Breast Cancer Screening
Summary of the Clinical Practice Guideline | September 2013

These recommendations are systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances. They should be used as an adjunct to sound clinical decision making.

**AVERAGE RISK POPULATION: RECOMMENDATIONS**

Use Mammography for Screening

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>39 years &amp; under</td>
<td>Screening is not recommended</td>
</tr>
<tr>
<td>40 to 49 years</td>
<td>The balance of benefits and risks is not great enough to recommend routine screening. Consider woman’s preference. If screened, the optimal interval is annual.</td>
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<tr>
<td>50 to 74 years</td>
<td>Screening recommended</td>
</tr>
<tr>
<td>75+ years</td>
<td>Consider individual health factors and woman’s preference. Screen every 2 years.</td>
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**HIGH RISK POPULATION: RECOMMENDATIONS**

Women Requiring More Intensive Screening

- One or two first degree relatives with invasive breast cancer, but do not meet the criteria for referral to Medical Genetics.
- Breast biopsy showing atypical hyperplasia or lobular carcinoma in situ and following surgical management to rule out invasive carcinoma.
- History of chest wall radiation at age 30 or younger.

Women Requiring Referral to Medical Genetics

- Maternal or paternal family history of:
  - Multiple individuals with breast and/or ovarian* cancer (e.g., 3 or more cases in 2 or more generations, at least one case onset before age 50), related to each other
  - Bilateral primary breast cancer, first onset age 50 or younger
  - Breast cancer at age 35 or younger
  - Breast cancer that is hormone receptor negative and HER2 negative (a.k.a., triple negative), age 60 or younger
  - Primary breast and primary ovarian cancer in the same individual
  - Male breast cancer, age 65 or younger, or at any age with close family history of breast cancer
  - Breast or ovarian cancer in a family with Ashkenazi Jewish heritage
  - BRCA1 or BRCA2 mutation in the family
  - *Serous epithelial cancer of the ovaries, fallopian tube cancer or primary peritoneal cancer

- Annual mammography starting 5 to 10 years younger than the youngest case in the family, but no earlier than age 25 and no later than age 40.
- Annual CBE starting age 25.
- Annual mammography
- Annual CBE
- Annual mammography and screening breast MRI starting 5 to 10 years after radiation given, but no earlier than age 25 and no later than age 40.
- Annual CBE

Breast augmentation, breast reduction, sex-reassignment: As above. Note presence of implants in history section of mammography requisition form.

Clinical Breast Exam (CBE): Do not use for screening. Consider as part of physical exam.

Not recommended for routine screening: MRI, ultrasound, tomosynthesis, thermography, breast self-examination.

Note: Telehealth services are available for women living in remote areas.

Note: Refer to Medical Genetics in Edmonton or Calgary for potential counseling +/- genetic testing.

Follow recommendations from Medical Genetics regarding screening and risk reduction.

For eligible women who decline or are unable to attend counseling, follow the recommendations for women with one or two first degree relatives with invasive breast cancer (see above).
KEY DISCUSSION POINTS FOR HEALTH CARE PROVIDERS AND WOMEN

1. Initiate discussion about screening mammography with women of the appropriate age, including potential benefits and risks of mammography

   Health care providers should remind women of the possibility of additional tests in order to reduce anxiety. For age-specific benefits and risks, refer to Information on Mammography for Women Aged 40 and Older: A Decision Aid for Breast Cancer Screening in Canada, Public Health Agency of Canada, 2009. Available at: www.phac-aspc.gc.ca/cd-mc/mammography-mammographie-eng.php.

2. Encourage breast awareness

   Women should report changes in their breasts, in particular: nipple discharge, rash on nipples, inversion, dimpling or new mass in the breast or axilla.

3. 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, physical activity, weight management, and smoking. These should be addressed in the context of overall disease prevention, as should appropriate use of hormone replacement therapy.

IMPLEMENTATION STRATEGIES

Use outreach, opportunistic screening and checklists to increase the likelihood of engaging women to make informed decisions about screening.

GENERAL RESOURCES


RESOURCES FOR HIGH RISK POPULATION

- Calgary Cancer Genetics Clinic: Dr. R.B. Lowry Genetics Clinic, Alberta Children’s Hospital, 2888 Shaganappi Trail NW, Calgary, AB T3B 6A8. Phone: (403) 955-7137. Fax (403) 955-2701
- Calgary High Risk Breast Cancer Clinic: The High Risk Breast Cancer Clinic, Calgary Zone Alberta Health Services accepts referrals using the Central Access and Triage system. Phone (403) 944-2240
- Edmonton Cancer Genetics Clinic Referral Criteria: www.medicalgenetics.med.ualberta.ca. Edmonton Medical Genetics Clinic, 8-53 Medical Sciences Building, University of Alberta, Edmonton, Alberta T6G 2H7, Phone (780) 407-7333, Fax (780) 407-6845
- Allard Hereditary Breast and Ovarian Clinic, Royal Alexandra Hospital, Robbins Pavilion, Ground Level, 10240 Kingsway Avenue, Edmonton, Alberta, T5H 3V9, Phone (780) 735-4718, Fax (780) 735-4020

For the complete guideline refer to the TOP website: www.topalbertadoctors.org

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