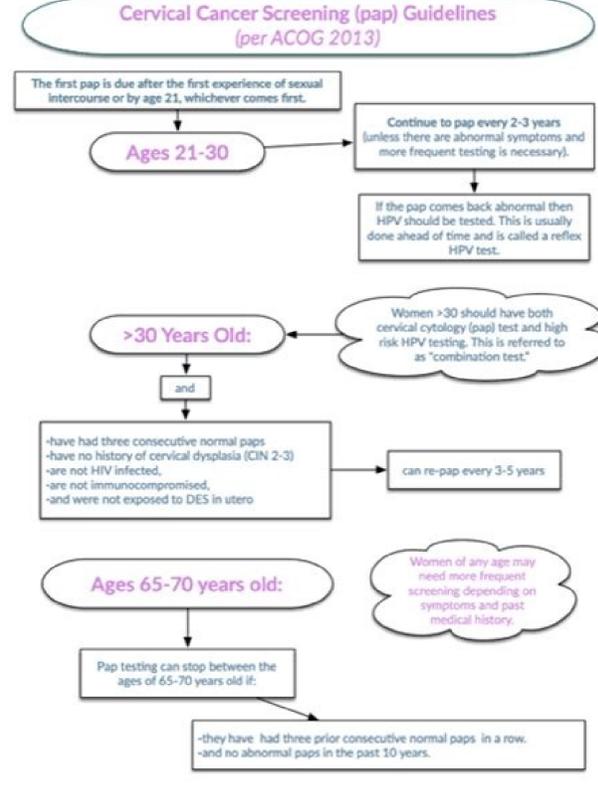


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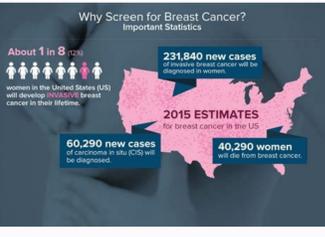
Screening Modality	AMERICAN CANCER SOCIETY	AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS	U.S. PREVENTIVE SERVICES TASK FORCE
Breast Self Exam	Recommends against self breast exam, but encourages breast self awareness	Breast Self Awareness encouraged	Recommends against
Clinical Breast Exam	Recommends against clinical exam at any age	Every one to three years from 30 to 39 years of age and annually thereafter	Insufficient evidence to support clinical breast exams.
Magnetic Resonance Imaging	Offer annually to women at high risk	Offer annually to women at high risk	Insufficient evidence to support clinical breast exams.
Mammogram	Routine annual screening beginning at 45 years of age and up to age 54. May consider screening for women 55 years and older who have a life expectancy greater than 10 years	Routine annual screening beginning at 40 years of age	Routine biennial screening for women 50 to 74 years of age

TABLE I. Recommendations of seven US medical organizations for mammography screening

Organizations	Recommendations
American College of Radiology (ACR)	Women >40 years of age should have an annual mammogram.
National Comprehensive Cancer Network (NCCN)	
Society of Breast Imaging (SBI)	
US Preventive Services Task Force (USPSTF)	<ul style="list-style-type: none"> Women 40-49 years old: The decision to start screening mammography in women younger than 50 years should be an individual one. (Women who place a higher value on the potential benefits than on the potential harms may choose to begin screening every 2 years between the ages of 40 and 49 years.) Women 50-74 years old: Screening mammography is recommended every 2 years for women aged 50 to 74 years. Women >75 years: Current evidence is insufficient to assess the balance of benefits and harms of screening mammography in women age 75 years and older.
American Cancer Society (ACS)	<ul style="list-style-type: none"> Women 40-44 years old should have the choice to start annual breast cancer screening with mammography if they wish to do so. Women 45-54 years old should undergo mammography annually. Women 55 years old can switch to mammography every 2 years or can continue yearly screening. Screening should continue as long as a woman is in good health and is expected to live 10 more years or longer¹⁰
American Congress of Obstetricians and Gynecologists (ACOG)	Women past the age of 40 years who are at average risk should undergo screening mammography every 1-2 years in consultation with their obstetrician-gynecologist. The first screening should occur no later than age 50. Beyond the age of 75, the decision to continue screening should be made by each woman together with her provider and should be informed by the woman's health status and longevity. ¹¹

For women of average risk, the American Cancer Society recommends the following:

Woman's Age	ACS Recommendation
40-44	They have the option to start annual mammograms.
45-54	Should have an annual mammogram
55+	Can either have a mammogram every other year or continue with annual screening.



Acog mammogram guidelines 2021. Acog mammography screening guidelines. Acog screening mammogram guidelines. Acog mammogram guidelines high risk. Acog breast screening guidelines.

