*From the MAFP Presidents Pen -*

# Guidelines, Not Gospels

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In October, The American Cancer Society (ACS) issued their latest guidelines for breast cancer screening. There are some changes that have sparked controversy but the ACS states these recommendations are based on more recent evidence-based analysis with more attention paid to "cost-effectiveness" than previous recommendations.

A comparison of the old guidelines from 2003 shows that previously they had advised starting annual mammograms at age 40 for "average-risk" women and continuing as long as a person remained in good health. The revised guidelines now advises delaying the first annual mammogram until age 45, changing to every other year until after 55, and then stopping when a woman has a life-expectancy under 10 years. This marked reduction in the number of lifetime tests reflects several concerns about mammograms.

- **First**, these studies themselves involve a small amount of radiation, which in itself can cause harm.
- **Second**, it is a known drawback of screening that mammograms will result in a number of "false-positive" results which require an expensive and potentially painful biopsy. Fewer total mammograms will entail fewer of these false alarms.

This strategy to reduce the frequency of testing echoes similar reductions advocated by the US Preventive Services Task Force (USPTF), who in 2009 advised that women should start getting mammograms at age 50 and then go only every other year until 74. Both expert panels looked at the number of potentially missed early breast cancers with the reduced frequency of tests and concluded that the generally slow beginning of these cancers would allow them to be discovered on the every other year schedule.

Many women have been concerned by the apparent lessened vigilance in these guidelines, but the ACS did address this concern by allowing patients and their clinicians the opportunity to individualize their screening based on their own risks for breast cancer. These recommendations would be for the woman with "average risk", while the women with a strong family history or environmental risks, such as previous radiation treatment for conditions such as Hodgkin's disease, could start at an earlier age and stay longer on an annual schedule.

The flexibility in the new guidelines is a positive development in how these protocols are usually written, and the ACS is promising further clarification on risk factors to help patients and their doctors in this effort to customize more appropriately. Other guidelines have also begun advocating that providers have a conversation with patients to help them to arrive at a



personal decision based on understanding the risks and benefits of screening, rather than be simply told that it should or shouldn't be done. Yet to be determined is how third party insurances will respond to the ambiguity in risk-based guidelines and this remains a source of unease for many.

However, there is one more element of the new guidelines that may prove to be the most controversial – the ACS now states that the clinical breast exam which has been an essential element of the well-woman physical now has 'no screening value' and should be omitted. This advice is based on studies that show that clinical exams can find even more lumps that are more likely not to represent true cancers and result in unnecessary further radiologic studies as well as negative biopsies. While many patients may be relieved to avoid a breast exam by a medical professional potentially for their entire life-span, as a physician I am a bit uneasy by the implications of this omission. I have served as a faculty physician for younger clinicians and have observed how learning accurate physical diagnosis takes years of exposure to many patients. Like learning any skill, one must "practice medicine" in order to develop the ability to determine normal from abnormal. If there is no more "routine breast exam", then there will be fewer doctors who have skill in this area of medicine and all women will be at a disadvantage when they ask their clinician to evaluate a new breast problem. The only answer will be automatic testing and biopsy rather than the clinical judgment to say "this change is normal", thus defeating the effort to decrease testing and unnecessary biopsies.

This devaluation of the skill of the physical exam is not new to the latest ACS guidelines. Unfortunately, we have seen other expert panels' advice against routine genital or prostate exams in men of all ages, even advising against routine skin exams for patients having a physical! This view holds that the physical exam itself is not a good use of either the patient's or the clinician's time and has led to the annual "Preventive Health Visit" (not even called a 'physical') during which a clinician reviews a list of immunizations and other screening tests to see if a patient is in compliance, and not a stitch of clothing is ever removed. If all providers stop doing routine skin, genital and breast exams, only the "experts" will be able to give an educated guess that a particular mole, breast lump or testicular swelling is acceptable or not.

A guideline should be judged both by its intended and unintended consequences. Fewer doctors who have skill at a breast exam will be an unintended consequence of the new advice that routine clinical breast exams be jettisoned. I would advocate that patients and their providers demonstrate their commitment to fighting breast cancer not by wearing pink ribbons or running shoes, but by continuing the practice of clinical breast exams during all preventative health visits for women.