

 <p>MaineHealth CANCER CARE NETWORK SUPPORTED BY THE HAROLD ALFOND* FOUNDATION</p>	Breast Cancer Screening for Average and High Risk Patients	
	Original Date: 7-18-17	Review Date:
	MaineHealth Breast Work Group	

Cancer Screening Choices

It is fundamentally important for individual patients to make an informed choice on cancer screening, especially when to start, what test, and interval of testing. This process should begin with a careful Shared Decision Making discussion between the patient and their primary care physician and/or oncology specialist. All guidelines are carefully developed and they also differ*. They do not differ, however, with the firm recommendation that any given approach must be carefully considered between the patient and their physician. It is important to take advantage of understanding the benefits and risks of cancer screening aligned with the patient’s personal wishes, medical history, and family history.

*Refer to attached table “Comparison of Breast Screening Guidelines”

Our recommendations for women at average risk for breast cancer are:

1. Consider practicing breast self-exams to maintain self-breast awareness
2. Consider annual clinical breast exams with a primary care provider
3. Receive routine screening mammograms:
 - Age onset: 40-50*
At age 40, patients should be offered the option to consider initiation of screening in a shared decision making discussion
 - Frequency: 1-2 years*
Decision based on shared decision making
 - Technique
 - a. Tomosynthesis – preferred pending access and insurance coverage
(Tomosynthesis is no longer investigational. It is an emerging evidence-based modality and represents an advance in breast imaging.)
 - b. Digital – when tomosynthesis is not available and/or covered by insurance
 - Age to stop:
 - a. When detected cancer would not be treated
 - b. Age > 75 – individual decision guided by life expectancy (<10 years)
Life expectancy Calculator, Social Security: www.ssa.gov/planners/lifexpectancy.html

** Breast Imaging / Radiology reports will continue to reflect the guidelines of ACR and NCCN and may not be consistent with the screening plan developed for every patient.*

Average risk is defined as (modified from NCCN):

- No symptoms

- No history of invasive or in situ breast cancer or atypia
- No history of chest radiation between ages 10 and 39 years of age. (A radiation therapy to treat Hodgkin's disease and some other conditions)
- No family history suggestive of a hereditary syndrome
 - A blood relative with:
 - Known mutation in a gene that increases cancer risk
 - Two or more primary breast cancers
 - Ovarian cancer
 - Breast cancer before age 45
 - Male breast cancer
 - Two or more relatives with breast cancer on the same side of the family with at least one diagnosed before age 50
 - Anyone of Ashkenazi Jewish ancestry with breast, ovarian, or pancreatic cancer at any age

Women at high risk for breast cancer should:

1. Consider practicing breast self-exams to maintain self-breast awareness
2. Consider clinical breast exams with a primary care provider every 6-12 months
3. Receive annual screening mammograms:
 - Age onset: 30
 - i. Rule of 10*
 - ii. Not before age 25
 - Frequency: **annual**
 - Technique
 - i. Tomosynthesis- pending access and insurance coverage (Tomosynthesis is no longer investigational. It is an emerging evidence-based modality and represents an advance in breast imaging.)
 - ii. Digital
 - Age to stop:
 - i. Life expectancy of at least 5-7 years
(Life Expectancy Calculator, Social Security:
<https://www.ssa.gov/planners/lifeexpectancy.html>)
4. Additional screening MRI or US:
 - Age onset: 25
 - i. Rule of 10*
 - ii. Not before age 25
 - Frequency: annual
 - iii. Staggered 6 months from mammogram after age 30
 - Technique
 - iv. MRI preferred to whole breast US unless there is a contraindication
(Including insurance coverage)

*Rule of 10 = 10 years prior to youngest family member but not less than age 25 years old

High risk is defined as (modified from NCCN):

- 20% or greater risk
- LCIS or atypical hyperplasia
- Chest radiation (10 -30yo) – start 8 -10 years after radiation but not before age 25
- Hereditary mutation
 - i. BRCA, Li-Fraumeni Syndrome (LFS), Cowden, Bannayan-Riley-Ruvalcaba
Known carrier or untested 1st relative of mutation carrier
 - ii. ATM,CDH1, CHEK2, PAL2, STK11

**MaineHealth Breast Work Group: Comparison of Breast Screening Guidelines*

MAINEHEALTH BREAST WORK GROUP: COMPARISON OF BREAST SCREENING GUIDELINES							
RECOMMENDED	NCCN	ACOG	AMA	ACS	USPSTF	ACR/SBI	ASBrS
Age to start Mammograms	40	40	40	45 Individual choice 40-44	50	40	45 Individual choice 40-44
Age to stop Mammograms	Upper age limit not established	Annual as long as women in good health	When life expectancy <10 years	When life expectancy <10 years	74	When life expectancy is <5-7 years	When life expectancy is <10 years
Interval	Annual	Annual	Annual	Annual 45-54 1-2 years 55+	2 years	Annual	Annual 45-54 1-2 years 55+
Tomosynthesis (3D Mammo)	Consider tomosynthesis Multiple studies show a combined use of digital mammography and tomosynthesis appears to improve cancer detection and decrease call back rates	Further study to confirm whether cost-effective replacement for digital mammography alone as first-line screening	Silent	Improvement in detection, lower chance of recall	Insufficient evidence to support routine use; grade “I”	No longer investigational; represents an advance in breast imaging	No longer investigational; Represents an advance in breast imaging
Notes			Eligible at age 40, if they choose their doctors agree; annual at age 50	40-44 opportunity to begin screening 45-54 Annual exam: 55+1-2 years transition to biennial or opportunity for annual exam	40-49 Grade “C” individual decision 50-74 Grade “B” biennial screening 75+ Grade “I” insufficient evidence	Tomosynthesis shown to improve key screening parameters compared to digital mammography	Tomosynthesis Shown to improve key screening parameters compared to digital mammography