

BREAST CANCER SCREENING GUIDELINES

The purpose of this section is to provide SEARHC providers and Screening Providers with breast cancer screening guidelines, which are based upon recommendations from the American College of Radiology, American Cancer Society, U.S. Preventive Services Task Force and California Department of Health Services, Cancer Detection Section, Clinical Breast Protocols Workgroup Members.

Women should have clinical breast examinations and mammography performed on a regular basis depending on age. There are variations to recommendations for mammography based on the presence of positive physical findings. In the absence of positive physical findings, women should be screened using the following recommendations.

METHOD	AGE	FREQUENCY	BENEFIT
Clinical Breast Examination	20-30	Every 3 years and/or frequency based on provider/patient counseling	
Clinical Breast Examination	Over 30	Every year	
Mammography	40-49	One to two years based on provider/patient counseling	May reduce risk of dying from breast cancer by 17%.*
Mammography	50-74	Every year based on provider/patient counseling	May reduce risk of dying from breast cancer by 30%.*
Mammography	>74	Based on Provider evaluation (case by case basis)	Unknown

* Source: U.S. Preventive Services Task Force

Any woman who has positive physical findings on her clinical breast exam should follow the protocol outlined on the breast cancer screening algorithm.

BREAST SELF EXAMINATION

For years, monthly breast self examinations (BSE) has been recommended for women age 20 and older to aid in the early detection of breast cancer, but due to recent studies, BSE is now optional. This controversial change is accepted with some hesitation as there are various groups and individuals who believe BSE are important to women's health. Under these guidelines, BSE is being recognized as a way for women to know how their breasts normally feel and to notice any changes. This approach focuses on the importance of *self-awareness* rather than *early detection*.

SEARHC Clinical experts remain divided on whether there is benefit to BSE, therefore they conclude that the evidence is insufficient to recommend for or against teaching or performing routine BSE.

CLINICAL BREAST EXAMINATION

Clinical breast examination (CBE) is recommended at least every three years on women between the ages of 20-30 years (may coincide with Pap test) and every year on women over 30 years.

Annual training in CBE for health care providers is offered by the SEARHC Breast and Cervical Health Program.

The recommended method for reporting CBE findings is as follows:

- Normal/Negative CBE: Normal Breast Characteristics.
- Non-significant finding (specify).
- Does or does not have breast implants.
- Has or has not had mastectomy/lumpectomy or prior breast surgery.
- Has any associated clinical finding - please specify if appropriate: size, location, mobility if any, or fixed, and texture.

Further evaluation needed if:

- ⇒ Distinct palpable mass or lumpiness of concern to examiner.
- ⇒ Skin dimpling/reddening.
- ⇒ Nipple discharge that is unilateral, spontaneous, localized to one duct, bloody or purulent.
- ⇒ Skin retraction or scaliness around nipple not associate with a surgical scar.
- ⇒ Recent occurrence/onset of an Inverted nipple in non-pregnant or non-lactating woman.

Further evaluation may include:

- ⇒ Repeat Clinical Breast Examination (CBE).
- ⇒ If over 30 years of age, diagnostic mammography and ultrasound if indicated;
- ⇒ **Referral to surgeon or specialist even if mammography is negative in the presence of physical findings.**
- ⇒ All dominant masses that are solid by needle aspirations or ultrasound should be referred to a surgeon regardless of age, risk factors, or mammography findings.

Follow Up for Abnormal CBE

In the case of an abnormal BCE:

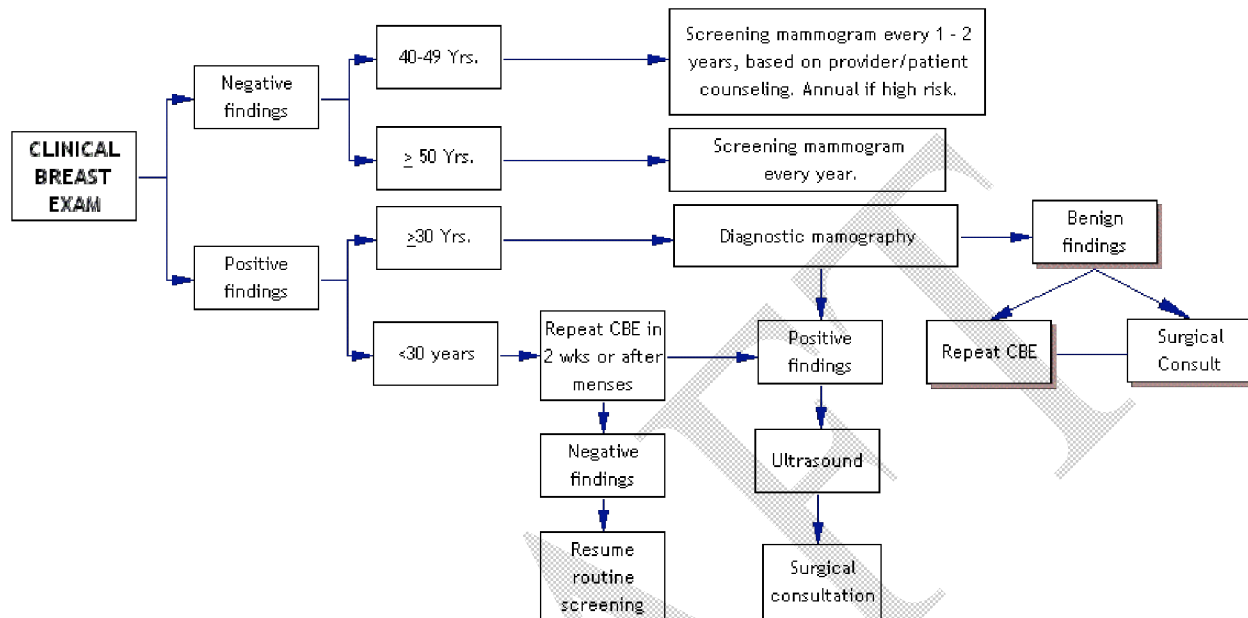
- The provider should not discount an abnormal CBE because of a negative mammogram or other imaging examination.
- Providers must follow-up all conflicting or abnormal findings to satisfactory resolution using the actions outlined below.
- All radiology referrals must ensure that a copy of the CBE report is provided to radiologist performing follow-up imaging to assist in examination and interpretation.

