Breast Cancer Screening Final Recommendation Statement
Frequently Asked Questions

About the 2016 Final Recommendations

What are the Task Force's breast cancer screening recommendations?

With these final recommendations, the Task Force recognizes that mammography is an important tool in the fight against breast cancer. Our systematic review of the science indicates that the value of mammography screening increases with age, and the Task Force recommends that women ages 50 to 74 should get a mammogram every 2 years.

For women in their 40s, the Task Force also found that mammography screening every 2 years can reduce deaths from breast cancer. The chance of benefiting from screening is less than for older women, and the potential harms are proportionally greater. For this reason, the Task Force recommends women ages 40 to 49 make their own decision whether and when to get a mammogram, in consultation with their doctors. This decision should be based on their health history, preferences, and how they value the potential benefits and harms of screening.

For women age 75 and older, the evidence of the overall benefit of mammography screening is unclear, and the Task Force is unable to make a recommendation for or against screening. The evidence on additional screening beyond mammograms for women with dense breasts is also unclear, and the Task Force is unable to make a recommendation for or against additional screening for these women. Older women and women with dense breasts should talk with their doctors to determine what is best for their individual health needs. There is another area which the Task Force reviewed but did not yield enough evidence to make a recommendation: digital breast tomosynthesis (3D mammography). The evidence of this service's overall benefit remains unclear. The Task Force is calling for more research in all three of these areas.

Ultimately, the Task Force hopes these final recommendations will empower women with the best scientific data about the potential benefits and harms associated with breast cancer screening, so they can make informed decisions with their doctor.

What did the Task Force find about women age 75 and older?

The Task Force found that there is not enough evidence to determine the balance of benefits and harms of screening women in this age group. As a result, the Task Force is unable to make a recommendation for or against screening and has issued an I statement**.** The Task Force suggests that older women talk with their doctor about the potential benefits and harms of mammography screening given their personal health history and make a decision based on their own values and preferences. The Task Force is calling for more research on screening in this age group so that older women can be better informed about the potential benefits and harms of mammograms that are unique to them.

Does the Task Force recommend 3D mammography?

While 3D mammography (or digital breast tomosynthesis) is a promising new technology for the detection of breast cancer, the Task Force did not find enough evidence to determine whether it will result in better overall health outcomes for women. Therefore, the Task Force cannot make a recommendation for or against 3D mammography screening, and has issued an I statement. The Task Force strongly encourages additional research in this area.

How do women know if they have dense breasts and what does the Task Force recommend for these women?
Having dense breasts is very common. It is a risk factor for developing breast cancer, and it also reduces the ability of a mammogram to find and accurately identify breast cancer. Breast density is determined by the radiologist examining a woman's mammogram. A woman has increased breast density when there is more breast and connective tissue than fat.

The evidence on how additional screening with an ultrasound, MRI, or 3D mammography may or may not help women with dense breasts is unclear. Therefore, the Task Force cannot make a recommendation for or against additional screening, and is issuing an I statement.

We know that this important issue impacts many women. The Task Force hopes that in the future, there will be more evidence available to make a more definitive recommendation. Women with dense breasts should talk with their doctor to determine what is best for their individual health needs.

Did the Task Force consider the public comments that it received at the draft stage?
The Task Force carefully reviewed each and every comment we received, and made updates to the final recommendation statement as needed, based on the comments. For example, the Task Force updated or clarified certain terminology, such as "digital breast tomosynthesis," clarified the difference between misdiagnosis and overdiagnosis, and clarified that the Task Force reviewed contemporary observational data. There is also additional context around the description of the potential risks of radiation exposure due to mammography screening.

We also provided additional context about the age to start screening and the screening interval in response to new evidence published with the American Cancer Society's updated breast cancer screening guidelines.

The final recommendation statement includes a section that provides an overview of the public comments received and our response to them.

What's the difference between this recommendation and the 2009 recommendation?
For the first time, the Task Force looked at the effectiveness of digital breast tomosynthesis (3D mammography) as a way to screen for breast cancer. While 3D mammography is an emerging technology, there is very little evidence available that examines the ultimate effectiveness of this newer screening method (e.g., whether it reduces deaths, if there are harms of treatment from breast cancer, or improves quality of life), and therefore, the Task Force was unable to make a recommendation for or against its use. This is also the first time that the Task Force looked at the effectiveness of additional screening for women who have dense breasts but an otherwise negative mammogram. The evidence on how additional screening with an ultrasound, MRI, or 3D mammography may or may not help women with dense breasts is unclear. Therefore, the Task Force cannot make a recommendation for or against additional screening. These are all important areas for future research.

