Alberta Breast Cancer Screening Clinical Practice Guideline 2022 Update

Dr Lisa Stevenson MD CCFP

Co-Chair ABCSP CPG Committee

SPEAKER: DISCLOSURES

Calgary Zone
webinar series
Mental health
& hot topics

Dr. Lisa Stevenson
MD CCFP

Disclosures

- Family Physician: Richmond Square Medical Clinic (fee for service)
- Co-chair ABCSP Clinical Practise Guideline update committee (honorarium)
- Co-chair ACCSP HPV Screening Working Group (honorarium)
- Digestive Health SCN GI pathways Committee (honorarium)
- Chair of the Pearls for Family Practise Course
- Pharma: Nil

https://twitter.com/promotecore/status/1179146489207111680

2022 UPDATE: OVERVIEW

Calgary Zone webinar series
Mental health & hot topics

The who

the why &

the how?

Who?

Public Health and Preventative Medicine Physicians, Family Physicians, Radiologists, Radiology Tech, Nurse Practitioner, Patient Advocate, Medical Oncologist, Surgical Oncologist, Research Team and External Reviewers

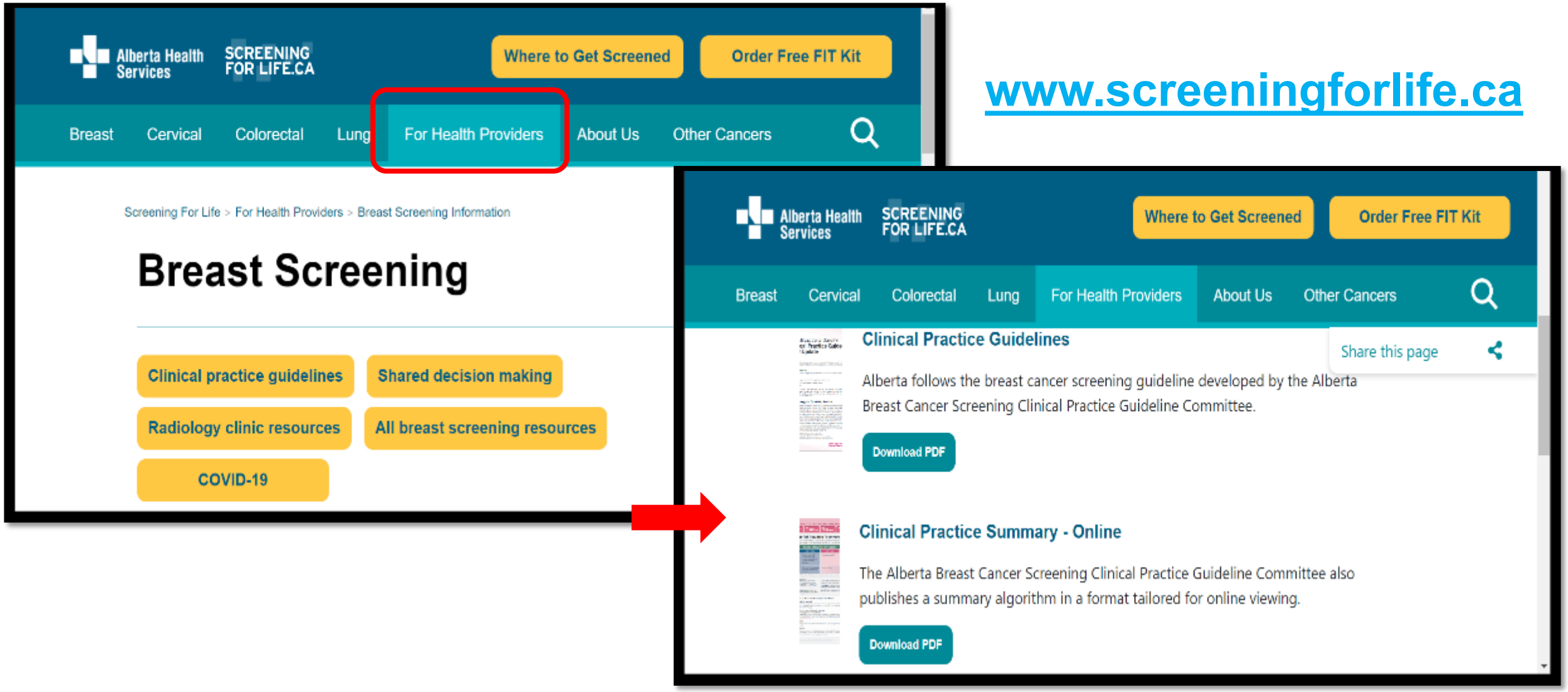
Why?

New evidence in literature and new international guidelines since last update 2013

How?

