# Clinicians' perspectives on issues around DCIS detected through age-extended screening

Jolyn Hersch,

Jesse Jansen, Brooke Nickel, Claudia Rutherford, Nehmat Houssami, Alexandra Barratt, Christobel Saunders, Andrew Spillane, Kirsty Stuart, Elizabeth Wylie, Geraldine Robertson, Kirsten McCaffery

SYDNEY MEDICAL SCHOOL

Sydney School of Public Health

THE UNIVERSITY OF SYDNEY

@jolynhersch

WISER HEALTHCARE
A RESEARCH COLLABORATION FOR REDUCING OVERDIAGNOSIS AND OVERTREATMENT

# INTRODUCTION

- Incidence of ductal carcinoma in situ (DCIS) has increased greatly since the introduction of organised breast screening

- DCIS encompasses a spectrum of disease, including some lesions that may be indolent and not progress
- Growing concern about overdiagnosis and overtreatment

- Women aged 70-74 years are included in the expanded age range targeted for population screening
- This group may differ from younger women in terms of potential for benefit and harm

# METHODS

- Qualitative study aiming to understand views of relevant healthcare professionals about DCIS

- Doctors and nurses working with DCIS patients in diverse settings around Australia and New Zealand

- N = 26, recruited via professional organisations and contacts
  - Breast surgeons (n = 10)
  - Radiation oncologists (n = 6)
  - Breast physicians (n = 3)
  - Breast care nurses (n = 7)

# METHODS

- Semi-structured qualitative interviews conducted by telephone

- Interview topics included…
  - Management of DCIS
    - Current practice
    - Future directions
  - Communication with patients
  - Benefits and harms of screening women >70

- General patient population
- Specifically patients >70

- Interviews audio-recorded, transcribed, analysed thematically

# RESULTS

- Many participants felt the screening age extension was justified because life expectancy has increased

"they've just started screening women up to 75. And I think that's appropriate because when BreastScreen was first introduced the life expectancy of a woman was 75. Now the life expectancy is 86." *Surgeon*

"I think it's very reasonable to continue screening… If you're currently 70, on average you should live another 13 years. So that's time to get into strife from invasive breast cancer… so it's reasonable to be screened." *Radiation oncologist*

# RESULTS

- Women often interpret their screening invitations stopping as an indication that they are no longer at risk of breast cancer

"Once a woman gets a letter saying you are not being invited for breast screening any more, every one of them interprets that as, oh well I can't get breast cancer now… Every woman with breast cancer over 75 says to me, I thought that I can't get breast cancer now because they didn't ask me to come and have another mammogram." *Surgeon*

"a lot of women… have the impression that because they no longer receive their BreastScreen letter that they're no longer at risk of breast cancer. And they become less proactive even when they feel a lump because they think, well I don't get my letter any more, I don't need to go to BreastScreen, so I'm not at risk of getting breast cancer." *Nurse*

# RESULTS

- Continuation of screening >70 should depend on individual health and comorbidities as this affects chance of benefit
- Risk of harm, e.g. through overdiagnosis and overtreatment of low-grade DCIS among older women in poor health

"If the woman's life expectancy is likely to be another 5-10 years in good health then she should continue screening if she wishes to do so, because finding breast cancer with that life expectancy may actually affect her longevity and quality of life. If on the other hand… she's got Alzheimer's or severely crippled with arthritis, osteoporosis, wheelchair bound, is finding a breast cancer in a woman like that going to benefit her? Not greatly. She's more likely to die of something else." *Breast physician*

# RESULTS

"Some of these patients really become a victim of modern technology… If you're in a wheelchair because you've become elderly and decrepit… I then feel really concerned because they want to go for their screening and then a low grade or small malignancy is then detected and then you're onto a conveyor belt and go through all… the risks of an anaesthetic… but do they actually come out of things worse at the end of the day? That's always the worry." *Radiation oncologist*

"There has to be a bit of a cut off. It's difficult with exactly just using age alone, because I think it's age plus health that's important. There will come a time in everybody's life when they shouldn't have screening… But if they're still in really fit health… and there's no other issues, then they can continue… but it's hard on a screening program. You can't assess health." *Radiation oncologist*

# RESULTS

- Women should be informed about benefits and harms of screening and be involved in deciding whether to be screened

"I do have a strong talk to women about whether or not they're going to have screening, when they get to 70. Um, and I think that that's important to have that discussion about whether they want to have screening and what the pros and cons of screening are, and that they may choose that they're not going to have screening." *Breast physician*

"I think it's probably best had as an individualized conversation with the GP looking at the history and their current co-morbidities, and then discussion with the patient as to the risks and benefits." *Nurse*

# DISCUSSION

- Doctors/nurses who work with DCIS patients offer a valuable perspective on current issues around detection and treatment

- Screening age extension seems to make sense given trend for increasing life expectancy in the population, but…
  - Individual differences in health status have implications for likely balance between potential for benefit vs harm
  - Hard to incorporate this into a population screening program – need to better support shared decision making somehow
  - Beyond the age where screening is appropriate, need to better communicate the need to investigate any symptoms

# ACKNOWLEDGEMENTS


- Jesse Jansen, Brooke Nickel, Claudia Rutherford, Nehmat Houssami, Alexandra Barratt, Christobel Saunders, Andrew Spillane, Kirsty Stuart, Elizabeth Wylie, Geraldine Robertson, Kirsten McCaffery

- Sydney Catalyst – Pilot and Seed Funding grant



**jolyn.hersch**@sydney.edu.au

@jolynhersch