XIX Reunión anual Red Programas de Cribado de Cáncer

¿Ampliar el cribado de cáncer de mama a los 74 años?

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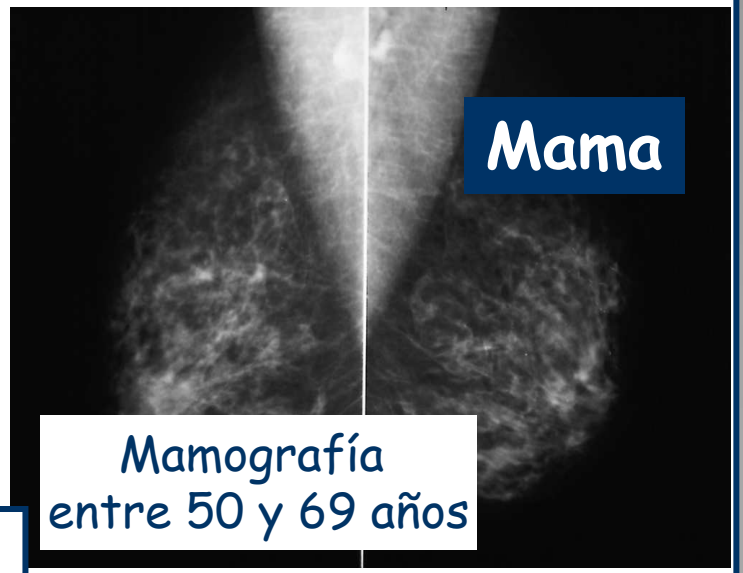
Red de Programas de Cribado de Cáncer

Playa Blanca, 11-13 mayo 2016

Recomendaciones europeas sobre cribado de cáncer (dic. 2003)

Citología a partir de los 25 años
(no más de 30)

Cervix

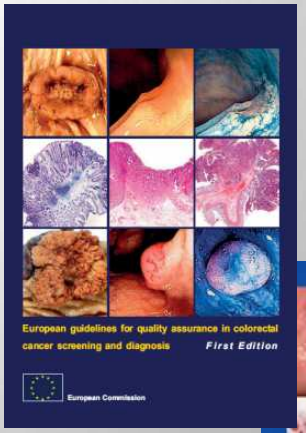


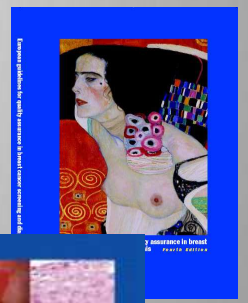
Mama

Mamografía
entre 50 y 69 años

CCR

Sangre Oculta en Heces
entre 50 y 74 años





Según las recomendaciones de la Comisión el cribado debería ofrecerse con información sobre riesgos y beneficios en el marco de "programas organizados" con garantía de calidad

XIX Reunión anual Red Programas de Cribado de Cáncer

INTERNATIONAL JOURNAL OF ONCOLOGY 45: 1785-1792, 2014

Breast cancer in European Union: An update of screening programmes as of March 2014 (Review)

E. ALTOBELLI[1,2] and A. LATTANZI[1]

[1]Department of Life, Health and Environmental Sciences, University of L'Aquila, L'Aquila;
[2]Epidemiologic and Social Marketing Unit, AUSL 4 Teramo, Italy

Table II. Distribution of cancer screening programmes in EU28 as of March 2014.

Region/member state	Programme type and extension	Screening method in use	Views	Double reading	Screening interval (years)	Age of target population	Programme start date	Natw coverage	Attendance in 2010 (%) (46)
Austria	NPB Natw	Fm	2	No	2	>40	1974	-	NA
	PB Reg[a]	Dm	2		1/2	40-59/60-69	2007	2008	57.0 (35)
Belgium	PB Natw	Dm	2	Yes	2	50-69	2001	-	61.0 (12)
Bulgaria	NPB Local	Fm	-	-	-	45-69	2011	-	NA
Croatia	PB Natw	Fm Dm	2	Yes	2	50-69	-	2006	63.0
Cyprus	PB Natw	Dm	2	Yes	2	50-69	2003	2006	56.0 (43)
Czech Republic	NPB Natw	Fm Dm	2	Yes	2	45-69	2002	2007	70.0 (46)
Denmark	PB Natw	Dm	2	Yes	2	50-69	1991	2010	73.0
Estonia	PB Natw	Dm	-	-	2	50-65	2002	2007	51.0
Finland	PB Natw	Dm	2	Yes	2	50-69	1987	1989	85.0
France	PB Natw	Fm Dm CBE	2	Yes	2	50/74	1989	2004	52.0
Germany	PB Natw	Fm Dm	2	Yes	2	50-69	2005	2009	54.1
Greece	NPB Pilot	Fm	2	-	1/2	40-50/64	-	-	NA
Hungary	PB Natw	Fm	2	Yes	2	45-65	2002	-	53.5 (55)
Ireland	PB Natw	Dm	2	Yes	2	50-64	2000	2008	78.0 (12)
Italy	PB Natw	Fm Dm	2	Yes	2	50-69 (74)	1990	2007	69.1
Latvia	PB Natw	Fm Dm	2	No	2	50-69	2008	2009	37.1
Lithuania	PB Natw	Fm	2	Yes	2	50-69	2005	-	NA
Luxembourg	PB Natw	Dm	2	Yes	2	50-69	1992	1992	64.0
Malta	PB Natw	Dm	2	-	3	50-59	2008	2009	55.0 (46)
The Netherlands	PB Natw	Dm	2 (1)	Yes	2	50-74	1988	1997	80.0
Poland	PB Natw	Dm	2	Yes	2	50-69	2006	2007	39.0
Portugal	PB Natw	Dm	2	Yes	2	45-69	1990	2005	63.0
Romania	NPB Local	Fm	2	No	(3) (2) 1	40+	-	-	13.5 (46)
Slovakia	NPB -	-	-	-	2	40+	-	-	NA
Slovenia	PB Natw	Dm	2	Yes	2	50-69	2008	-	75
Spain	PB Natw	Fm Dm	2	Yes	2	(45) 50-69	1990	2009	67.0
Sweden	PB Natw	Fm Dm	2	Yes	(1.5) 2	40 (50)-(69) 74	1986	1996	70.0
United Kingdom	PB Natw	Fm Dm	2	No	3	50-(64) 70	1988	1995	73.3