2022 UPDATE: OVERVIEW

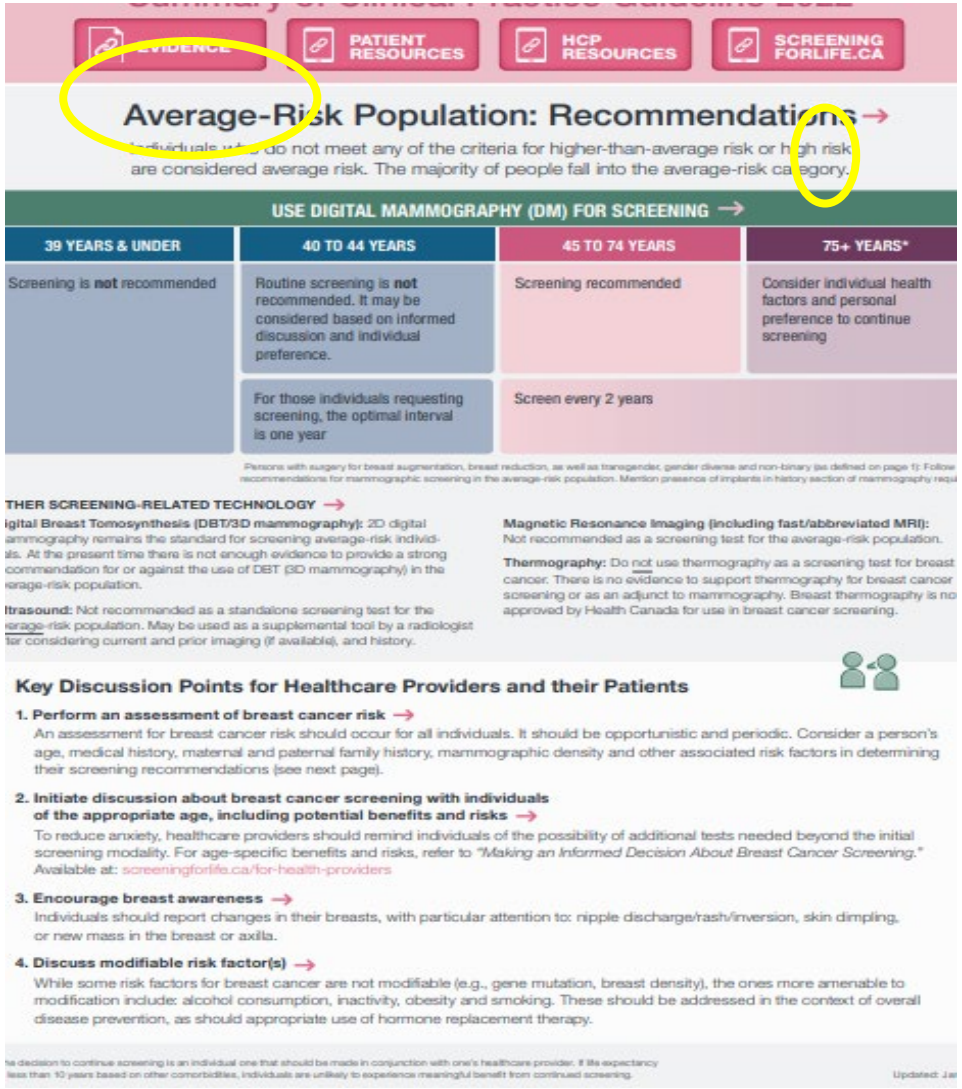
Where do I find the new guideline?



www.screeningforlife.ca

2022 UPDATE: SUMMARY DOCUMENT

Two-page summary document and quick links



EVIDENCE | PATIENT RESOURCES | HCP RESOURCES | SCREENING FORLIFE.CA

Average-Risk Population: Recommendations →

Individuals who do not meet any of the criteria for higher-than-average risk or high risk are considered average risk. The majority of people fall into the average-risk category.

USE DIGITAL MAMMOGRAPHY (DM) FOR SCREENING →

39 YEARS & UNDER	40 TO 44 YEARS	45 TO 74 YEARS	75+ YEARS*
Screening is **not** recommended	Routine screening is **not** recommended. It may be considered based on informed discussion and individual preference.	Screening recommended	Consider individual health factors and personal preference to continue screening
	For those individuals requesting screening, the optimal interval is one year	Screen every 2 years	

Persons with surgery for breast augmentation, breast reduction, as well as transgender, gender diverse and non-binary (as defined on page 1): Follow recommendations for mammographic screening in the average-risk population. Mention presence of implants in history section of mammography requ

THER SCREENING-RELATED TECHNOLOGY →

igital Breast Tomosynthesis (DBT/3D mammography): 2D digital ammography remains the standard for screening average-risk individ- als. At the present time there is not enough evidence to provide a strong commendation for or against the use of DBT (3D mammography) in the erage-risk population.

ltrasound: Not recommended as a standalone screening test for the erage-risk population. May be used as a supplemental tool by a radiologist ter considering current and prior imaging (if available), and history.

Magnetic Resonance Imaging (including fast/abbreviated MRI): Not recommended as a screening test for the average-risk population.

