Approved: 03/08/10
Date

MINUTES OF THE SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

The meeting was called to order by Chairman Jim Barnett at 1:32p.m. on January 21, 2010, in Room 546-S of the Capitol.

All members were present.

Committee staff present:
Nobuko Folmsbee, Office of the Revisor of Statutes
Renae Jefferies, Office of the Revisor of Statutes
Iraida Orr, Kansas Legislative Research Department
Terri Weber, Kansas Legislative Research Department
Melissa Calderwood, Kansas Legislative Research Department
Jan Lunn, Committee Assistant

Conferees appearing before the Committee:
James Hamilton, MC, FAC, Volunteer Chair, Government Relations Committee, American Cancer Society
Peggy Johnson, Public Policy Chair, Kansas Cancer Partnership
Lori Maris, Executive Director, Susan G. Komen for he Sure, Greater Kansas City Affiliate
Dr. Andrew Allison, Kansas Health Policy, Acting Executive Director
Debbie Schulte, private citizen
Deba Brant, private citizen
Tina Herold, private citizen
Brad Smoot, Legislaltive Counsel, Blue Cross Blue Shield of Kansas and Blue Cross Blue Shield of Kansas City,

Others attending:
See attached list.

Chairperson Barnett welcomed all those attending the hearing concerning mammography guidelines recommended by the U. S. Preventive Services Task Force (USPSTF). The recommended guidelines were released in November 2009.

Terri Weber, Legislative Research Department, provided an overview of these guidelines which recommend biennial mammography screening for women aged 50 to 74 years. In addition, the USPSTF recommends against teaching breast self-examination (BSE), suggests current evidence is insufficient to assess additional benefits and harms of clinical breast examination (CBE) beyond screening mammography in women 40 years and older, and concludes that current evidence is insufficient to assess additional benefits and harms of digital mammography or magnetic resonance imaging (MRI) instead of film mammography as screening modalities. Ms. Weber reviewed the USPSTF grading system, the report used to formulate the November recommendations, and described the USPSTF panel as well as its background and mission (Attachment 1).

Dr. James Hamilton provided testimony indicating the USPSTF recommended guidelines were based on a cost containment analysis with little qualitative data. Early detection does save lives, particularly in younger women who typically present with a more aggressive disease process (Attachment 2). Dr. Hamilton encouraged women to continue American Cancer Society guidelines of yearly mammography screening for breast cancer at age 40 and continuing for as long as the individual is in good health.

Peggy Johnson, Kansas Cancer Partnership, spoke about the Kansas Comprehensive Cancer Control and Prevention Plan (http://ww.cancerkansas.org/cancer_plan.htm) which is comprised of individuals from healthcare facilities, clinics, county health departments and advocacy groups. She reported members of the Kansas Cancer Partnership have been working in communities with partner organizations (Susan G. Komen for the Cure, American Cancer Society) to bring education and awareness for the need of screening mammography for women at age 40. She indicated that while mammography is not a cure, it is the best tool for women and healthcare professionals to find breast cancer at the earliest stages (Attachment 3).

Lori Maris, Executive Director, Susan G. Komen for the Cure, Greater Kansas City, reported that

members in this organization recommend no impediments to breast cancer screening (Attachment 4). Ms. Maris encouraged third party payers to fund annual mammography if a woman and her healthcare provider opt for this approach. Ms. Maris detailed the contributions Komen Greater Kansas City and Komen Mid-Kansas Affiliates have provided to cover breast health education, screening, and treatment programs in Kansas. Ms. Maris indicated Susan G. Komen for the Cure recommends that organization stands for breast self-awareness including BSE.

Dr. Andrew Allison, Acting Director, Kansas Health Policy Authority, reported coverage provided by Medicaid, CHIP, and the State Employee Health Plan (SEHP) for preventive services and tests are without age-specific recommendations (Attachment 5). Senator Colyer inquired about the clinical guidelines that the SEHP wellness vendor uses to advise state employees about health choices and specifically, concerning BSE. Dr. Allison indicated he would provide feedback at a later time.

Debbie Schulte, private citizen, shared her personal story concerning her breast cancer diagnosis at age 41. She described the treatment plan and attributed her survival to early diagnosis (Attachment 6).

Deba Brant, private citizen, provided testimony related to her early breast cancer diagnosis (Attachment 7), and her belief that her survival is directly correlated to early mammography screening. She encouraged all women to continue diagnostic mammography screening at 40.

Brad Smoot, Blue Cross Blue Shield of Kansas and Blue Cross Blue Shield of Kansas City (BCBS), indicated he had inquired of his clients regarding what changes, if any, have been made to mammogram coverage resulting from the new federal breast cancer screening recommendations (Attachment 8). Mr. Smoot indicated BCBS has not changed their long-standing practice of paying for mammograms. Senator Colyer inquired whether there was a co-pay for mammograms, whether self examination and mammograms are promoted to its members, and whether BCBS allows women with implants to receive magnetic resonance imaging (MRI) rather than mammogram screening. Mr. Smoot will provide information related to these questions at a later date.

Tina Herold, private citizen, testified concerning her breast cancer diagnosis at age 34 and her course of treatment (Attachment 9). Ms. Herold indicated early screening, surgical intervention, chemotherapy, and cancer drug therapy have saved her life. She encouraged all women to practice total breast self awareness including BSE, early diagnostic screening, and continuing education on new technologies and treatments.

Written testimony was submitted by Marlee Carpenter, Executive Director, Kansas Association of Health Plans, and Bill Sneed, representing America's Health Insurance Plans, (Attachments 10 and 11, respectively) who indicate member companies have not changed their policies related to mammography screening since USPSTF recommendations were released.

Senator Barnett expressed appreciation to all conferees for attending and adjourned the meeting at 2:30PM.

U.S. Preventive Services Task Force

About USPSTF

The U.S. Preventive Services Task Force (USPSTF), first convened by the U.S. Public Health Service in 1984, and since 1998 sponsored by the Agency for Healthcare Research and Quality (AHRQ), is the leading independent panel of private-sector experts in prevention and primary care. The USPSTF conducts rigorous, impartial assessments of the scientific evidence for the effectiveness of a broad range of clinical preventive services, including screening, counseling, and preventive medications. Its recommendations are considered the "gold standard" for clinical preventive services.

The mission of the USPSTF is to evaluate the benefits of individual services based on age, gender, and risk factors for disease; make recommendations about which preventive services should be incorporated routinely into primary medical care and for which populations; and identify a research agenda for clinical preventive care.

Background and Mission

Public Law Section 915 mandates that AHRQ convene the USPSTF to conduct scientific evidence reviews of a broad array of clinical preventive services, develop recommendations for the health care community, and provide ongoing administrative, research, technical, and dissemination support.

The Task Force's pioneering efforts began with the 1989 *Guide to Clinical Preventive Services*. A second edition of the *Guide* was published in 1996. The current *Guide to Clinical Preventive Services* is available on the Web.

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Process

The Task Force makes its recommendations on the basis of explicit criteria. Recommendations issued by the USPSTF are intended for use in the primary care setting. The USPSTF recommendation statements present health care providers with information about the evidence behind each recommendation, allowing clinicians to make informed decisions about implementation.*

The USPSTF is supported by an Evidence-based Practice Center (EPC). Under contract to AHRQ, the EPC conducts systematic reviews of the evidence on specific topics in clinical prevention that serve as the scientific basis for USPSTF recommendations.

The USPSTF reviews the evidence, estimates the magnitude of benefits and harms for each preventive service, reaches consensus about the net benefit for each preventive service, and issues a recommendation.

The Task Force grades the strength of the evidence from "A" (strongly recommends), "B" (recommends), "C" (no recommendation for or against), "D" (recommends against), or "I" (insufficient evidence to recommend for or against).

*From: Harris RP, Helfand M, Woolf SH, et al. Current methods of the U.S. Preventive Services Task Force: a review of the process. *Am J Prev Med* 2001;20(suppl 3):21-35.

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Senate Public Health and Welfare
Date: 01/21/10
Attachment: 1

Members of the USPSTF

The USPSTF comprises primary care clinicians (e.g., internists, pediatricians, family physicians, gynecologists/obstetricians, and nurses). Individual members' interests include: decision modeling and evaluation; effectiveness in clinical preventive medicine; clinical epidemiology; the prevention of high-risk behaviors in adolescents; geriatrics; and the prevention of disability in the elderly.

Current members of the Task Force are listed below. They have recognized expertise in prevention, evidence-based medicine, and primary care.

Bruce N. Calonge, M.D., M.P.H. (Chair)
Chief Medical Officer and State Epidemiologist
Colorado Department of Public Health and Environment, Denver, CO

Susan Curry, Ph.D.
Dean, College of Public Health
Distinguished Professor
University of Iowa, Iowa City, IA

Allen J. Dietrich, M.D.
Professor, Community and Family Medicine
Dartmouth Medical School, Hanover, NH

David Grossman, M.D., M.P.H.
Medical Director, Preventive Care and Senior Investigator, Center for Health Studies, Group Health Cooperative
Professor of Health Services and Adjunct Professor of Pediatrics
University of Washington, Seattle, WA

George Isham, M.D., M.S.
Medical Director and Chief Health Officer
HealthPartners, Minneapolis, MN

Michael L. LeFevre, M.D., M.S.P.H.
Professor, Department of Family and Community Medicine
University of Missouri School of Medicine, Columbia, MO

Rosanne Leipzig, M.D., Ph.D
Professor, Geriatrics and Adult Development, Medicine, Health Policy
Mount Sinai School of Medicine, New York, NY

Joy Melnikow, M.D., M.P.H.
Professor, Department of Family and Community Medicine
Associate Director, Center for Healthcare Policy and Research
University of California Davis, Sacramento, CA

Bernadette Melnyk, Ph.D., R.N., C.P.N.P./N.P.P.
Dean and Distinguished Foundation Professor in Nursing
College of Nursing & Healthcare Innovation
Arizona State University, Phoenix, AZ

Wanda Nicholson, M.D., M.P.H., M.B.A.
Associate Professor
Johns Hopkins School of Medicine and Bloomberg School of Public Health, Baltimore, MD

J. Sanford (Sandy) Schwartz, M.D.
Leon Hess Professor of Medicine, Health Management, and Economics
University of Pennsylvania School of Medicine and Wharton School, Philadelphia, PA

Timothy Wilt, M.D., M.P.H.
Professor, Department of Medicine, Minneapolis VA Medical Center
University of Minnesota, Minneapolis, MN

Role of AHRQ Staff

It is AHRQ's mission to improve the safety, quality, efficiency, and effectiveness of health care for all Americans. The USPSTF is a prime example of the Agency's efforts to translate research on preventive medicine into practice.

