Breast cancer screening cannot be justified, says researcher

Book argues harm outweighs small number of lives saved, and accuses mammography supporters of misconduct

Sarah Boseley, health editor
The Guardian, Monday 23 January 2012

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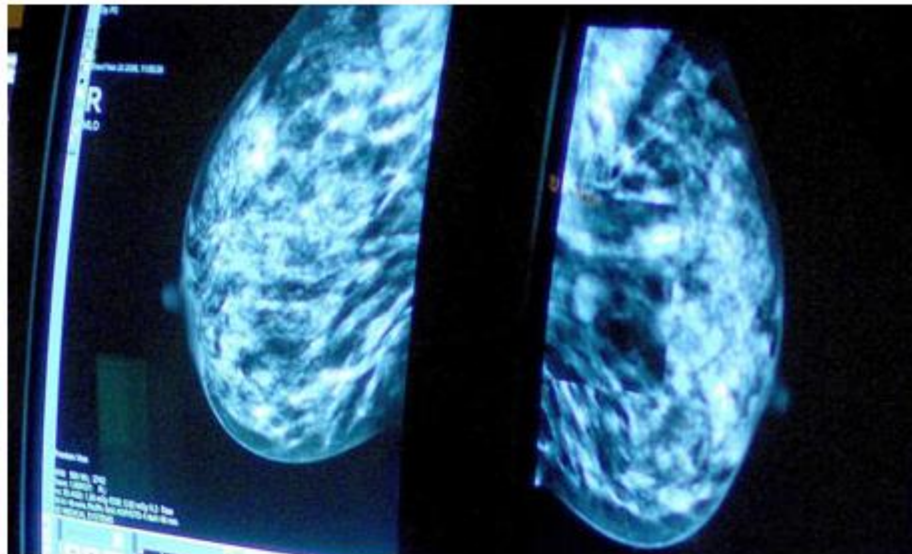


Scenario 1

A 47 year old women has been called to the screening programme and has come to the surgery clutching a copy of The Guardian newspaper with the heading " Breast Cancer Screening cannot be justified, says researcher". She wants to know should she go for her mammogram.

Mammograms

To screen or not to screen that is the question?

Screening population

- Women
- 47-70
- 3 yearly
- 2.3 million women 2010-2011
- 73.4% uptake

What is the primary aim of screening

- “to catch it early”
- To reduce mortality from Breast cancer
- To improve quality of life

- Reduced breast cancer mortality is balanced against the cost of screening in terms of physical and psychological harm to women and the financial impact on health services

over diagnosis

- A diagnosis of a condition that would never cause Sx or require Rx during a patients life time
- Over investigation- pain and anxiety from MMG and biopsy- transitory
- Over diagnosis – anxiety associated with a cancer label- life time
- Over treatment- reduced quality of life and increase in secondary cancers

Over diagnosis

- Difficult to quantify
- Historical RTCs were used from 20-50 yrs ago
- Out moded screening and treatments
- Observational studies with potential bias

Marmot Findings

- 1 death from breast cancer avoided for every 235 women invited to screening
- For every breast cancer death prevented approximately 3 over diagnosed cases will be identified and treated

Other considerations

- Mortality from breast cancer is decreasing – 40/100,000 women in 1990 to 24/100,000 in 2010
- Improvement in all aspects of Rx is responsible for this
- So potential for screening to affect mortality is therefore reducing.
- THE PROBLEM IS KNOWING WHICH INDIVIDUAL IS BEING OVERDIAGNOSED

conclusion

- “The level of risk that is acceptable will vary for the individual women and the decision on whether to participate in screening is a personal one “
- “ we need to help women weigh the benefits and the harms of screening by providing them with up to date and transparent information including information on the uncertainties”
- Cliona Kirwan – BMJ editorial 26th Jan 2013

Scenario 2

A 60 year old women ,who has been on HRT for 15 years comes to the surgery to renew her prescription. She is a lecturer at the local college and she finds she needs the HRT to help her keep mentally agile and keep one step ahead of the students as well as for helping the hot flushes as they interrupt her sleep. She has tried on several occasions to stop the HRT but finds she cannot cope without it.