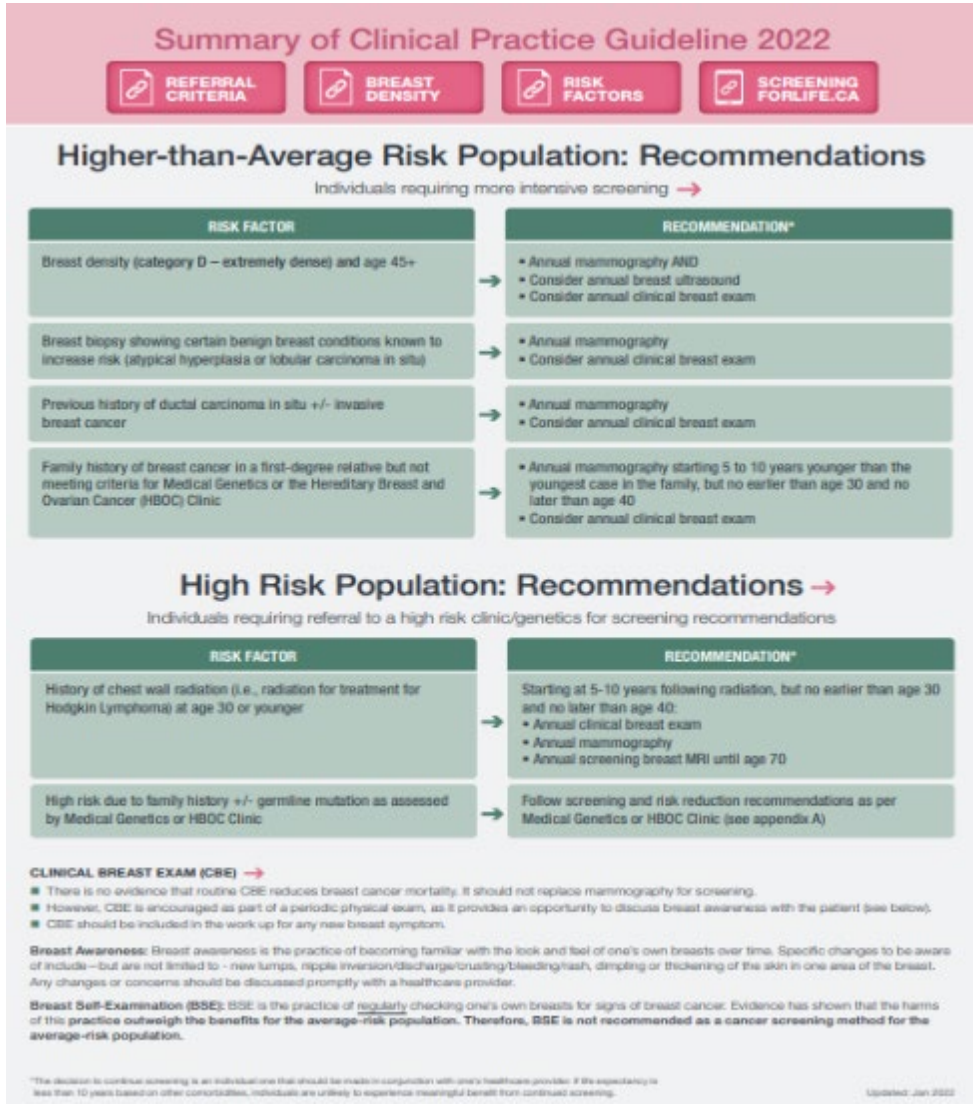
Thermography: Do not use thermography as a screening test for breast cancer. There is no evidence to support thermography for breast cancer screening or as an adjunct to mammography. Breast thermography is no approved by Health Canada for use in breast cancer screening.

Key Discussion Points for Healthcare Providers and their Patients

1. **Perform an assessment of breast cancer risk →**
   An assessment for breast cancer risk should occur for all individuals. It should be opportunistic and periodic. Consider a person's age, medical history, maternal and paternal family history, mammographic density and other associated risk factors in determining their screening recommendations (see next page).
2. **Initiate discussion about breast cancer screening with individuals of the appropriate age, including potential benefits and risks →**
   To reduce anxiety, healthcare providers should remind individuals of the possibility of additional tests needed beyond the initial screening modality. For age-specific benefits and risks, refer to *"Making an Informed Decision About Breast Cancer Screening."* Available at: screeningforlife.ca/for-health-providers
3. **Encourage breast awareness →**
   Individuals should report changes in their breasts, with particular attention to: nipple discharge/rash/inversion, skin dimpling, or new mass in the breast or axilla.
4. **Discuss modifiable risk factor(s) →**
   While some risk factors for breast cancer are not modifiable (e.g., gene mutation, breast density), the ones more amenable to modification include: alcohol consumption, inactivity, obesity and smoking. These should be addressed in the context of overall disease prevention, as should appropriate use of hormone replacement therapy.

he decision to continue screening is an individual one that should be made in conjunction with one's healthcare provider. If life expectancy less than 10 years based on other comorbidities, individuals are unlikely to experience meaningful benefit from continued screening.

Updated: Ja



Summary of Clinical Practice Guideline 2022

REFERRAL CRITERIA | BREAST DENSITY | RISK FACTORS | SCREENING FORLIFE.CA

Higher-than-Average Risk Population: Recommendations

Individuals requiring more intensive screening →

RISK FACTOR	RECOMMENDATION*
Breast density (category D – extremely dense) and age 45+	• Annual mammography AND • Consider annual breast ultrasound • Consider annual clinical breast exam
Breast biopsy showing certain benign breast conditions known to increase risk (atypical hyperplasia or lobular carcinoma in situ)	• Annual mammography • Consider annual clinical breast exam
Previous history of ductal carcinoma in situ +/- invasive breast cancer	• Annual mammography • Consider annual clinical breast exam
Family history of breast cancer in a first-degree relative but not meeting criteria for Medical Genetics or the Hereditary Breast and Ovarian Cancer (HBOC) Clinic	• Annual mammography starting 5 to 10 years younger than the youngest case in the family, but no earlier than age 30 and no later than age 40 • Consider annual clinical breast exam

High Risk Population: Recommendations →

Individuals requiring referral to a high risk clinic/genetics for screening recommendations

RISK FACTOR	RECOMMENDATION*
History of chest wall radiation (i.e., radiation for treatment for Hodgkin Lymphoma) at age 30 or younger	Starting at 5-10 years following radiation, but no earlier than age 30 and no later than age 40: • Annual clinical breast exam • Annual mammography • Annual screening breast MRI until age 70
High risk due to family history +/- germline mutation as assessed by Medical Genetics or HBOC Clinic	Follow screening and risk reduction recommendations as per Medical Genetics or HBOC Clinic (see appendix A)

CLINICAL BREAST EXAM (CBE) →

- There is no evidence that routine CBE reduces breast cancer mortality. It should not replace mammography for screening.
- However, CBE is encouraged as part of a periodic physical exam, as it provides an opportunity to discuss breast awareness with the patient (see below).
- CBE should be included in the work up for any new breast symptom.

Breast Awareness: Breast awareness is the practice of becoming familiar with the look and feel of one's own breasts over time. Specific changes to be aware of include—but are not limited to - new lumps, nipple inversion/discharge/crusting/bleeding/rash, dimpling or thickening of the skin in one area of the breast. Any changes or concerns should be discussed promptly with a healthcare provider.

