***North Carolina Advisory Committee on Cancer Coordination and Control***

Breast Cancer Screening Recommendation

Breast cancer is the second leading cause of cancer mortality in women in North Carolina and the United States. An estimated 10,220 new cases of breast cancer will be diagnosed in North Carolina in 2022 and over 20,480 are expected to die of the disease (ACA, 2022).

Breast cancer mortality can be reduced through a program of early detection and treatment. Screening mammography in average risk women ages 40 to 74 has been found to decrease breast cancer deaths. Annual screenings result in 40% more life years saved and averts two more deaths per 1,000 from breast cancer (50-74 years), however, generates 845 more false positive tests compared to biennial screening. The evidence for screening with clinical breast exam (CBE) and breast self-exam (BSE) is less clear. With respect to screening, CBE and BSE do not appear to offer benefit beyond that of mammography alone.

In January 2016, the U.S. Preventive Services Task Force (USPSTF) released updated recommendations for breast cancer screening. In January 2021, the USPSTF had begun their revisions for breast cancer screening. In May 2023, they released their draft screening recommendations that lower the age from 50 to 40 years old. In fall 2015, the American Cancer Society (ACS) also released updated breast cancer screening recommendations. Both guidelines are based on a systematic review of the literature, modeling by CISNET, and additional analyses as needed. Key similarities and differences between the USPSTF and ACS recommendations are highlighted in the table, below:

**Table: Summary of Breast Cancer Screening Recommendations for Average Risk Women**

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|  | **USPSTF (2016)** | **ACS (2015)** |
| Mammography screening in women 40 – 44 | Individualized decision-making, taking into consideration patient values, benefits and harms | Option to start screening with mammogram every year |
| Mammography screening in women 45 – 49 | **Individualized decision- making, taking into consideration patient values, benefits and harms** | **Annual screening** |
| Mammography screening in women 50 – 54 | **Screen every two years** | **Annual screening** |
| Mammography screening in women 55 – 74 | **Screen every two years** | **Transition to screening every two years but have opportunity to continue annual screening. Continue as long as overall health is good and life expectancy ≥10 years** |

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| **Age to stop mammography screening** | **Insufficient evidence to assess benefits and harms age 75 and older** | **Continue screening every 1-2 years as long as overall health is good and life expectancy**  **≥10 years** |
| Clinical Breast Exam (CBE) | No comment | Not recommended for average risk individuals |
| Breast Self Exam (BSE) | No comment | Not recommended; however, women should be familiar with how their breasts normally look and feel and report any changes to a health care provider right away |
| Digital breast tomosynthesis (DBT) | Insufficient evidence to assess benefits and harms as primary screening method | Studies are still too early to determine additional benefit |
| Adjunctive tests for with Dense Breasts | Insufficient evidence to assess benefits and harms of ultrasound, MRI, DBT or other tests for women with normal mammogram | No comment |

The NC Advisory Committee on Cancer Coordination and Control (NC ACCCC) endorses the following breast cancer screening recommendations:

* Women ages 40 to 74 should receive mammography screening every one to two years.
* Women ages 40 to 49 should be counseled regarding the risks and benefits of screening, including the mortality benefit and the potential risks of false positives and benign biopsies in this age group.
* Women ages 75 and older should be counseled regarding the risks and benefits of screening, including the potential risk of over diagnosis in this age group.
* All individuals (including females, males, nonbinary, transgender individuals, etc.) should participate in shared decision-making with their health care providers, discussing individual preferences and factors affecting risks and benefits.
* Because of conflicting opinion on the utility of clinical breast exam (CBE) and breast self- exam (BSE), the Advisory Committee recommends that women be educated about the potential benefits and harms of clinical breast exam (CBE) and breast self-exam (BSE).
* Digital breast tomosynthesis or 3D mammography was added to the list of approved codes for the NC Breast and Cervical Cancer Control Program (NC BCCCP) in November 2016. The Advisory Committee makes no recommendation regarding its use for primary screening or as an adjunct to mammography for routine screening, but that women with dense breasts or determined to be higher risk should discuss potential benefits of 3D imaging with their health care provider.

Because decisions regarding screening need to be individualized, these recommendations should not be used as justification for insurers making decisions regarding denial of coverage for mammography screening in any age group.

The NC ACCCC recommends that scientific evidence related to breast cancer screening be re- examined in five years (2027). If, however, compelling evidence regarding screening becomes available before the scheduled review, the NC ACCCC recommends immediate review of the current position statement.

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