

Overtreating earliest cancers -- but which ones?

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Breast cancer survivor D.J. Soviero poses for a photograph at her office in San Francisco, Thursday, June 10, 2010. Soviero wanted the least treatment that would beat back her small, early-stage breast cancer, and sought help choosing from a novel program at the University of California, San Francisco, that offers patients unbiased information on the pros and cons of different options, plus an aide to help them come up with questions for the doctors and record the answers. (AP Photo/Jeff Chiu)

(AP) -- D.J. Soviero wanted the least treatment that would beat back her small, early-stage breast cancer, but her first doctor insisted she had only one option: tumor removal followed by radiation and chemotherapy.

Then she found a novel program at the University of California, San Francisco, that gave her an unbiased evaluation of the pros and cons of all treatment options.

"I realized that I didn't need to use a sledgehammer. It was my choice," said Soviero, of San Francisco, who went with the [lumpectomy](#) and radiation, but refused the chemo.

It's an unthinkable notion for a generation raised on the message that early [cancer detection](#) saves lives, but specialists say more tumors actually are being found too early. That is raising uncomfortable questions about how aggressively to treat early growths - in some cases, even how aggressively to test - along with a push for more of the informed-choice programs such as the one Soviero used.

"The message has been, 'Early detection, early detection, early detection.' That's true for some things but not all things," said Dr. Laura Esserman, a [breast cancer](#) specialist at UCSF. She helped lead a study, reported last week, that found mammography is increasing diagnoses of tumors deemed genetically very low risk.

"It's not just all about finding any cancer. It's about being more discriminating when you do find it," she added.

Today's cancer screenings can unearth tumors that scientists say never would have threatened the person's life. The problem is there aren't surefire ways to tell in advance which tumors won't be dangerous - just some clues that doctors use in prescribing treatment.

Work is under way to better predict that, and even the staunchest supporters of screening call overdiagnosis a problem that needs tackling.

"We're really at a tipping point right now, where we have a trade-off

between the benefits of finding cancer early and the harms that are caused," said Dr. Len Lichtenfeld of the American Cancer Society. "We treat more patients than we know will benefit. ... We just don't know who they are."

Nowhere is the disconnect more obvious than with prostate cancer screening. Most men over 50 have had a PSA blood test to check for it even though major medical groups don't recommend routine PSAs, worried they may do more harm than good for the average man.

What's the evidence? A study of 76,000 U.S. men, published last year, concluded annual PSAs didn't save lives. A separate study estimated two of every five men whose prostate cancer was caught through a PSA test had tumors too slow-growing ever to be a threat.

A European study of 162,000 men screened less aggressively - a PSA every four years versus none - found seven fewer deaths per 10,000 men screened. But 48 men had to be treated to prevent each death, meaning many men who weren't facing death experienced treatment that can have such side effects as incontinence and impotence.

Thus, the American Cancer Society urges that men weigh the limitations of PSAs against their individual risk and fear of cancer before deciding for themselves. Government guidelines say men over 75 shouldn't get a PSA at all - although about one-third do.

"PSA is the controversy that refuses to die," said Dr. Michael Barry of Massachusetts General Hospital and the Foundation for Informed Medical Decision-Making, which pushes programs that help patients make such choices. "But in some ways, it's the prototypical close call that we have to come to grips with in American medicine - that there just isn't one right answer for everybody."

Mammograms aren't nearly as controversial, except for the when-to-start-them question. Most medical groups advise age 40; a government task force ignited complaints last year by advising not until 50. Generally, studies find they cut the risk of death from breast cancer by roughly 20 percent.

The trade-off: More than three-quarters of the 1 million-plus anxiety-provoking biopsies done each year to check out suspicious spots turn out to have been false alarms.

The bigger unknown is overdiagnosis, as closer mammogram readings spot ever-earlier growths.

A study in last month's Journal of the National Cancer Institute said nearly one-quarter of breast tumors found by mammograms may be overdiagnosed. That includes invasive cancer, but also a common milk-duct growth called DCIS, or ductal carcinoma in situ.