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In keeping with its mission and the importance of prevention, AHRQ has augmented its support staff for the USPSTF and for its prevention programs in general. The AHRQ Center for Primary Care, Prevention, and Clinical Partnerships oversees operation of the USPSTF, and provides administrative, programmatic, and technical support for the USPSTF program.

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Role of Partners

Partners to the U.S. Preventive Services Task Force are drawn from the fields of primary care, public health, health promotion, policy, and quality improvement. Liaisons from these groups and from Federal health agencies contribute their expertise in the peer review of draft USPSTF documents and help disseminate the work of the USPSTF to their members.

Primary care partners include:

- American Academy of Family Physicians (AAFP)
- American Academy of Nurse Practitioners (AANP)
- American Academy of Pediatrics(AAP)
- American Academy of Physician Assistants (AAPA)
- American College of Obstetricians and Gynecologists (ACOG)
- American College of Physicians (ACP)
- American College of Preventive Medicine (ACPM)
- American Osteopathic Association (AOA)
- National Association of Pediatric Nurse Practitioners (NAPNAP)

Policy, population, and quality improvement partners include:

- America's Health Insurance Plans (AHIP)
- AARP
- National Committee for Quality Assurance (NCQA)

Federal partners include:

- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare & Medicaid Services (CMS)
- U.S. Food and Drug Administration (FDA)
- Health Resources and Services Administration (HRSA)
- Indian Health Service (IHS)
- National Institutes of Health (NIH)
- Veteran's Health Administration (VHA)
- Department of Defense/Military Health System (DoD/MHS)
- Office of Disease Prevention and Health Promotion (ODPHP)
- Office of the Surgeon General

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Impact of the USPSTF

USPSTF recommendations have formed the basis of the clinical standards for many professional societies, health organizations, and medical quality review groups. Previous editions of the Guide to Clinical Preventive Services have been used widely in undergraduate and post-graduate medical and nursing education as a key reference for teaching preventive care.

The work of the USPSTF has helped establish the importance of including prevention in primary health care, ensuring insurance coverage for effective preventive services, and holding providers and health care systems accountable for delivering effective care.

USPSTF recommendations highlight the opportunities for improving delivery of effective services and have helped others in narrowing gaps in the provision of preventive care in different populations.

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For More Information

Go to http://www.ahrq.gov/clinic/uspstfix.htm:

- To access recommendations made by the USPSTF and the articles that summarize the evidence on which the recommendations are based.

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- To find out how to receive CD-ROM and print publications of USPSTF recommendations.
- And, to sign up for AHRQ's Prevention Program LISTSERV®.

To download the Electronic Preventive Services Selector (ePSS), a searchable PDA and online tool of USPSTF recommendations, go to: http://pda.ahrq.gov.

For more information, contact:

Therese Miller, Dr.P.H.
Project Coordinator
Center for Primary Care, Prevention, & Clinical Partnerships
Agency for Healthcare Research and Quality
540 Gaither Road
Rockville, MD 20850
Phone: (301) 427-1585
Fax: (301) 427-1597
E-mail: Therese.Miller@ahrq.hhs.gov

The recommendations of the USPSTF are made for asymptomatic populations; the recommendations made by the Task Force are not disease—or individual—specific. If you have concerns about your health, contact your medical care provider.

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Current as of January 2010

Internet Citation:

About USPSTF. U.S. Preventive Services Task Force. January 2010. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/clinic/uspstfab.htm

U.S. Preventive Services Task Force

Grade Definitions After May 2007

What the Grades Mean and Suggestions for Practice

The U.S. Preventive Services Task Force (USPSTF) has updated its definitions of the grades it assigns to recommendations and now includes "suggestions for practice" associated with each grade. The USPSTF has also defined levels of certainty regarding net benefit. These definitions apply to USPSTF recommendations voted on after May 2007.

Grade	Definition	Suggestions for Practice
A	The USPSTF recommends the service. There is high certainty that the net benefit is substantial.	Offer or provide this service.
B	The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.	Offer or provide this service.
C	The USPSTF recommends against routinely providing the service. There may be considerations that support providing the service in an individual patient. There is at least moderate certainty that the net benefit is small.	Offer or provide this service only if other considerations support the offering or providing the service in an individual patient.
D	The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.	Discourage the use of this service.
I Statement	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.	Read the clinical considerations section of USPSTF Recommendation Statement. If the service is offered, patients should understand the uncertainty about the balance of benefits and harms.

Levels of Certainty Regarding Net Benefit

Level of Certainty*	Description
High	The available evidence usually includes consistent results from well-designed, well-conducted studies in representative primary care populations. These studies assess the effects of the preventive service on health outcomes. This conclusion is therefore unlikely to be strongly affected by the results of future studies.
Moderate	The available evidence is sufficient to determine the effects of the preventive service on health outcomes, but confidence in the estimate is constrained by such factors as: • The number, size, or quality of individual studies. • Inconsistency of findings across individual studies. • Limited generalizability of findings to routine primary care practice. • Lack of coherence in the chain of evidence. As more information becomes available, the magnitude or direction of the observed effect could

	change, and this change may be large enough to alter the conclusion.
Low	The available evidence is insufficient to assess effects on health outcomes. Evidence is insufficient because of: • The limited number or size of studies. • Important flaws in study design or methods. • Inconsistency of findings across individual studies. • Gaps in the chain of evidence. • Findings not generalizable to routine primary care practice. • Lack of information on important health outcomes. More information may allow estimation of effects on health outcomes.

* The USPSTF defines certainty as "likelihood that the USPSTF assessment of the net benefit of a preventive service is correct." The net benefit is defined as benefit minus harm of the preventive service as implemented in a general, primary care population. The USPSTF assigns a certainty level based on the nature of the overall evidence available to assess the net benefit of a preventive service.

Current as of May 2008

Internet Citation:

U.S. Preventive Services Task Force Grade Definitions After May 2007. May 2008. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/clinic/uspstf/gradespost.htm

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Evidence Review Update
Number 74

Screening for Breast Cancer: Systematic Evidence Review Update for the U. S. Preventive Services Task Force

Prepared For:
Agency for Healthcare Research and Quality
U.S. Department of Health and Human Services
540 Gaither Road
Rockville, MD 20850
www.ahrq.gov
Contract Number 290-02-0024, Task Order Number 2

Prepared By:
Oregon Evidence-based Practice Center
Oregon Health & Science University
3181 SW Sam Jackson Park Rd.
Portland, Oregon 97239
www.ohsu.edu/epc/usptf/index.htm

Investigators:
Heidi D. Nelson MD, MPH
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Benjamin Chan, MS
Peggy Nygren, MA
Linda Humphrey MD, MPH

AHRQ Publication No. 10-05142-EF-1
November 2009

This report is based on research conducted by the Oregon Evidence-based Practice Center (EPC) under contract to the Agency for Healthcare Research and Quality (AHRQ), Rockville, MD (Contract No. 290-02-0024). The investigators involved have declared no conflicts of interest with objectively conducting this research. The findings and conclusions in this document are those of the authors, who are responsible for its content, and do not necessarily represent the views of AHRQ. No statement in this report should be construed as an official position of AHRQ or of the U.S. Department of Health and Human Services.

The information in this report is intended to help clinicians, employers, policymakers, and others make informed decisions about the provision of health care services. This report is intended as a reference and not as a substitute for clinical judgment.

This report may be used, in whole or in part, as the basis for the development of clinical practice guidelines and other quality enhancement tools, or as a basis for reimbursement and coverage policies. AHRQ or U.S. Department of Health and Human Services endorsement of such derivative products may not be stated or implied.

Acknowledgements

This project was funded by AHRQ for the U.S. Preventive Services Task Force (USPSTF). Additional support was provided by the Veteran's Administration Women's Health Fellowship (Dr. Tyne) and the Oregon Health & Science University Department of Surgery in conjunction with the Human Investigators Program (Dr. Naik). Data collection for some of this work was supported by the NCI-funded Breast Cancer Surveillance Consortium (BCSC) cooperative agreement (U01CA63740, U01CA86076, U01CA86082, U01CA63736, U01CA70013, U01CA69976, U01CA63731, U01CA70040). The collection of cancer incidence data used in this study was supported in part by several state public health departments and cancer registries throughout the United States. A full description of these sources is available at http://breastscreening.cancer.gov/work/acknowledgement.html.

The authors acknowledge the contributions of the AHRQ Project Officer, Mary Barton, MD, MPP, and USPSTF Leads Russ Harris, MD, MPH; Allen Dietrich, MD; Carol Loveland-Cherry, PhD, RN; Judith Ockene, PhD, MEd; and Bernadette Melnyk, PhD, RN, CPNP/NPP. Andrew Hamilton, MLS, MS, conducted the literature searches and Sarah Baird, MS, managed the bibliography at the Oregon EPC. The authors thank the BCSC investigators, participating mammography facilities, and radiologists for the data used in this project. A list of the BCSC investigators and procedures for requesting BCSC data for research purposes are available at http://breastscreening.cancer.gov/. The authors also thank Patricia A. Carney, PhD; Steve Taplin, MD; Sebastien Haneuse, PhD; and Rod Walker, MS, for their direct work with this project.

