Preventing Overdiagnosis 2015 Highlights

PREVENTING OVERDIAGNOSIS

Winding back the harms of too much medicine

Nachlese und Diskussion dieses 3. Weltkongresses

aks

11. Jänner 2016

SEPTEMBER 2015

National Insitutes of Health
Bethesda, Maryland USA

WEITER
Bridge Over Diagnosis - a parody of Bridge Over

0:14 / 5:51

https://www.youtube.com/watch?v=gfesuNG0-kQ

PREVENTING OVERDIAGNOSIS

Winding back the harms of too much medicine

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NIH National Cancer Institute

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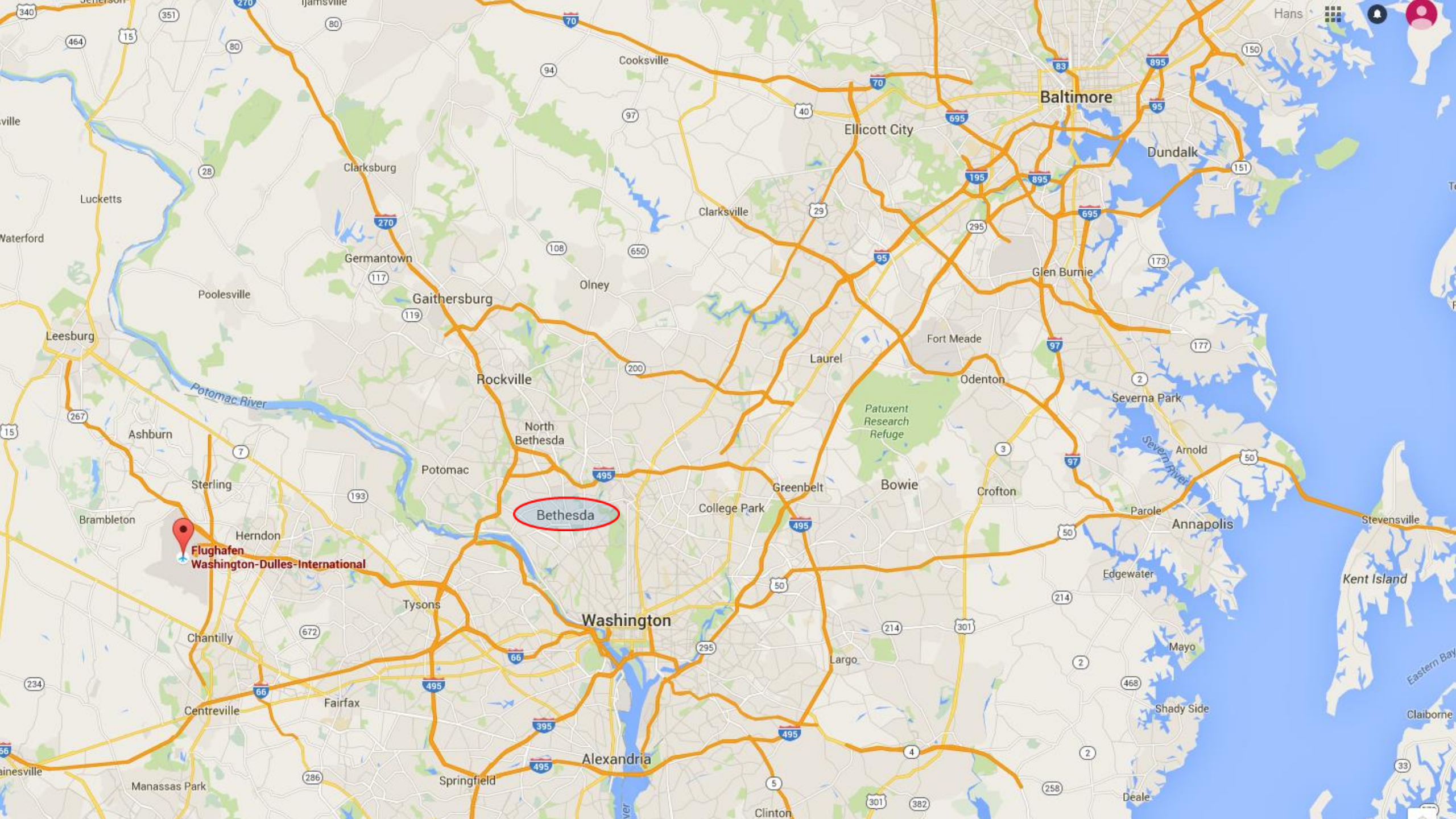
Third Preventing Overdiagnosis conference is scheduled for September 1st – 3rd 2015

Following the sell out 2014 conference, we are pleased to announce a third Preventing Overdiagnosis conference is scheduled for September 1st – 3rd 2015 in Washington DC, US. Hosted by the National institutes of Health, National Cancer Institute. Call for abstracts and registration will open early November 2014, sign up to our mailing list and receive notifications. … Read More....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Arnold
Parole
Annapolis
Edgewater
Mayo
Shady Side
Largo
Deale
Stevensville
Kent Island
Claiborne
Eastern Bay
Severn River
Hans


The National Cancer Act, December 23, 1971
President Richard Nixon:
War on Cancer
Misserfolge und Kollateralschäden
100 Millionen US-Dollar zusätzlich für das
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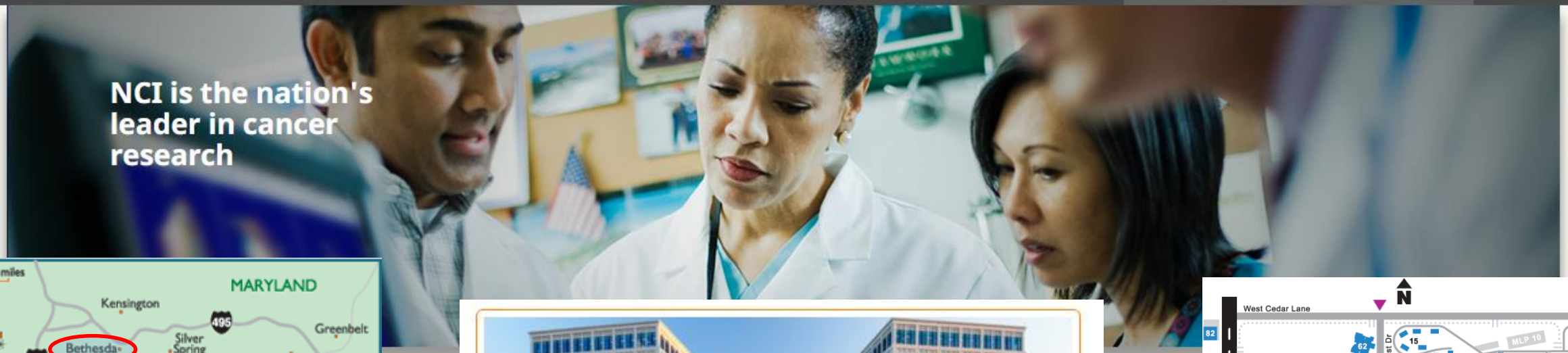
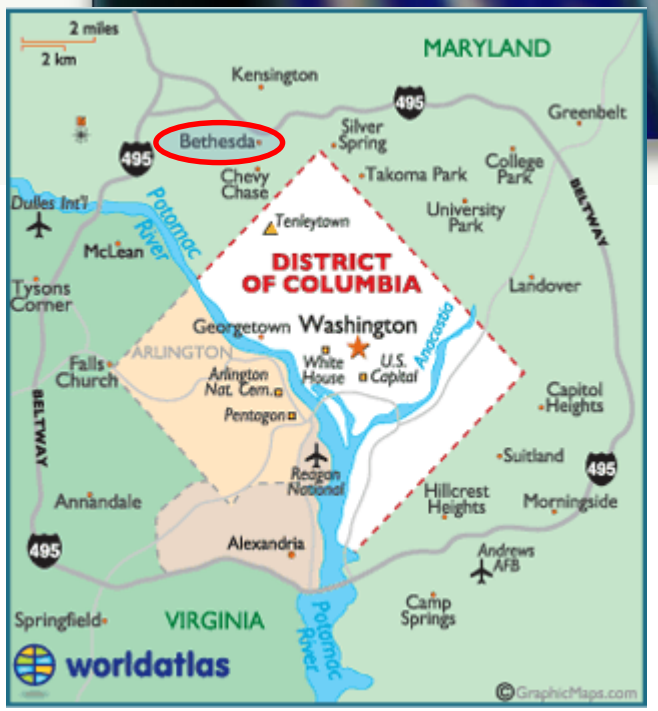
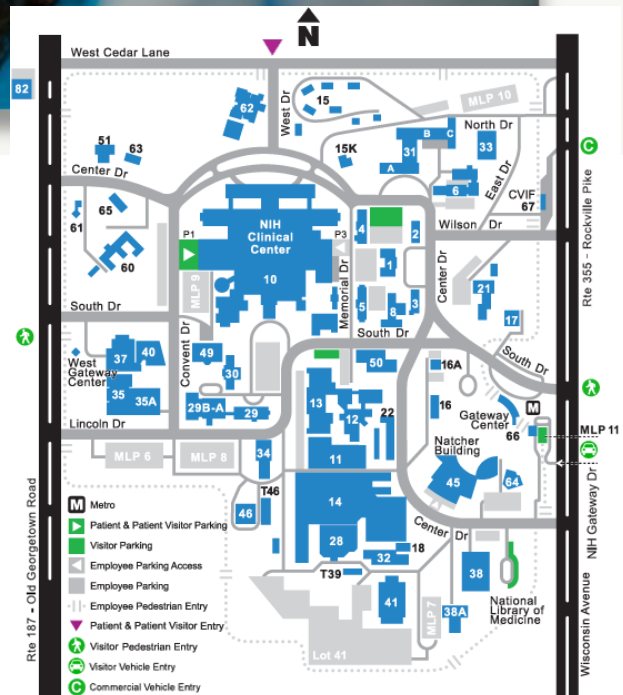






