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## Have you had your mammogram, doctor?

Mary E. Guinan, MD, PhD

Breast cancer incidence continues to increase in the United States, with more than 130,000 new cases and 42,000 deaths expected this year. Today, one in every ten women in the United States will develop breast cancer at sometime during their lives. Breast cancer can be prevented by early prophylactic bilateral mastectomy, ie, removal of the breasts before any signs or symptoms develop. This practice was advocated by a male gynecologist colleague of mine. When I expressed horror at his suggestion that I have such a procedure at age 32, he challenged me to defend myself against advocating a practice that would save hundreds of thousands of women from developing breast cancer. At the time, my only response was to ask whether all men should have early (about age 30) prophylactic prostatectomies to prevent cancer of the prostate. Now, after many years of mulling over the problem of breast cancer, I am still unsure of the appropriate strategy with regard to breast cancer—for myself and others. There is no acceptable way to prevent breast cancer, but the related morbidity and mortality can be reduced by early diagnosis. Screening mammography is at present the best method for early diagnosis, but at what age and how frequently is unclear.

I am often asked by friends, relatives, and colleagues what I do about various health issues, so that I know I am being used as a role model. In fact, the knowledge that my behavior might affect the health behavior of other women and men was probably one of the most heavily weighted factors in my decision to stop smoking cigarettes. When it comes to breast cancer, I am uncomfortable being a role model for other women because I am confused about the issues and not sure what behavior is

appropriate for my age group (40–49). Perhaps many of you share my confusion. If so, what are you recommending to your patients? Do your personal choices about mammography affect what you tell your patients? What are women physicians doing about breast cancer, both personally and in their practices? I am hoping to do a survey of the AMWA membership to find an answer to these questions.

I expect that if I'm confused about mammography, then so are women without medical training. I would like to present the issues as I see them. The current American Cancer Society recommendations for breast cancer screening are: 1) all women have a baseline mammography between age 35 and 39; 2) women from ages 40 to 49 have a mammogram every one to two years; 3) women aged 50 and over have a mammogram every year. The data supporting annual mammography in women aged 50 and over are convincing. This recommendation is supported by the National Cancer Institute and numerous other professional organizations.<sup>1</sup> Annual screening mammography can significantly reduce mortality from breast cancer in women 50 and over. This applies to *all* women in this age group including those without signs and symptoms or risk factors for breast cancer.

Are all AMWA members 50 and over having screening mammographies? If not, I urge you all to do this as an excellent way of reducing the morbidity and mortality of breast cancer that will develop in at least one in every ten of us. This recommendation should be emphasized because *fewer than 50% of American women aged 50 and over are taking advantage of this preventive measure*. In a 1987 survey in Rhode Island, only 38% of women between 50 and 59, 42% of women aged 60 to

69, and 29% of women 70 and over had had a mammogram in the preceding year.<sup>1</sup> The proportion of women undergoing this procedure increased with both age and income. When asked why they did not have a mammogram, 32% of all women over 40 said they did not believe it was necessary, 23% stated it had *not been recommended by their physicians*, and 3% stated that their *physicians recommended against* having a mammogram. Of all women whose physicians recommended a screening mammogram, 60% had had one, compared with only 8% of women not receiving this recommendation. Therefore, physicians are very influential in affecting this positive health behavior. It would be interesting to know if women physicians have more influence in this regard or are comparably or less influential than their male colleagues. Let us assume that we have at least equal or greater influence on women's behavior. Are we exercising this influence appropriately? If you are 50 or over, are you having *your* annual mammogram, doctor? And are you advising your patients 50 and over to do the same?

That part is easy, since the recommendations for women 50 and over are not controversial, and I have not yet reached age 50. Now comes the difficult part. Although it makes sense to have a baseline mammography for comparison with later ones, no studies have shown that women who have had baseline mammographies at ages 35 to 39 are better off than those who do not. Even more confusing are the differences of opinion on screening women aged 40 to 49. The studies that did and did not show benefits from screening women under age 50 were recently reviewed.<sup>2</sup> The authors concluded that the choice is unclear. In an accompanying editorial, however, John Bailar, MD, very forcefully

stated that there is "no justification for routine mammographic screening of women aged 50 and younger."<sup>3</sup> Charles R. Smart, MD, of the National Cancer Institute strongly disagreed,<sup>4</sup> stating that such screening can reduce breast cancer mortality by 50%. To add to the controversy, some have suggested that physicians who do *not* recommend mammography to their patients 50 and under put their liability at stake. Is it true that the argument against screening women under 50 was made only to protect practicing clinicians from lawsuits by women who developed breast cancer and had not been advised to have a mammography, as some have charged?<sup>4</sup> Very mixed messages are being directed at the medical community and the public. In the meantime, what should we be doing? Are you confused?

Well, the good news is that this is another reason for women to be happy to reach age 50. As this will happen to me quite soon, I will be relieved to know that I should be having a mammogram every year. I hope I will be convinced enough to be a good role model both personally and professionally.

#### References

1. Use of mammography for breast cancer screening—Rhode Island, 1987. *MMWR* 1988;37:357-360.
2. Eddy DM, Hasselblad V, McGivney W, et al: The value of mammography screening in women under age 50 years. *JAMA* 1988;259:1512-1519.
3. Bailar JC: Mammography before age 50 years? *JAMA* 1988; 259:1548-1549.
4. Thomas P: The muddle over screening breast ca. *Med World News*, May 9, 1988, pp 34-48.

#### NOMAD, continued

—Most hospitals, both osteopathic and allopathic, are essentially the same. It is the people working in them that makes the difference.

—I feel that you can tell how much the hospital cares about teaching by how they treat their externs, interns, and residents, and if the lectures come off on a fairly regular basis. If externs/interns are treated like glorified orderlies and H&P machines this may not be the place you want to spend any more of your professional training time. I found some places treated me like a human being and others treated me like a piece of property. And it was interesting that the places that treated me, the lowly clinical clerk, humanely had the most content interns and residents.

#### Final suggestions:

—Try to go to the office if at all possible. It gives you an opportunity to see what the bread and butter of the specialty is like. Remember that with few exceptions the office is where most healing is done. How can you evaluate a specialty to see if it is the one you wish to do for the rest of your life if you don't know what the bulk of it is like? I also found that the attendings (for the most part) were willing to share business information and tips about life in their types of practice. All you need to do is to express interest. You never know what you might learn or when it could come in handy.

—Just because a hospital is small don't dismiss it as not worthy of your attention, there is a lot to learn there. I think that there is an advantage in not having 12 different levels of interns and residents between you and the patients or attendings. Also remember that most of us will be practicing in community hospitals and not the teaching meccas that we were trained in.

All in all, I would do it again. I guess I just have that "gypsy" blood flowing through my veins.

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