National Center for Health Promotion and Disease Prevention
Office of Patient Care Services
Veterans Health Administration

Clinician Guide

Discussing Breast Cancer Screening Decisions with Average Risk* Women in Their 40's

KEY POINTS

- The decision to start regular screening every 2 years with mammography in average risk women before the age of 50 should be an individual one.
- Discussions between providers and women in their 40's about whether to be screened may be initiated by either the provider or the patient and do not need to occur on a set schedule.
- The discussion should include both benefits and harms of screening and take into consideration the patient's values and concerns.

VHA Guidelines

VHA recommends screening for breast cancer with mammography every two years for women ages 50 through 74. The decision to start regular screening every 2 years with mammography before the age of 50 should be an individual one, which takes into account the patient's values, including values about specific benefits and harms. The evidence is insufficient to make a recommendation for or against screening of women ages 75 and older. Please refer to the VHA Breast Cancer Screening Guidance Statement[1] for complete recommendations.

Encourage women to report changes in their breasts

All women, regardless of their decision about whether or when to undergo screening, should be encouraged to promptly report any breast lumps or other changes they notice. This is important even if a recent mammogram was normal.

When to discuss

The initiation and/or timing of discussions between providers and women in their 40's about whether to be screened may be determined on a case-by-case basis. With some patients (for example, those who have already started screening), providers may choose to initiate the discussion (a *proactive* approach) during a visit. The ideal frequency for this discussion is uncertain. In other cases, providers may choose to wait and respond to questions only as they arise from patients (a *reactive* approach).

How to discuss

Key components of this discussion may include:

- Conveying that breast cancer screening for women in their 40's is a choice that women need to be involved in making, not an automatic recommendation.
- Providing information about potential benefits and harms (see Table on back).
- Considering the values and concerns of the individual woman.

Patients' values and concerns that may influence screening decisions

Values of women who may lean toward screening:

- I want to do everything I can to avoid dying of breast cancer.
- I am action-oriented.
- I have a high level of fear of breast cancer.
- Screening will give me peace of mind.

Values of women who may lean against screening:

- I want to avoid the anxiety caused by false positive results.
- I want to avoid the potential pain caused by an unnecessary biopsy.
- I want to minimize my exposure to radiation from mammograms.
- I am comfortable waiting until I'm 50 to begin screening.

*Average risk means that the patient is not known to be BRCA+, does not have a specific maternal or paternal family history of breast and/or ovarian cancer that is associated with BRCA+ and does not have a history of chest irradiation. Women with certain high-risk conditions or a family history of breast or ovarian cancer may need to begin regular screening at an earlier age. Please refer to Breast Cancer Screening Guidance Statement (*http://vaww.prevention.va.gov/Screening_for_Breast_Cancer.asp*) for complete definitions and recommendations.

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Discussing Benefits and Harms

Benefits: A woman's chance of dying from breast cancer in the next 10 years is decreased by being screened but that benefit is smaller for younger women[2].

- For women in their 40's, one woman in 2000 avoids death by being screened.
- For women in their 50's, four women in 2000 avoid death by being screened.
- For women in their 60's, six women in 2000 avoid death by being screened.

Harms: There is a risk of having a false positive mammogram result in all age groups, but that risk is higher for younger women[3].

- The cumulative 10-year risk of having a false positive mammogram for women in their 40's is 30.3%. If 2000 women in their 40's are screened every 2 years for 10 years (5 mammograms), 606 women are likely to have a false positive result sometime in those 10 years.
- The cumulative 10-year risk of having a false positive mammogram for women in their 50's and 60's is 23.8%. If 2000 women in their 50's and 60's are screened every 2 years for 10 years (5 mammograms), 476 women are likely to have a false positive result sometime in those 10 years.

TABLE: Benefits and Harms of Breast Cancer Screening for 2000 Women in Different Age Groups

	Age group of women		
	40–49	**50–59**	**60–69**
Breast Cancer Mortality Rates[2] Number of women (out of 2000) who will die from breast cancer over 10 years if:			
No screening is done	5	12	16
Screening is done every 2 years for 10 years	4	8	10
Benefit[2]			
Breast cancer deaths avoided because of screening	1	4	6
Harms[3]			
Number of women (out of 2000) who are likely to have at least one false positive mammogram result sometime in 10 years with every 2-year screening	606 (30.3%)	476 (23.8%)* *includes women up to age 79 who started screening when aged 50–69	

Additional Information

- The percentage of women who undergo a biopsy (rather than further imaging studies) following a positive mammogram increases slightly with age[4].
- Clinicians should be aware that about 10–25% of screen-detected breast cancers are thought to be over-diagnosed, cancers that would not have been diagnosed based on clinical symptoms or signs during the woman's life had they not been detected by screening[5,6].

REFERENCES

[1] VHA Clinical Preventive Services Guidance Statement: Breast Cancer Screening. Available at: *http://vaww.prevention.va.gov/Guidance_on_Clinical_Preventive_Services.asp.*

[2] Barratt A, Howard K, Irwig L, Salkeld G, Houssami N. Model of outcomes of screening mammography: information to support informed choices. *BMJ,* doi:10.1136/bmj.38398.469479.8F (published 8 March 2005).

[3] Elmore JG, Barton, MB, Moceri VM, Polk S, Arena PJ and Fletcher SW. Ten-year risk of false positive screening mammograms and clinical breast exams. *NEJM.* 1999;338:1089–96

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[6] Woloshin S, Schwartz LM. The benefits and harms of mammography screening: understanding the trade-offs. *JAMA.* 2010;303:164–5.

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