Breast Self-Examination (BSE): BSE is the practice of regularly checking one's own breasts for signs of breast cancer. Evidence has shown that the harms of this **practice outweigh the benefits for the average-risk population. Therefore, BSE is not recommended as a cancer screening method for the average-risk population.**

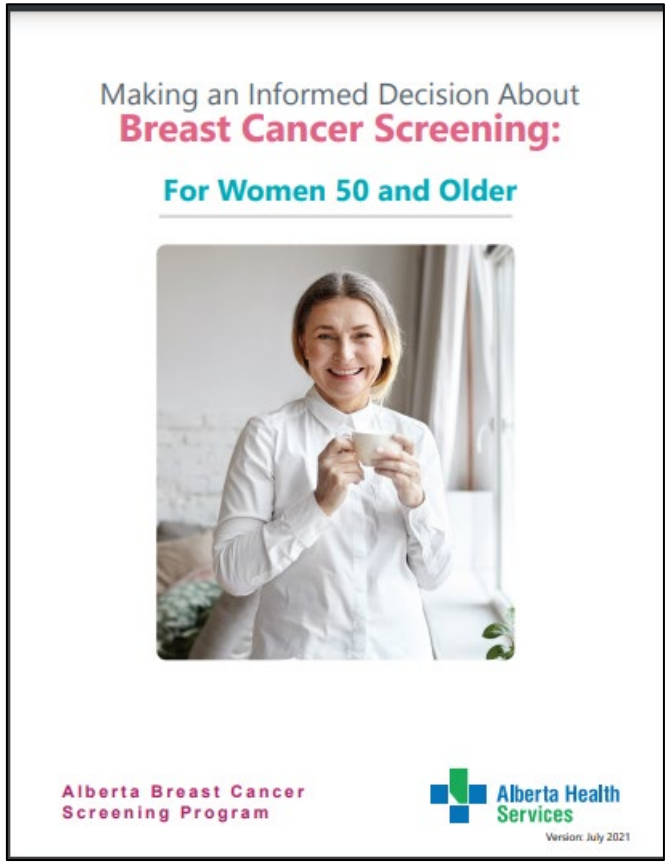
*The decision to continue screening is an individual one that should be made in conjunction with one's healthcare provider. If life expectancy is less than 10 years based on other comorbidities, individuals are unlikely to experience meaningful benefit from continued screening.

Updated: Jan 2022

2022 UPDATE: SCREENING RISKS, BENEFITS

Calgary Zone
webinar series
Mental health
& hot topics

What are the risks and benefits to screening?



Benefits	Risks
Lives Saved: Having a regular mammogram is the best way to find breast cancer early when treatment is most likely to be successful.	**False Positive:** Sometimes screening can lead to further testing even though no cancer is actually present.
Mammograms are safe and effective: Mammograms can usually find lumps 2 to 3 years before you or your health care provider can feel them.	**Over Detection:** You may end up getting treatment for a cancer that never would have become life-threatening even if it was untreated.
Easier Treatment: Finding Breast Cancer early can often mean that less invasive treatment is needed.	**Missed Breast Cancer:** Mammogram x-rays aren't perfect. You may develop breast cancer that doesn't get seen by screening.
Peace of Mind: You may feel better knowing that your are taking steps to find breast cancer early.	**Anxiety:** You may find breast cancer screening to be stressful because it may detect cancer that you were not aware of. You may also find the screening itself uncomfortable. **Low Doses of Radiation:** Mammograms use low doses of radiation, the benefits of make up for the risks of getting these small amounts of radiation.

★ Stay tuned for an updated guide for 45+

www.screeningforlife.ca

Target population

Mammograms are recommended as per the guidelines for all:

1. Asymptomatic (cis-gender*) women, *or*
2. Transgender, gender diverse and non-binary people who are:
   - a) Assigned female at birth and have not undergone top surgery (mastectomy); or
   - b) Assigned male at birth and have been on feminizing hormone therapy for 5 or more years in total.

*Cisgender refers to people who have a gender identity that matches the sex they were assigned at birth.

