

# A general pullback on cancer screening?

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A very interesting turn of events occurred this past week in the world of cancer prevention. It was not so much a major discovery or new drug trial result, but rather a political and communication phenomenon. It happened on a couple of fronts.

Noted breast surgeon Laura Esserman at USCF and urologist Ian Thompson at UT-San Antonio published an opinion piece in the widely read and influential *Journal of the American Medical Association* entitled "Rethinking Screening for Breast and Prostate Cancer." They argue that screening gained momentum as clear differences between the outcomes of early and more advanced stage cancers were noted a long time ago, supporting the importance of early detection of asymptomatic cancer. However, mortality rates attributable to screening have only modestly improved for breast cancer and have not even perceptibly changed for prostate cancer--this may be due to the fact that early detected cancers may never have affected the mortality, or even been clinically detected in the lifetime, of many of the screened cancer cases. Yet the diagnoses of early-stage breast and prostate cancers rose significantly with screening. So did the number of patients requiring therapies that have significant consequences, such as breast surgery effects and early menopause for women and urinary incontinence and erectile dysfunction for men.

Time to rethink screening? This would have been heresy a couple of years ago. In fact, when the National Cancer Institute developed consensus recommendations for mammography in 1993, the disharmony was anything but a consensus among the experts who debated like a hung jury. This culminated in an awkwardly written final statement that screening should begin at age 40, but that individual risks and benefits should be discussed with patients (and how many of you reading this blog who have had mammographic screening remember having this type of discussion with your doctor?)

The other big event was an admission by the American Cancer Society--who has steadfastly maintained the paramount importance of screening--that perhaps they have overstated the benefits of screening. Bravo to the ACS! This is an organization that depends politically and financially on such messages, yet they had the courage to recognize the emerging evidence and make an acknowledgment that is likely to confuse and possibly infuriate their constituency.

So what is the public to do now? They are getting used to contradictory statements on a weekly basis about the importance of a specific vitamins, food supplements, or physical activity. But cancer screening? Wasn't this based on the highest level of evidence and chiseled in stone?

Well, sort of.

No doubt that for cervical cancer, mortality has dropped 90% with Pap smears--an observation so dramatic that randomized trials were not ethical to even perform. Colon cancer is also reasonably secure--in fact just ONE colonoscopy in a lifetime can probably save many lives, and regular screening may lower the cancer death rate by nearly a third. Even mammographic screening for breast cancer does lower breast cancer deaths and should still be carried out as recommended (although interestingly, overall mortality decreases have not really been demonstrated). Prostate screening mortality benefits remain unproven, but clinical data suggests that more aggressive cancers in younger individuals or populations at higher risks (such as those with family history and of African descent) *might* benefit.

As Drs. Esserman and Thompson point out, the answer may lie in better selecting who and when we screen, and of course, by improving our screening technology to not just pick up ANY malignancy (because as we get older, cancers we harbor are less likely to kill us), but to detect the dangerous ones--based on the biology of the silent cancer as well as host risk factors such as age, family history, and maybe someday, gene testing. Until that time, cancer screening needs to be looked at just like all other medical decisions--a tradeoff between the potential benefits and the risks.

Even in the new era of "personalized screening," tradeoffs will have to be made, but should lead fewer people down the path of unnecessary treatment while still minimizing cancers that present at later and less curable stages.

For more on the recent controversy surrounding cancer screening, read *CURE's* ["Life Preserver?"](#) from the Fall 2009 issue.