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Study combats 'anxiety' as barrier to breast cancer screening

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Recent American Cancer Society (ACS) breast cancer screening guidelines consider the anxiety created by false-positive mammography an "important but not critical outcome" when deciding who should be screened. In other words, in these guidelines, the chance that mammography will create needless cancer worry is a light thumb on the scale against breast cancer screening in some populations. A study published in the *Journal of the American College of Radiology* describes a successful intervention to decrease this anxiety, lessening this barrier to screening. The study reports that after attending a public informational talk by a trained radiologist speaking about the logistics and outcomes of mammography, 117 participants scored a mean of "4" on a scale from 1-5 describing decreased screening anxiety.

"Our question was, if the ACS - and before them the U.S. Preventative Task Force - considered anxiety a harm that could prevent screening, how could we minimize that harm," says Lara Hardesty, MD, investigator at the University of Colorado Cancer Center and associate professor of Radiology-Diagnostics at the University of Colorado School of Medicine, one of the paper's co-authors.

Hardesty and collaborator Jiyon Lee, MD, assistant professor in the New York University School of Medicine Department of Radiology, hypothesized that in this case, information would reduce anxiety. Lee delivered this information in the form of lunchtime lectures to a diverse group of organizations in the New York City area, including business, religious and community groups. A questionnaire administered before

the informational talk discovered sources of screening anxiety, with 56 percent worried about unknown results, 22 percent anticipating pain with the procedure, 15 percent worried about how known risk factors may influence the likelihood of a breast cancer diagnosis, 13 percent citing general uncertainty, 9 percent blaming increased anxiety on waiting for results, and 4 percent citing the possibility of more procedures as a factor that provokes anxiety.

"Our intention was to teach women what to expect from having a mammogram done and what to expect if you are called back for further testing. This happens to 10 percent of women, and we wanted them to know that a positive screening mammogram doesn't mean you definitely have cancer," Hardesty says.

After an hour-long informational session, a follow-up questionnaire found that nearly all attendees were able to correctly answer questions about the rationale for screening, the difference between the need for additional testing and a cancer diagnosis, the benefit of negative screenings as a baseline for future comparisons, and the continued importance of physical examinations. Lectures were associated with gains in understanding (4.7 on a 1-5 scale), encouragement to screen (4.6) and reduced anxiety (4.0).

"There is a major difference between the concepts of over-diagnosing and over-treating breast cancer," Hardesty says. In her opinion, it remains essential to screen aggressively for breast cancer in hopes of catching the disease in an early, treatable stage.

"I personally have found breast cancers on the screening mammograms of many women from ages 40 to 45, whose cancers tend to be of a type that grow rapidly and act aggressively," she says. "In cases where mammography discovers a cancer that is unlikely to be harmful, patients and doctors can still decide not to treat. In either case, it's good to

know."

Hardesty hopes that the current study demonstrates the ability to soothe anxieties surrounding mammography and its results, removing one factor that could influence the decision to not screen.

More information: www.ncbi.nlm.nih.gov/pubmed/26482812

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