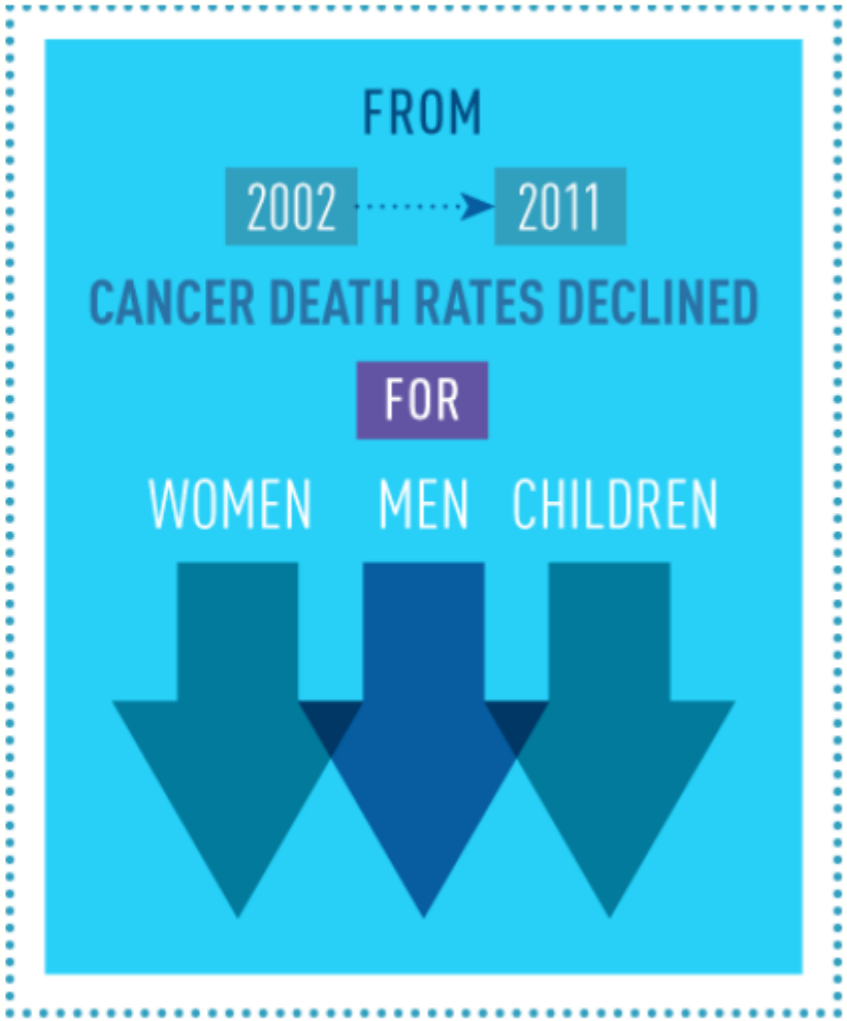
Mortality Highlights

The report showed continuing declines in cancer death rates for both men and women, for children, and for nearly all major cancer sites. The report also found that there has been a relatively consistent decline in overall cancer death rates since the early 1990s.

Specifically, cancer death rates decreased:

- Among men, by about 1.8 percent per year from 2002 through 2011
- Among women, by about 1.4 percent per year from 2002 through 2011
- Among children up to 19 years old, death rates have continued to mostly decrease since 1975

Mortality trends are the gold standard for evidence of progress against cancer.



NATIONAL CANCER INSTITUTE
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www.cancer.gov

NATIONAL CANCER INSTITUTE
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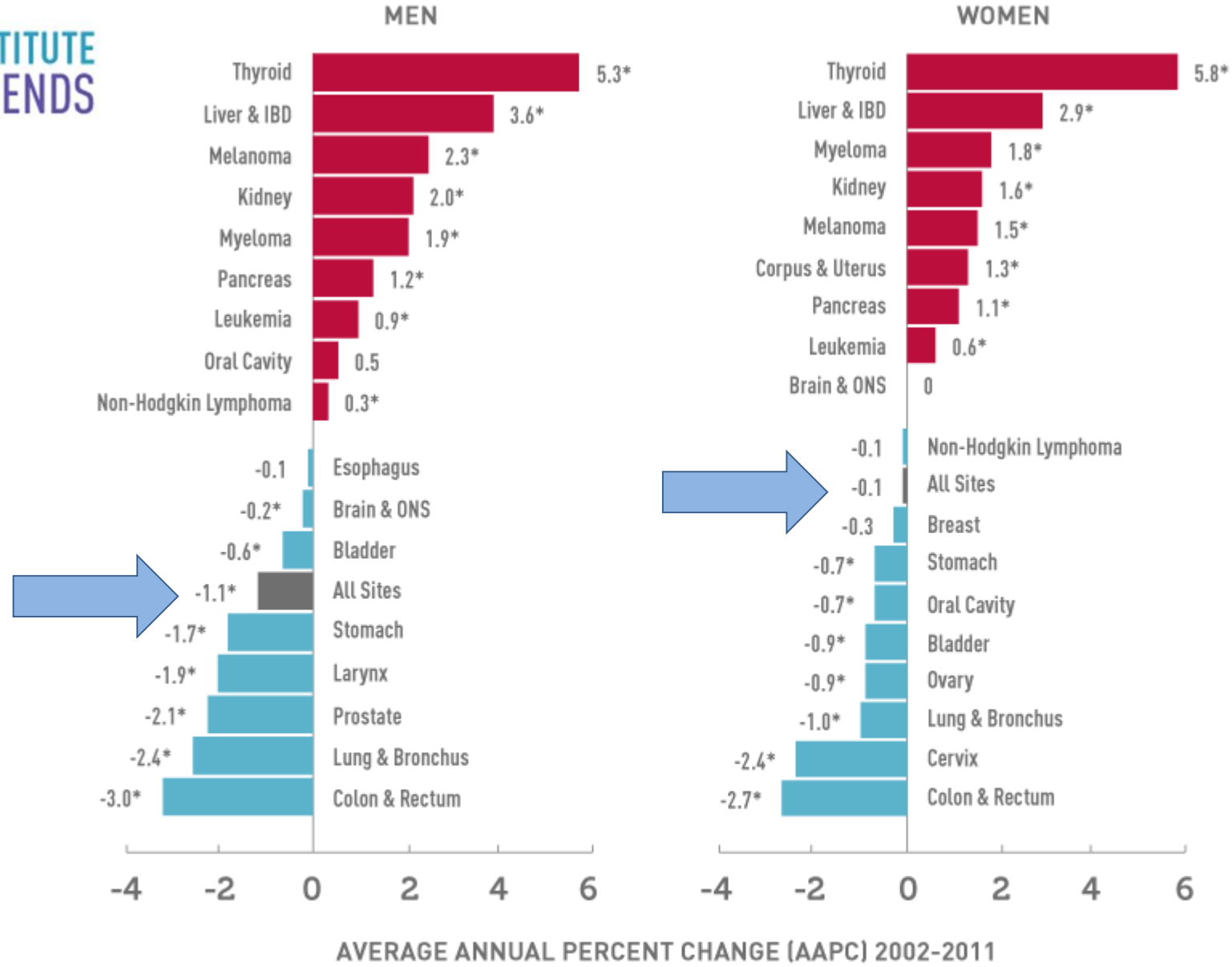