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Volumetric breast density affects performance of digital screening mammography. *Breast Cancer Res Treat* 2017; 162: 95-103. doi: 10.1007/s10549-016-4090-7 [PMC free article] [PubMed] [CrossRef] [Google Scholar]Page 2Recommendations for Breast Cancer Screening in Average Risk Women American College of Obstetrics and GynecologistsU.S. Preventive Services Task ForceAmerican Cancer SocietyNational Comprehensive Cancer NetworkAmerican College of Radiology/Society of Breast ImagingClinical breast examinationMay be offered every 1-3 years for women 25-39 years and annually for women 40 years and olderInsufficient evidence to recommend for or againstDoes not recommendRecommend every 1-3 years for women 25-39 years and annually for women 40 years and olderMammography initiation ageOffer starting at age 40 years.Initiate at ages 40-49 years after counseling, if patient desires.Recommend by no later than age 50 if patient has not already initiatedRecommend at age 50 years.Age 40-49 years: the decision to start screening mammography in women before age 50 years should be an individual oneOffer at age 40-45 years.Recommend at age 45 yearsRecommend at age 40Mammography screening intervalAnnual or biennialBiennialAnnual for women aged 40-54 years.Biennial with the option to continue annual screening for women 55 years or olderAnnualAnnualMammography stop ageContinue until age 75 years.Beyond age 75 years, the decision to discontinue should be based on shared decision-making process that includes a discussion of the women's health status and longevityThe current evidence is insufficient to assess the balance of benefits and harms of screening mammography in women 75 years and olderWhen life expectancy is less than 10 yearsWhen severe comorbidities limit life expectancy to 10 years or lessWhen life expectancy is less than 5-7 years Mammography is a special type of low-dose x-ray imaging used to create detailed images of the breast. Mammography is currently the best available population-based method to detect breast cancer at an early stage, when treatment is most effective. Mammography can demonstrate microcalcifications smaller than 100 µm; it often reveals lesions before they become palpable by clinical breast examination (CBE) and, on average, 1-2 years before being found by breast self-examination (BSE). An estimated 48 million mammograms are performed each year in the United States. The US Preventive Services Task Force (USPSTF) estimates the benefit of mammography in women aged 50-74 years to be a 30% reduction in risk of death from breast cancer. For women aged 40-49 years, the risk of death is decreased by 17%. There are 2 types of mammography examinations: screening and diagnostic. Screening mammography is done in asymptomatic women. Diagnostic mammography is performed in symptomatic women (eg, when a breast lump or nipple discharge is found during self-examination or an abnormality is found during screening mammography). This examination is more involved, time-consuming, and expensive than screening mammography and is used to determine the exact size and location of breast abnormalities and to image the surrounding tissue and lymph nodes. Women with breast implants or a personal history of breast cancer will usually require the additional views used in diagnostic mammography. The American College of Radiology (ACR) has established the Breast Imaging Reporting and Data System (BI-RADS) to guide the breast cancer diagnostic routine. BI-RADS is the product of a collaborative effort between members of various committees of the ACR in cooperation with the National Cancer Institute (NCI), the Centers for Disease Control and Prevention (CDC), the FDA, the American Medical Association (AMA), the American College of Surgeons (ACS), and the College of American Pathologists (CAP). [12] The BI-RADS system includes categories or levels that are used to standardize interpretation of mammograms among radiologists. For referring physicians, the BI-RADS categories indicate the patient's risk of malignancy and recommend a specific course of action. Of all of the screening mammograms performed annually, approximately 90% show no evidence of cancer. On necessary further diagnostic testing, approximately 2% of all screening mammograms are shown to be abnormal and require biopsy. Among cases referred for biopsy, approximately 80% of the abnormalities are shown to be benign, and 20% are shown to be cancerous. See Mammography in Breast Cancer for more information. Mammographic sensitivity for breast cancer declines significantly with increasing breast density, and the risk of breast cancer is higher in women with dense breasts. Hormonal status has no significant effect on the effectiveness of screening independent of breast density. Although mammography remains the most cost-effective approach for breast cancer screening, it is far from a perfect screening test. The accuracy of screening mammography increases with increasing patient age, in tandem with the increasing incidence of breast cancer. Mammography has a sensitivity of 76.5% and a specificity of 87.1% for women younger than 40 years. [13] By comparison, in women 50 to 59 years old, the sensitivity of screening mammography is 77.3% and the specificity is 98.7%. [14] In women older than 80 years, mammography has a sensitivity of 86% and a specificity of 94%. [15] A retrospective trend analysis comparing rates of breast cancer mortality in pairs of neighboring European countries where mammography screening had been implemented at different times. Findings suggest that mammography screening has little detectable impact on mortality due to breast cancer. [16] Mammography uses low-dose ionizing radiation, which may be harmful to the patient. Nevertheless, the benefits of mammography far outweigh the risks and inconvenience. False-positive results may arise when benign microcalcifications are regarded as malignant. Tissue summation shadows may appear as local parenchymal distortion; this may erroneously be called malignant tissue. A benign, circumscribed lesion may show signs suggestive of malignancy, along with other findings, such as an irregular border and no halo sign. In the United States, approximately 9.5% of screening mammograms yield false-positive results; of US women screened annually for 10 years, approximately 50% will experience a false positive, and 7-17% of those will undergo breast biopsies. [17] False positives occur most commonly with first mammograms; when prior mammograms are available for comparison, the likelihood of a false positive decreases by about 50%. [18] False-negative rates of screening mammography (ie, cases in which invasive breast cancer is present but undetected by mammography) range from 6% to 46%. [17] Possible causes for missed breast cancers include the following: Dense parenchyma obscuring a lesion Poor positioning or technique Perception error Incorrect interpretation of a suspect finding Subtle features of malignancy Slow growth of a lesion Birdwell et al performed a multicenter study and found that on previous mammograms with missed cancers, 30% of the 115 lesions were calcifications, with 49% (17 of 35) clustered or pleomorphic. [19] Approximately 70% were mass lesions, with 40% spiculated or irregular. For calcifications and masses, the most frequently suggested reasons for possible miss were dense breasts (34%) and distracting lesions (44%). Some cancers (eg, mucinous carcinomas) may have well-defined borders and mammographic features suggestive of a benign lesion. A ductogram, or galactogram, is sometimes helpful for determining the cause of nipple discharge. In this specialized examination, a fine plastic tube is placed into the opening of the duct in the nipple. A small amount of contrast medium is injected, which outlines the shape of the duct on a mammogram, and shows whether a mass is present inside the duct. Women with breasts augmented by implants may pose a special challenge. Specific 4-view mammograms may be performed to evaluate the breasts; MRI may be especially useful for detecting breast cancer and silicon implant rupture in this group of patients. See Postsurgical Breast Imaging for more information.

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