Suggested Citation: Nelson HD, Tyne K, Naik A, Bougatsos C, Chan B, Nygren P, Humphrey L. Screening for Breast Cancer: Systematic Evidence Review Update for the U.S. Preventive Services Task Force. Evidence Review Update No. 74. AHRQ Publication No. 10-05142-EF-1. Rockville, MD: Agency for Healthcare Research and Quality; 2009.

Structured Abstract

Background: This systematic review is an update of new evidence since the 2002 U.S. Preventive Services Task Force recommendation on breast cancer screening.

Purpose: To determine the effectiveness of mammography screening in decreasing breast cancer mortality among average-risk women age 40-49 years and 70 years and older; the effectiveness of clinical breast examination (CBE) and breast self examination (BSE) in decreasing breast cancer mortality among women of any age; and harms of screening with mammography, CBE, and BSE.

Data Sources: The Cochrane Central Register of Controlled Trials and Cochrane Database of Systematic Reviews (through the fourth quarter of 2008), MEDLINE® searches (January 2001 to December 2008), reference lists, and Web of Science® searches for published studies and Breast Cancer Surveillance Consortium for screening mammography data.

Study Selection: Randomized, controlled trials with breast cancer mortality outcomes for screening effectiveness, and studies of various designs and multiple data sources for harms.

Data Extraction: Relevant data were abstracted, and study quality was rated by using established criteria.

Data Synthesis: Mammography screening reduces breast cancer mortality by 15% for women age 39-49 (relative risk [RR] 0.85; 95% credible interval [CrI], 0.75-0.96; 8 trials). Results are similar to those for women age 50-59 years (RR 0.86; 95% CrI, 0.75-0.99; 6 trials), but effects are less than for women age 60-69 years (RR 0.68; 95% CrI, 0.54-0.87; 2 trials). Data are lacking for women age 70 years and older. Radiation exposure from mammography is low. Patient adverse experiences are common and transient and do not affect screening practices. Estimates of overdiagnosis vary from 1-10%. Younger women have more false-positive mammography results and additional imaging but fewer biopsies than older women. Trials of CBE are ongoing; trials of BSE showed no reductions in mortality but increases in benign biopsy results.

Limitations: Studies of older women, digital mammography, and magnetic resonance imaging are lacking.

Conclusions: Mammography screening reduces breast cancer mortality for women age 39-69 years; data are insufficient for women age 70 years and older. False-positive mammography results and additional imaging are common. No benefit has been shown for CBE or BSE.

acceptable surgical treatment for breast cancer.[46] As more knowledge is gained regarding genetic and molecular profiles of individual breast cancers, greater emphasis is being placed on targeted therapy. The goal is to tailor therapy to each particular patient in order to maximize benefits and minimize toxicity.[47] Because there are now often multiple options for treatment, patient preferences play a large role in determining the treatment course.

Screening Recommendations of Other Groups

Mammography

Most organizations in the United States support the use of mammography for average-risk women age 40 years and older; however, differences include the recommended starting age for screening and the screening interval (**Table 1**).

Clinical Breast Examination

The ACS recommends that women age 20-39 years undergo CBE every 3 years, and annually after age 40.[48] The NCI states that fair evidence shows that CBE reduces breast cancer mortality.[49] The American College of Obstetricians and Gynecologists (ACOG) recommends that all women have CBE annually as part of the physical examination.[50] The Canadian Task Force on Preventative Health Care (CTFPHC) recommends CBE for women age 50-69 years and makes no recommendation for or against CBE for women age 40-49 years.[51] The World Health Organization (WHO) does not recommend screening by CBE, but states CBE should be offered to women who present to a primary health care center for other medical reasons.[52]

Breast Self Examination

Since 2001, several organizations have changed their recommendations about BSE as a routine screening modality. The ACS changed its recommendation to make BSE optional as a screening method.[48] The NCI states that teaching BSE does not reduce breast cancer mortality.[49] The CTFPHC now recommends against its use, stating there is fair evidence of no benefit and good evidence of harm.[53, 54] The WHO advises that national cancer control programs should not recommend screening by BSE.[52] ACOG advises that despite a lack of definitive evidence for or against BSE, it can still be recommended.[50]

Table 1. Breast Cancer Screening Recommendations for Average-Risk Women

	American Academy of Family Physicians (AAFP)	American Cancer Society (ACS)	American College of Obstetricians and Gynecologists (ACOG)	American College of Physicians (ACP)*	American College of Preventive Medicine (ACPM)	American College of Radiology (ACR)	American Medical Association (AMA)	Canadian Task Force on Preventive Health Care (CTFPHC)	National Cancer Institute (NCI)	National Comprehensive Cancer Network (NCCN)	US Preventive Services Task Force (USPSTF)	World Health Organization (WHO)
Mammography												
Age 40+, annual		x				x	x			x		
Age 40+, every 1-2 years	x							x	x		x	
Age 40-49, every 1-2 years			x									
Age 50+, annual			x									
Age 50-69, annual or biennial					x							x
Age 70+					x							
MRI												
Not recommended for average risk women		x								x		
CBE												
Age 40+, annual		x	x							x		
Periodic evaluation (1-3 years), ages vary		x					x	x ages 50-69	x	x		
Insufficient evidence											x	
Not recommended												x
BSE												
Recommended			x				x			x		
Insufficient evidence	x	x							x		x	
Not recommended								x				x

*Suggests periodic, individualized screening for women age 40-49 years.

Abbreviations: BSE=breast self examination; CBE=clinical breast examination; MRI=magnetic resonance imaging.

U.S. Preventive Services Task Force

Screening for Breast Cancer

Release Date: November 2009
Updated: December 2009

Summary of Recommendations / Supporting Documents

Summary of Recommendations

- **The USPSTF recommends biennial screening mammography for women aged 50 to 74 years.**
  Grade: B recommendation.
- **The decision to start regular, biennial screening mammography before the age of 50 years should be an individual one and take patient context into account, including the patient's values regarding specific benefits and harms.**
  Grade: C recommendation.

> "So, what does this mean if you are a woman in your 40s? You should talk to your doctor and make an informed decision about whether mammography is right for you based on your family history, general health, and personal values."
>
> Diana Petitti, MD, MPH
> Vice Chair, U.S. Preventive Services Task Force
> November 19, 2009

- **The USPSTF concludes that the current evidence is insufficient to assess the additional benefits and harms of screening mammography in women 75 years or older.**
  Grade: I Statement.
- **The USPSTF recommends against teaching breast self-examination (BSE).**
  Grade: D recommendation.
- **The USPSTF concludes that the current evidence is insufficient to assess the additional benefits and harms of clinical breast examination (CBE) beyond screening mammography in women 40 years or older.**
  Grade: I Statement.
- **The USPSTF concludes that the current evidence is insufficient to assess the additional benefits and harms of either digital mammography or magnetic resonance imaging (MRI) instead of film mammography as screening modalities for breast cancer.**
  Grade: I Statement.

> On December 4, 2009, the USPSTF unanimously voted to update the language of their recommendation regarding women under 50 years of age to clarify their original and continued intent.

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Supporting Documents

Screening for Breast Cancer, November 2009
- Recommendation Statement (PDF File, 300 KB; PDF Help)
- Supporting Article (PDF File, 200 KB; PDF Help)
- Evidence Update Article (PDF File, 350 KB; PDF Help)
- Evidence Synthesis (PDF File, 1 MB; PDF Help)
- Clinical Summary (PDF File, 118 KB; PDF Help)

- Previous (2002) Recommendation Statement

Persons with disabilities experiencing problems accessing portions of the PDF file for the evidence synthesis should contact Lisa Nicolella at (301) 427-1906. The accessible version of this report will be available by December 30, 2009.

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Current as of December 2009

Internet Citation:

Screening for Breast Cancer, Topic Page. November 2009. U.S. Preventive Services Task Force. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/clinic/uspstf/uspsbrca.htm

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TO: SENATOR JAMES BARNETT, CHAIR
SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

FROM: JAMES HAMILTON, MD, FAC
VOLUNTEER CHAIR, GOVERNMENT RELATIONS COMMITTEE
AMERICAN CANCER SOCIETY

DATE: JANUARY 21, 2010

RE: NEW FEDERAL GUIDELINES FOR MAMMOGRAPHY SCREENING

LEGISLATIVE TESTIMONY ON BEHALF OF THE
AMERICAN CANCER SOCIETY

For many years, the accepted practice in healthcare has been to commence routine mammography screening for breast cancer in women beginning at age 40. In November, 2009, the United States Preventive Services Task Force issued recommendations that broke from the accepted practice and instead recommend the commencement of routine mammography screening at age 50. For your background, I have attached an article from the New York Times that explains the Task Force's procedure and the basis for its conclusions.

The American Cancer Society continues to firmly recommend that women obtain yearly mammograms beginning at age 40, and continuing for as long as the woman is in good health. I have also attached an article written by Dr. Len Lichtenfeld, Deputy Chief Medical Officer for the national office of the American Cancer Society, in which Dr. Lichtenfeld responds to the Task Force recommendations and explains why the Society continues to recommend routine mammograms starting at age 40. The key components of the Society's position are as follows:

- In 2009, it was estimated that 1,790 Kansas women would be newly diagnosed with breast cancer. In most cases, the earlier the cancer is detected, the less likely it is that the woman will die from the disease.
- There is no question that routine mammography screening, beginning at age 40, saves lives. Without routine screening, Kansas will see an increase in the number of deaths due to breast cancer that would have otherwise been preventable.
- Mammograms are safe and do not lead to death from radiation exposure.

