Dense Breasts Canada Submission to the Standing Committee on Status of Women

November 2024

DENSE BREASTS
CANADA

The Canadian Task Force on Preventive Health Care (Task Force) misinforms physicians and Canadians by underestimating the benefits and overstating the harms of breast cancer screening. The guideline making process lacks accountability, transparency, ethical oversight, scientific rigour, objectivity, and credibility and must be reformed.

1. Rebuild a Task Force that has an appropriate accountability structure.
When the Task Force was re-established in 2009, the design failed to include oversight. The conduct of the Task Force, in terms of how members are appointed, how working groups are composed, how evidence is selected, how recommendations are made, etc. requires an accountable governance structure.

2. Rebuild a Task Force that has full and appropriate transparency.

- The 2024 draft recommendations were released before computer modelling results. Still waiting.
- The Task Force figures for overdiagnosis and the number of breast cancer cases in 2018 differ significantly from numbers in the 2024 draft guidelines, with no explanation given.
- There is no communication between the different evidence review centres, resulting in siloing.
- The Task Force points to inclusion of four breast cancer experts and three patients in its Working Group, but none were allowed to vote on the recommendations.

3. Rebuild a Task Force that has ethics oversight.

- According to HESA testimony by expert advisors from the Ottawa Evidence Review Synthesis Centre (ERSC), their expert input was disregarded and the Task Force dictated to them what evidence to consider. They insisted on including 40–60-year-old Randomized Controlled Trials.
- Healthcare providers are instructed to use only absolute numbers for patient discussions, a nonstandard practice: data should be presented in both absolute and relative terms.
- Before the Task Force had even begun its work on this guideline, the co-chair publicly stated that there was no new evidence and that the recommendations did not need to change.

4. Errors made in the 2018 guidelines have gone unchecked.

- The Task Force stated in 2018 that there were 7 cancers in 1000 women aged 40-49 in 7 years, but in the 2024 guideline, they stated that there are 19 cancers in 1000 women aged 40-49 in 10 years.
- In the 2018 recommendations, the Task Force presented an inflated value of 48% for overdiagnosis. This figure came from the Canadian National Breast Screening Study (CNBSS), which is currently under investigation by the University of Toronto for subverted randomization. More credible reports, ignored by the Task Force, suggested 1-10%.

5. Rebuild a Task Force that has content expert leadership with methodologist assistance.

- Unlike the US Task Force, the Canadian Task Force continued to use randomized trials including technology and therapy that are no longer representative of current practice.
- The Task Force set arbitrary thresholds to assess the data (no explanation given as to how set).
- The Task Force used too short an observation time to allow the full impact of the benefits to be measured. The misplaced emphasis on short-term (10-year) survival ignored the long-term survival benefit of early detection.
- The Task Force suggestion of a 3-year screening interval is without solid basis in evidence.
- The Task Force overlooked the benefit of early-stage diagnosis and decreased morbidity of treatment. The only metric used in their knowledge translation tool was decreased mortality, but not the years of life gained (highly important for younger women) or the options to avoid mastectomy, chemotherapy, and armpit surgery.
- The Task Force has a dangerous misunderstanding that improved life expectancy is attributable only to better treatment, implying that early detection is unimportant. This is not the case as the stage of diagnosis matters. Some Task Force members claim that screening can't save the lives of

women with rapidly growing cancers. Statistics Canada has shown the opposite: when aggressive triple negative cancer is detected at stage one, the five-year survival is 96%, but at stage four, it's only 7%.

6. A lack of equitable and accessible breast screening for racialized women

- The Task Force acknowledges Canadian data showing the increased risk of breast cancer in racialized women aged 40-49, their increased mortality, and earlier peak incidence and yet the panel did not lower the screening age to provide an equitable opportunity for early detection.
- Participants in the historical RCTs (such as the flawed CNBSS) were almost entirely White.
- The Task Force 1000-person tool does not individualize a women's risk to inform her of her own personalized benefit of screening.

7. Task Force did not perform its own evidence review on supplemental screening for dense breasts

- The Task Force downgraded the value of two RCTs that looked at the benefit of ultrasound and MRI, showing reduced interval cancers by 50% and 80%. Reduction of interval cancers is accepted as a surrogate for mortality reduction. A statistically significant interval cancer reduction of a factor of 4 was seen in the J-START RCT, but disregarded by the Task Force.
- The Task Force disregarded a recent comprehensive 300-page review of supplemental screening done by Ontario Health, which recommended supplemental screening. The Edmonton review team disregarded the Ontario evidence review because of differences in eligibility criteria between Ontario and the US Task Force.

8. No auditing of the outcomes of previously released recommendations

- Since the 2011 Task Force recommendation not to routinely screen women in the 40s, there has been a 10% increase in the incidence of late-stage breast cancer in women in their 40s and 50s.

9. No responsiveness to the rapid evolution of breast cancer detection, research, and treatment

- Once the guidelines are published, they remain in place ~7 + years, as seen in the case of the cervical and prostate guidelines. Recommendations must be updated faster.

10. A lack of up-to-date modelling

- Since additional randomized trials will not be conducted due to ethical considerations, cost and the length of time required, it will be necessary to rely on high-quality simulations, along with available empirical data to inform healthcare policies. The model used by the Task Force must be up to date to reflect technological advances in treatment with improved outcomes.

11. A lack of recommendations for high-risk women

- The Task Force does not provide appropriate guidance for women who have an elevated or high risk of developing breast cancer, such as those with certain genetic mutations, a family history, or dense breasts. They say that these guidelines are for women at average or moderately increased risk. Women at moderately increased risk should not be lumped in with average risk women.

12. No consideration of the cost savings of finding cancer early

- Recently published Canadian research xxv https://pubmed.ncbi.nlm.nih.gov/37754486/ shows that there are large reductions in treatment costs when cancers are detected earlier. One stage 4 patient can cost up to $500,000.
- A recent Canadian study shows potential savings of hundreds of millions of dollars annually by screening women aged 40-74 and avoiding the need for expensive therapies used for late-stage disease.

The Task Force guideline creation processes are shown to be flawed. Breast screening experts, breast cancer organizations, the public, and the Health Minister have all expressed concern. The Task Force must be rebuilt with appropriate accountability, transparency, and ethical oversight. To do anything less will mean the continued avoidable deaths and suffering of Canadian women.