidelines did not previously recommend routine screening mammograms for average risk women aged 40–49 years, nor was routine breast self-examination recommended for women of any age.<sup>2</sup>

Our guidance on mammography and breast self-examination for average risk women is consistent with national recommendations and current clinical practice from the United States, Australia and the United Kingdom.<sup>2</sup> Although routine clinical breast examination has popular appeal, there is no evidence that it reduces breast cancer mortality and some evidence that it increases the risk of unnecessary breast biopsies.<sup>2</sup> Although these data may be disappointing, they suggest that eliminating routine clinical breast examination would not adversely affect the health of Canadian women.

Similarly, because the potential benefits of screening mammograms in women aged 50–74 years are accompanied by an appreciable risk of clinically relevant harms, a strong recommendation would not have been appropriate. Further, screening mammography would not be appropriate for women with the signs and symptoms described by Wong<sup>1</sup> — women in that situation should see their physicians immediately.

We can reassure Wong that our guidelines<sup>2</sup> have been formally endorsed by the College of Family Physicians of Canada. Because they are aimed at primary care practitioners, we did not seek endorsement from the Royal College of Physicians and Surgeons of Canada.

We thank Doyle<sup>3</sup> for the clarification regarding the recommended frequency of screening in prior Canadian Task Force on Preventive Health Care (CTFPHC) guidance. Our document<sup>2</sup> stated that the 1994 CTFPHC guidelines recommended annual mammographic screen-

ing for women aged 50–69 years, which is factually correct. We agree that it is important to clarify that the subsequent 1998 CTFPHC guidance<sup>4</sup> amended the recommended screening frequency for this age group to one to two years.

Modern approaches to breast cancer screening should encourage a careful discussion with each woman about the potential benefits as well as the potential risks and harms of screening — thereby supporting informed choices. We agree with Doyle that decision aids are an important tool in facilitating such discussions in conjunction with organized breast cancer screening programs.

### The Canadian Task Force on Preventive Health Care

### References

1. Wong WT. Breast cancer guidelines [letter]. *CMAJ* 2012;184:921.
2. 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.
3. Doyle G. Breast cancer guidelines [letter]. *CMAJ* 2012;184:921-2.
4. The Canadian Task Force on Preventive Health Care. 1998 rewording. Screening for Breast Cancer. 1998. Available: [www.canadiantaskforce.ca/\\_archive/Tables/Ch65tab2.htm](http://www.canadiantaskforce.ca/_archive/Tables/Ch65tab2.htm) (accessed 2012 Feb. 27)

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### CORRECTION

#### Insulin in patients with type 2 diabetes

In the Review article in the Apr. 17 issue of *CMAJ*,<sup>1</sup> the numbers in the reference list were in the wrong order; however, the citations in the text and their corresponding numbers are correct. The HTML version available online at [www.cmaj.ca](http://www.cmaj.ca) is correct. *CMAJ* apologizes for the inconvenience this may cause.

#### Reference

1. Lau ANC, Tang T, Halapy H, et al. Initiating insulin in patients with type 2 diabetes. *CMAJ* 2012;184:767-76.

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