* AAPC is significantly different from zero (p<.05).

Rates were adjusted for reporting delay in the registry.

This email alert is a digest of all press releases issued by *The BMJ* from Monday 4 January to Friday 7 January 2016. This service is aimed at readers, so they can see how a paper's findings were communicated to the media. Media professionals receive these as embargoed releases in advance of the paper's publication.

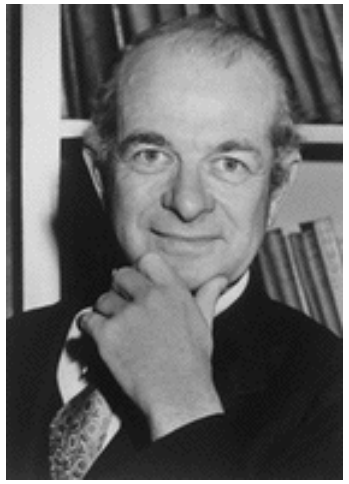
Cancer screening has never been shown to "save lives," argue experts

Harms of screening are certain, but benefits in overall mortality are not â€¦ "We must be honest about this uncertainty," they say

Cancer screening has never been shown to "save lives" as advocates claim, argue experts in *The BMJ* today.

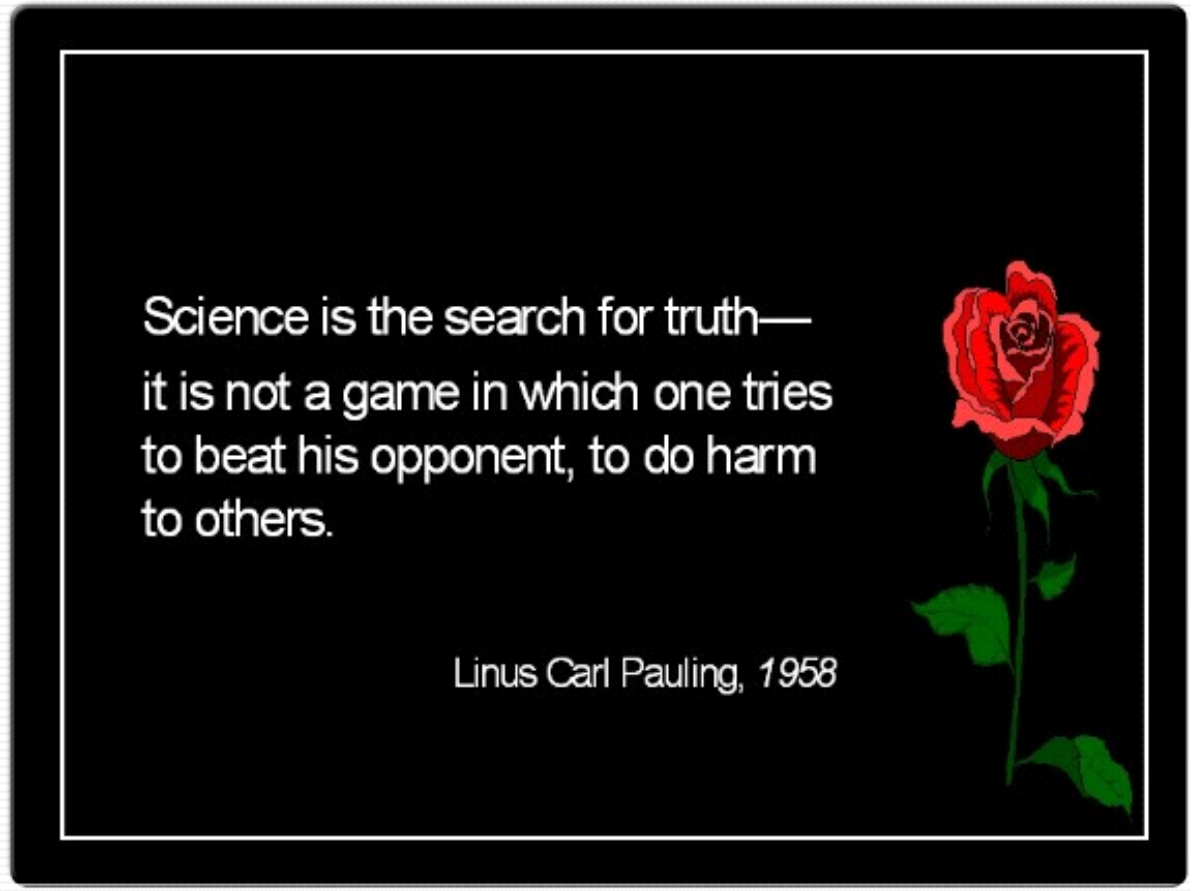
This assertion rests on reductions in disease specific mortality rather than overall mortality, say Vinay Prasad, Assistant Professor at Oregon Health and Science University and colleagues.

They argue that overall mortality should be the benchmark against which screening is judged and call for higher standards of evidence for cancer screening.