PB, population-based; NPB, non-population-based; Natw, nationwide; Reg, regional; Local, limited to some municipalities; Fm, screen-film mammography; Dm, digital ma
breast examination; NA, data not available. [a]Target population includes women living in Tyrol region.

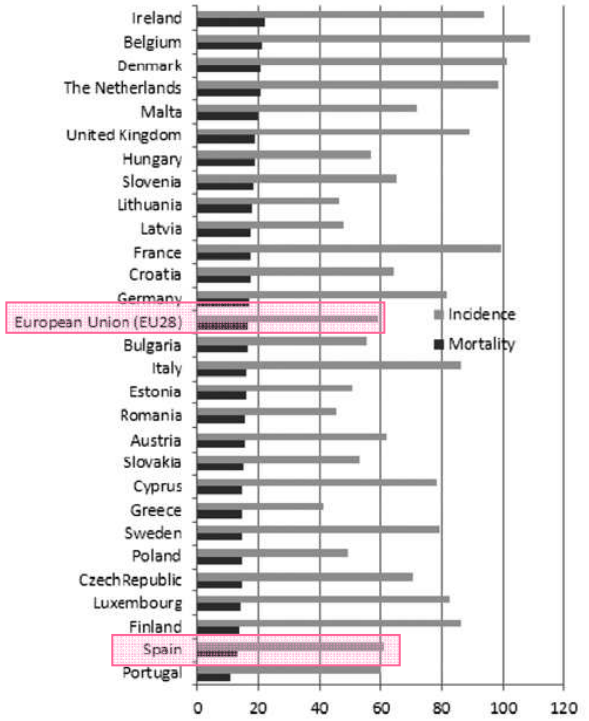


Figure 1. Breast cancer incidence and mortality in the European Union (EU28). ASR-W, world age-standardized rates per 100,000.

ORIGINAL ARTICLE

Extending the age range for breast screening in England: pilot study to assess the feasibility and acceptability of randomization

Kath Moser, Sarah Sellars, Margot Wheaton, Julie Cooke, Alison Duncan, Anthony Maxwell, Michael Michell, Mary Wilson, Valerie Beral, Richard Peto, Mike Richards and Julietta Patnick

J Med Screen 2011;**18**:96–102
DOI: 10.1258/jms.2011.011065

Cancer May 1, 2015

Performance of Digital Screening Mammography Among Older Women in the United States

Louise M. Henderson, PhD[1]; Ellen S. O'Meara, PhD[2]; Dejana Braithwaite, PhD[3]; and Tracy Onega, PhD[4]; for the Breast Cancer Surveillance Consortium

TABLE 5. Adjusted Odds Ratios and 95% Confidence Intervals for Performance Measures, the Recall Rate, and the Cancer-Detection Rate of Digital Screening Mammography by Age Group

Performance Measure	Age Group: aOR (95% CI)[a]					P_{Trend}
	65-69 Years	70-74 Years	75-79 Years	80-84 Years	≥85 Years	
Recall rate	Referent	0.96 (0.92-1.01)	0.93 (0.88-0.99)	0.86 (0.80-0.92)	0.79 (0.71-0.89)	< .001
Sensitivity	Referent	1.02 (0.60-1.71)	0.79 (0.48-1.31)	0.69 (0.39-1.23)	0.84 (0.42-1.65)	.17
Specificity	Referent	1.06 (1.01-1.11)	1.09 (1.03-1.16)	1.18 (1.10-1.27)	1.34 (1.19-1.50)	< .001
PPV_1	Referent	1.24 (1.06-1.45)	1.33 (1.13-1.56)	1.25 (0.99-1.56)	1.91 (1.45-2.51)	< .001
CDR	Referent	1.18 (1.02-1.37)	1.21 (1.04-1.40)	1.07 (0.86-1.33)	1.46 (1.13-1.90)	.01

Abbreviations: aOR, adjusted confidence interval; CDR, cancer detection rate per 1000 examinations; CI, confidence interval; PPV_1, positive predictive value.
[a]The aOR was adjusted for registry site, race/ethnicity, family history of breast cancer, breast density, history of breast procedure, current hormone therapy use, time since previous mammogram, and examination year.