HRT- Benefit

- Symptom relief – hot flushes, sweats, mood swings, loss of concentration and memory difficulties, vaginal dryness and soreness, irritability, insomnia, joint aches, palpitations, urinary frequency, change in visual acuity.
- Osteoporosis

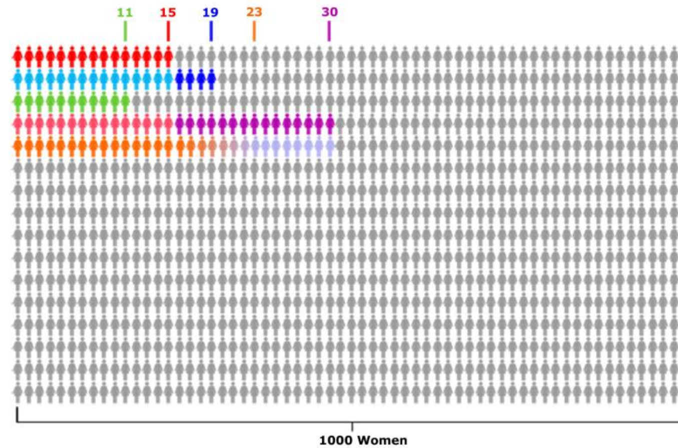
HRT- Risks

- Breast cancer
  - www. Menopausematters.co.uk
- VTE
  – base line risk 1/10,000/ year
  - 1.7/10,000/year
  - normal weight = placebo
  - greatest risk first year of use
- CVD –increased risk , combined HRT ,20+ years post menopausal, in first year of use. No overall increase by end of trial. HRT should not be taken for a presumed CVD benefit. Commence HRT close to natural menopause it is unlikely to be harmful and may be beneficial.
- Endometrial ca- no risk if progesterone taken with intact uterus
- Ovarian ca – There is an association , if there is a risk it is very small.

Years of HRT	No. of cases of breast cancer / 1000 women aged 50-70	No. of extra cases / 1000 women
0	45	0
More than 5	47	2
More than 10	51	6
More than 15	57	12

Breast cancer risk

KEY	Relative risk of breast cancer	Number of women developing breast cancer over the next 5 years, per 1,000 women	Number of extra (**or less*) cases of breast cancer over the next 5 years, per 1,000 women
No HRT	1	15	0
Combined HRT (estrogen plus progestogen)	1.26	19	4
Estrogen only HRT	0.73	11	- 4 *
Obese, older than 50 years (BMI greater than 35)	2	30	15
Alcohol - 2 or more units/day	1.5 - 2	23 - 30	8 - 15



Figures from Women's Health Initiative trial for women aged 50-79 years

- To calculate your BMI, click here.
- To calculate your alcohol intake, click here.

HRT: Balancing Risks & Benefits

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Benefits

- Symptom control
- Quality of life
- Osteoporotic fracture
- Large bowel cancer

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Risks

- VTE (blood clots)
- Breast cancer
- Stroke
- Gall bladder disease

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- AGE UNDER 50
- AGE 50-60 AND HAVING SYMPTOMS

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- AGE 60 +

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- AGE OVER 70
- PAST HISTORY OF HEART DISEASE AND STROKE

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Alternatives to HRT

- Complimentary therapies

- Drugs

  Venlafaxine

  SSRIs

  Gabapentin

Scenario 3

A 53 year old who is on the mirena (pop or nexplanon) for contraception has had no periods for 1 year. She asks if she can stop all contraception now. What do you advise ?

Diagnosis of menopause with progesterone contraception

- The patient can either be advised to continue with contraception until she is 55 when it is assumed that most women are no longer fertile.
- Or, if she is over 50 , do an FSH.If it is > 30 on 2 occasions, 6 weeks apart then the menopause can be diagnosed She would then require 1 further year of contraception.

Scenario 4

A 45 year old women attends surgery with IMB. She has a BMI 30, is a nullip and diabetic. How should the consultation progress?

IMB

- Definition- Unexpected bleeding in between regular periods , significant to require protection, not associated with hormonal contraception, not mid cycle.

Under 40

- 6/12 history
- History/examination- look at cervix/ menstrual calendar
- Swabs , smear if due only.
- US- vaginal probe
- Probable pathology – benign polyps.
- If persists refer for hysteroscopy

40-45

- Risk factors- nullip, infertile,obeise,diabetic, FH – ca colon
- If risk factors – refer for US and Hysteroscopy
- If no risk factors refer for US – vaginal probe

Over 45

- 3/12 history
- History and examination- look at the cervix (www.mybeutifulcervix.com/cervix-photo-galleries/)
- Swabs and cervical smear if not up to date (cervical smear is a screening tool. Its is no use as a diagnostic tool)
- Refer for US and Hysteroscopy

PCB

- ? Forgotten coc
- Sexual history
- Look at cervix
- Swabs
- Smear if not had one
- Under 40 –if needs referral - to GU
- Over 40 – if needs referral to colposcopy
- Ectropion- if needs referal for cryotherapy as above