Linus Carl Paulig

1954 Nobelpreis für Chemie
1962 Friedensnobelpreis



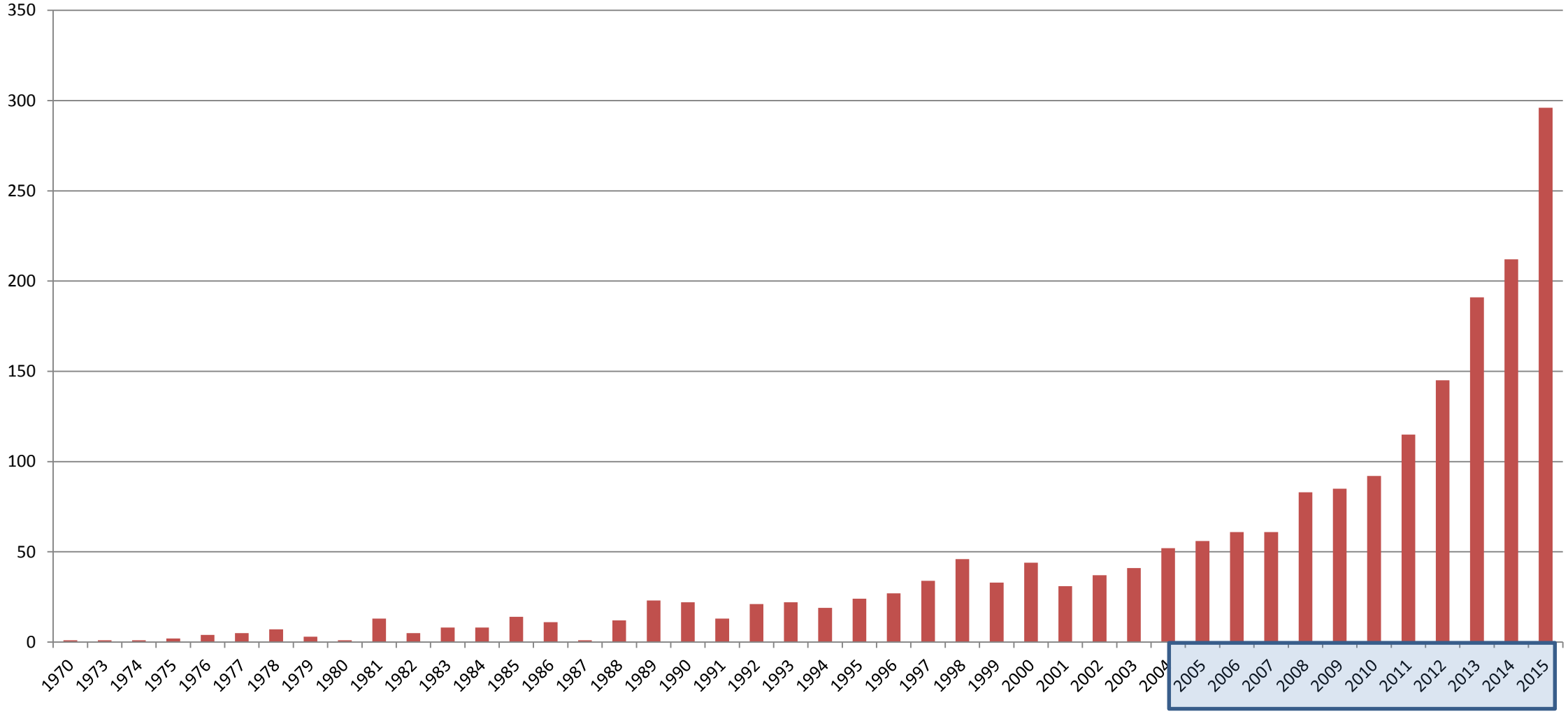
Overdiagnosis

From Wikipedia, the free encyclopedia

Overdiagnosis is the diagnosis of "disease" that will **never cause symptoms or death** during a patient's lifetime.
Overdiagnosis is a **side effect of screening** for early forms of disease.
…it may **turn people into patients** unnecessarily and may lead to treatments that do no good and perhaps do harm.

PubMed 08.12.2015

„Overdiagnosis“ im Titel peer-reviewter Publikationen



Dr. Fiona Godlee

Editor-in-Chief, The BMJ

Impact Factor bei 17,445

Fi has been editor-in-chief of The BMJ since 2005. She trained as a general physician in Cambridge and London, and she is a Fellow of the Royal College of Physicians. In 1994 she spent a year at Harvard as a Harkness Fellow, evaluating efforts to bridge the gap between medical research and practice. On returning to the UK, she led the development of BMJ Clinical Evidence in 1999.

Campaigns

Too much medicine

The BMJ's Too Much Medicine campaign aims to highlight the threat to human health posed by overdiagnosis and the waste of resources on unnecessary care. There is growing evidence that many people are overdiagnosed and overtreated for a wide range of conditions, such as prostate and thyroid cancers, asthma, and chronic kidney disease.

Patient partnership

In June 2014 *The BMJ* launched a new strategy to promote patient partnership. It took this step because it sees partnering with patients, their families, carers, advocacy groups, and the public as an ethical imperative, which is essential to improving the quality, safety, cost effectiveness, and sustainability of healthcare.

Die BMJ „Too Much Medicine“ Kampagne zielt darauf ab, die Bedrohung für die menschliche Gesundheit durch Überdiagnose und die Verschwendung von Ressourcen für unnötige Behandlungen aufzuzeigen.
Es wird immer deutlicher, dass viele Menschen für eine Vielzahl von Bedingungen überdiagnostiziert und übertherapiert werden, wie Prostata- und Schilddrüsenkarzinome, Asthma und chronische Nierenerkrankungen

Choosing Wisely®

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The *Choosing Wisely* lists were created by national medical specialty societies and represent specific, evidence-based recommendations clinicians and patients should discuss. Each list provides information on when tests and procedures may be appropriate, as well as the methodology used in its creation.

In collaboration with the partner organizations, Consumer Reports has created resources for consumers and providers to engage in these important conversations about the overuse of medical tests and procedures that provide little benefit and in some cases harm.

Choosing Wisely recommendations should not be used to establish coverage decisions or exclusions. Rather, they are meant to spur conversation about what is appropriate and necessary treatment. As each patient situation is unique, providers and patients should use the recommendations as guidelines to determine an appropriate treatment plan together.

For Clinicians
Specialty society lists of things clinicians and patients should question

For Patients
Patient-friendly resources from specialty societies and Consumer Reports

Stellungnahmen

Gemeinsam Klug Entscheiden

ad-hoc-Kommission Gemeinsam Klug Entscheiden

Nutzenbewertung

Qualitätsmanagement

DRG-Fachgruppe

Kuratorium Klassifikation

Partner & Links

Gemeinsam Klug Entscheiden

Das Präsidium der AWMF hat in seiner Sitzung am 24. 02. 2015 auf Empfehlung der Arbeitsgruppe die Einrichtung einer Ad Hoc Kommission zum Thema **"Gemeinsam Klug Entscheiden"** beschlossen.

„Gemeinsam Klug Entscheiden“

- ist eine **Qualitäts-Offensive der Wissenschaftlichen Medizinischen Fachgesellschaften unter dem Dach der AWMF**
- zielt auf die **Verbesserung der Versorgungsqualität durch ausgewählte Empfehlungen zu prioritären Themen**
- betont die **Gemeinsamkeit der Fachgesellschaften in der AWMF, die gemeinsame fach- und berufsgruppenübergreifende Versorgung und die gemeinsame Entscheidungsfindung von Arzt und Patient**

Manual "Entwicklung von Empfehlungen im Rahmen der Initiative Gemeinsam Klug Entscheiden" - Konsultationsfassung

Überdiagnosen vermeiden
Gesundheit erhalten

Hans Concin

Arbeitskreis
für Vorsorge und
Sozialmedizin, Bregenz

JAMA Published online July 29, 2013

VIEWPOINT

Overdiagnosis and Overtreatment in Cancer
An Opportunity for Improvement

Laura J. Esserman, MD, MBA
University of California, San Francisco.

Ian M. Thompson Jr, MD
University of Texas Health Science Center at San Antonio.

Brian Reid, MD, PhD
Fred Hutchinson Cancer Research Center, Seattle, Washington.

Over the past 30 years, awareness and screening have led to an emphasis on early diagnosis of cancer. Although the goals of these efforts were to reduce the rate of late-stage disease and decrease cancer mortality, secular trends and clinical trials suggest that these goals have not been met; national data demonstrate significant increases in early-stage disease, without a proportional decline in later-stage disease. What has emerged has been an appreciation of the complexity of the pathologic condition called cancer. The word "cancer" often invokes the specter of an inexorably lethal process; however, cancers are heterogeneous and can follow multiple paths, not all of which progress to metastases and death, and include indolent disease that causes no harm during the patient's lifetime. Better biology alone can explain better outcomes. Although this complexity complicates the goal of early diagnosis, its recognition provides an opportunity to adapt cancer screening with a focus on identifying and treating those conditions most likely associated with morbidity and mortality.

Changes in cancer incidence and mortality[1] reveal 3 patterns that emerged after inception of screening (Table). Screening for breast cancer and prostate cancer appears to detect more cancers that are potentially clinically insignificant.[4] Lung cancer may follow this pattern if high-risk screening is adopted.[5] Barrett esophagerally leads to overtreatment. This Viewpoint summarizes the recommendations from a working group formed to develop a strategy to improve the current approach to cancer screening and prevention.

