Cancer Society Warns Against Premature Screenings

The American Cancer Society warned Wednesday that premature screening could lead to overtreating or overlooking cancer. Gwen Ifill reports.

GWEN IFILL: The message has often been a simple one: Screening for cancer saves lives. But that message has masked a growing debate over whether screening offers risks of its own, including too many diagnoses and overtreatment.

Now today, a new article in "The Journal of the American Medical Association." Researchers looking at two decades' worth of screening for breast and prostate cancer conclude that, though beneficial, screening is not always a guard against later-stage cancers.

Here to sort through the questions these conclusions raise are the paper's lead author, Dr. Laura Esserman, a breast surgeon and director of the breast care center at the University of California San Francisco Medical Center, and Dr. Victor Vogel, vice president of research for the American Cancer Society.

Welcome to you, both.

GWEN IFILL: Dr. Vogel, I will start with you. It sounds like Dr. Esserman is still trying to get her audio.

So, I want to start with you anyway, because the question this raises was -- I guess, exacerbated this debate that has been going on by comments made by the American Cancer Society to "The New York Times" about whether or not screening is being
overdone. So, what's your answer to the question of whether there is too much screening going on?

DR. VICTOR VOGEL, vice president of research, American Cancer Society: Well, we don't believe, at the American Cancer Society, Gwen, that there is too much screening going on.

But we are starting to have discussions about the real scientific benefits and merits of screening. And we are now recognizing, along with the scientific community, that screening is not perfect. Now, on the other hand, we know that screening saves lives, so we don't want people to stop doing it. But we're continually reexamining the science, looking at the evidence, and always doing research to find better methods of screening.

GWEN IFILL: Dr. Esserman, I think you're with us now.

Give us a sense of the pros and cons of getting this -- all this early screening, which has now become so much the watchword of how we take care of ourselves.

DR. LAURA ESSERMAN: I think the message has to be clear, that screening has limitations.

And I think if we understand what it can do and it can't do, then we have the opportunity to make it better.

I think the message is that, after 25 years of screening for both breast and prostate cancer, we have increased the number of cancers that we have detected. Most of these cancers have been early cancers. While that, on the surface, seems good, one of the problems is that we haven't seen a commensurate decline in the number of later-stage cancers.

So, that tells us there's a problem. The problem is that we are detecting early cancers that may not become life-threatening or may not be particularly aggressive, and that can lead us to overtreatment. And, at the same time, we're not necessarily catching the people who are at risk for the most serious cancers.

So, I think the message is that people have to understand what screening can do. And we have to be careful to try and figure out how we can improve screening and how we can tailor it and personalize it, do less screening in groups of women who may not benefit or who -- where there is no evidence of benefit, and there may only be harm -- and that's women over 70 or 75 -- and more screening for the women who we think might be at risk for the most serious cancers.

**Drawing the line for screening**

GWEN IFILL: Well, let me ask you Dr. Vogel about that.
How do we draw the line about what's -- when it's necessary, when it's not, when it's --
when it's doing too much and doing too little?

DR. VICTOR VOGEL: Well, Gwen, we use the evidence from controlled clinical trials.

And we know that, for example, in women between 50 and 70, there's clear evidence
from 20 years of screening trials that mammographic screening reduces the risk of dying
from breast cancer from -- by about 25 to 30 percent.

We also know, though, as Dr. Esserman points out, that, when you do screening in
populations, you will detect disease that would never be a threat to the person's life. And
the problem is current biological understanding right now doesn't sort those out. That
doesn't mean we stop screening.

It means we continue to do the work that's required to distinguish between those cancers
detected at screening that are life-threatening and those that are in fact not life-
threatening. And we could say the same thing about colorectal screening. And we have
certainly proven that, over the last century, cervical cancer screening in the United States
has essentially eliminated the disease as a problem for those women who get screened.

The real concern that we have is that there are large numbers of people who should be
having screening and could benefit from screening who are not being screened.

GWEN IFILL: How do you balance it out, Dr. Esserman, because the great fear for so
many people is that they have something that's undiagnosed? How do you speak to them?
It's easy to say, well, there are some cancers which are more easily detected by screening
and some that are not, and we don't know what they are.

It seems awfully confusing.

DR. LAURA ESSERMAN: Well, actually, I don't think it needs to be confusing.

Again, as I said, I think it's an opportunity to make things better. I think it's really
important for women to understand that not all cancers are killer cancers. And if they are
detected with a cancer, they need to find out what kind of cancer they have.

