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The American College of Physicians wants us to rethink cancer screening

By Nicholas Staropoli — May 19, 2015

The American College of Physicians has come out with a report that questions the value of current screening recommendations and protocols. The report, released yesterday in the *Annals of Internal Medicine* [1], calls into question whether current screening practices exhibit high value for patient care or if they are doing more harm than good. The report also lists the organization s recommendation for what they consider high value screening for 5 common cancers: breast, cervical, colorectal, ovarian and prostate.

The goal of high value screening is to find a test and a frequency of testing for each cancer that will catch nearly all of the dangerous cancers, while minimizing detection of indolent (non-threatening) abnormalities, and maximizing the time between screenings for a patient. By finding this magic formula we do not put patients lives in danger, nor do we stress their wallets or their psyches with unnecessary (and often dangerous) tests that far too frequently pick up innocuous growths.

Dr. Russell Harris MD, one of the report's lead authors summarizes this nicely: "*If we were to take everybody and screen them for breast cancer starting at age 25 or 30, and screen them every 6 months instead of every year, we would find more cancers, but we would also hurt a whole lot of people by overtreating them and by overdiagnosing them. It is the balance that we are looking for, rather than finding every single one*.

When it comes to achieving high value cancer screening, the problem, according to the ACP report, is that our view on cancer is wrong. Harris points out that *We have been thinking about screening the wrong way. We have been thinking about trying to find every last cancer we can find. So when we find out that there is some screening test that seems to work, then we want to do it as often as we can and use the most sensitive test*.

Dr. Harris s point is spot on. Not every thing that looks like cancer on a screening test is a cancer. For example, 50% of positive Prostate Specific Antigen tests result in a negative prostate biopsy. This problem is compounded by the fact that many patients (and some physicians) don t understand that these tests aren t perfect. The president of the ACP Dr. Wayne Riley explains, *Many people have a lack of understanding about the tradeoffs of screening. Study after study has consistently shown that patients and many physicians overestimate the benefits and are unaware of and/or downplay the potential harms of cancer screening.*

So what does the ACP consider high value screening? The following is a summary from the report, which you can read in full here [1]:

- Breast cancer Average risk women aged between 50 and 74 should ONLY receive mammograms every 2 years. Women outside this age range should not receive mammograms unless their personal risk indicates extra precaution.
- Cervical cancer From 30 to 65 years of age, average risk women should receive a combo screening of a pap smear and an HPV test every 5 years. Women 21-30 should receive a pap smear every 3 years. Women under the age of 21 or over the age of 65 should not receive screening for this cancer.
- Ovarian cancer Average risk women should not be screened for ovarian cancer.
- Colorectal cancer Average risk patients between the ages of 50 and 75 should follow one of the following protocols: high-sensitivity fecal occult blood test (FOBT) or fecal immunochemical test (FIT) every year, sigmoidoscopy every 5 years, combined high-sensitivity FOBT or FIT every 3 years plus sigmoidoscopy every 5 years, optical colonoscopy every 10 years.
- Prostate cancer Physicians should discuss the PSA test with average risk men aged 50-69 and inform them about the limited benefits of this test. They should not routinely perform this test on average risk men.

It is important to reiterate that these recommendations are for patients of average risk, those patients with increased risk for particular cancers should consult with their doctors before varying from these protocols. It s also important to understand that these recommendations may be transient and subject to change with more data. For example, recently a study [2] was released that showed testing for two additional biomarkers along with PSA may decrease the risk for unnecessary biopsy. As this test is improved and perfected it may influence the ACP to characterize this test as a high value screening.

A transition in the way we think about cancer detection will not be easy, as it may mean missing some cancers, but as Dr. Harris says it s worth it in the long run**:** "*If we go to a high-value approach rather than a maximal-detection approach, we are going to miss some cancers. You have to give in to that. If we don't do that, then what we end up doing is hurting a lot of people. So yes, by changing the way we think about the way we are going with screening now, we may miss a few, but there will be a whole lot more people who will be helped by not being hurt.*

Links

[1] http://annals.org/article.aspx?articleid=2294149

[2] http://www.europeanurology.com/article/S0302-2838(15)00397-8/abstract/urine-tmprss2-erg-plus-pca3-for-individualized-prostate-cancer-risk-assessment