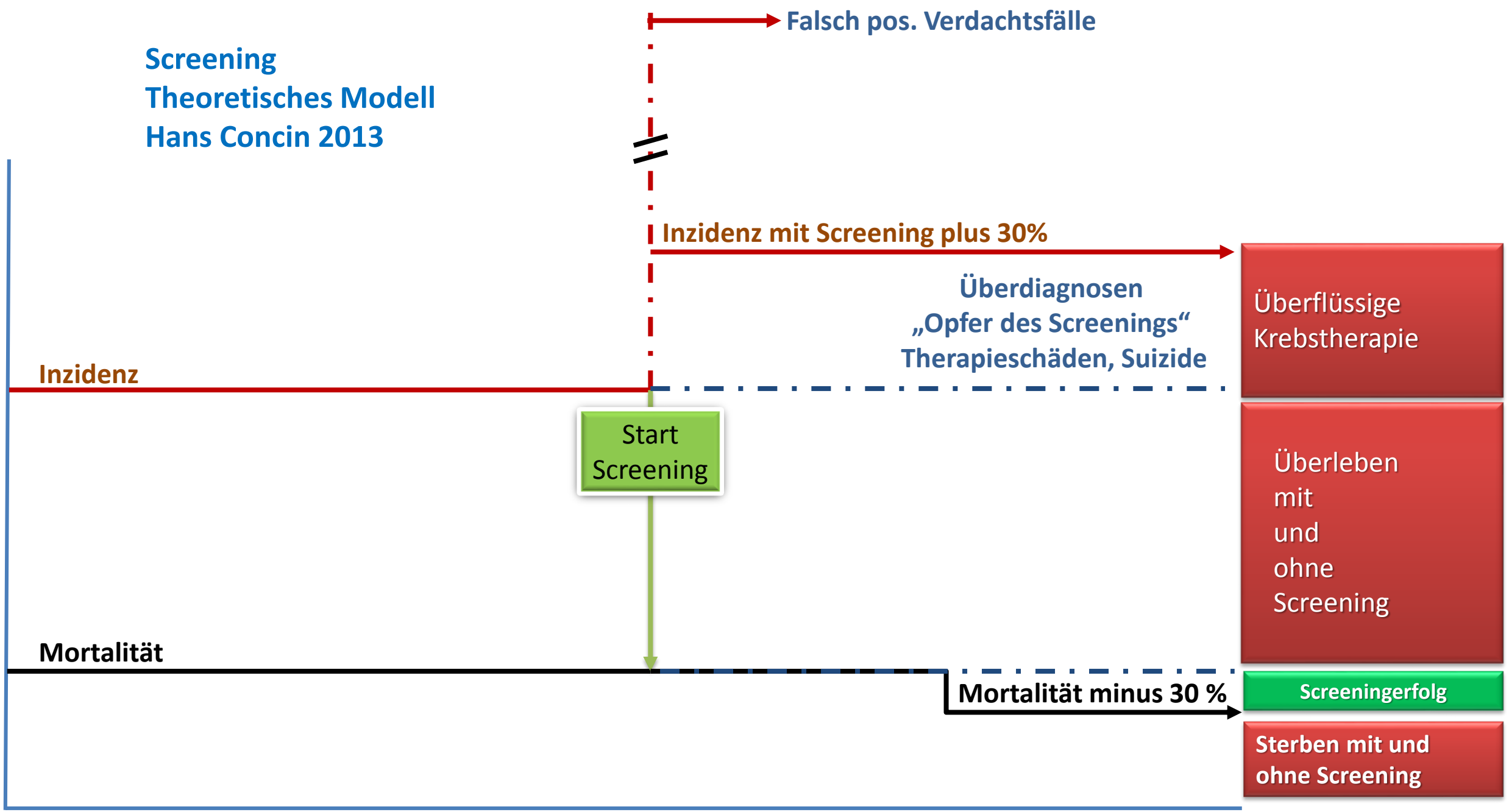
Periodic screening programs have the potential to identify a reservoir of indolent tumors.[4] However, cancer is still perceived as a diagnosis with lethal consequences if left untreated.

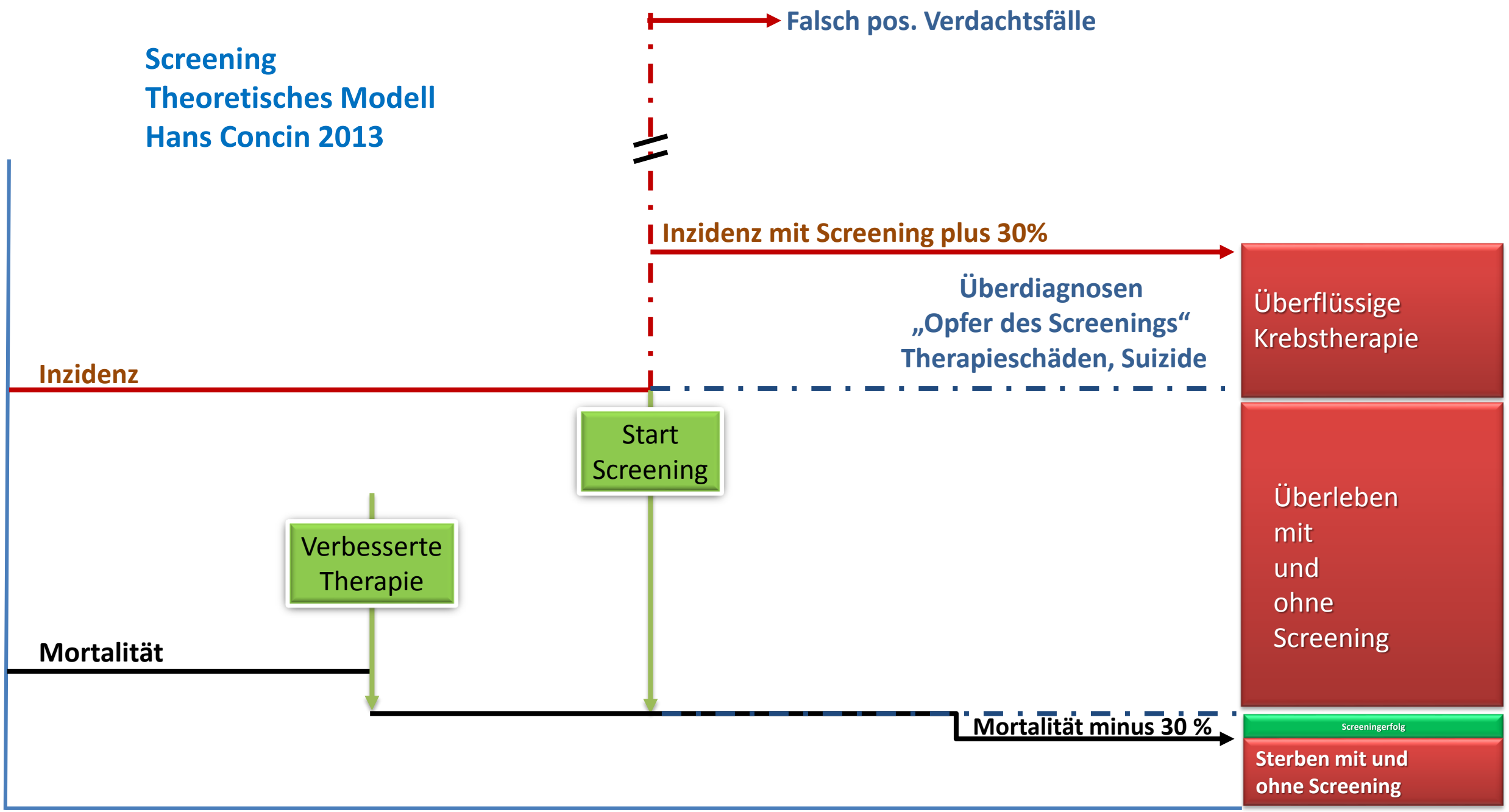
An ideal screening intervention focuses on detection of disease that will ultimately cause harm, that is more likely to be cured if detected early, and for which curative treatments are more effective in early-stage disease. Going forward, the ability to design better screening programs will depend on the ability to better characterize the biology of the disease detected and to use disease dynamics (behavior over time) and molecular diagnostics that determine whether cancer will be aggressive or indolent to avoid overtreatment. Understanding the biology of individual cancers is necessary to optimize early detection programs and tailor treatments accordingly. The following recommendations were made to the National Cancer Institute for consideration and dissemination.

