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The authors respond

In response to the letter by Wong,[1] our recommendations do not represent a substantial departure from previous guidance.[2] 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.[2]

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.[2] 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.[2] 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[1] — women in that situation should see their physicians immediately.

We can reassure Wong that our guidelines[2] 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[3] for the clarification regarding the recommended frequency of screening in prior Canadian Task Force on Preventive Health Care (CTFPHC) guidance. Our document[2] stated that the 1994 CTFPHC guidelines recommended annual mammographic screening for women aged 50–69 years, which is factually correct. We agree that it is important to clarify that the subsequent 1998 CTFPHC guidance[4] 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

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CORRECTION

Insulin in patients with type 2 diabetes

In the Review article in the Apr. 17 issue of *CMAJ*,[1] 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 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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Some letters have been abbreviated for print. See www.cmaj.ca for full versions and competing interests.