High Plains Division, Inc., Kansas City Metro Office
6700 Antioch Rd, Ste 100, Merriam, KS 66204 913.432.3277 fax) 913.432.1732
Cancer Information 1.800.ACS.2345 www.cancer.org

- The Task Force recommendations were based upon imperfect data and statistical models that vary widely in their conclusions.
- The Task Force's conclusion was based solely on a subjective cost/benefit analysis, giving little qualitative weight to the lives saved through routine mammography screening.
- The medical community is developing more targeted therapies for the treatment of the particularly aggressive breast cancers more likely to occur in younger women. This will only increase the importance of identifying the disease at an earlier stage through routine mammography screening, and will allow even more lives to be saved.

James J. Hamilton, Jr., MD, FAC

Raised in western Kansas, Dr. Hamilton attended Kansas State University and transferred to the University Of Kansas School Of Medicine, where he received his medical degree. Dr. Hamilton completed his surgical residency at Harvard Medical School in Boston, Massachusetts. He furthered his training to include a year of vascular surgery at the University of Aberdeen, Scotland. He also performed a fellowship in liver surgery at the University of Bern, Switzerland. Dr. Hamilton is board certified in General Surgery and is a Fellow of the American College of Surgeons.

American Cancer Society

The American Cancer Society is the nationwide community-based, voluntary health organization dedicated to eliminating cancer as a major health problem by preventing cancer, saving lives, and diminishing suffering from cancer, through research, education, advocacy, and service.

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Finding Breast Cancer Early: Age 40, Every Year

Posted on 11/16/2009 4:49 PM by Dr. Len Lichtenfeld

The United States Preventivec Services Task Force (USPSTF) today released a series of reports updating their guideline recommendations for screening mammography for the early detection of breast cancer. Their conclusions are bound to raise another round of intense discussion about the benefits, risks and harms of screening for breast cancer.

There is certainly nothing wrong with that, with the exception that if we make the wrong decisions or offer women the wrong guidance about the early detection of breast cancer, we could reverse the considerable progress that has been make in reducing deaths from this disease over the past twenty years.

Unlike the Task Force, the American Cancer Society is not changing its current recommendations that women at average risk of getting breast cancer should get a mammogram every year starting at age 40.

In this era of health care reform, these new Task Force guidelines could have real implications for how insurers, government programs and maybe even the pending health care reform bills will cover screening mammography in the future.

Before I actually discuss the guidelines, I would like to set the stage with the very last sentence of the report that came from one of the evidence reports written by researchers from the Oregon University Health Sciences Center (OHSU). I do this because I think it puts the issue into context:

> "Mammography screening at any age is a tradeoff of a continuum of benefits and harms. ***The ages at which this tradeoff becomes acceptable to individuals and society are not clearly resolved by the available evidence.***" (emphasis mine)

With that as a starting point, here are the short versions of the Task Force's new recommendations for screening mammography:

1) The Task Force recommends ***against*** routine screening for women ages 40-49. Whether to start screening before age 50 should be an individual choice.

2) The Task Force recommends screening every two years for women between ages 50 and 74.

3) The Task Force can't make any recommendations on whether women ages 75 and over should be screened, because there is not enough evidence upon which they can base a recommendation.

4) There is not enough evidence to make a recommendation about the value of clinical breast examination (a careful breast exam done periodically by a trained medical professional) for women 40 years of age or older

5) There is no evidence that teaching women how to do breast self examination makes an difference, so they recommend against teaching women how to do it

6) There isn't enough evidence to say anything about the value of digital mammography and MRI screening in women at average risk of breast cancer

So now the recommendations of the Society are considerably different from the Task Force, whereas in the past the only real difference was whether a screening mammogram should be done every year (ACS) or every one to two years (Task Force). Until now, both organizations had recommended starting screening for breast cancer at age 40.

Those recommendations had been in place for many years. These changes are bound to confuse women and health care professionals who must now make a professional and a personal choice as to which recommendations to follow. The worst outcome would be if the confusion leads women to do nothing since the experts can't seem to make up their minds.

The Task Force believes their new recommendations can retain most of the benefits of mammograms—that is, decreasing deaths from breast cancer—while reducing the risks and harms of the procedure, which includes such things as having to get additional studies to clarify a suspicious finding on a mammogram, or getting a biopsy of a suspicious lesion that turns out not to be breast cancer, or perhaps having a woman embark on a treatment for an actual breast cancer that would never have interfered with her life.

The review of the various clinical trials as reported by OHSU showed that mammography reduced deaths from breast cancer by about 15% in women ages 40-49. They also found that 1904 (range 929-6378) women had to be screened over 10 years to save one life. For women ages 50-59 years, the reduction in deaths was about the same (14%). The number that needed to be screened was 1339 (range 322-7455). In women ages 60-69, the reduction in deaths was 32%, and the number who needed to be screened over 10 years was 377.

What this means is that mammograms are indeed successful in reducing deaths from breast cancer in all age groups, especially women between 60 and 69 years old. But since the actual incidence of breast cancer is less in women ages 40-49, the absolute/actual numbers of lives saved is also less. So you have to screen more women to get the same benefit.

Stated another way, the Task Force agrees that mammography reduces deaths in women ages 40-49. It just doesn't save enough lives, in their opinion.

What about those risks and harms of getting a mammogram? Here is what did the OHSU investigators have to say:

- No significant damage was seen from the radiation associated with mammograms.
- Mammograms can be painful, but "few (women) would consider this a deterrent from future screening."

- There was no consistent effect on most women with regards to the anxiety associated with mammograms, but it was an issue for some women.

- "False positive" mammograms—where the screening mammogram suggests there may be a cancer, but eventually none is found—are an issue, with more of them in younger women compared to older women. But false positive mammograms that lead to an actual biopsy are less common in younger women than in older women, which means that younger women may need more extra mammograms or ultrasounds to take a look at a suspicious area but don't actually have to have a biopsy done when compared to older women where the opposite is true. (In more precise terms, according to the paper, in women ages 40-49, for every case of invasive breast cancer that is diagnosed 556 women have a mammogram, 47 have additional images, and 5 have biopsies.)

- Overdiagnosis was a difficult issue to address, because there really is no direct way of determining which breast cancers we treat are cancers that might lead to a woman's death as compared to breast cancers we treat that would never cause a problem. They concluded that overdiagnosis rates in various studies ranged from 1% to 30%, with most falling between 1% to 10%.

  As the Oregon researchers point out based on this analysis, "These estimates are difficult to apply because, for individual women, it is not known which types of cancer will progress, how quickly cancer will advance and expected lifetimes."

The largest burden of overdiagnosis probably occurs in the population of older women, where you can diagnose and treat a breast cancer but woman wouldn't have a problem with the breast cancer because she had another serious disease and died from something other than breast cancer. If that is where the bulk of the problem lies, then that is a different situation than having overdiagnosis in a young woman, where it could impact the quality of her life for many more years.

What about new technologies such as digital mammograms (which are quickly becoming the only type of mammogram available in many cities in this country) and MRI screening for women at average risk of breast cancer?

Here is what the OHSU researchers to say about those topics as well as a comment about how often mammograms should be done:

> "New technologies, such as digital mammography and MRI, have become widely used in the United States without definitive studies of their effect on screening. Consumer expectations that new technology is better than old may obscure potential adverse effects, such as higher false-positive results and expense. No screening trials incorporating newer technology have been published, and estimates of benefits and harms in this report are based predominantly on studies of film mammography. No definitive studies of the appropriate interval for mammography screening exist, although trial data reflect screening intervals from 12 to 33 months."

Let's now focus on the other research report which was based on a very sophisticated computer model designed and supported by the National Cancer Institute. The purpose of this model was

to try and determine at what age screening mammography should begin, when it should end, and how often it should be done.

The model actually looked at 20 different age/frequency "scenarios." Six different institutions around the country that participate in this project looked at each of these scenarios and came up with their own estimates of how the different combinations of age and frequency impacted the benefits of getting a screening mammogram.

I suspect to no one's surprise, each of these six complex computer models came up with different answers for the same questions.

For example, in one model, if you screened only women from 50-74 and did it every two years, you reduced breast cancer deaths by about 28%. If you did it every year from age 40 to 84, you reduced mortality by about 54%. In another model, the same numbers were about 22% and 38%. In the first study, doing mammograms every other year for more years made a big difference. In the second study, it still made a difference, but not quite as much. And there were still other studies where it made little or no difference

And, not unexpectedly, the later you started getting a screening mammogram and how often you did it resulted in a significant difference in the number of mammograms a woman would have over her lifetime. Start later, end earlier and get it every two years required many fewer lifetime mammograms than starting at 40, screening to a later age, and getting it every year.

So what did these experts conclude from their computer models?

> "This study uses 6 established models that use common inputs but different approaches and assumptions to extend previous randomized mammography screening trial results to the US population and to age groups in whom trial results are less conclusive. All 6 modeling groups concluded that the most efficient screening strategies are those that include a biennial screening interval. Conclusions about the optimal starting ages for screening depend more on the measure chosen for evaluating outcomes. If the goal of a national screening program is to reduce mortality in the most efficient manner, then programs that screen biennially from age 50 years to age 69, 74 or 79 years are among the most efficient on the basis of the ratio of benefits to the number of screening examinations. If the goal of a screening program is to efficiently maximize the number of life-years gained, then the preferred strategy would be to screen biennially starting at age 40 years. Decisions about the best starting and stopping ages also depend on tolerance for false-positive results and the rate of overdiagnosis."

The bottom line of this research was that you could get somewhere between 70-99% of the benefit of screening mammograms (that is, reducing deaths from breast cancer) while reducing the harms by about 50% if you started screening at age 50 and did it every two years as compared to starting at age 40 and doing it every year.

Eventually, someone has to take this information and make some recommendations, and that is exactly what the Task Force did.

We probably have learned as much as we are going to learn from large clinical trials of mammography. If we are going to extend our knowledge about the benefits, risks and harms of mammography, it probably won't come from new, large clinical trials. We have to find other ways to answer our questions about the early detection of breast cancer, and one of the ways to do that is through computer models.