Physicians, patients, and the general public must recognize that overdiagnosis is common and occurs more frequently with cancer screening. Overdiagnosis, or iden-

Table. Change in Incidence and Mortality of Cancers Over Time From 1975 to 2010 as Reported in Surveillance, Epidemiology and End Results[1]

Change[a]	Incidence			Mortality		
	Per 100 000		% Change	Per 100 000		% Change
	1975	2010[b]		1975	2010[b]	
Example 1						
Breast[c]	105.07	126.02	20	31.45	21.92	−30
Prostate	94	145.12	54	30.97	21.81	−30
Lung and bronchus[d]	52.26	56.68	8	42.56	47.42	11
Example 2						
Colon	41.35	28.72	−31	28.09	15.51	−45
Cervical	14.79	6.71	−55	5.55	2.26	−59
Example 3						
Thyroid	4.85	13.83	185	0.55	0.51	−7
Melanoma	7.89	23.57	199	2.07	2.74	32


Screening
Theoretisches Modell
Hans Concin 2013
Falsch pos. Verdachtsfälle
Inzidenz mit Screening plus 30%
Überdiagnosen
„Opfer des Screenings“
Therapieschäden, Suizide
Überflüssige Krebstherapie
Inzidenz
Start Screening
Überleben mit und ohne Screening
Mortalität
Mortalität minus 30 %
Screeningerfolg
Sterben mit und ohne Screening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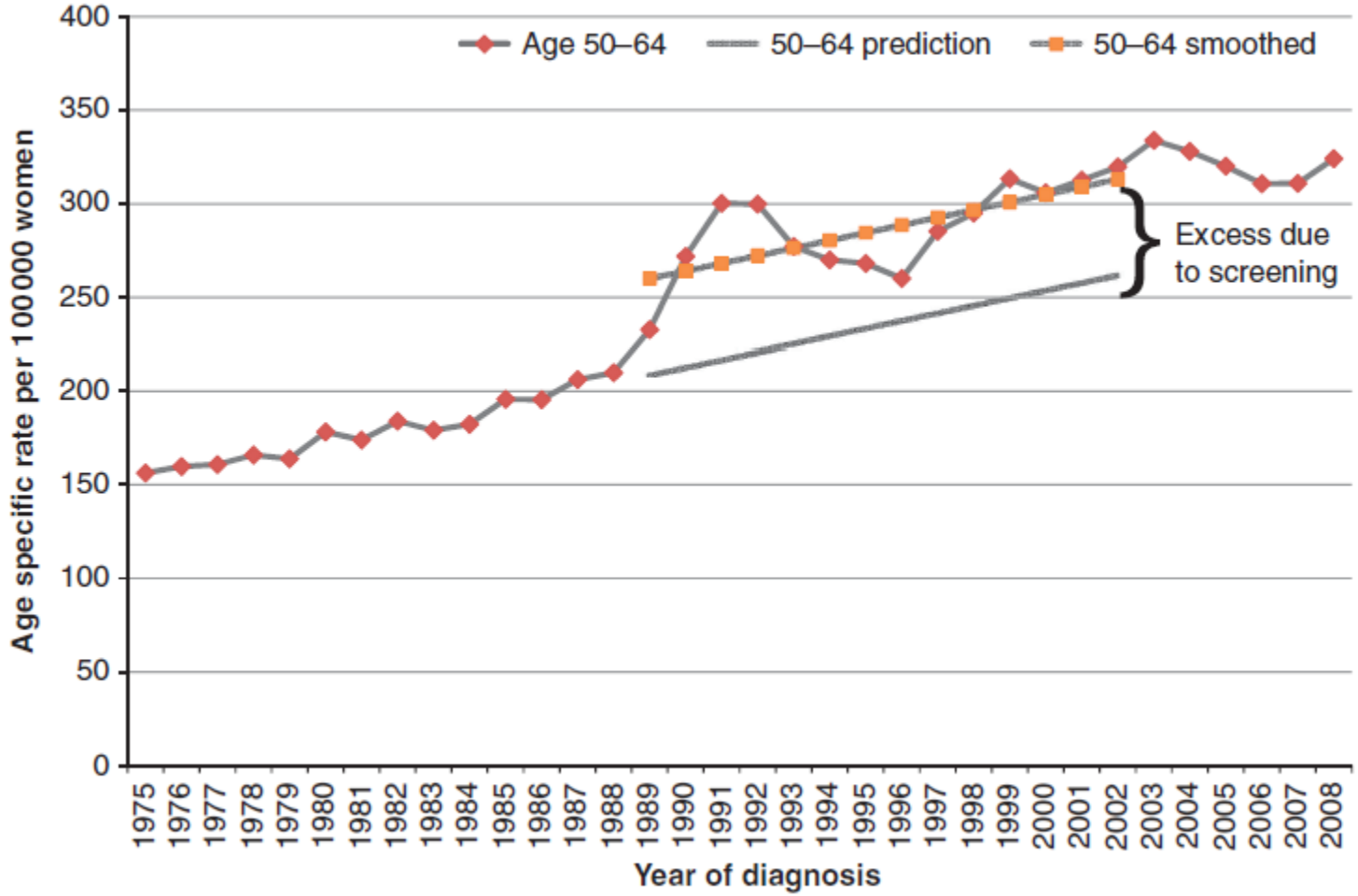


Breast cancer age-specific incidence rates, England 1975–2008, age 50–64 with expected, observed and smoothed data.

BRITISH JOURNAL OF CANCER Report 2232 bjc 2013

The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812 SEPTEMBER 23, 2010 VOL. 363 NO. 13

Effect of Screening Mammography on Breast-Cancer Mortality in Norway

Mette Kalager, M.D., Marvin Zelen, Ph.D., Frøydis Langmark, M.D., and Hans-Olov Adami, M.D., Ph.D.

ABSTRACT

BACKGROUND

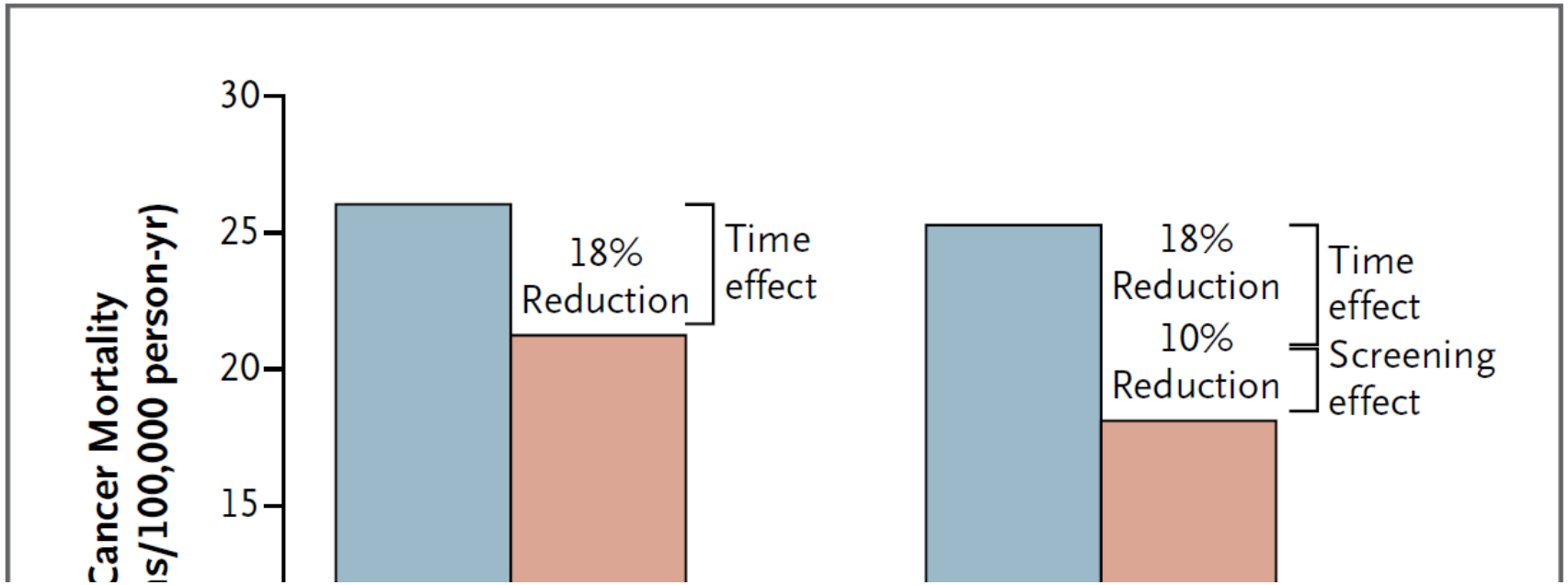
A challenge in quantifying the effect of screening mammography on breast-cancer mortality is to provide valid comparison groups. The use of historical control subjects does not take into account chronologic trends associated with advances in breast-cancer awareness and treatment.