Menorrhagia

- Regular
- Under 45 – menstrual calendar

  - Fbc, TSH, Clotting screen
  - US only if uterus enlarged
  - coc/ mirena/Tx acid
  - if no response refer for US +/- Hysteroscopy

Menorrhagia

- Over 45- if risk factors refer
- Over 50 – refer all

Irregular bleeding

- More likely to be pathology
- Lower threshold for referral

PMB

- Bleeding 1 year after the last period or unscheduled bleeding on HRT(excluding bleeding with in 6 months of starting)
- Refer any episode
- Chaotic bleeding over 50
- Bleeding on Tamoxifen
- Pelvic mass

PMB

- Unscheduled bleeding on HRT – can stop the HRT for 4 weeks and see if bleeding stops if under aged 55. Less likely to be pathology if on progesterone especially if on continuous. It usually takes 6/12 for bleeding to settle when switch from cyclical to continuous combined . Tibolone has a lower bleed profile.
- If recent investigation for PMB re-refer if
  - if any change in symptoms
  - if symptoms recur after 3-6/12
- Risk factors- Obesity, PCOS, Tamoxifen

Scenario 5

A 19 year old comes with painful periods. They have been painful ever since her periods started and she always had to have time off school in order to cope with them. She has just started work after a year at college, but her employer is beginning to be unsympathetic to her regular absences. What can you advise her?

Endometriosis

Time to diagnosis

- 3 years to come to GP
- 5 years for GP to refer
- 3 years for Gynaecologists to do laparoscopy.

Symptoms

- 90% of under 19s with endometriosis have lost an average 5.4 days/month
- Very painful periods from menache
- +/- Pelvic pain (more common in older women , more likely to have deep pelvic disease)
- Deep Dysparunia (more common in older women as less sexual intercourse)

Signs

Pelvic examination

- Younger women – no deep tenderness or fixed pelvis (no deep disease)
- Older women – Tender uterosacral ligament, fixed R/V uterus, tender P of D (If a/v uterus with no tenderness in P of D it is unlikely to be endometriosis)

Investigations

- US – only helpful if a pelvic mass is present
- Laparoscopy is the mainstay of diagnosis

Treatments- Disease reducing

- Prevention of further endometriosis
- Suppression of ovulation and menstruation to prevent progression
- COC - continuous
- Mirena
- GnRH + add back Tibolone (older women)Licenced for 6/12 use only

Treatments- Pain relief

Acute – Aim to prevent chronic pain developing

- NSAI – regular during period
- Paracetamol to top up

Chronic – Develop strategies to cope with disease for next 40 years

- TCA
- Gabapentin

When to refer

- Non responders to adequate pain relief
- Non responders to continuous coc
- Having a lot of time off school/ work

- Support groups – www.endometriosis.org.uk
- Specialist nurse
- CBT/Motivational coaching

Scenario 6

A couple have been trying to have a baby for 1 year now and have come for your advice and help. What further information do you need, what other investigations would you do and how can you advise them?

Preconception Advice

- Folic acid
- Rubella
- PMH/Diabetes/Epilepsy
- Chlamydia
- Weight/alcohol/drugs/smoking
- FH

All get QOF points

Infertility

- Refer if there is an identifiable cause at any time.
- Is there an egg ?
- Is there sperm ?
- Can they meet ?

What to do at 3-6 months

- Sex- Advise to have sex every 2-3 days , not to concentrate on ovulation as fresh sperm is best.
- Over 40 refer
- If regular periods can reassure 90% will be ovulating(Regular means 7 days between longest and shortest periods)
- Do a sperm test
- PID history, PMH – appendix, endometriosis, PCOS (Refer at 1 year not 2 years)
- BMI- <19/ > 30 reduced fertility- advise

What to do at 1 year under 35

- Semen analysis –OK
- Progesterone 7 days before period- normal
- No tubal factors
- Low risk

Keep trying for total of 2 years- Reassure that at 1 year of trying – 84% will be pregnant , and at 2 years 92% will be pregnant.

What to do at 1 year under 35

Refer if:

- Semen abnormal

(normal – 2 ml,

- >20million,
- >10% normal forms,
- >50% mobility)

- No ovulation
- Tubal problems

What to do over 35 but under 40

- Refer at 1 year
- Semen analysis
- Progesterone 7 days before period
- LH/FSH (if FSH >15 will not get IVF)

Criteria for NHS IVF

- <40 at start of treatment
- No children in any relationship
- BMI <30 > 19
- FSH < 15
- Older than 23