EUROPEAN COMMISSION
JOINT RESEARCH CENTRE

Directorate F - Health, Consumers & Reference Materials (Ispra)
Health in Society

European Commission Initiative on Breast Cancer (ECIBC): European guidelines on breast cancer screening and diagnosis

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QUESTION

Should organised mammography screening vs. no mammography screening be used for early detection of breast cancer in women aged 40 to 44?

POPULATION:	Women aged 40 to 44
INTERVENTION:	organised mammography screening
COMPARISON:	no mammography screening
MAIN OUTCOMES:	Breast cancer mortality (short case accrual); Breast cancer mortality (longest case accrual available); Other cause mortality; Stage IIA breast cancer or higher; Stage III+ breast cancer or tumour size ≥40 mm; Rate of mastectomies; Provision of chemotherapy; Overdiagnosis (long case accrual); Quality of life (inferred from psychological effects); False-positive related adverse effects (psychological distress); and False-positive related adverse effects (biopsies and surgeries)
SETTING:	European Union
PERSPECTIVE:	Population (National Health System)
BACKGROUND:	Although mammography screening has both potential benefits and harms, many countries have organised programmes for women aged 50 or older. However, there continues to be debate about recommendations for mammography screening (Jorgensen 2009, Arie 2014) particularly for women aged 40 to 49 (Petitti 2010).
CONFLICT OF INTEREST:	Management of Conflicts of Interest (CoI): CoIs for all Guidelines Development Group (GDG) members were assessed and managed by the Joint Research Centre (JRC) following an established procedure in line with European Commission rules. GDG member participation in the development of the recommendations was restricted, according to CoI disclosure. Consequently, for this particular question, the following GDG members were recused from voting: Roberto d'Amico, Jan Danes, Axel Gräwingholt and Ruben van Engen. More information

ASSESSMENT

Problem

Is the problem a priority?

JUDGEMENT	RESEARCH EVIDENCE	ADDITIONAL CONSIDERATIONS
○ No ○ Probably no ○ Probably yes ● Yes ○ Varies ○ Don't know	Breast cancer is the second most common cancer in the world and, by far, the most frequent cancer among women with an estimated 1.67 million new cancer cases diagnosed in 2012—accounting for 25% of all cancers (GLOBOCAN 2012). Breast cancer ranks as the fifth leading cause of cancer death worldwide and the second leading cause of cancer-related death in developed regions (GLOBOCAN 2012). In the European Union, 367 090 women were diagnosed with breast cancer and 92 000 women died from the disease in 2012 (Ferlay 2013). Breast cancer ranks fourth among the top five cancers with the highest disease burden (Tsilidis 2016). Annual incidence of breast cancer in the EU, in women aged 40 to 44 is 1.2 per 1 000 and mortality is 0.1 per 1 000 (GLOBOCAN 2012)	The GDG prioritised this question for the ECIBC.

Desirable Effects

How substantial are the desirable anticipated effects?

JUDGEMENT	RESEARCH EVIDENCE	ADDITIONAL CONSIDERATIONS
○ Trivial ● Small ○ Moderate ○ Large ○ Varies ○ Don't know		These studies used an 'intention-to-treat' analysis thus, a per protocol approach would lead to larger absolute effects. GDG members mentioned that modelling studies describing quality

Outcomes	№ of participants	Certainty of the evidence	Relative effect	Anticipated absolute effects* (95% CI)

