Summary of Breast Cancer Screening Clinical Practice Guideline 2022

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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.

OTHER SCREENING-RELATED TECHNOLOGY

Digital Breast Tomosynthesis (DBT/3D mammography): 2D digital mammography remains the standard for screening average-risk individuals. There is insufficient evidence at this time to recommend DBT for screening the average-risk population. However, it may be used for screening in conjunction with synthetic or standard 2D mammography.

Ultrasound: Not recommended as a standalone screening test for the average-risk population. May be used as a supplemental tool by a radiologist after 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 not 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.

*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: Dec 2022

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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: Dec 2022