METHODS

The Norwegian breast-cancer screening program was started in 1996 and expanded geographically during the subsequent 9 years. Women between the ages of 50 and 69 years were offered screening mammography every 2 years. We compared the incidence-based rates of death from breast cancer in four groups: two groups of women who from 1996 through 2005 were living in counties with screening (screening group) or without screening (nonscreening group); and two historical-comparison groups

From the Cancer Registry of Norway, Oslo (M.K., F.L., H.-O.A.); the Departments of Epidemiology (M.K., H.-O.A.) and Biostatistics (M.Z.), Harvard School of Public Health; and the Dana–Farber Cancer Institute and Harvard Medical School (M.Z., H.-O.A.) — all in Boston; and the Department of Medical Epidemiology and Biostatistics, Karolinska Institutet, Stockholm (H.-O.A.). Address reprint requests to Dr. Kalager at Oslo University Hospital, Department of Surgery, Montebello, 0310 Oslo, Norway, or at mkalager@hsph.harvard.edu.

N Engl J Med 2010;363:1203-10.



CONCLUSIONS

The availability of screening mammography was associated with a reduction in the rate of death from breast cancer, but the screening itself accounted for only about a third of the total reduction. (Funded by the Cancer Registry of Norway and the Research Council of Norway.)

ORIGINAL ARTICLE

Effect of Three Decades of Screening Mammography on Breast-Cancer Incidence

Archie Bleyer, M.D., and H. Gilbert Welch, M.D., M.P.H.

N Engl J Med 2012; 367:1998-2005 | November 22, 2012 | DOI: 10.1056/NEJMoa1206809

Conclusions

Despite substantial increases in the number of cases of early-stage breast cancer detected, screening mammography has only marginally reduced the rate at which women present with advanced cancer.
Although it is not certain which women have been affected, the imbalance suggests that there is substantial overdiagnosis, accounting for nearly a third of all newly diagnosed breast cancers, and that screening is having, at best, only a small effect on the rate of death from breast cancer.

Schlussfolgerungen

Trotz erheblichem Anstieg der entdeckten Zahl von Brustkrebs-Frühstadien, hat das Mammographie-Screening nur geringfügig die Rate der Frauen mit Krebs im fortgeschrittenen Stadium reduziert.
Obwohl es nicht sicher ist, welche Frauen betroffen sind, deutet das Ungleichgewicht darauf hin, dass es eine erhebliche Überdiagnose gibt, die fast ein Drittel aller neu diagnostizierten Brustkrebsfälle ausmachen und dass das Screening, im besten Fall nur einen geringen Einfluss auf die Sterberate von Brustkrebs hat.

ORIGINAL ARTICLE

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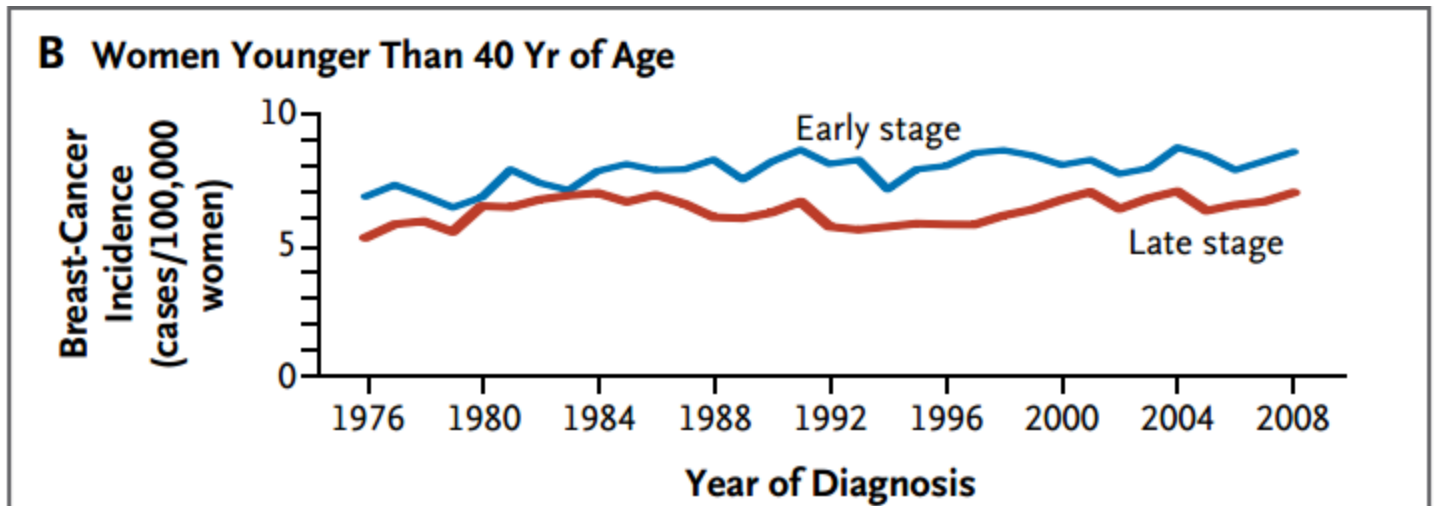
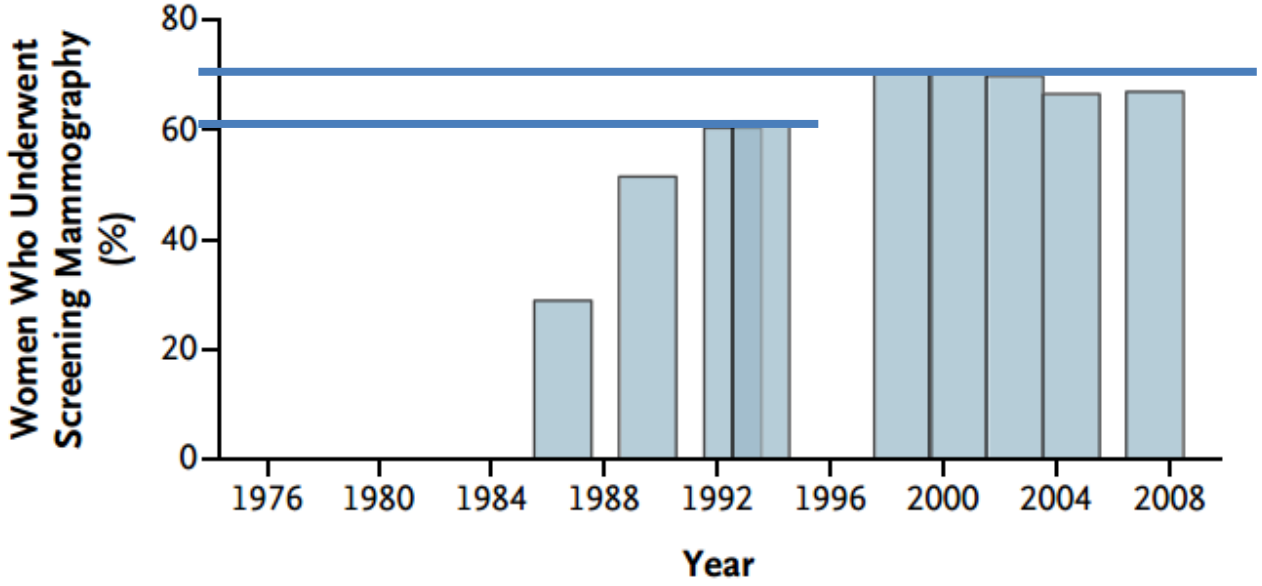
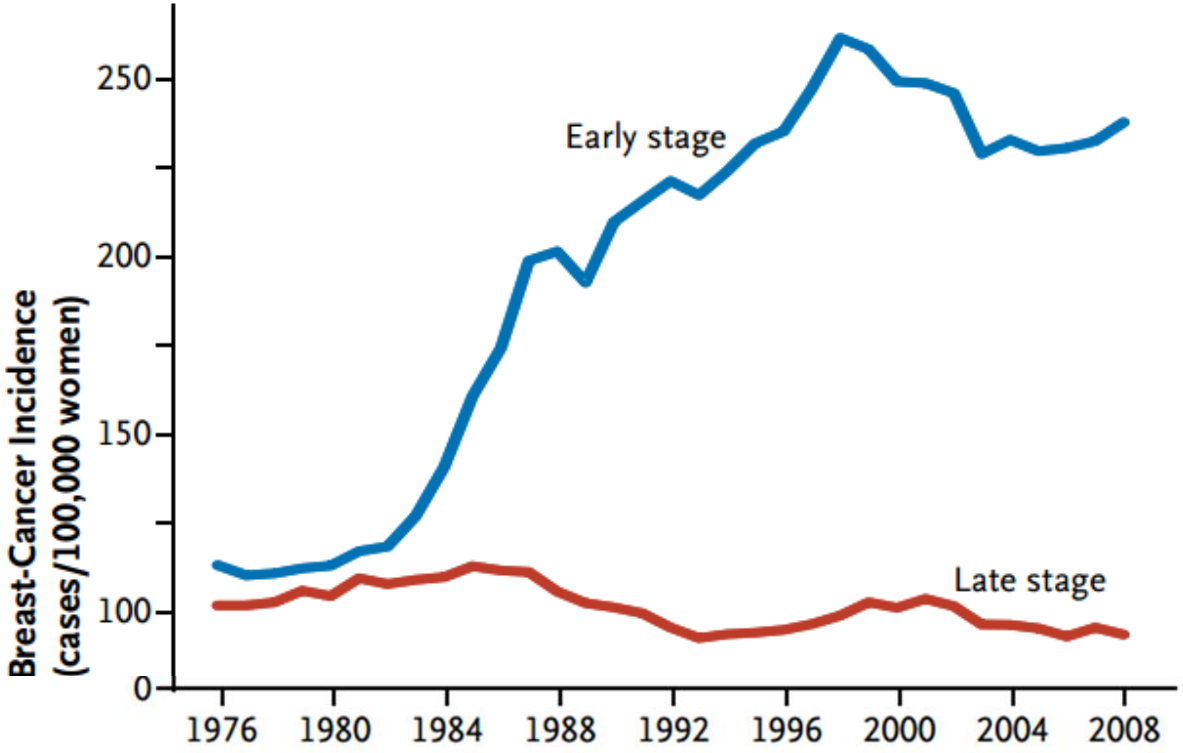