The question, however, is whether or not the models are sufficiently accurate to tell us with reasonable certainty what would happen under a particular situation. It is one thing to try to predict the future or support a theory. It is quite a different thing, in my opinion, when you take computer models and make public policy that affects millions of women with respect to a life threatening disease. Even though the models may be very well designed, there are always questions about how well they truly reflect or predict "real life."

Aside from the confusion this report is going to sow in the minds of women about when (and maybe even whether) they should be screened for breast cancer, there is the question about how we are going to provide insurance coverage for women who need mammograms.

It remains to be seen how insurers, Medicare, Medicaid and states where insurers are required to cover screening mammograms are going to react to these recommendations. Hopefully, they will continue to recognize that other respected organizations—such as the American Cancer Society—have different thoughts on this issue and are still appropriate benchmarks to use when determining whether or not to pay for screening mammograms.

And then there is health care reform, where the influence of the Task Force may be considerable under the various legislative proposals currently wending their way through Congress.

If the Task Force recommendations become the benchmark in the new legislation, then we may have a problem. If that turns out to be the case, hopefully Congress will realize that recommendations from other organizations that have looked at the same evidence and who have come to different conclusions should also be considered as valid when making coverage decisions for new or existing insurance plans. If not, then it will be much more difficult for a woman to get a mammogram if she is between 40 and 49 years old, or if she wants to get one every year as we currently recommend.

The American Cancer Society is not changing our recommendations for breast cancer screening as a result of this report. Based on our initial review of this new guideline, we see no reason to change a strategy that has proven effective in reducing the death rates for breast cancer in all age groups, including those women ages 40-49.

We will review the evidence offered by the computer modeling approach since it represents new research, and we will continue to examine information from other sources as it becomes available. And, if that information or research is compelling, we will always be open to updating our recommendations. But until such time as we are convinced that such evidence supports such a change, our guidelines will remain as they have been for the past 12 years.

What we know—as noted in the Task Force report—is that deaths from breast cancer have declined 2.3% per year for all women and 3.3% per year for women aged 40-50 years beginning in 1990. That may not seem much year to year, but the total impact over 19 years has been significant, and cannot be ignored. This is especially true when one considers that the death rate was absolutely stable for the preceding six decades. Screening mammograms and better treatments are responsible for that success.

We do no agree that 70% of the benefit from screening mammograms is the right way to go. We do believe that we should aim to choose 100% of the benefit. We should not forget that the "benefit" in this situation is reducing deaths from breast cancer. A 30% reduction in saving lives is not acceptable.

We also recognize that mammograms are not perfect. We realize that women do have to get additional studies for suspicious lesions. We realize that some women have biopsies that do not show breast cancer. We realize that our predictive tests are not perfect, so that we can't say with certainty which breast cancers are aggressive and require intensive treatment and which would—if left alone—never cause a problem.

We realize that we need better screening tools, and that we must work diligently to improve the quality of screening mammography across the country.

Until we have something better, what we have to work with to detect breast cancer early is the screening mammogram. Is it imperfect? Yes. Has it saved lives and reduced deaths from breast cancer? Absolutely.

And that is the fact that simply cannot be ignored.

Mammography Guidelines: You Can't Dress It Up

Posted on 12/10/2009 1:16 PM by Dr. Len Lichtenfeld

I don't like to keep kicking the proverbial can down the road, but a **column** in yesterday's Wall Street Journal about the statistics in the recent **mammogram guideline** recommendations from the U S Preventive Services Task Force is worthy of comment.

Aside from "getting it right" in my opinion, Carl Bialik's **("The Numbers Guy")** discussion highlights the imperfection of the statistics that the Task Force relied on in making a recommendation to the public that we should abandon a long standing (and, in my opinion, effective) public health recommendation that women at average risk of breast cancer get a screening mammogram every year beginning at age 40.

The reality is that the fall out from the Task Force recommendations is just beginning, with one state government cutting mammograms for women in their 40's and insurers concerned that their contracts with companies to provide health insurance benefits for employees will require them to do the same.

Mr. Bialik points out that one of the key statistics was not as perfect as one might think. In fact, the statistic is so imperfect in this case as to make it meaningless.

As Mr. Bialik reported, the "number needed to screen to save one life"—which the task force said was 1904 for women in their 40's and 1339 for women in their 50's—could have in fact been much lower or much larger both for 40-49 year old women and the 50-59 year old age group (see my **initial blog** on the Task Force report for further discussionon the **confidence intervals** for these numbers).

If you look at the number and understand statistics, you realize that the Task Force concluded there was a real difference in the impact of screening mammography in saving lives from breast cancer between the 40 and 50 year old age groups. That led the Task Force to conclude there was sufficient benefit in the older women but not in the younger women.

From a science standpoint, as pointed out in the column, that simply isn't true. There was so much overlap in the statistic between the two groups as to make any reliable difference in benefit impossible to detect with any degree of certainty.

Then there was the issue of the computer model and the role of value judgments comparing years-of-life-lost to how many "extra" mammograms would be required to save those years of life (as though the computer models all agreed on the same numbers, which they don't).

Would I be intemperate to suggest that if given a choice, women would rather have the extra mammogram than die?

Putting an extra mammogram up against losing your life--and coming to the conclusion that women would prefer to avoid that extra mammogram as opposed to saving their life--is an incredibly naïve conclusion in my opinion. And that's assuming the computer model is perfect in its conclusions, which is probably not the case.

A comment in the article from a Task Force member also has me concerned:

> "Diana Petitti, a professor in biomedical informatics at Arizona State University and vice chairwoman of the panel, said the task force looked at a range of evidence in making its recommendation. 'This is purposely a qualitative assessment and not an assessment based on some magic number,' she said in an email."

The Task Force, on its website says it is the "gold standard" in determining what medical screening interventions are effective and which are not.

I have sat through a number of presentations from the Task Force—including one from its current chairman—where they have emphasized the impartiality of the task force, and the fact that they use a strict "evidence based" standard to make their recommendations. No evidence or insufficient evidence means no recommendation for or against a particular screening test.

In this current situation, their vice-chair is now saying that they made "qualitative assessments." My interpretation of that statement is that they applied their own values to the interpretation of the evidence, which is what I wrote when their report first came out. They have ignored the valid scientific/data based assessments of others, who have looked at the same data and came to different conclusions about the value of screening mammograms in women ages 40-49.

That is not what I thought the Task Force was supposed to do.

I went to the **Task Force website** today, and here is what I found for their current recommendation language:

> "The decision to start regular, biennial screening mammography before the age of 50 years should be an individual one and take patient context into account, including the patient's values regarding specific benefits and harms. Grade: **C recommendation**.
>
> **"On December 4, 2009, the USPSTF unanimously voted to update the language of their recommendation regarding women under 50 years of age to clarify their original and continued intent."** (emphasis mine)

Follow the embedded link for "C recommendation" and this is what you will find:

Definition:	Suggestions for practice:
The USPSTF recommends against routinely providing the service. There may be considerations that support providing the service in an individual patient. There is at least moderate certainty that the net benefit is small.	Offer or provide this service only if other considerations support the offering or providing the service in an individual patient.

Tap dance all you want, the bottom line is that the task force still recommends against routine screening mammography.

What's worse in my opinion is that there is ***no evidence based research*** to show that following the Task Force recommendation will in fact save lives from breast cancer for women in their 40's. None, nada, nothing.

This is beginning to look like an effort to put "lipstick on the pig".

What happened to evidence based recommendations?

Clearly their "suggestions for practice" has no evidence base whatsoever for women at average risk of breast cancer. No study has ever been done which confirms that physicians and other health care professionals can accurately predict which women in their 40's are at greater risk of getting breast cancer and should therefore be advised to get a screening mammogram. That's important when you consider the fact that most women who get breast cancer in fact have no specific risk factors for the disease, and that there is a not inconsequential incidence of breast cancer in this age group.

All of this discussion would be nothing more than interesting chatter and disagreement among scientists if it did not have practical implications.

Already, we are hearing that insurance companies are concerned they may have to change their policies based on contracts that require them to follow the Task Force recommendations. And the state of California has taken advantage of the dispute to restrict screening mammograms to disadvantaged women under 50 because of the state's budget crisis. The guideline is the reason they have made this decision.

So what is the solution?

A respected, evidence-based organization comes out with a guideline that is formed in no small part by opinion rather than solid evidence. They fail to provide compelling evidence that would support the need for them to change their prior recommendations, which in fact were fairly consistent with other organizations. They try to "dress up" their recommendation, but when you look behind the screen you see that in fact they still haven't changed their recommendation, which is against routine mammography for women in their 40's. State governments and perhaps insurance companies start to restrict their coverage, in accordance with insurance contracts and other political considerations.

Maybe it is time for some further action. Maybe it is time for the Task Force to at least admit that the evidence is inconclusive one way or the other. Although many of us don't agree with that, at least it would move us in the right direction.

The organizations that have supported the USPSTF because those organizations believe the Task Force relied on solid evidence may not be so comfortable when they actually look at the evidence, or consider the comments from the Task Force. And I suspect they may be a bit concerned that the task force now admits they made a judgment call, and not one based only on what the science was clearly telling them.

And let's also note that supporters of the Task Force—invoking the "evidence standards" of the Task Force—suggested that those who disagreed with the Task Force did so only because of their uninformed or otherwise conflicted reasoning, as though organizations like the American Cancer Society don't consider the evidence before coming out with their own recommendations or comments.

It appears that the Task Force feels that decreasing the number of mammograms is a better deal than saving lives. All one has to do is listen to the outcry from other scientists, physicians, and the public to figure out that there are a couple of folks out there who don't agree with them.

It's time they set the record straight, even if it means changing their recommendation.

Too many lives may hang in the balance.

November 23, 2009

Behind Cancer Guidelines, Quest for Data

By GINA KOLATA

A few years ago, an independent group that issues guidelines on cancer screening decided to review its recommendations for breast cancer. It had last issued guidelines in 2002, but things had changed — there was new science and researchers had become more sophisticated in analyzing existing data.