	(studies) Follow up	(GRADE)	(95% CI)	Risk with no mammography screening	Risk difference with organised mammography screening
Breast cancer mortality (short case accrual) for women aged 40 to 44 follow up: mean 16.8 years	348478 (8 RCTs)[1,2,3,4,5,6,7,a]	⨁⨁⨁◯ MODERATE[b,c,d]	**RR 0.88** (0.76 to 1.02)	Low	
				400 per 100.000[e]	**48 fewer per 100.000** (96 fewer to 8 more)
				High	
				700 per 100.000[f]	**84 fewer per 100.000** (168 fewer to 14 more)
Breast cancer mortality (longest case accrual available) for women for women aged 40 to 44 follow up: mean 15.2 years	348478 (8 RCTs)[1,10,5,7,8,9,a]	⨁⨁⨁◯ MODERATE[b,c,d]	**RR 0.92** (0.83 to 1.02)	Low	
				480 per 100.000[e]	**38 fewer per 100.000** (82 fewer to 10 more)
Other cause mortality follow up: mean 10.8 years	290417 (6 RCTs)[10,11,12,13,14,a]	⨁◯◯◯ VERY LOW[b,c,d,g]	**RR 1.04** (0.95 to 1.15)	Low	
				2.500 per 100.000[e]	**100 more per 100.000** (125 fewer to 375 more)
Breast cancer stage IIA or higher follow up: mean 13.6 years[h]	300307 (5 RCTs)[12,15,16,4,7,8,9,a]	⨁◯◯◯ VERY LOW[d,i,j]	**RR 0.88** (0.78 to 0.99)	Low	
				380 per 100.000[e]	**46 fewer per 100.000** (84 fewer to 4 fewer)
Breast cancer	274212	⨁⨁◯◯	**RR 0.98**	Low	

and duration of 'life gained' should be considered.

Long case accrual may dilute the effect of the intervention as for some trials it will include cases diagnosed after closure of the trial when both arms are receiving the same intervention. Therefore, we performed a sensitivity analysis including only studies that reported long case accrual estimates and we observed a small although not significant diluting effect (RR 0.92; 95% CI 0.83 to 1.02).

GDG members agreed that the desirable health effects differ by age group and the age at first screening. For women in the 40 to 44 age group, the GDG agreed these women would have smaller anticipated beneficial health effects compared to older age groups.

Observational data provided supplementary evidence supporting the RCT evidence (see evidence profile).

Test accuracy is poorer in younger women, largely due to mammographic breast density. Digital mammography, which was not in use at the time of most of the studies reviewed here, may result in greater test accuracy in women aged 40 to 44.

In the Sweden Mammography Screening of Young Women (SCRY) cohort, which compared breast cancer mortality between women invited and not invited to screening; RRs of 0.82 (95% CI, 0.67-1.00) and 0.63(95% CI, 0.54-0.75) for the age groups of 40 to 44 and 45 to 49 years were respectively reported. The weighted RR for the 40 to 49 years did not differ from the unweighted estimate of 0.71 (95% CI, 0.62-0.80).

stage III+ or tumour size ≥40 mm follow up: mean 13.5 years[h]	(4 RCTs)[12,15,16,7,8,a]	LOW[b,c,d]	(0.74 to 1.29)	90 per 100.000[e]	**2 fewer per 100.000** (23 fewer to 26 more)
Rate of mastectomies	249550 (5 RCTs)[10,17,18,19,20,a]	⨁⨁◯◯ LOW[b,c,k]	**RR 1.20** (1.11 to 1.30)[l]	Low	
				900 per 100.000[e]	**180 more per 100.000** (99 more to 270 more)
Provision of chemotherapy	99454 (2 RCTs)[10,19,20,a]	⨁◯◯◯ VERY LOW[c,d,k,m,n]	**RR 0.86** (0.53 to 1.40)[l]	Low	
				400 per 100.000[e]	**56 fewer per 100.000** (188 fewer to 160 more)
Overdiagnosis (population perspective)	50430 (1 RCT)[12,a]	⨁⨁⨁◯ MODERATE[c]	-	12.4% (95% CI 9.9%-14.9%)[o]	
Overdiagnosis (woman perspective)	50430 (1 RCT)[12,a]	⨁⨁⨁◯ MODERATE[c]	-	22.7% (95% CI 18.4%-27.0%) [p]	
Quality of life (inferred from psychological effects)[h]	(54 observational studies)[21]	⨁⨁◯◯ LOW[q]	-	One systematic review with 54 studies included -no meta-analysis - (Brett 2005). Mammographic screening does not appear to create anxiety in women who are given a clear result after a mammogram and subsequently placed on routine recall. Mixed results about anxiety in women recalled for further testing: several studies reported transient or long term (from 6 months to 1 year after recall) anxiety, while other studies reported no differences in anxiety levels. The nature and extent of further testing seem to determine the extent of anxiety.	
False-positive related adverse effects (psychological	(24 observational studies)[22,23]	⨁⨁◯◯ LOW	-	Two systematic reviews. One review included 17 studies and found that women who received a false-positive mammogram result had greater distress, fear, anxiety, and worry about breast	