2022 UPDATE: RISK

Calgary Zone
webinar series
Mental health
& hot topics

First assess your patient's breast cancer risk

- Average risk
- Higher than average risk ****NEW
- High risk

Alberta Breast Cancer Screening Clinical Practice Guideline 2022 Update

2022 UPDATE: RISK

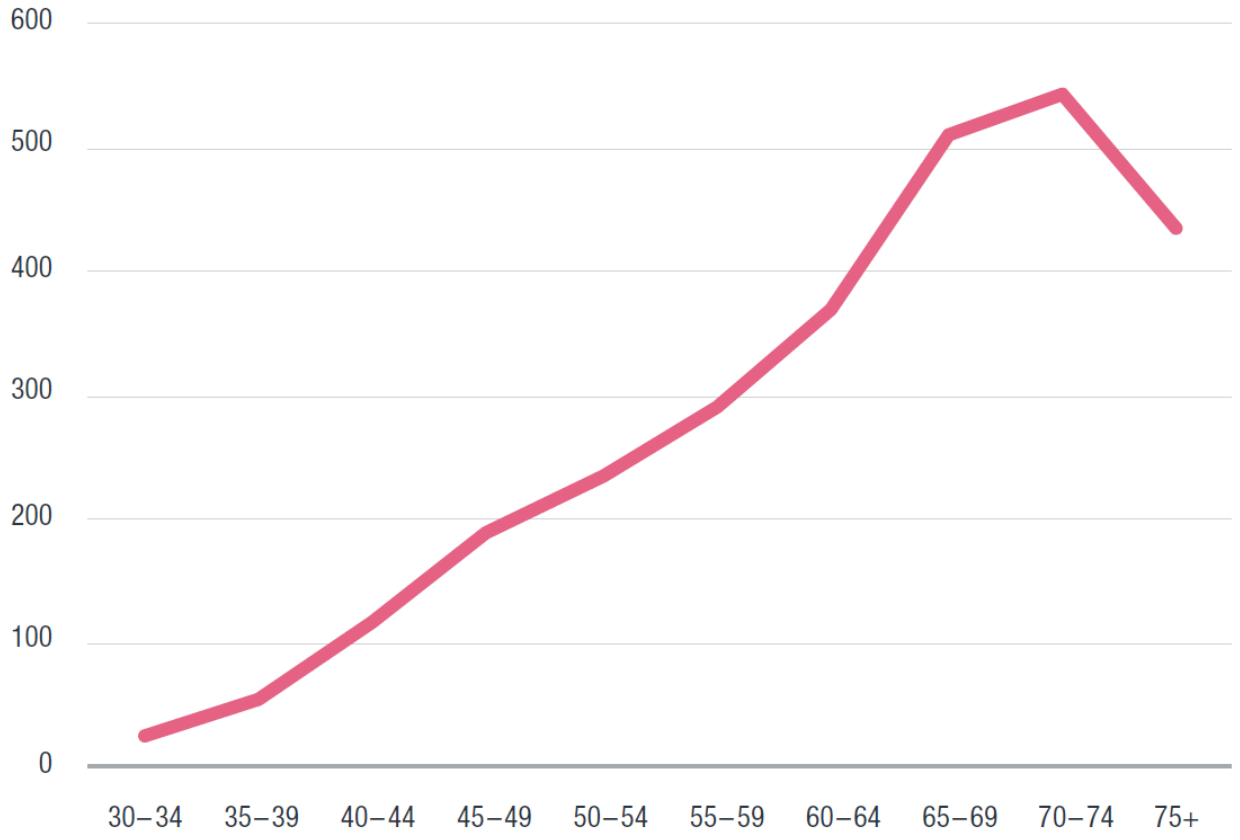
Calgary Zone webinar series
Mental health & hot topics

Non-modifiable

- Age and sex – 1/7 women will be dx with breast cancer and 1/35 will die from the disease
- Family hx – both maternal and paternal
- Breast density (*much smaller than age/sex*)
- Previous abnormal breast biopsy
- Chest wall radiation

- Early menarche, late menopause

Alberta breast cancer (all types) incidence per 100,000 in 2018 by age

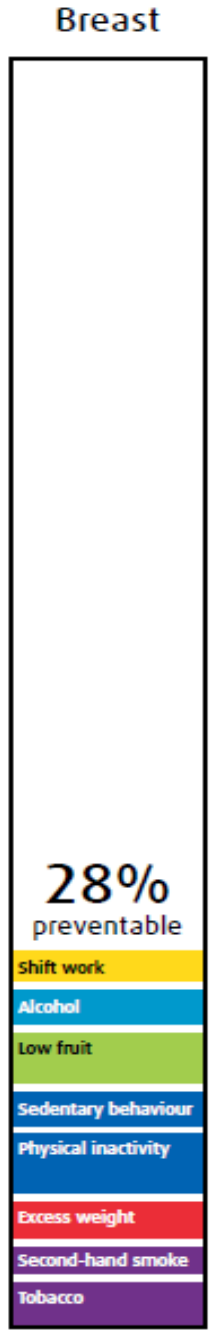


2022 UPDATE: RISK

Risk factors

Modifiable

- Excessive body weight
- Low physical activity
- Alcohol consumption
- Smoking
- BCP, HRT



~28% of breast cancers are preventable

ComPARe 2019
Prevent.cancer.ca

2022 UPDATE: RECOMMENDATIONS

New recommendations for the average risk population (80% of the population)

Summary of Clinical Practice Guideline 2022

EVIDENCE | PATIENT RESOURCES | HCP RESOURCES | SCREENING FORLIFE.CA

Average-Risk Population: Recommendations →

Individuals who do not meet any of the criteria for higher-than-average risk or high risk are considered average risk. The majority of people fall into the average-risk category.

USE DIGITAL MAMMOGRAPHY (DM) FOR SCREENING →

39 YEARS & UNDER	40 TO 44 YEARS	45 TO 74 YEARS	75+ YEARS*
Screening is **not** recommended	Routine screening is **not** recommended. It may be considered based on informed discussion and individual preference.	Screening recommended	Consider individual health factors and personal preference to continue screening
	For those individuals requesting screening, the optimal interval is one year	Screen every 2 years	

Persons with surgery for breast augmentation, breast reduction, as well as transgender, gender diverse and non-binary (as defined on page 1): Follow above recommendations for mammographic screening in the average-risk population. Mention presence of implants in history section of mammography requisition.

2022 UPDATE: AGE, FREQUENCY

Calgary Zone
webinar series
Mental health
& hot topics

Why did we change the recommended age and frequency of mammograms for average risk women?

New higher quality evidence in the literature

Epidemiology of breast cancer in Alberta

Simulation modeling outcomes using Alberta data

2022 UPDATE: NEW RISK CATEGORY

Calgary Zone
webinar series
Mental health
& hot topics

Summary of Clinical Practice Guideline 2022

REFERRAL CRITERIA | BREAST DENSITY | RISK FACTORS | SCREENING FORLIFE.CA

Higher-than-Average Risk Population: Recommendations

Individuals requiring more intensive screening →

NEW!

