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| **Preventive**  **Health**  **Guideline** | Procedure: | Breast Cancer Screening |
| Guideline Review Cycle: | 2018 |
| Reviewed By: | QI Committee |
| Review Date: | February 2018 |
| Committee Approval Date: | 02/21/2018 |
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*\*Arizona Priority Care has adopted the Breast Cancer Screening Preventive Health Guideline from the US Preventive Services Task Force*

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| **Population** | Women aged 40 to 49 years | Women aged 50 to 74 years | Women aged > 75 years |
| **Recommendation** | The decision to start screening should be an individual one.  Grade: C | Screen every 2 years.  Grade: B | No recommendation.  Grade: I statement (insufficient evidence) |

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| **Risk assessment** | These recommendations apply to asymptomatic women aged > 40 years who do not have preexisting breast cancer or a previously diagnosed high-risk breast lesion and who are not at high risk for breast cancer because of a known underlying genetic mutation (such as *BRCA1* or *BRCA2* gene mutation or other familial breast cancer syndrome) or a history of chest radiation at a young age. Increasing age is the most important risk factor for most women. | | |
| **Screening tests** | Conventional digital mammography has essentially replaced film mammography as the primary method for breast cancer screening in the United States. Conventional digital screening mammography has about the same diagnostic accuracy as film overall, although digital screening seems to have comparatively higher sensitivity but the same or lower specificity in women aged <50 years. | | |
| **Starting and stopping ages** | For women who are at average risk for breast cancer, most of the benefit of mammography results from biennial screening during ages 50 to 74 years. While screening mammography in women aged 40 to 49 years may reduce the risk for breast cancer death, the number of death averted is smaller than that in older women and the number of false-positive results and unnecessary biopsies is larger. The balance of benefits and harms is likely to improve as women move from their early to late 40s. | | |
| **Screening interval** | For most women, biennial mammography screening provides the best overall balance of benefit and harms. | | |
| **Treatment and interventions** | These recommendations apply to asymptomatic women aged > 40 years who do not have preexisting breast cancer or a previously diagnosed high-risk breast lesion and who are not at high risk for breast cancer because of a known underlying genetic mutation (such as *BRCA1* or *BRCA2* gene mutation or other familial breast cancer syndrome) or a history of chest radiation at a young age. Increasing age is the most important factor for most women. | | |
| **Balance of benefits and harms** | The net benefit of screening mammography in women aged 40 to 49 years, while positive, is small. | The net benefit of screening mammography in women aged 50 to 74 years is moderate. | Evidence on mammography screening in women aged > 75 years is insufficient, and the balance of benefits and harms cannot be determined. |
| **Other relevant USPSTF recommendations** | The USPSTF has made recommendations about the use of medications to reduce women’s risk for breast cancer, as well as risk assessment, genetic counseling, and genetic testing for *BRCA1*- or *BRCA2*-related cancer (including breast cancer). These recommendations are available on the USPSTF website (<http://www.uspreventiveservicestaskforce.org>). | | |

For summary of the evidence systematically reviewed in making this recommendation, the full recommendation statement and supporting documents, please go to <http://www.uspreventiveservicestaskforce.org>.

Adopted from US Preventive Services Task Force. Screening for breast cancer: US Preventive Services Task Force recommendation statement. Ann Intern Med 2009, 151:716-726.