One or more of the following follow-up options are available:

- Repeat CBE.
- Medical management of probably benign condition.
- Referral to surgical consultation, radiology and or breast specialist.
- Imaging (ultrasound, mammography, and magnetic resonance imaging).
- Aspiration.

- Biopsy (percutaneous or excisional).

SEARHC clinical experts require a CBE done within six months prior to receiving a mammogram.



MAMMOGRAPHY

Ideally, the CBE immediately precedes any imaging studies.

It is strongly recommended that ALL clinically suspicious breast masses require additional evaluation.

- ⇒ Ultrasound, especially in women <30 y.o.
- ⇒ Diagnostic mammography in women ≥ 30 y.o.

Screening Mammography

According to the American College of Radiology (ACR), screening mammography is defined as an *x-ray breast examination of asymptomatic woman in an attempt to detect breast cancer when it is small, nonpalpable, and confined to the breast.*

SEARHC Guidelines for Screening Mammography:

- ⇒ Screening mammography is indicated for asymptomatic, age-appropriate women.
- ⇒ Not often helpful in women under age 30 (except in carefully selected cases) due to high breast density.
- ⇒ Not indicated while breastfeeding - wait until four to six months after weaning.
- ⇒ It is the consensus of SEARHC clinical experts that women age 40 and over should be offered routine screening mammography every one to two years based on provider/patient counseling. For women aged 40-49, who are at risk*, annual screening's are highly recommended.
- ⇒ Women age 50 years and older should have a screening mammogram every year.

Although mammography has the ability to detect breast lumps that are not yet palpable, mammography is not intended to replace CBE.

Diagnostic Mammography

The American College of Radiology defines diagnostic mammography as *mammography performed on women who, by virtue of symptoms or physical findings, are considered to have a substantial likelihood of having breast disease.*

Guidelines for Diagnostic Mammography are:

- ⇒ Indicated when breast masses are present or suspected on examination or screening mammography.
- ⇒ Includes additional views (cone down compression or magnification)
- ⇒ A woman over age 30 years who has a breast lesion on examination or screening mammography not consistent with benign breast changes.

Mammography results should be reported as ACR Assessment Codes (0-6) of the Breast Imaging Reporting and Data Systems/BI-RADS Reporting System. For more information on BI-RADS - Mammography 4th Edition please refer to the article at the end of this section.

Assessment Categories

- ACR 0 - Need additional imaging evaluation and/or prior mammograms for comparison.
- ACR 1 - Negative.
- ACR 2 - Benign Finding.
- ACR 3 - Probably Benign Finding - Initial short-interval follow-up suggested.
- ACR 4 - Suspicious Abnormality - Biopsy should be considered.
- ACR 5 - Highly suggestive of malignancy - appropriate action should be taken.
- ACR 6 - Known Biopsy - Proven malignancy - Appropriate action should be taken.

ULTRASOUND

Ultrasound is considered a useful tool in detecting lobular carcinoma, a type of breast cancer that is difficult to see on a mammogram.

Not indicated for routinely screening asymptomatic women of any age.

Guidelines for Ultrasound are:

- ⇒ Evaluating dominant breast lumps in women under age 30.
- ⇒ Differentiating solid from cystic masses.
- ⇒ Detecting masses where there are palpable findings but negative mammogram.
- ⇒ Evaluating focal areas of breast pain.
- ⇒ Mammographic findings of focal asymmetric densities, architectural distortion or solid masses.
- ⇒ Guiding interventional breast procedures.

MAGNETIC RESONANCE IMAGING (MRI)

Magnetic Resonance Imaging (MRI) is a technology that is currently used to detect a number of anatomic disorders while reducing the risk of exposure to x-ray and other potentially harmful radiographic materials.

For breast imaging, the MRI is considered a promising technique, but existing evidence does not show the modality to be sensitive or specific enough to become a standard part of screening and diagnostic armamentarium. In addition, the cost of these procedures is prohibitive and MRI is not cost effective for mass use as a screening tool. Considerably more research on use of this tool for early detection of breast cancer is needed before it can become a standard screening study.

Therefore, MRI is not recommended as a routine screening modality at this time.

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