CONCLUSIONES

- Aumenta nº mujeres mayores (aumento expectativa de vida)
- Beneficios similares a los de mujeres jóvenes
- Similar o menor sobrediagnóstico
- Estudios a futuro: optimizar y personalizar screening➔ qué mujeres mayores y con qué frecuencia deben someterse a screening

International Agency for Research on Cancer. IARC handbooks of cancer prevention. Vol. 7. Breast cancer screening. Lyon,2002.

Ensayos clínicos

Eficacia cribado mediante mamografía en reducción de la mortalidad por CM

- LIMITADA
  40-49 AÑOS
- SUFICIENTE
  50-69 AÑOS
- INADECUADA
  <40->69 AÑOS

The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL REPORT

Breast-Cancer Screening — Viewpoint of the IARC Working Group

Béatrice Lauby-Secretan, Ph.D., Chiara Scoccianti, Ph.D., Dana Loomis, Ph.D., Lamia Benbrahim-Tallaa, Ph.D., Véronique Bouvard, Ph.D., Franca Bianchini, Ph.D., and Kurt Straif, M.P.H., M.D., Ph.D., for the International Agency for Research on Cancer Handbook Working Group

Table 1. **Evaluation of Evidence Regarding the Beneficial and Adverse Effects of Different Methods of Screening for Breast Cancer in the General Population and in High-Risk Women.***

Method	Strength of Evidence†
Mammography	
Reduces breast-cancer mortality in women 50–69 yr of age	Sufficient
Reduces breast-cancer mortality in women 70–74 yr of age‡	Sufficient
Reduces breast-cancer mortality in women 40–44 yr of age§	Limited
Reduces breast-cancer mortality in women 45–49 yr of age§	Limited¶
Detects breast cancers that would never have been diagnosed or never have caused harm if women had not been screened (overdiagnosis)	Sufficient
Reduces breast-cancer mortality in women 50–74 yr of age to an extent that its benefits substantially outweigh the risk of radiation-induced cancer from mammography	Sufficient
Produces short-term negative psychological consequences when the result is false positive	Sufficient
Has a net benefit for women 50–69 yr of age who are invited to attend organized mammographic screening programs	Sufficient
Can be cost-effective among women 50–69 yr of age in countries with a high incidence of breast cancer	Sufficient
Can be cost-effective in low- and middle-income countries	Limited
Ultrasonography as an adjunct to mammography in women with dense breasts and negative results on mammography	
Reduces breast-cancer mortality	Inadequate
Increases the breast-cancer detection rate	Limited
Reduces the rate of interval cancer‖	Inadequate
Increases the proportion of false positive screening outcomes	Sufficient
Mammography with tomosynthesis vs. mammography alone	
Reduces breast-cancer mortality	Inadequate
Increases the detection rate of in situ and invasive cancers	Sufficient
Preferentially increases the detection of invasive cancers	Limited
Reduces the rate of interval cancer‖	Inadequate
Reduces the proportion of false positive screening outcomes	Limited
Clinical breast examination	
Reduces breast-cancer mortality	Inadequate
Shifts the stage distribution of tumors detected toward a lower stage	Sufficient
Breast self-examination	
Reduces breast-cancer mortality when taught	Inadequate
Reduces the rate of interval cancer when taught‖	Inadequate
Reduces breast-cancer mortality when practiced competently and regularly	Inadequate
Screening of high-risk women	
MRI as an adjunct to mammography	
Reduces breast-cancer mortality in women with a *BRCA1* or *BRCA2* mutation	Inadequate
Increases the detection rate of breast cancer in women with lobular carcinoma in situ or atypical proliferations	Inadequate
Clinical breast examination as an adjunct to MRI and mammography	
Increases the detection rate of breast cancer in women with a high familial risk	Inadequate
Ultrasonography as an adjunct to mammography	
Increases the detection rate of breast cancer in women with a personal history of breast cancer	Inadequate
Increases the proportion of false positive screening outcomes in women with a personal history of breast cancer as compared with those without such a history	Inadequate
MRI as an adjunct to mammography plus ultrasonography	
Increases the proportion of false positive screening outcomes in women with a personal history of breast cancer as compared with those without such a history	Inadequate
MRI as an adjunct to mammography vs. mammography alone	
Increases the proportion of false positive screening outcomes in women with lobular carcinoma in situ or atypical proliferations	Limited

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Produces short-term negative psychological consequences when the result is false positive	Sufficient
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Can be cost-effective among women 50–69 yr of age in countries with a high incidence of breast cancer	Sufficient
Can be cost-effective in low- and middle-income countries	Limited

‡ The evidence for a reduction in breast-cancer mortality from mammography screening in women in this age group was considered to be sufficient. However, published data for this age category did not allow for the evaluation of the net benefit.

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