

## For debate

# Should healthy populations be screened for breast cancer? A perspective from someone with previously diagnosed breast cancer

Mitzi Blennerhassett BA RSA Cert (Counselling Skills)

Kings Health Partners' Key Opinion Leaders' Panel and Trustee of the Rarer Cancers Forum, UK

Women have been encouraged to attend breast screening as the best way of reducing deaths from breast cancer, but since 1999 mounting evidence has raised serious concerns about the harms and benefits of screening and, following a survey, the information material provided by professional advocacy groups and governmental organisations has been described as 'information poor and severely biased in favour of screening'.<sup>1</sup>

Following the NHS Breast Screening Independent Review,<sup>2</sup> Professor Sir Mike Richards said screening should be the woman's decision, but he still recommended it. However, the UK independent panel's estimates of overdiagnoses and cancer deaths avoided have been robustly challenged.<sup>3–5</sup>

The general public's understanding has been that all cancers grow, spread and kill people unless found 'early'. But some of the changes found by screening develop so slowly that they would never develop into real cancer within a lifetime, yet all are treated because doctors cannot tell which are life-threatening and which are not.<sup>6</sup> This is what women need to understand before agreeing to be screened, one of the points made so eloquently by Miriam Pryke.<sup>7</sup>

The effect of 'screening saves lives' campaigns can be difficult to overcome. In a recent study, women told of the risk of overdiagnosis were not deterred from screening, although many struggled to understand the concept.<sup>8</sup> One way to quantify overdiagnosis is to say 'for every death from breast cancer that is avoided by screening, two other women will have unnecessary breast cancer diagnoses and treatment'. But that is an oversimplification of the reality, which is that for a woman diagnosed with breast cancer within a screening programme, there is about a 2 in 3 chance of her treatment being unnecessary and a 1 in 3 chance of her treatment resulting in avoidance of death from breast cancer.<sup>9</sup> Yet there is no proper consent process for breast screening.<sup>10</sup>

The potential harms of overdiagnosis range from anxiety and unnecessary biopsies to surgery and other treatments. Radiotherapy can increase the rate of ischaemic heart disease in a dose-dependent manner<sup>11</sup> and cause cardiomyopathy, radiation-induced bone loss, lung fibrosis, lymphoedema and other cancers. There can be severe side effects from drug therapies and chemotherapy, although the latter is unlikely to be given when disease has not spread.

Owen Dempsey (a general practitioner; GP) explores 'several contradictions, incoherencies and silences' which he says have been revealed in debates over the UK breast screening programme and comments that 'withholding information on harms to ensure attendance, as disturbingly suggested in Bekker's editorial in 2010, would seem to give a green light for any politically motivated programme to be marketed at a vulnerable population via a "consider an offer" approach'.<sup>12,13</sup> While elsewhere, Jonathan Sleath (GP) reports the 'surprised and bewildered' reactions of many of his patients on learning that 'most breast cancers detected by screening would not have caused them problems if left untreated; there is no evidence that screening reduces overall mortality, and the evidence that screening reduces breast cancer deaths at all is controversial'.<sup>14</sup> He says the breast screening establishment 'still seems determined to pressurise women to accept screening mammography'. For me, pressure to accept screening begins with the set appointment. By contrast, lack of a reply to my GP surgery health check invitation is accepted as declining the offer (patient autonomy).

Most women with screen-diagnosed cancers think screening saved their lives, but some will have been treated unnecessarily and for some others earlier treatment will have made no difference to their prognosis. Although some women diagnosed by screening live longer than they would otherwise have done and do not die from breast cancer, it is not possible to identify which women fall into this category.

So, if there is no way to identify harmless and potential killer cancers, why extend the screening age, why have an age-extended trial,<sup>15</sup> and what is the point of the current breast screening programme?

'Does screening for cancer improve length or quality of life?' is the key question according to Professor Michael Baum.<sup>5</sup> Would it not be better to target those most at risk and improve breast services? Women need and deserve to know.

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## CONFLICTS OF INTEREST

None.

## PEER REVIEW

Commissioned; not externally peer reviewed.

## ADDRESS FOR CORRESPONDENCE

Mitzi Blennerhassett  
Wyville Lodge  
Slingsby  
York YO62 4AQ  
UK  
Email: [b\\_mitzi@yahoo.co.uk](mailto:b_mitzi@yahoo.co.uk)

Received 7 May 2013

Accepted 8 June 2013