Increasingly, we have tools available to help us understand that. As Dr. Vogel said, it isn't
that we stop screening. It's that we do a better job with the information that we get.

But I think an important message is that our current methods of screening will not detect
all aggressive cancers early. So, women who develop a mass or a symptom should make
sure that they go in, even if they have had a recent normal mammogram.

A lot of cancer -- of the most serious cancers, some of them grow very quickly and may
not be found early with screening. So our message is that we need to keep working on
finding better ways to treat the aggressive cancers, learn why people are at risk for them, and try and find some new tools...

GWEN IFILL: Dr. Vogel -- I'm sorry.

DR. LAURA ESSERMAN: ... to help that particular woman -- that particular group of women.

**Focusing on the right cancers**

GWEN IFILL: Dr. Vogel, is the focus on the wrong cancers? I mean, are we paying so much time telling men to get prostate PSAs and women to get mammograms, that somehow we're not devoting the research or attention to other more lethal cancers that grow more quickly and are therefore less detectable?

DR. VICTOR VOGEL: No, I think in both women and men, colorectal cancer is very important, and they both need to consider colorectal screening and talk to their doctors.

And, in women, I certainly wouldn't want to abandon mammographic screening. But, as Dr. Esserman says, we have to learn how to do it better and in a more biologically and scientifically informed way.

Now, the question about prostrate screening is one that does require some discussion, because recent data that the American Cancer Society has responded to and acted on and modified our screening recommendations says that doctors and their male patients need to have very careful discussions about PSA screening because of the very real risk, with that screening test, for the overdiagnosis of prostate cancers that will not be a threat to those men.

So, we try to distinguish, by cancer site, where the evidence is good to support the use of screening, and where the data require more careful discussion between doctor and patient.

GWEN IFILL: Dr. Esserman, is there a cost for overtreatment? That is ... I'm sorry. Can you hear me, Dr. Esserman? I don't think she can hear me right now.

DR. LAURA ESSERMAN: So, I -- yes, I can hear you now.

GWEN IFILL: OK.

DR. LAURA ESSERMAN: I want to -- I want to say...

GWEN IFILL: Go ahead.

DR. LAURA ESSERMAN: ... I think it's very important that, in colorectal cancer, we have definitely seen a decrease in the number of invasive cancers.
I think that's great. And I think one of the reasons that Dr. Thompson and I put these two cancers together is that the story in breast cancer is more similar to the story in prostate cancer than we understood.

So, I think it is very important for us, also, to make sure that we prepare women who are undergoing screening for what may happen. They may be called back for a biopsy. They may be called back and told they have a cancer, but they don't need to panic, because what we are learning is that a lot of the biopsies will turn out to be nothing, and some of the cancers we detect may not be life-threatening.

So, we need to make sure that people are prepared for the consequences of screening. I'm not saying that screening shouldn't be done. I'm saying that we have to accept its limitations. If we don't, we cannot make it better, and we don't, or we will miss the opportunity to figure out how to tailor it better and properly.

**Screening alternatives**

GWEN IFILL: Dr. Vogel, are there other kinds of screenings that are overlooked? For instance, we have heard about MRI screenings, for instance.

DR. VICTOR VOGEL: Well, the Cancer Society looked at the newly emerging data about MRI and said that it is not something that should be done with all women or for all women.

But there are certainly groups of women, particularly those with lifetime risks of breast cancer greater than 20 percent, who would benefit from MRI screening. And women with lesser risk need to have a discussion with their health care providers about the risks and benefits.

So, it's not possible to make blanket recommendations. But what we do is consider the evidence at each cancer site and, based on the screening modalities that are available, and try to stratify those recommendations based on the patient's risk of the disease.

GWEN IFILL: Dr. Esserman, quickly, if you want to respond to that.

DR. LAURA ESSERMAN: Yes, I do. I think we have to be careful with MRI screening. I think that that is a screening test for the people at the highest risk, people who have 40 to 50 percent lifetime risk of screening. Those are people who -- like BRCA1 carriers -- those are people who should get screening every six months, and fairly intensively.

I think that a lot of people are clamoring for MRIs. And MRIs have more false positives than mammograms. And I think that we want to be very careful not to overuse technology and not to cause more harm and not to cause more expense that won't really help people.
GWEN IFILL: All right.

Thank you very much, Dr. Laura Esserman and Dr. Victor Vogel.