In 2015, the Task Force reviewed studies of analog (film) mammography as well as more recent observational evidence about the efficacy of digital mammography, and the modeling data also looked at digital mammography. The Task Force is using all available evidence, including models, to help guide women and their screening decisions.

Insurance Coverage

What does this final recommendation mean for insurance coverage?
The Task Force does not make recommendations for or against insurance coverage and its final recommendations do not impact insurance coverage for breast cancer screening. Through a unique provision of federal law, legislators guaranteed that women in their 40s, as well as older women, who have private insurance will not have a co-pay for their screening mammogram. Coverage of mammography for Medicare beneficiaries was established by another statute and is not bound by Task Force recommendations.

How are the Task Force's final recommendations tied to insurance coverage in general?
Congress used the recommendations of several organizations, including the Task Force, to create a base level of coverage for preventive services under the Affordable Care Act. To learn more about the clinical preventive service benefits of the Affordable Care Act, visit: www.healthcare.gov/prevention.

Does an A or B recommendation mean that the Task Force recommends insurance coverage for a service?
An A or a B grade from the Task Force is not a recommendation for insurance coverage, as the Task Force does not make recommendations for or against insurance coverage. An A or B grade recommendation means that the Task Force found the benefits for a service outweigh the harms, and that the Task Force recommends that primary care providers consider offering that preventive service to their patients. While the Task Force's A and B recommendations on preventive services such as screenings, counseling services, and preventive medications are sometimes used by insurance companies and policymakers when making coverage decisions, this is not factored into the development of the Task Force's science-based recommendations. It's important to note that the Affordable Care Act also states that grades other than an A or B, including the Task Force's C and D grades and I statements, cannot be used by insurance companies or others to deny coverage. The linkage between its recommendations and the coverage mandate sets a minimum standard for coverage of preventive services—that is, as a "floor" and not a "ceiling."

How to Interpret Specific Recommendations

Are these recommendations for all women?
No. The Task Force's recommendations apply to women age 40 and older who do not show any signs or symptoms of breast cancer, have not been previously diagnosed with breast cancer or a high-risk breast lesion like DCIS, and who are not at high risk for breast cancer (meaning they do not have a known genetic mutation or a history of chest radiation at a young age). Women at high risk of breast cancer should consult their doctor for individualized recommendations regarding screening.

When does mammography provide women with the greatest benefit?
The evidence continues to show that the benefit of mammography screening increases with age, with women ages 50 to 74 benefiting most. The benefit of mammography is that it reduces a woman's risk of dying from breast cancer. The Task Force found that women get the best balance of benefit to harm when screening is done every 2 years.

What is the Task Force proposing women in their 40s do?
The Task Force recognizes that mammograms can help women in their 40s reduce their risk of dying from breast cancer, and recommends that the decision to start mammography screening before age 50 be an individual one. Because the risk of developing breast cancer is lower for women in their 40s, the likelihood of benefiting from mammography is smaller, and the risk of harm is proportionally greater than in women ages 50 to 74.

The Task Force also recommends that women in their 40s have a discussion with their doctor about the potential benefits and harms of screening every 2 years in order to make an informed choice. Women in their 40s who have a mother, sister, or daughter with breast cancer are at increased risk of developing breast cancer, and may benefit more than average-risk women by beginning screening before age 50.

What should women in their 40s with a family history of breast cancer do?
Women who have a mother, sister, or daughter with breast cancer are at increased risk for breast cancer and may benefit more than average-risk women by beginning screening in their 40s. The Task Force recommends that they talk with their doctor and determine whether screening is right for them.

Why is the Task Force recommending screening every 2 years instead of annually?
The Task Force reviewed the strongest available science on the benefits and harms of mammography screening, as well as commissioned modeling studies, to look specifically at the benefits and harms of screening every 2 years versus every year. For breast cancer screening, the new evidence the Task Force reviewed continues to show that women get the best balance of benefit to harm when screening is done every 2 years.

Is a C grade a recommendation against screening?
No. A C grade is still a positive recommendation that recognizes small net benefit; mammograms can help women in their 40s reduce their risk of dying from breast cancer.

Because the risk of developing breast cancer is lower for women in their 40s, the likelihood of benefiting from mammography is smaller, and the risk of harm is proportionally greater than in women ages 50 to 74. As a result, the Task Force recommends that the decision to initiate screening at ages 40 to 49 years be an individual one based on a woman's preferences and her personal and family health history, and issued a C recommendation.