	distress)[h]				cancer (Saltz 2010). The second review included 7 studies, the psychological distress using diseases-specific mesuarements, in women (age not specified) with a false-positive mammogram at 35 months after the last assessment was ; for women that needed further mammography RR=1.28 (95%CI 0.82-2.00); for women placed in early recall the RR=1.82 (95%CI 1.22-2.72); for women that needed a fine needle puncture aspiration RR=1.80 (95%CI 1.17-2.77); for women that needed a biopsy RR=2.07 (95%CI 1.22-3.52); no differences in generic measures of general anxiety and depression were observed at 6 weeks after assessment and 3 months after screening Bond (2013).	
	False-positive related adverse effects (biopsies and surgeries)[h]	(4 observational studies)[24]	⨁◯◯◯ VERY LOW[r]	-	Results from literature review (4 studies, 390 000 women aged 50 to 69) showed an overall false-positive screening result of 19.7% in women undergoing 10 biennial screening tests (pooled risk estimate based on 3 studies; range 8 - 21%). This was related to a 2.9% pooled cumulative risk of an invasive procedure with benign outcome (range 1.8% to 6.3%; based on 2 studies) and 0.9% risk of undergoing surgical intervention with benign outcome (based on 1 study) (Hofvind 2012). Cross-sectional data from the EUNICE Project (women aged 50 to 69): 17 countries, 20 screening programmes, 1.7 million initial screens, 5.9 million subsequent screens; showed that 2.2% and 1.1% of all screening examinations resulted in needle biopsy among women without breast cancer (initial and subsequent screens, respectively). In addition, 0.19% and 0.07% of all screening examinations resulted in surgical interventions among women without breast cancer (initial and subsequent screens.	

				respectively).

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a. The reference listed in the evidence profiles correspond to the specific publications used

	to extract crude data for estimating the outcomes´ effect sizes. Additional reference describing the characteristics of the included studies can be found in the document´s main text of this systematic review. b. Some studies did use methods that would not be accepted for random allocation today. One study had non-blinded assessment of 'cause of death'. The GDG felt that the CNBSS-1 possibly had issues with achieving prognostic balance. The GDG felt that lack of allocation concealment in this set of studies did not lead to high risk of bias. Given the lack of single trials driving the overall results and similarity in effect sizes (the test for subgroup differences - low vs high risk of bias trials - was non-significant) and overlapping confidence intervals (CIs), the risk of bias was rated as 'not serious'. c. Trials were conducted more than 20 years ago. Currently, women have higher adherence to breast cancer screening and the quality control of screening and breast cancer care have improved. A large non-randomised study (Hellquist B 2011) showed a reduced risk for breast cancer deaths in women aged 40 to 49 years invited to screening, compared with women not invited (RR=0.74; 95%CI, 0.66-0.83) which is consistent with RCT results. The GDG did not rate downgrade for indirectness for breast cancer mortality but considered it serious for other outcomes. d. 95% CI probably crosses the clinical decision threshold (as the CI is wide, a different clinical decision regarding the intervention may be taken depending on whether the lower or the higher limit is considered). e. Median or mean of the control group of the included studies unless otherwise specified f. Baseline risk calculated from the ITACAN database. http://itacan.ispo.toscana.it/italian/itacan.htm g. Unexplained inconsistency with statistical heterogeneity (I^2 = 62%, P = 0.02). h. Importance of the outcome was lowered from 'critical' to 'important' because the GDG members felt this outcome influenced neither the direction nor the strength of the recommendation. i. Some studies were sub-optimally randomised and had non-blinded assessment of stage of disease; when analysis was restricted to low risk of bias trials, the risk estimate was non-significant j. Indirectness same as for women aged 50 to 69. k. Population included women aged 40-74 years old. Therefore, a much broader age range than the 40-44 age group studied here. Observational studies do not confirm these results, instead they provide opposite results. l. Due to lead time, there may be greater numbers of cancers to be treated in the screened group, during the period of observation, which may lead to an increased rate of chemotherapy and mastectomies in the screened group m. Unexplained inconsistency with statistical heterogeneity (I^2 = 71%, P = 0.06). n. Chemotherapy protocols and indications have significantly changed (e.g. node status was not determined in earlier studies). o. Overdiagnosis calculated from CNBSS-1 trial, in which women in the control group were not offered mammography screening at the end of the trial. Excess cancers as a proportion of cancers diagnosed over whole follow-up period in women invited for screening (population perspective). p. Overdiagnosis calculated from CNBSS-1 trial, in which women in the control group were not offered mammography screening at the end of the trial. Excess cancers as a proportion of cancers diagnosed during screening period in women invited for screening (woman perspective). q. Unexplained inconsistency for variability in anxiety in the group of women recalled for further testing. r. Studies included women aged 50 to 69. Estimates for the 40 to 44 age stratum are likely to be higher.	

