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“Should I have a mammogram?” Handout helps women decide

The ACP urges us to discuss mammography with women in their 40s. This handout can help

David L. Hahn, MD, MS, Dean Medical Center East Clinic, Madison, Wisc; dlhahn@wisc.edu

I was disappointed, recently, when I read a handout from the American College of Physicians (ACP) that was designed to help physicians talk to patients about the benefits and harms of screening mammography in women ages 40 to 49. The problem: The summary simply didn't provide enough relevant information to help patients make an informed choice.

The patient handout was part of a collection of ACP articles that appeared in the *Annals of Internal Medicine*. (See related POEM on page 530.) The first article was a systematic review of screening mammography in women 40 to 49 years of age documenting current data on benefit and harms.¹

The ACP also published a clinical practice guideline that included the recommendation that “clinicians should inform women 40 to 49 years of age about the potential benefits and harms of screening mammography.”² Accompanying that article was a summary for patients.³ Unfortunately, though, this summary failed to provide answers to the following questions: (1) What is my risk of dying of breast cancer if I am not screened? (2) What is the quantitative benefit if I am screened? (3) What is the quantitative harm if I am screened?

Filling the gap between recommendations and practice

To provide patients with the informa-

tion they need to make an informed choice, I developed a one-page patient information sheet (**PATIENT HANDOUT**). My handout outlines the benefit and harms as numbers per 1000 women over 10 years, as was done in a recently validated patient education pamphlet.⁴

I used a readily available epidemiological source⁵ for the base-case (without screening) breast cancer death risks, and calculated the putative decreases in breast cancer deaths due to screening using the 15% relative risk reduction adopted by the ACP,² the USPSTF,⁶ and the Cochrane Collaboration editors.⁷

The science behind the bullet points

I kept the grid simple, but recognize that my colleagues would appreciate knowing where the numbers came from, and what was the basis for certain explanatory statements. So here is some background on the first three bullets.

- **“Benefit: Less likely to die from breast cancer.”** The explanation (#1) that is tagged to this statement notes that the benefit of mammograms may be larger if a woman is at higher risk. This statement was taken from the ACP meta-analysis and guideline.^{1,2} The second part of this explanatory sentence, which indicates that “the benefit of mammograms may be smaller or even zero if the best quality research studies are correct” is based on the results of the Cochrane Review⁷ and

Weighing benefit and harms: Mammography for women, ages 40–49

For every 1000 women in their 40s, what are the benefits and harms of mammogram screening over a period of 10 years?

	WITH MAMMOGRAMS OVER 10 YEARS	WITHOUT MAMMOGRAMS OVER 10 YEARS	LIVES SAVED PER 1000 WOMEN SCREENED WITH MAMMOGRAMS OVER 10 YEARS
BENEFIT OF MAMMOGRAMS • Less likely to die from breast cancer ¹	Breast cancer death Black women 3.6 White women 2.1 Other women 1.3	Breast cancer death Black women 4.2 White women 2.5 Other women 1.5	Less than 1 Less than 1 Less than 1
HARMS OF MAMMOGRAMS • More likely to have false alarms ² • More likely to have unnecessary diagnosis and treatment for breast cancer ³ • More likely to have pain or discomfort from mammography ⁴ • More likely to have radiation exposure ⁵ • More likely to have false reassurance ⁶	Harms of screening 450 5 320–550 1000 Uncertain	None None None None None	

¹The benefit of mammograms may be larger if you are at higher risk, or the benefit of mammograms may be smaller or even zero if the best quality research studies are correct.

²False alarms are abnormal results that are not cancer, leading to unnecessary repeat mammograms, biopsies, and worry.

³Not all cancer detected by mammography will cause symptoms or death. This is because not all cancers will continue to grow or spread. Doctors cannot always tell which cancers detected by mammography need treatment and which do not need treatment.

⁴Many women complain of temporary discomfort or pain during mammography because the breasts are squeezed.

⁵All mammography uses radiation. Doctors do not know whether this radiation causes cancer, but most doctors believe the harm is very small or nonexistent.

⁶Some women who develop breast cancer before their next screening mammogram might delay treatment because their previous mammogram was normal.

is acknowledged in the ACP guideline.²

• **“Harm: More likely to have false alarms (false positive mammograms).”** I presented the percentage of false positive mammograms as 45% based on the 5-year (30%) and 10-year (56%) false-positive percentages reported for the Harvard Pilgrim Health Care study by the ACP.²

• **“Harm: More likely to have unnecessary diagnosis and treatment for breast cancer.”** I listed the number of women likely to suffer this harm as 5, based on the Cochrane Collaboration Review on screening for breast cancer with mammography.⁷

Is it easier to just order the test?

In talking with my colleagues, I gather that many are aware that controversies surround the “B”-rated USPSTF recommendation for mammography for women ages 40 to 49. However, my colleagues often lack the time to discuss the details with each patient, so they tell me that it’s “just easier to order the test.”

I disagree. Physicians can use the patient information sheet I’ve developed to provide basic relevant information to women who are trying to decide whether or not to get a mammogram. If my sheet

doesn’t meet your needs, consider others. (See Fast Track, below right.)

The ACP may have fallen short with its mammography screening summary for patients, but your discussion with patients need not. ■

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FAST TRACK

Another helpful resource is the Cochrane Plain Language Summary at

www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD001877/frame.html