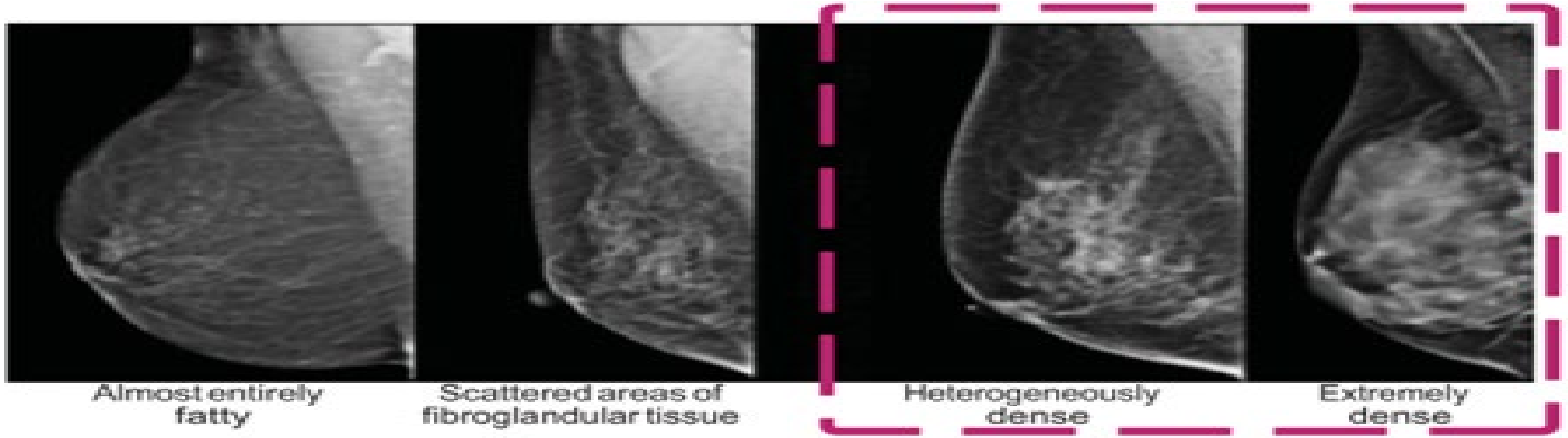
RISK FACTOR	RECOMMENDATION*
Breast density (**category D – extremely dense**) and age 45+	▪ Annual mammography AND ▪ Consider annual breast ultrasound ▪ Consider annual clinical breast exam
★ Breast biopsy showing certain benign breast conditions known to increase risk (atypical hyperplasia or lobular carcinoma in situ)	▪ Annual mammography ▪ Consider annual clinical breast exam
★ Previous history of ductal carcinoma in situ +/- invasive breast cancer	▪ Annual mammography ▪ Consider annual clinical breast exam
★ Family history of breast cancer in a first-degree relative but not meeting criteria for Medical Genetics or the Hereditary Breast and Ovarian Cancer (HBOC) Clinic	▪ Annual mammography starting 5 to 10 years younger than the youngest case in the family, but no earlier than age 30 and no later than age 40 ▪ Consider annual clinical breast exam

★ Previously “High Risk Population”

Previously no earlier than age 25

2022 UPDATE: BREAST DENSITY

- A – almost entirely fatty
- B – scattered areas of fibroglandular density
- C – heterogeneously dense, may obscure small masses
- D – extremely dense, lower sensitivity of mammograms, 2.1 x higher relative risk of breast ca (now moves them into the higher-than-average risk category)



2022 UPDATE: HIGH RISK RECOMMENDATIONS

Calgary Zone
webinar series
Mental health
& hot topics

High Risk Population: Recommendations →

Individuals requiring referral to a high risk clinic/genetics for screening recommendations

RISK FACTOR	RECOMMENDATION*
History of chest wall radiation (i.e., radiation for treatment for Hodgkin Lymphoma) at age 30 or younger	Starting at 5-10 years following radiation, but no earlier than age 30 and no later than age 40: ▪ Annual clinical breast exam ▪ Annual mammography ▪ Annual screening breast MRI until age 70
High risk due to family history +/- germline mutation as assessed by Medical Genetics or HBOC Clinic	Follow screening and risk reduction recommendations as per Medical Genetics or HBOC Clinic (see appendix A)