DCIS isn't invasive cancer and isn't life-threatening; it's described as "stage zero" cancer or even pre-cancer. But it is a risk factor for later developing invasive disease, and many of the 50,000 DCIS cases a year get the same care as women with outright early cancer.

Research is examining when and how to scale back aggressive DCIS care. At UCSF, Dr. Shelley Hwang is testing whether hormone drugs such as tamoxifen allow DCIS patients to avoid surgery altogether.

A colleague, Dr. Karla Kerlikowske, this spring reported tumor markers that suggest up to 44 percent of DCIS patients might skip aggressive treatment. A government panel last year even urged removing the word "carcinoma" from the name, to lessen fear.

Beyond DCIS, Esserman is designing a first-of-a-kind study to start by

summer's end at five University of California health centers. Women whose mammograms turn up a specific type of suspicious spot that is unlikely to be aggressive cancer will get the option of skipping today's usual biopsy and repeating the scan in six months instead. She hopes to learn which early abnormalities are safe to leave alone.

"If you've had a normal mammogram and develop a new mass, don't ignore that. If you have a new symptom, those are things you don't want to ignore," Esserman said. "The public also has to understand that it's complicated and there are some cancers that are very slow-growing."

"The problem with our tests is they can see too much," added study author Dr. H. Gilbert Welch of Dartmouth and the Veterans Affairs Outcomes Group, who led the overdiagnosis study published last month. He says raising the threshold at which tests signal suspicion could help.

Welch also found diagnoses of thyroid cancer have more than doubled while the death rate remains unchanged, saying the new cases are almost entirely a small, low-risk type spotted with increasing medical scans.

Another issue is overscreening - testing people who won't benefit, or testing too often.

Just on Monday, a survey of 950 doctors published in Archives of Internal Medicine found fewer than one-third follow national guidelines that say 30-somethings at low risk of cervical cancer need a Pap smear every three years instead of every year. They even too frequently screen women who tested free of the virus that causes this slow-growing tumor.

Worse, a 2004 study estimated nearly 10 million women had still received a Pap, which only checks for signs of cervical cancer, after losing their cervix to a hysterectomy for noncancerous reasons.

Then there are the "incidentalomas," a word recently coined to describe another growing problem. Get a chest CT scan to check for, say, heart disease. In addition to your arteries, it might also show your lungs - and any dot or shadow leads to even more testing to rule out cancer.

That happened to Lichtenfeld, the cancer society expert, during his own heart CT two years ago. A follow-up scan six months later showed the small nodule on his lung wasn't growing, but did flag as suspicious additional tiny inflamed spots. Lichtenfeld knew those spots weren't very risky and refused doctors' recommendations for pricey additional tests.

However those overarching questions turn out, patients today face tough treatment choices - and that's where "shared decision-making" programs come in. They help patients balance the right amount of care for their comfort level. Some, like Soviero, want less while others want more.

"What's underuse to one person might be overuse to another," said Jeff Belkora, who directs the decision-services program at UCSF's Breast Care Center.

UCSF's program sends newly diagnosed breast cancer patients a DVD to watch before that all-important first visit with a cancer specialist, to outline treatment options for their [cancer](#) stage and dispel myths. Patients also are offered a unique service, the aid of an intern to create a good list of questions to ask at that visit - and then to attend with them, recording the doctor's answers so they won't forget.

Soviero, now 63, first used the program in 2000 and her right breast remains cancer-free, affirming her choice to avoid [chemotherapy](#). Last year, a mammogram spotted a tiny, unrelated tumor in her other breast. She went through the program again, and her fears about another round of radiation were relieved. She chose the same care - lumpectomy and radiation but no [chemo](#).

"The hard part of making a decision is you never know. ... I was lucky. I made the right decision, but you only know that down the road, looking back," Soviero said.

More information: UCSF Decision Services:

<http://www.decisionservices.ucsf.edu/>

Foundation for Informed Medical Decision-Making:

<http://www.informedmedicaldecisions.org>

Archives of Internal Medicine: <http://archinte.ama-assn.org/>

Journal of the National Cancer Institute: <http://jnci.oxfordjournals.org/>

Veterans Affairs Outcomes Group: <http://www.vaoutcomes.org>

American Cancer Society: <http://www.cancer.org>

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