So the group, the U.S. Preventive Services Task Force, started what it thought would be a straightforward job: gathering the newest science and asking about the benefits and risks of breast cancer screening, the best time to start and how often women should be screened.

The group ended up recommending that most women forgo routine mammograms in their 40s and test every other year instead of every year.

The response was swift and angry. Professional groups, like the American College of Radiology, advocacy groups, like the American Cancer Society, and politicians said the guidelines would deprive women of a life-saving test. And some said the guidelines were politically motivated to save money.

Panel members have been taken aback by the response. Their work seemed almost mundane, they say, just an effort to gather and evaluate the best possible evidence.

The task force, a 16-member panel of experts appointed by the Department of Health and Human Services, began its work as usual. It went to an academic center, in this case the Evidence-Based Practice Center at the Oregon Health and Science University, and asked for an extensive review of all the relevant papers published on breast cancer screening, including ones used in the last review. At that time, the task force recommended routine screening starting at 40, saying that there were benefits although they became greater as age increased. The Oregon group had done similar reviews for the panel, including a review for the 2002 guidelines.

This time, the panel hoped that it could get missing pieces of the puzzle. New studies allowed scientists to zero in on benefits and harms for women in their 40s and to evaluate with far more certainty not just whether women should be screened but also how often.

The Oregon scientists began by combing the literature. By November 2007, the researchers, led by Dr. Heidi D. Nelson, a professor of medicine, medical informatics and clinical epidemiology at the university, had finished its review and sent its work to 15 outside scientists for review, then sent it to the panel. Finally, the researchers were ready to make their first full presentation to the panel members.

Part of that evidence, which Dr. Nelson's group included, was new results from a huge study in England of mammograms for women in their 40s. This study, published in 2006, compared 54,000 women offered mammograms starting at age 40 with 107,000 women the same age who were not offered them. Previous studies of women in their 40s had them starting at various times in that decade of their lives and so were less useful.

But the British study saw only a small decline in the breast cancer death rate after 10 years, and it was not statistically significant, meaning it could have occurred by chance. Previous studies also failed to find a statistically significant effect for women in their 40s.

Dr. Nelson's group did a new analysis combining all the studies. By adding up all the small benefits, the researchers concluded that there was a slight benefit of screening, a statistically significant 15 percent decline in the death rate from breast cancer for women in their 40s.

That means, they said, that 1,900 women ages 40 to 50 must be screened to prevent one death from breast cancer up to 20 years later. At the same time, even with the screening, five deaths would have occurred anyway, probably because many of those cancers grew so fast that no matter how early they were found it was impossible to cure the women. So in the end, 1 out of 6 deaths would have been prevented.

The task force wanted more information. What about the harms of screenings for women in their 40s, it asked?

One harm is excess tests, like biopsies. But there was not much published data.

Dr. Nelson's group drew upon a National Cancer Institute database of eight million mammograms in the United States telling what sort of mammogram — digital or film — the women got, when they got it, and whether they had follow-up tests. Analyzing those data, she concluded that women in their 40s have about a 10 percent chance of a false positive and a 1 percent chance of having a biopsy each time they have a mammogram. While those risks are small, they gain more significance when weighed against the relatively small risk of cancer for women in their 40s — a risk of 1.5 per of 1,000 women.

The serious harm, panel members said, is overdiagnosis, finding cancers that are better off not being found.

In 2002, when the group last reviewed breast cancer screening studies, the idea of overdiagnosis was not well formed. It has been hard for many people, even scientists, to believe that some cancers start then stop or even regress. But researchers all over the world have been finding overdiagnosis in studies of all sorts of cancers.

Dr. Barnett Kramer of the National Institutes of Health, who was not part of the panel, described overdiagnosis as "pure harm" because it means that women are treated with measures like chemotherapy, radiation and surgery for tumors that do not need treating.

Dr. Russell Harris, who was a panel member and is a professor of medicine at the University of North Carolina, said overdiagnosis "became an issue in discussions and it was not an issue before."

One way of looking at cancer is as three different diseases, Dr. Harris said. One type grows so fast that early diagnosis is futile. Another grows so slowly it does not need to be found early to be cured. And as many as a quarter of those slowing-growing cancers would never be noticed in a woman's lifetime. Cancers in the third group can be cured if they are caught early. But, Dr. Harris said, at least with breast cancers, that third group makes up only 15 percent of the deadly cancers.

The panel struggled to get an estimate of overdiagnosis, but could not get a precise figure.

"Harms at least need to be discussed," said Dr. Timothy Wilt, a panel member and a professor of medicine at the University of Minnesota. "More tests and more treatment isn't necessarily a better health outcome." Dr. Wilt estimated that as many as 30 percent of cancers found by mammograms in women in their 40s were overdiagnosed.

The panel wanted more, though. It wanted a better handle on overdiagnosis at all ages, precise and accurate figures. And it had another question that had not been answered in 2002: What is the best interval between mammograms?

Clinical trials did not answer that question because they did not directly compare screening intervals.

In January 2008, the panel commissioned six independent groups to do statistical modeling and get the answers.

Overdiagnosis proved impossible to model, said Donald Berry, a statistician at MD Anderson Cancer Center who was one of the modelers. Estimates of overdiagnosis ranged from 6 percent

to 50 percent of breast cancers, and he was not comfortable putting a precise figure on the problem.

Screening intervals were a different story. There, the modelers agreed, the answer was clear. Their analyses concluded that mammograms every two years give the nearly the same benefit as annual ones but confer half the risk of harms. The analysis involved national data on how many women got mammograms and how many did not, at what interval, and what happened subsequently — how many women got cancer and how many women died of cancer.

The modelers gave their paper to the panel but did not know if they would use the analysis. Dr. Berry suspected the group would say pretty much what it said in 2002, not daring to so forcefully embrace the new findings, which he said clearly indicated that there is almost no benefit to screening women in their 40s and that women can be screened every two years instead of annually.

But the task force took the new research to heart.

"I was pleasantly surprised," Dr. Berry said.

Kansas State Senate
Public Health and Welfare Committee

Testimony of
Peggy L Johnson
Public Policy Chair
Kansas Cancer Partnership

Thursday, January 21, 2010

My name is Peggy Johnson, I am Executive Director/COO for the Wichita Medical Research and Education Foundation located in Wichita. I am here today representing the Kansas Cancer Partnership for whom I serve as the Public Policy Chair.

The Kansas Cancer Partnership is a group of approximately 200 individuals from institutions, clinics, county health departments, large and small hospitals, and advocacy groups who have worked together to develop a coordinated and comprehensive plan, the Kansas Comprehensive Cancer Control and Prevention Plan. The plan addresses the burden of cancer on Kansas citizens, families, communities and the government and provides the framework to reduce cancer incidence, morbidity and mortality in the state through prevention, early detection, screening, treatment and survivorship. The Plan was completed and published in March 2005. Each of you should have received a copy of the Plan and if you would like an updated copy I would be glad to make those arrangements.

The Plan looked at the burden of cancer in Kansas and selected 6 cancer sites to focus on in the document. Those sites are prostate, breast, cervical, lung, skin, and colorectal cancer. Breast cancer is the most frequently diagnosed cancer in women in Kansas and depending on the year the first or second leading cause of cancer death in women. Because of these numbers breast cancer became a high priority for the members of the Kansas Cancer Partnership. It is well known that the earlier that breast cancer is detected the better the outcome for the woman.

According to Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System Survey Data, Kansas ranks 32nd in the nation with 74% of Kansas women over the age of 40 reporting they have had a mammogram in the previous one or two years. In other words, 31 states had a larger percentage of women receiving a mammogram over a two year period than in Kansas. This is not a glowing picture for Kansas.

The members of the Kansas Cancer Partnership have been working in their communities along with their partners Susan G Komen for the Cure®, the American Cancer Society and others to bring education and awareness for the need for a screening mammogram for women starting at the age of 40. The message also includes that each women should have a yearly conversation with her health care provider about her personal risks, the benefits of a mammogram along with adopting

healthy life styles for general good health. The Kansas Cancer Partnership does not intend to change those guidelines.

While mammography is not a perfect science, at this point it is still the best tool women and their health care professionals have to find breast cancer at its earliest stages. The Partnership believes that a change in guidelines at this point would be very detrimental and a disservice to the women of Kansas. Until research provides a better diagnostic tool than mammography, it will be the detection method of choice.

Access to quality cancer care is also an important part of the Comp Cancer Plan. Access includes the ability to have a woman's healthcare insurance continue to allow women 40 and over access to quality mammography. The worst possible scenario for women would be to allow Kansas health insurers to be able to stop covering routine mammography for women starting at the age of 40. It should be a personal decision between a woman and her healthcare provider, not the decision of the insurer.

Senator Barnett, our members thank you for this opportunity to provide you with our concerns and our outlook on a difficult subject. We do hope you will continue to be our advocate on this difficult subject.

Thank you.

SUSAN G. KOMEN FOR THE CURE®

Kansas Affiliates

Kansas State Senate
Public Health and Welfare Committee

Testimony of
Lori Maris
Executive Director
Susan G. Komen for the Cure® Greater Kansas City Affiliate

Thursday, January 21, 2010

Senator Barnett and members of the Committee, thank you for the opportunity to testify today about the new recommendations from the U.S. Preventive Services Task Force (USPSTF) concerning mammography screening. My name is Lori Maris, and I am Executive Director of the Susan G. Komen for the Cure® Greater Kansas City and representing both the Komen Greater Kansas City and Komen Mid-Kansas Affiliates. On behalf of the breast cancer patients, survivors, families, friends, researchers, scientists and advocates in the Komen family, thank you for holding this informational hearing.