Women in their 40s who have a mother, sister, or daughter with breast cancer are at increased risk of developing breast cancer, and may benefit more than average-risk women by beginning screening before age 50.

Guidelines of Others

How do the Task Force's final recommendations converge with recent guidelines from others?
The Task Force, the American Cancer Society, and many others have affirmed that mammography is an important tool to reduce breast cancer mortality and that the benefits of mammography increase with age. Support of a personal, informed choice for women in their early 40s is shared by the Task Force, the American Cancer Society, the American College of Physicians, the American Academy of Family Physicians, and the Canadian Task Force on Preventive Health Care.

Why did the Task Force and the American Cancer Society look at similar evidence but get different results?
The Task Force can't speak to how the American Cancer Society interpreted the science for its 2015 guidelines. Experts can interpret the evidence on the benefits and harms of screening differently. This is most likely, however, when the evidence is sparse or inconsistent, or when the level of benefit is small.

That said, there are many similarities between the American Cancer Society's guidelines and the Task Force's final recommendations. The Task Force agrees that women need to be empowered with the best science about the potential benefits and harms of mammography, so that they can make the best possible decisions for themselves, with their doctor. The American Cancer Society and the Task Force also both recognize that mammography can be an effective tool in reducing deaths from breast cancer; that women benefit from regular mammography screening in their 50s, 60s, and early 70s; and that mammography should be a personal, informed choice for women in their early 40s.

Recognizing that there are modest differences, the Task Force is hopeful that its recommendations and the American Cancer Society's guidelines will facilitate dialogue between women and their doctors, and lead to additional research into the potential benefits and harms of mammography screening.

More About the Benefits and Harms of Screening

What's the harm of getting a mammogram? Isn't finding cancer early, when it is more treatable, always a good thing?
While there are benefits of mammography screening, it is also important to be aware of the potential harms of this type of screening. The most serious harm is overdiagnosis. Overdiagnosis is when a woman is diagnosed with, and receives treatment for, breast cancer that would not become a threat during her lifetime.

The most common potential harm of mammography screening is a false-positive test result. A false positive is a test result suggesting that a woman has breast cancer when she does not. False-positive results often lead to additional followup procedures to confirm a true diagnosis, some of which are invasive (such as breast biopsy). While some women don't mind the anxiety that often accompanies a false-positive mammogram, others consider this to be a harm. False positives are more common in women younger than 50, who are less likely to have breast cancer.

Why is overdiagnosis a serious harm?
Overdiagnosis can lead to several potentially harmful consequences. For example, it unnecessarily labels a woman as someone with cancer, which can affect her perceptions of her health; her social, family, and work relationships and functioning; and her general quality of life.

Also, because doctors cannot reliably distinguish between breast cancers that will progress to cause illness or death from those that will not, overdiagnosis almost always leads to treatment. Treatment for breast cancer can include surgery, radiation, and chemotherapy. These treatments will not benefit women whose cancer never would have affected her during her lifetime, and can have negative short- and long-term effects.

How can women get the most benefit out of mammography screening?
The evidence continues to show that women receive the best balance of benefits and harms from mammography screening if they are screened every 2 years between the ages of 50 and 74.

Women in their 40s should talk to their doctor about their individual risk of breast cancer and their personal values related to screening. Women may value the possibility of avoiding a breast cancer death, despite how infrequently it occurs in this age range, more than the potential harms of being unnecessarily overdiagnosed or overtreated. These women may choose to begin screening every 2 years before age 50. Additionally, women with a mother, sister, or daughter with breast cancer may benefit more from beginning screening before age 50.

Family History and Other Risks

How do I know if I am at high risk for breast cancer?
Women at high risk for breast cancer are not included in these recommendations and should consult their doctor for individualized recommendations regarding screening. This includes women who have been previously diagnosed with breast cancer or a high-risk breast lesion like DCIS, or who have a history of chest radiation at a young age.

This also includes women who have a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (*BRCA1* or *BRCA2*). The Task Force has a separate recommendation on *BRCA1* and *BRCA2* counseling and genetic testing, available here.

My mother had breast cancer and I'm worried about my health, what should I do?
Women who have a mother, sister, or daughter with breast cancer are at an increased risk of developing breast cancer themselves. They may benefit more than women without a family history from starting mammography screening before age 50. The Task Force recommends that women younger than age 50 who are concerned about their risk talk to their doctor about the benefits and harms of screening and make a decision that factors in their family history, as well as their values and preferences.