Previously age 25

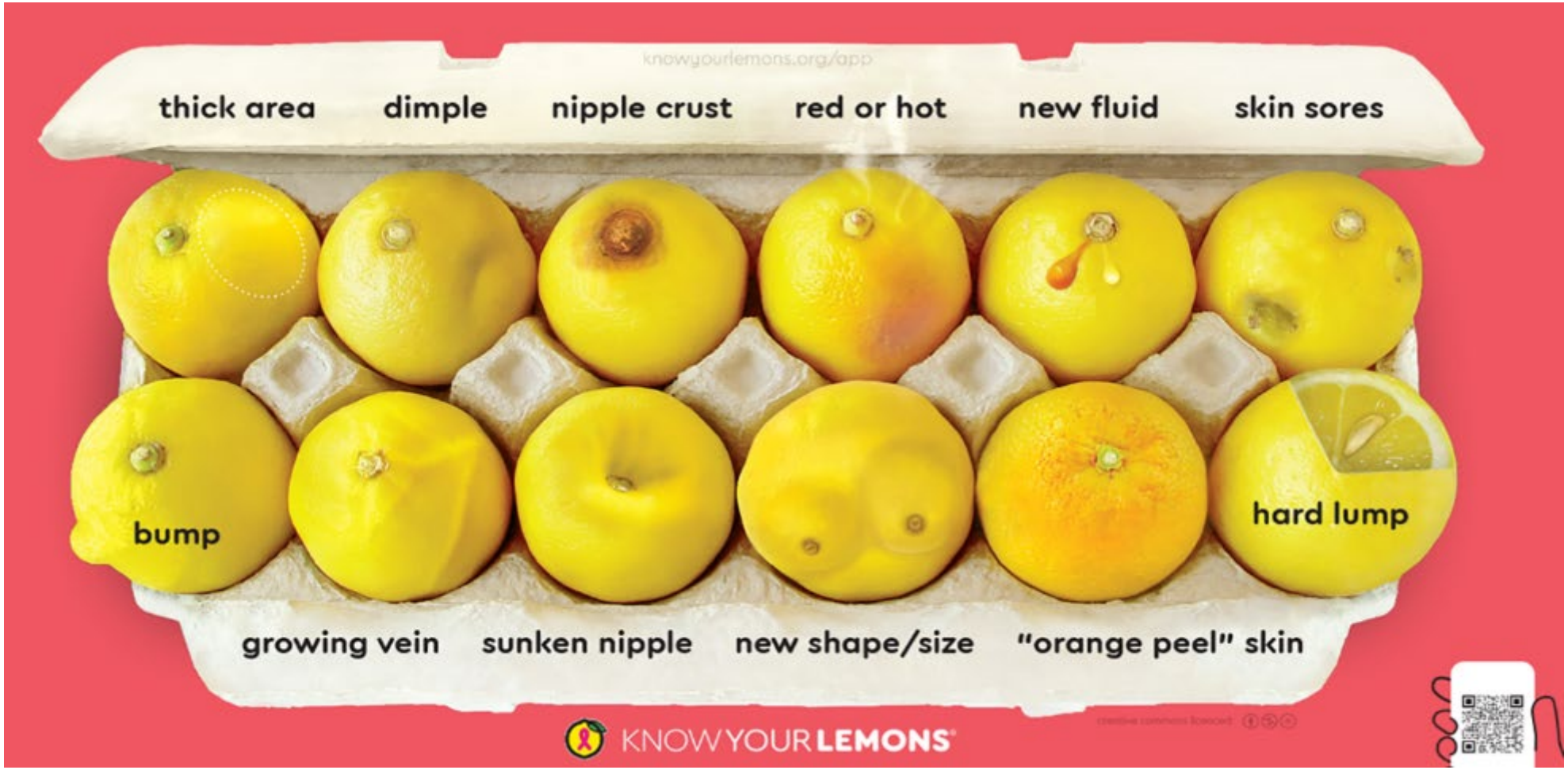
Updated to match current clinic criteria

Previously no end age

2022 UPDATE: KNOW YOUR LEMONS

Calgary Zone
webinar series
Mental health
& hot topics

What about: Clinical breast exam vs. self breast exam vs. breast self awareness?



www.knowyourlemons.org

2022 UPDATE: SUPPLEMENTARY SCREENING

Calgary Zone
webinar series
Mental health
& hot topics

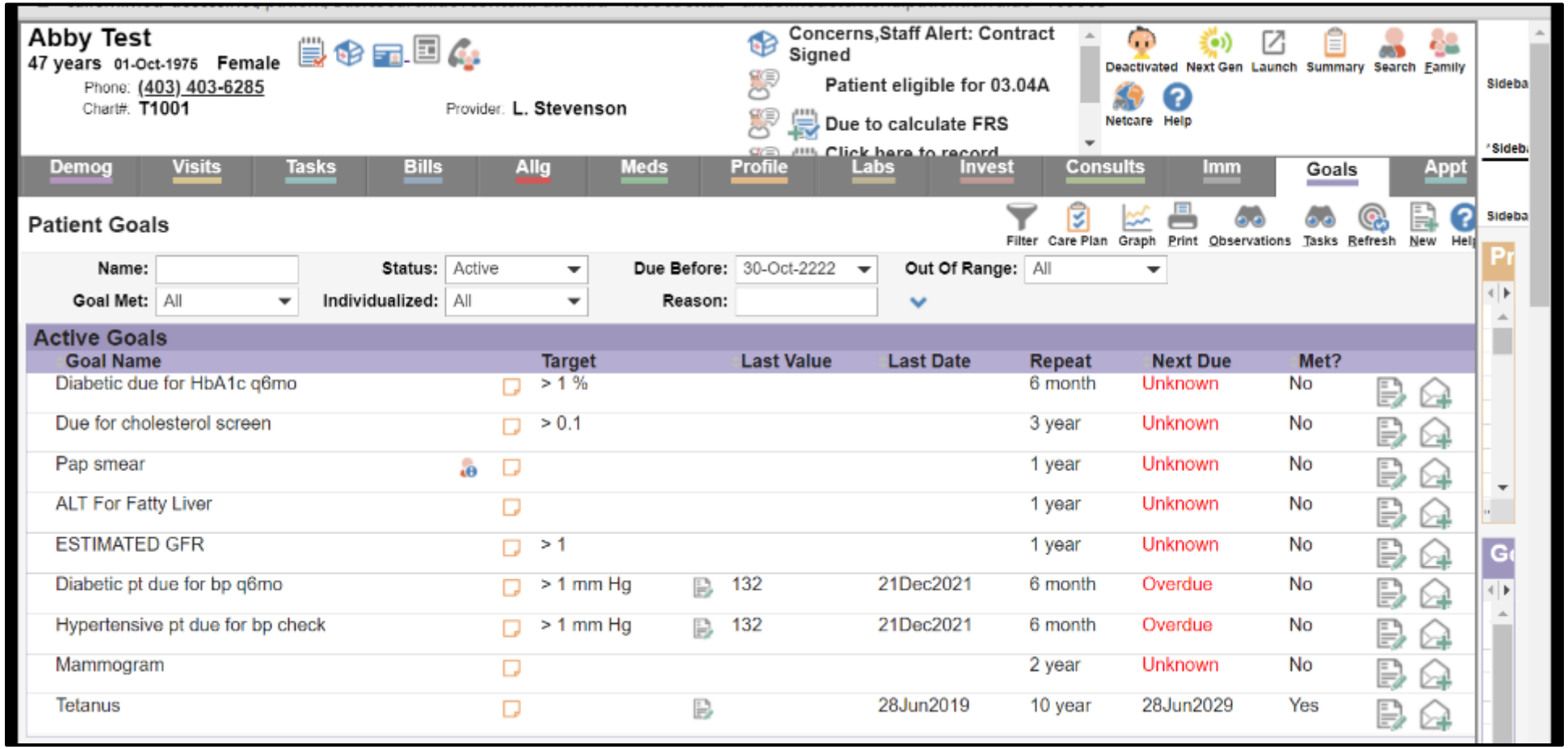
What about supplementary screening with tomosynthesis, breast ultrasound, MRI?