Susan G Komen for the Cure® recommends no impediments to breast cancer screening until science improves, current screening recommendations should remain. **Early detection of breast cancer is a key to survival. After all, when detected early and still confined to the breast, the 5-year relative breast cancer survival rate is 98 percent — versus just 23 percent if cancer has metastasized or spread to other parts of the body.**

Komen for the Cure, the world's leading breast cancer advocacy organization, has carefully reviewed the data and new recommendations from the U.S. Preventive Services Task Force (USPSTF) concerning mammography screening. Komen for the Cure issued the following statement from Eric P. Winer, M.D., chief scientific advisor and chair of Komen's Scientific Advisory Board.

> "Susan G. Komen for the Cure wants to eliminate any impediments to regular mammography screening for women age 40 and older. While there is no question that mammograms save lives for women over 50 and women 40–49, there is enough uncertainty about the age at which mammography should begin and the frequency of screening that we would not want to see a change in policy for screening mammography at this time. Komen's current screening guidelines will not be changed.
>
> "Our real focus, however, should be on the fact that one-third of the women who qualify for screening under today's guidelines are not being screened due to lack of access, education or awareness. That issue needs focus and attention: if we can make progress with screening in vulnerable populations, we could make more progress in the fight against breast cancer.
>
> "Mammography is not perfect, but is still our best tool for early detection and successful treatment of this disease. New screening approaches and more individualized recommendations for breast cancer screening are urgently needed. Susan G. Komen for the Cure is currently funding research initiatives designed to improve screening, and we believe that it is imperative that this research move forward rapidly. Komen also provides funding for more than 1,900 education, awareness and screening programs throughout the country including here in the State of Kansas through the Komen Greater Kansas City and Komen Mid-Kansas Affiliates.

"We encourage women to be aware of their breast health, understand their risks, and continue to follow existing recommendations for routine screenings including mammography beginning at age 40."

There has been a longstanding debate over the most appropriate age to begin mammography screening and the frequency of screening examinations. As with all screening tests, the decision to perform a mammogram must include an evaluation of the benefits and the risks of the screening tool, as well as a consideration of patient preference.

The recent controversy about mammography should not suggest that there is debate about the most important issues. Most breast cancer experts agree far more than they disagree. For example, there is no debate that mammography reduces the risk of dying from breast cancer. As stated in the new USPSTF recommendations, extensive scientific evidence demonstrates that mammography reduces breast cancer mortality both among women aged 50 and older, as well as among women aged 40 to 49.

Because breast cancer false positive results are more common in women under 50, some argue for a different screening approach in women 40-49 than in those over 50. The USPSTF suggests that women 40-49 consider their individual risk of developing breast cancer before making a decision about screening mammography. They further suggest that those women at increased risk should strongly consider regular mammography screening. Women at lower risk, who wish to initiate screening in their 40s should recognize that the benefits of screening are less than in older women.

As to the timing of mammography, the USPSTF also suggests that screening every other year is likely to be as effective as annual screening, and that this approach would decrease false positives. Biennial screening is already practiced in many countries. Different organizations, based on a review of the same data, may recommend either yearly or every other year screening for women at average risk of breast cancer between the ages of 40-75. We believe that the timing of assessment is best left to a woman and her health care provider. **We call upon third party payers to fund annual mammography if a woman and her health care provider opt for this approach. We urge third party payers such as insurance companies not use these recommendations as an excuse not to pay for annual mammography.** There are no studies that directly address the role of mammography in women over the age of 75. We recommend that older women, particularly those in excellent health, discuss the role of ongoing screening with their health care provider.

One-third of all American women do not undergo regular screening. The failure of age appropriate women to undergo mammography costs lives and reflects problems with access to care and breast cancer education. We need to work as rapidly as possible to correct these deficiencies, and Susan G. Komen for the Cure continues to fund research and education designed to eliminate health care disparities.

We want to eliminate any impediments to regular mammography screening for women age 40 and older. It is our view, however, that the exact timing of assessments is less important than guaranteeing access to screening. New screening approaches and more individualized recommendations for breast cancer screening are urgently needed. Susan G. Komen for the Cure supports research initiatives designed to improve screening, and we believe that it is imperative that this research move forward rapidly.

As a breast cancer community, we must all recognize that both breast cancer screening and breast cancer treatment are moving targets. As treatment continues to evolve in the years ahead, these changes may have an impact on the optimal approaches to screening as well.

In the meantime, honest differences in opinion can and do exist, and such differences represent attempts on the part of individuals and/or organizations to provide the best possible care to women of all ages and to minimize mortality and suffering from breast cancer. We encourage women with unresolved questions about breast cancer screening to engage in discussion with their health care providers.

In Kansas, the USPSTF recommendations created confusion and frustration with breast cancer survivors age 40-49. They were outraged at these recommendations. Kansan breast cancer survivors in their 40s felt like their lives did not matter. To Susan G. Komen for the Cure, all women's lives matter to us. Komen will not change our screening recommendations and we will continue to fund local programs that provide screening to women beginning at the age of 40. These recommended guidelines are based on the "numbers" only X% of lives saved. Can we really put a value on a human life? What about quality of human life? Human life is invaluable and quality of life has significant value not just survival. What we has not been focused on around these guidelines are the women who did not die but fought this disease in their 40s and are grateful to be alive today. It is well established that if we discontinue mammography for women in their 40's, the cancers eventually detected will be larger, more likely need more aggressive surgery, more likely need chemotherapy and more likely lead to other significant socio-economic concerns.

We are grateful that Debbie Schulte is here to share her story, but the reality is that we could have this room full of survivors, family, and friends who have similar stories.

About Susan G. Komen for the Cure® and the Komen Kansas Affiliates

Nancy G. Brinker promised her dying sister, Susan G. Komen, she would do everything in her power to end breast cancer forever. In 1982, that promise became Susan G. Komen for the Cure and launched the global breast cancer movement. Today, Komen for the Cure is the world's largest grassroots network of breast cancer survivors and activists fighting to save lives, empower people, ensure quality care for all and energize science to find the cures. Thanks to events like the Komen Race for the Cure®, we have invested nearly $1.5 billion to fulfill our promise, becoming the largest source of nonprofit funds dedicated to the fight against breast cancer in the world.

In Kansas, the Komen Greater Kansas City and Komen Mid-Kansas Affiliates have granted over $6.1 million into Kansas communities to cover local breast health education and breast cancer screening and treatment programs. This includes over $2 million in grant funds to the State of Kansas' Early Detection Works (free breast and cervical cancer screening program funded through the Center for Disease Control) that funds mammography to Kansas women age 40-49. Komen Kansas Affiliates have paid for more than 26,000 mammograms for women under the age of 50. If the EDW program had additional funds they would be best used to provide screening from women under 50.

Another community grant funds the Flint Hills Community Health Center in Emporia, Kansas. It is a federally-funded health center with a service area including Lyon, Chase, Greenwood, and Osage counties. FHCHC is both a community health center (Primary Care Clinic) and public health department for Lyon County. It has operated as a Federally Qualified Health Center since 1997; therefore is uniquely positioned in the community to provided breast health services to all women in their service area. FHCHC served 8,836 patients in 2007. Of those patients, 4,249 were uninsured. Of the population served, 33% are 18 and under, 46% are ages 19-44, 14% are ages 45-64, and 7% are 65 and older. FHCHC has been a provider for Early Detection Works since 1998. FHCHC has had 22 abnormal mammograms in women under the age of 50 in 2009. 3 of these were diagnosed with breast cancer in which one woman died, one woman had a lumpectomy, and one woman had a lumpectomy and chemo. So from the 22 abnormal mammograms, 14% were diagnosed with breast cancer, an additional woman had surgery and is pending the results. To Susan for the Cure, these women matter.

For more information about Susan G. Komen for the Cure in Kansas, visit www.komenkansascity.org or www.komenmidks.org.

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Review and Impact of New Federal Guidelines for Mammography Screening

Testimony before the Senate Public Health & Welfare
January 21, 2010

Dr. Andrew Allison, KHPA Acting Executive Director

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U.S. Preventive Services Task Force Recommendations
December 4, 2009

- **Screening for Breast Cancer**
  - Biennial screening mammography for women aged 50 to 74 years
  - "The decision to start regular, biennial screening mammography before the age of 50 years should be an individual one and take patient context into account, including the patient's values regarding specific benefits and harms."
  - Current evidence is insufficient to assess the additional benefits and harms of screening mammography in women 75 years or older
  - Recommends against teaching breast self-examination
  - Current evidence is insufficient to assess the additional benefits and harms of screening mammography in women 40 to 49 years
  - Current evidence is insufficient to assess the additional benefits and harms of either digital mammography or MRI instead of film mammography as screening modalities for breast cancer

2

2002 U.S. Preventive Services Task Force Guidelines

- Screening mammogram every one to two years for all women starting at age 40

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Responses of Professional Organizations

- **American College of Radiology** – Annual screening mammogram for women 40 and older
- **American Cancer Society** – Annual screening mammogram and clinical breast exam for women 40 and older
- **American College of Obstetricians and Gynecologists** – Annual or biennial screening mammogram for women 40 to 49. Annual screening mammogram for women 50 and older
- **National Cancer Institute** – Annual or biennial screening mammogram for women 40 and older

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Lessons from Kansas Medicaid Transformation Grant

- Kansans with disabilities, covered by Medicaid, experienced increased cancer screenings when targeted case managers were provided education and an electronic tool
- The gains, which were slight, required concerted resources for both the education and to learn and use the tool

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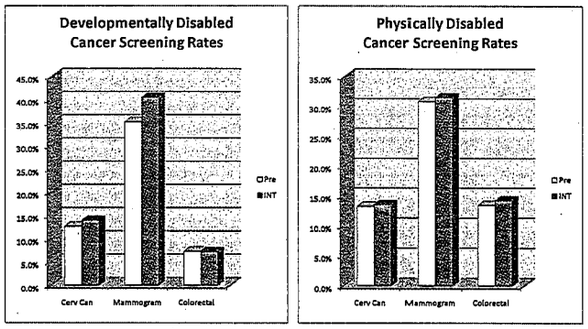
Health Promotion for Kansans with Disabilities – Medicaid Transformation Grant



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Kansas Breast Cancer Survivor – Debbie Schulte, Diagnosed at Age 41

In November, 2001, my OBGYN suggested that I should have scheduled a mammogram the previous year as I was now 41 so I needed another mammogram soon. My first mammogram was completed 5 years previously at age 36 because my OBGYN strongly believed in getting the base line at age 35, then begin yearly mammograms starting at age 40.