Undesirable Effects

How substantial are the undesirable anticipated effects?

JUDGEMENT	RESEARCH EVIDENCE	ADDITIONAL CONSIDERATIONS

● Large ○ Moderate ○ Small ○ Trivial ○ Varies ○ Don't know	See above.	Overdiagnosis and its magnitude are not greatly influenced by age at first screening. Overdiagnosis estimates from both CNBSS1 and CNBSS2 may have been overestimated by subsequent screening in the population (both organised and opportunistic) after screening ceased in the CNBSS in 1988. Thus, while at 25 years of follow-up a non-statistically significant excess of all breast cancers was observed in the intervention arm of CNBSS trials (difference 2.6; 95%CI -0.8 to 5.9), the excess rate of in-situ/invasive breast cancers actually increased over the first-years post-screening in the CNBSS1, and dramatically decreased after the 10 years post-screening in the CNBSS2. Due to lead time (diagnosis time being brought forward with screening), there may be greater numbers of cancers to be treated in the screened group, during the period of observation, which may lead to an increased rate of chemotherapy and mastectomies in the screened group. False-positive rates have been observed to be higher in women under age 50 than in women aged 50 to 69. The number of false-positives will depend on the age of first screening. The GDG considered this effect to be large. Radiation risk is higher in younger women. The radiation exposure and associated risk is dependent on the screening method and frequency that, in turn, will influence the balance of benefits and harms.

Certainty of evidence

What is the overall certainty of the evidence of effects?

JUDGEMENT	RESEARCH EVIDENCE	ADDITIONAL CONSIDERATIONS

○ Very low ○ Low ● Moderate ○ High ○ No included studies	The overall certainty (i.e. quality) of the evidence was considered moderate, as this was the lowest quality among the critical outcomes—namely, breast cancer mortality and overdiagnosis.	

Values

Is there important uncertainty about or variability in how much people value the main outcomes?