- Tomosynthesis (DBT)
- Supplemental Breast US
- MRI

2022 UPDATE: GOALS OF CARE

Calgary Zone
webinar series
Mental health
& hot topics

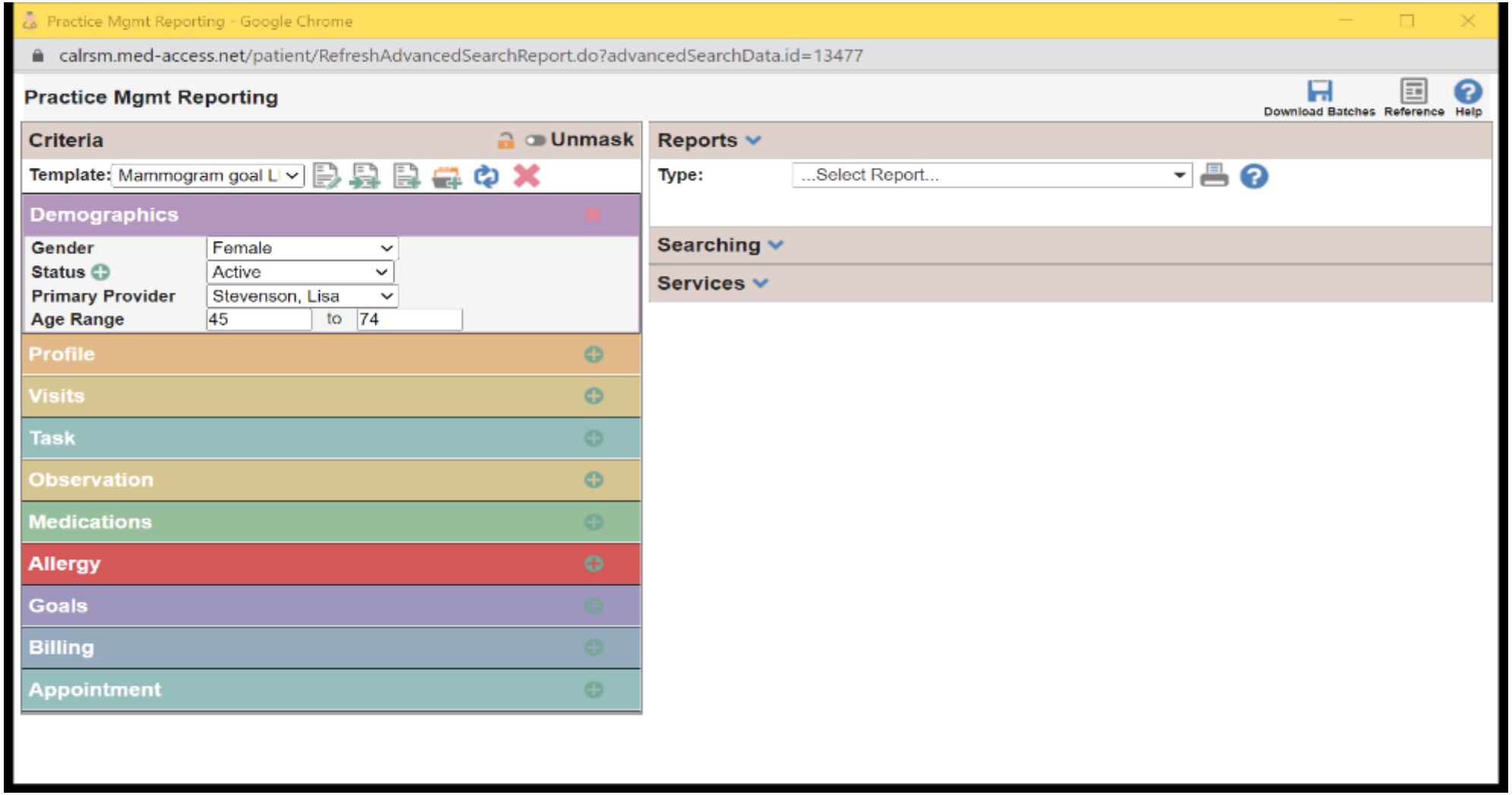
How will I change my practise with these new guidelines?
I have changed my “goals” of care for mammograms



2022 UPDATE: MANAGEMENT

Calgary Zone
webinar series
Mental health
& hot topics

Run a search – your HIC can help with this and provide outreach to your patients



A nice little
QI project!

2022 UPDATE: SUMMARY

Calgary Zone
webinar series
Mental health
& hot topics

- New ABCSP guideline is both practical, and easy to follow with great healthcare provider resources and patient resources

- New recommendation to lower the recommended age for biennial screening for average risk individuals from age 50 to age 45

- A new higher-than-average risk category requiring more intensive screening

- The high risk category is more clearly defined with referral information for both high risk assessment clinics and high risk genetics clinics