In December, 2001 I got the second mammogram and after the first pictures, they asked me to wait, then come back in for more pictures. I was never worried about a poor outcome because I have a positive attitude and no one in my family had ever had breast cancer or any cancer-plus I felt fine. I got a call back just before Christmas that they thought I needed a fine needle biopsy which was set up the first week of 2002. The radiologist said only 1 in 8 biopsies come out as cancer--so again with my positive attitude, I was not worried. He wanted to set a meeting for the results, but I said no please call me...so on January 11, 2002-----4 months after 9/11----he called to tell me he was sorry and I heard nothing else. After getting myself together, my sister and I called him back for the facts.

He said it was a small, .9 millimeters, grade 3, stage 1, very aggressive fast growing infiltrating ductal carcinoma. I was ER and Her2 positive. This was foreign language to me that I learned about fast. I received a lumpectomy, tamoxifin and radiation which was prescribed at that time. Due to the aggressive nature of Her2 positive breast cancer and the location of my tumor near my chest wall, I feel certain that I would not have felt this tumor until it had spread to locations that may have been fatal. To this day, I feel that I am alive because Dr. Tom Sullivan believed in and recommended the mammogram at age 41. I thank him and mammography for that decision.....that saved my life!

My name is Deba Brant and I am 51 years old. Ten years ago when I was 41, cancer was discovered in my left breast by means of a mammogram. At that time, my children were ages 3, 7, and 9.

I had a mammogram in my 30's that turned out negative. I skipped the usual "40 year old" mammogram. At 41 I thought I felt a lump in my right breast and went in for a mammogram. The radiologist told me up front he thought it was cancer, even though it appeared to look like calcium deposits in the ducts. He suggested I see a surgeon as soon as possible.

I saw the surgeon and he immediately scheduled a partial mastectomy—it was the only way to do a biopsy. Three days after surgery, he called me at home to tell me I had extensive high grade in situ ductal carcinoma and needed a mastectomy right away. He said it was an aggressive form of breast cancer and would spread fast. Five days later, I had a left modified radical mastectomy. It was the Thursday before Easter and I was afraid I wouldn't live to see my kids hunt Easter Eggs. Because of the mammogram and wonderful doctors, I survived the next 10 years to see two of my children graduate from high school and attend college. My youngest will graduate from middle school this year.

Because the cancer was caught early and had not spread,
I was told I did not require further treatment. I did not have to go through chemotherapy, which many of my friends have had to endure. I did not undergo radiation. I have had yearly mammograms and my life has gone forward.

As a survivor, I have watched my children grow up and celebrated 20 plus years of marriage with my husband. I volunteer for the American Cancer Society and help other women deal with breast cancer. I have had so many women tell me a mammogram saved their lives. They have been given a gift of life, and have lived to see their children and grandchildren grow.

I watched a friend die of breast cancer last summer. She lived for 9 years with cancer… and with dignity. She was 50. Now, her husband and six children must somehow go on without her.

Mammograms do not find all cancers. But with continued research and technological advances, we can catch them earlier. Mammograms are vital to that effort. No one wants to have to tell a child, "Maybe if your mother had had a mammogram, she would be alive today to see you dance, to see you graduate, to see her grandchildren… But she didn't, so …. sorry."

Please continue to support and encourage early mammography. Give all women the gift I have, the gift of life.
Thank you for taking the time to listen to me today.

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Statement of Brad Smoot, Legislative Counsel
Blue Cross Blue Shield of Kansas
And
Blue Cross Blue Shield of Kansas City
Senate Public Health & Welfare Committee
January 21, 2010

Mr. Chairman and Members:

I appear today on behalf of Blue Cross Blue Shield of Kansas and Blue Cross Blue Shield of Kansas City. Both are independent licensees of the BCBS Association. The Kansas plan is a mutual insurance company, owned by its members, operating in 103 Kansas counties. The Kansas City area plan covers more than 30 Missouri counties and the counties of Johnson and Wyandotte in Kansas. The Kansas City plan is a non-profit hospital and medical service corporation. Together, these plans provide more than 1 million of your fellow Kansans with quality health insurance coverage and contract with thousands of Kansas doctors, hospitals and other health care providers.

Per your request, Mr. Chairman, I have made inquiry of my clients and others in the health insurance industry in Kansas regarding what changes, if any, might be made to mammogram coverage as a result of the new federal breast cancer screening recommendations. BCBS of Kansas indicates that that it will continue coverage and reimbursement for mammograms as it always has. That means we will continue the policy of paying for mammograms for all women customers when ordered by a physician and allowing self referrals for women over 40. Likewise, BCBS of Kansas City is not changing their long standing practice of paying for annual mammograms for women 40 and over. Despite the new guidelines, the Blue plans continue to believe that the decision to have a mammogram is better left to the judgment of the patient and physician.

I have also provided to the Committee a copy of the statement of the American Health Insurance Plans indicating that its member companies plan no changes in coverage for mammography services as a result of the new breast cancer screening guidelines. In addition, a survey of the membership of the Kansas Association of Health Plans reveals a similar conclusion to continue existing coverage, benefits and reimbursement practices for breast cancer screenings. A copy of the letter from the KAHP is also provided to the committee.

Thank you for this opportunity to comment on this topic of great public interest.

My name is Tina Herold and I am from Overland Park. I found a lump in the shower when I was 34 years old. Breast cancer was NOT supposed to happen to me. I do not drink or smoke and I have always been a healthy weight. I had no known risk factors for breast cancer or any family history of any kind of cancer.

I touched this small lump on my chest and I knew something was wrong. I called my family practice doctor and went in the next day. She said it was most likely a cyst and we should wait 30 days. I didn't like that answer so I called a doctor friend of mine and asked if she would do an exam. She said it was probably a cyst, we see it all of the time in young women. My friend saw the concern on my face and said, "Would you like to see a breast surgeon?" "Is that who you see?" I asked. I had been healthy my whole life. We went to see the breast surgeon the next day and she also thought the lump was a cyst or an injury. "What can we do to be sure?" I asked. She reassured me that I would be the least likely person in the room to have anything wrong. I replied, "I really want to do something." I am practically begging at this point for a mammogram. The surgeon finally agreed to do a mammogram and a sonogram. There it was a dark mass with a shadow below it. She asked how long it had been there and I didn't know. She said, "We will have to biopsy this." I asked "When?" She said "Now."

The surgeon didn't give good or bad news over the phone so I had to return the next day. The next day I found out that I indeed had breast cancer.

What if I would not have been persistent? What if I wouldn't have had the screenings? I would be dead!

My cancer was extremely aggressive. I didn't realize the severity of my diagnosis until my oncologist said, "Wow, your tumor is really aggressive." I asked if she had treated other women with tumors this aggressive and she said a couple. I asked if they were alive and she said no.

Early screening, chemotherapy, and a new drug called Herceptin saved my life. I have 2 young daughters who were 3 and 5 when I was diagnosed with cancer. I couldn't imagine dying and leaving them without a mother. This was my fear and what every mother fears.

I am now a 3-year breast cancer survivor and early detection and screening saved my life. Last year my youngest daughter started kindergarten and while all of the other mothers were in the hall crying, I was waving goodbye and smiling. Smiling because I was grateful to be alive to see this day.

I could easily be your wife, daughter, sister, or friend. I am a normal woman that got breast cancer. Anyone that knows me well would tell you that you could line up 10 women and I would be the very last one chosen to have cancer. Thanks to early detection, I am alive today and thriving. I'm helping women every week cope with cancer diagnosis and treatment through my wig boutique, "Wigged Out" (www.imwiggedout.com). Oh, and my 2 little girls have a mom!

Please remember me and know that breast cancer does not discriminate. It could be a part of your family someday.

Kansas Association of Health Plans

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January 21, 2010

Federal Mammography Guidelines
Written Testimony before the Senate Public Health Committee
Marlee Carpenter, Executive Director

Chairman Barnett and members of the Committee;

I am Marlee Carpenter, Executive Director of the Kansas Association of Health Plans (KAHP). The KAHP is a nonprofit association dedicated to providing the public information on managed care health plans. Members of the KAHP are Kansas licensed health maintenance organizations, preferred provider organizations and other entities that are associated with managed care. KAHP members serve the majority of Kansans enrolled in private health insurance. KAHP members also serve the Kansans enrolled in HealthWave and Medicaid managed care. We appreciate the opportunity to provide comments to this committee.

In November, the US Preventative Services Task Force passed new mammography guidelines. We have surveyed KAHP member companies and none of the companies have changed any of their policies in regards to mammography screenings. They will continue to provide coverage for women both over and under the age of 50 years old, when prescribed by a physician.

Please let me know if you have any questions or comments.

Senate Public Health and Welfare
Date: 01/21/10
Attachment: 10

America's Health Insurance Plans

AHIP

Statement Regarding November 2009 USPSTF Breast Cancer Screening Recommendations

In the time period following the release of the new mammography screening recommendations by the U.S. Preventive Services Task Force, America's Health Insurance Plans has heard from member insurance plans that they will continue to provide coverage for mammograms for women over 50 and women under 50 when prescribed by a clinician.

America's Health Insurance Plans (AHIP) is a national trade association representing approximately 1,300 health insurance plans that provide coverage to more than 200 million Americans. AHIP members offer a broad range of health insurance products in the commercial marketplace including individual, group, and Medicare supplemental policies and also have demonstrated a strong commitment to participation in public programs.

January 19, 2010

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