JUDGEMENT	RESEARCH EVIDENCE	ADDITIONAL CONSIDERATIONS
○ Important uncertainty or variability ● Possibly important uncertainty or variability ○ Probably no important uncertainty or variability ○ No important uncertainty or variability ○ No known undesirable outcomes	A systematic review shows that participants place a low value on the psychosocial and physical effects of false-positive results and overdiagnosis (JRC Technical Report PICO 10-11, contract FWC443094012015; available upon request). Women generally consider these undesirable effects acceptable (low confidence in evidence). However, these findings are of limited value mainly given the significant concerns regarding the adequacy of the information provided to women, in order to make an informed decision about participation. Also, acceptability of false positive results is based on studies of participants who have already received a false positive result. Their preferences may differ from the general population. Another finding is that breast cancer screening represents a significant burden for some participants due to the associated psychological distress and inconvenience (moderate confidence in evidence). Regarding breast cancer diagnosis, very limited data is available addressing people's views. One of the main themes identified in the literature is that people disvalue highly the anxiety caused by delays in receiving diagnostic results, or by a lack of understanding of the tests due to suboptimal communication with physicians (moderate confidence in evidence). Also, people have a higher overall preference towards more comfortable, brief diagnostic procedures (moderate confidence in evidence). (JRC Technical Report PICO 10-11, contract FWC443094012015; available upon request)	

Balance of effects

Does the balance between desirable and undesirable effects favor the intervention or the comparison?

JUDGEMENT	RESEARCH EVIDENCE	ADDITIONAL CONSIDERATIONS
○ Favors the comparison ● Probably favors the comparison ○ Does not favor either the intervention or the comparison ○ Probably favors the intervention ○ Favors the intervention ○ Varies ○ Don't know		GDG members agreed that the balance of desirable and undesirable health effects for starting screening at age 40 probably favours the comparison (no screening), as the intervention has large undesirable effects and small desirable effects.

Resources required

How large are the resource requirements (costs)?

JUDGEMENT	RESEARCH EVIDENCE	ADDITIONAL CONSIDERATIONS

○ Large costs ● Moderate costs ○ Negligible costs and savings ○ Moderate savings ○ Large savings ○ Varies ○ Don't know	Differences in required resources for mammography screening versus no screening in women aged 40 to 49 in the studies analysed may be related to the inclusion or not of costs related to the screening process, diagnostic techniques, treatment and follow-up of diagnosed women (1)(2). Screening costs for a cohort of 10,000 women aged 47 to 49 years have been estimated to be £ 420,000 in the UK. The cost of diagnosis for positive results would be £ 70,000, and screening would lead to a saving of £ 17,000 in treatment costs (£480 per screen-detected cancer, calculated from the difference in treatment costs for the trial control and intervention arms), giving a net screening cost of £ 473,000 per 10,000 screened women (3.5% discount rate) (1). Based on the results of (2), the total cost of breast cancer diagnosis, treatment and death in the absence of screening was estimated to be € 1,161,008 per 1000 women aged 50 to 74 years, followed over their lifetime (3.5% discount rate). Biennial screening will cost € 1,298,065 per 1000 women (aged 50-74) screened and the reported costs per 1000 women aged 40 to 74 is € 1,467,598. Therefore, the estimated cost of screening 1000 women aged 40 to 49 years would be € 169,533.	Varies by screening interval and by country and by the presence of opportunistic screening. GDG members judged the cost to be at least moderate. However, substantial differences could be observed in European countries without population-based screening programmes or in those programmes with different screening policies. Estimates refer to organised screening programmes. Local/regional/country level resource/cost analyses exist or are required to estimate the cost for each setting.

Certainty of evidence of required resources

What is the certainty of the evidence of resource requirements (costs)?

JUDGEMENT	RESEARCH EVIDENCE	ADDITIONAL CONSIDERATIONS
○ Very low ● Low ○ Moderate ○ High ○ No included studies	The certainty of the evidence of resource requirements is low due to the study design of the included study (2). This was a modelling study based on observational data from a biennial screening programme using digital mammography. Based on this data, total cost per round of biennial screening in the Netherlands would be €61.3 (value of 2014). The formal assessment of the certainty in the evidence for cost and resources used was made using GRADE criteria and reported in the Evidence Profile (JRC Technical Report PICO 14-15, contract FWC443094012015; available upon request).	The study assessed the extension (i.e. starting at age 40 as compared to age 50) of a current population-based screening programme. As previously stated, substantial differences could be observed in European countries without population-based screening programmes or in those programmes with different screening policies.

