

Early Diagnosis Doesn't Solve Every Problem

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Last month, in an attempt to resolve the roiling debate over whether healthy women should have routine mammography screening, the U.S. Preventive Services Task Force announced flatly that "mammography reduces deaths from breast cancer." It would be nice if the issue were that simple. It's not. Some studies have suggested that screening mammography saves lives; others have found it does not. One thing is clear, however: The debate is drowning out other important discussion.

Thanks to the billions of dollars invested in mammography screening and the vested interest that the U.S. government and many organizations have in it, the mammography controversy will never die. But many women will—unless we make some real progress in breast cancer beyond mammography, and unless everyone diagnosed with breast cancer has access to advances in treatment.

The recent debate about mammography screening masks the real issue in breast cancer diagnosis: the value of early detection. Women are routinely told that early detection is their best protection, as breast cancer found early is almost 100% curable. The basis for the "almost 100%" figure is that 95% of women diagnosed by screening mammograms are alive five years after diagnosis. Being cancer-free for five years is considered a cure for some cancers, but breast cancer can and does recur at any time. Meanwhile, breast-cancer awareness campaigns urging women to have yearly mammograms are based on a flawed premise. Women diagnosed early with breast cancer fall into one of three groups. The first group has a very aggressive disease that, no matter how small a tumor is when it is found, cannot be effectively treated with current therapies. These women will die of breast cancer no matter what treatment they are given, unless something else kills them first.

The second group has a type of either non-aggressive (indolent) invasive disease or a kind of cancer called "ductal carcinoma in situ" that, left untreated, will never be life-threatening.

The third group responds to currently available treatments, and finding breast cancer earlier does increase the likelihood that treatment will work for them.

Given these divisions and the treatments currently available, early detection only matters for women in the latter group. We have no way of tracking how many women historically have fallen into each of these three groups, and we have no way of figuring out at the time of diagnosis which group a woman belongs to. The result is that we mistreat or over-treat a lot of women diagnosed with breast cancer in our effort to help the others. In the end, women are left simply to pray that they are in that lucky treatment-responsive group.

Until we have a way of distinguishing those who will be helped by treatment from those who won't, there are better ways to spend limited resources than on developing methods of ever-earlier breast cancer detection.

Resources could be well used today, for example, on making sure that women—and men—diagnosed with breast cancer have access to the most current information about treatment, as well as to the medical care necessary to take advantage of that information. While the public's attention is focused on the mammography controversy, a woman is being diagnosed with potentially life-threatening breast cancer every 3 minutes in this country, whether by mammogram, breast self-exam or clinical breast exam. With each diagnosis, another person enters a world filled with more questions than answers.

The answers available to a new member of the dreaded breast-cancer sorority are likely to be determined by her available resources. Well-educated women are far more likely to do the kind of research necessary to take advantage of new treatment developments. Women living