Cost effectiveness

Does the cost-effectiveness of the intervention favor the intervention or the comparison?

JUDGEMENT	RESEARCH EVIDENCE	ADDITIONAL CONSIDERATIONS
○ Favors the comparison ○ Probably favors the comparison ○ Does not favor either the intervention or the comparison ○ Probably favors the intervention ○ Favors the intervention ● Varies ○ No included studies	Based on the evidence provided by (2), the extension of biennial mammography screening starting at age 40 appears to be cost-effective at a 'willingness-to-pay' of €20 000 per Life Year Gained (LYG) with an Incremental Cost-Effectiveness Ratio (ICER) of €10 826 per LYG starting at age 40 instead of age 45.	GDG members agreed that cost-effectiveness is likely to vary across European countries, in particular with respect to countries without population-based screening programmes or across programmes with different screening policies.

Equity
What would be the impact on health equity?

JUDGEMENT	RESEARCH EVIDENCE	ADDITIONAL CONSIDERATIONS
○ Reduced ○ Probably reduced ○ Probably no impact ○ Probably increased ○ Increased ○ Varies ● Don't know		A systematic review on this topic has not been conducted. However, the utilisation of cancer screening services may largely depend on the availability of national public screening programmes; although European findings highlight that inequalities are larger in countries without population-based screening programmes (Palència, 2010).

Acceptability
Is the intervention acceptable to key stakeholders?

JUDGEMENT	RESEARCH EVIDENCE	ADDITIONAL CONSIDERATIONS
○ No ○ Probably no ○ Probably yes ● Yes ○ Varies ○ Don't know	A systematic review (JRC Technical Report PICO 16-17, contract FWC443094032016; available upon request) found the following barriers associated with breast cancer screening: (*a*) lack of knowledge and misperceptions regarding preventive medicine and breast health (high confidence in evidence), (*b*) poor communication skills of healthcare providers (high confidence in evidence), (*c*) poor accessibility to breast screening, especially among women with disabilities (high confidence in evidence), (*d*) fear and stress related to the procedure and the possibility of cancer diagnosis (high confidence in evidence), (*e*) pain and discomfort during the procedure (moderate confidence in evidence), (*f*) embarrassment and shyness during the procedure (moderate confidence in evidence), (*g*) lack of support and encouragement from family members, caregivers and social network (moderate confidence in evidence), (*h*) lack of information regarding the available resources (low confidence in evidence) and (*i*) low prioritisation of breast cancer screening (low confidence in evidence).	Some GDG members described some professional groups may find a screening programme not acceptable due to their financial interests.

Feasibility
Is the intervention feasible to implement?

JUDGEMENT	RESEARCH EVIDENCE	ADDITIONAL CONSIDERATIONS
○ No ○ Probably no ● Probably yes ○ Yes ○ Varies ○ Don't know		A systematic review on this topic has not been conducted. Some countries do not have screening programmes mainly due to lack of resources and/or infrastructure. Given that this recommendation would be additive to screening in older age groups (45 to 69), it was judged as being

		probably feasible to implement.

SUMMARY OF JUDGEMENTS

	JUDGEMENT						
PROBLEM	No	Probably no	Probably yes	**Yes**		Varies	Don't know
DESIRABLE EFFECTS	Trivial	**Small**	Moderate	Large		Varies	Don't know
UNDESIRABLE EFFECTS	**Large**	Moderate	Small	Trivial		Varies	Don't know
CERTAINTY OF EVIDENCE	Very low	Low	**Moderate**	High			No included studies
VALUES	Important uncertainty or variability	**Possibly important uncertainty or variability**	Probably no important uncertainty or variability	No important uncertainty or variability			No known undesirable outcomes
BALANCE OF EFFECTS	Favors the comparison	**Probably favors the comparison**	Does not favor either the intervention or the comparison	Probably favors the intervention	Favors the intervention	Varies	Don't know
RESOURCES REQUIRED	Large costs	**Moderate costs**	Negligible costs and savings	Moderate savings	Large savings	Varies	Don't know
CERTAINTY OF EVIDENCE OF REQUIRED RESOURCES	Very low	**Low**	Moderate	High			No included studies
COST EFFECTIVENESS	Favors the comparison	Probably favors the comparison	Does not favor either the intervention or the comparison	Probably favors the intervention	Favors the intervention	**Varies**	No included studies
EQUITY	Reduced	Probably reduced	Probably no impact	Probably increased	Increased	Varies	**Don't know**
ACCEPTABILITY	No	Probably no	Probably yes	**Yes**		Varies	Don't know
FEASIBILITY	No	Probably no	**Probably yes**	Yes		Varies	Don't know

TYPE OF RECOMMENDATION

Strong recommendation against the intervention	**Conditional recommendation against the intervention**	Conditional recommendation for either the intervention or the comparison	Conditional recommendation for the intervention	Strong recommendation for the intervention
○	●	○	○	○

CONCLUSIONS

Recommendation

For asymptomatic women aged 40 to 44 with an average risk of breast cancer, the ECIBC's Guidelines Development Group (GDG) suggests **not implementing mammography screening (conditional recommendation, moderate certainty in the evidence).**

Justification

Overall justification

The conditional recommendation (rather than strong) against mammography screening, in the context of an organised screening programme, was the result of a balance of the health effects that probably favours no mammography screening. GDG members agreed that mammography screening has large undesirable effects and small desirable effects when the first screening occurs at age 40.

Detailed justification

Desirable Effects
Mammography, compared to no screening, did not significantly reduce the risk of breast cancer mortality (77 fewer breast cancer deaths per 100 000, with a range from 7 more to 147 fewer deaths, or 44 fewer breast cancer deaths per 100 000, with a range from 4 more to 84 fewer breast cancer deaths, using a 0.7% and 0.4% baseline risk, respectively) in women invited to screening over 16.4 years of follow-up (moderate quality evidence). Mammography, compared to no screening, reduced the risk of stage IIA breast cancer or higher (46 fewer cases of breast cancer per 100 000 women during mean 13.6 years of follow-up) (very low quality evidence) but did not reduce the risk of all cause mortality, stage III+ breast cancer or tumour size ≥ 40 mm (low quality evidence) nor other cause mortality (very low quality evidence).

Undesirable Effects
Women aged 40 to 74 years randomised to 'invitation to screening' were more likely to undergo mastectomy (180 more mastectomies per 100 000 women) (low quality evidence). Overdiagnosis is estimated to be 12.4% (moderate quality evidence) from a population perspective and 22.7% from the perspective of a woman invited to screening (moderate quality evidence). The number of false-positives will depend on the age at first screening. Estimated cumulative risk of a false-positive screening result in women aged 50 to 69 undergoing 10 biennial screening tests was 19.7%. However, false-positive rates have been observed to be higher in women under age 50 than in women aged 50 to 69. In addition, 2.2% of women had a needle biopsy after the initial screening mammogram. False-positive mammograms are also associated with greater anxiety and distress about breast cancer as well as negative psychological consequences that may last up to three years (low quality evidence). Women who had further testing following their routine mammogram experienced significant short-term anxiety.

Subgroup considerations

This recommendation does not apply to high-risk women (see recommendations for women with high breast density).

Implementation considerations

GDG members agreed on the need for additional imaging techniques in this age group, as well as the need for shared decision making.

Monitoring and evaluation

Future monitoring and evaluation of screening services should consider benefits and risks in the context of evolving treatment and management protocols.

Monitoring and evaluation criteria are being developed within the ECIBC initiative.

Research priorities

1. Carry out evaluations of the efficacy of the intervention, time intervals, risk factors and stratification of women, as well as context specific cost-effectiveness in this age group.

2. Carry out studies addressing the role of other screening modalities (e.g. MRI) in this population.

REFERENCES SUMMARY

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