Figure 1. Use of Screening Mammography and Incidence of Stage-Specific Breast Cancer in the United States, 1976–2008.

Panel A shows the self-reported use of screening mammography and the incidence of stage-specific breast cancer among women 40 years of age or older. Panel B shows the incidence of stage-specific breast cancer among women who generally did not have exposure to screening mammography — those younger than 40 years of age.

A **Women 40 Yr of Age or Older**





RESEARCH

J R Soc Med 2013: 106: 234–242.

Breast cancer mortality trends in England and the assessment of the effectiveness of mammography screening: population-based study

Toqir K Mukhtar • David RG Yeates • Michael J Goldacre

Unit of Health-Care Epidemiology, Department of Public Health, University of Oxford, Oxford OX3 7LF, UK

Correspondence to: Toqir K Mukhtar. Email: toqir.mukhtar@dph.ox.ac.uk

DECLARATIONS

Competing interests

None declared

Funding

This work was supported by the English National Institute for Health Research (ref. RNC/035/02). The funding source had no influ-

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ow an effect of
ncer mortality in

Conclusions

We permuted the data in a number of different ways, over an observation period of 39 years, but the data show that, at least as yet, there is no evidence of an effect of mammographic screening on population-level breast cancer mortality.

Participants Women who died from breast cancer in the Oxford region

BJC

REPORT

British Journal of Cancer (2013) 108, 2205–2240 | doi: 10.1038/bjc.2013.177

The benefits and harms of breast cancer screening: an independent review

A report jointly commissioned by Cancer Research UK and the Department of Health (England) October 2012.

M G Marmot*[,1], D G Altman[2], D A Cameron[3], J A Dewar[4], S G Thompson[5], M Wilcox[6] – The Independent UK Panel on Breast Cancer Screening

[1]UCL Department of Epidemiology and Public Health, UCL Institute of Health Equity, 1-19 Torrington Place, London WC1E 7HB, UK; [2]Centre for Statistics in Medicine, University of Oxford, Botnar Research Centre, Windmill Road, Oxford, OX3 7LD, UK; [3]University of Edinburgh Cancer Research Centre and NHS Lothian, Western General Hospital, Edinburgh, EH4 2XR, UK; [4]Department of Surgery and Molecular Oncology, Medical School, Ninewells Hospital, Dundee DD1 9SY, UK; [5]Department of Public Health and Primary Care, University of Cambridge, Strangeways Research Laboratory, Worts Causeway, Cambridge CB1 8RN, UK and [6]Independent Cancer Patient's Voice, 17 Woodbridge Street, London EC1R 0LL, UK

1. SUMMARY

The benefits and harms of breast cancer screening: an independent review

A report jointly commissioned by Cancer Research UK and the Department of Health (England) October 2012.

M G Marmot*[,1], D G Altman[2], D A Cameron[3], J A Dewar[4], S G Thompson[5], M Wilcox[6] – The Independent UK Panel on Breast Cancer Screening

Marmot and colleagues acknowledged the limitations of their review, …

… on the basis of their estimate of
one death from breast cancer avoided for every 235 women invited to screening, they concluded that the UK breast screening programme should continue.

However, they also reported that
"for every breast cancer death prevented, approximately three overdiagnosed cases will be identified and treated."

BMJ

RESEARCH

Breast cancer mortality in organised mammography screening in Denmark: comparative study

Karsten Juhl Jørgensen, researcher,[1] Per-Henrik Zahl, senior researcher,[2] Peter C Gøtzsche, professor[1]

[1]The Nordic Cochrane Centre, Rigshospitalet, University of Copenhagen, Denmark

[2]Norwegian Institute of Public Health, Oslo, Norway

Correspondence to: K J Jørgensen kj@cochrane.dk

Cite this as: *BMJ* 2010;340:c1241

ABSTRACT

Objective To determine whether the previously observed 25% reduction in breast cancer mortality in Copenhagen following the introduction of mammography screening was indeed due to screening, by using an additional screening region and five years additional follow-up.

Design We used Poisson regression analyses adjusted for

non-screened areas and in age groups too young to benefit from screening, and are more likely explained by changes in risk factors and improved treatment than by screening mammography.

INTRODUCTION

Comprehensive systematic reviews of randomised trials

Conclusions

We were unable to find an effect of the Danish screening programme on breast cancer mortality.

The reductions in breast cancer mortality we observed in screening regions were similar or less than those in non-screened areas and in age groups too young to benefit from screening, and are more likely explained by changes in risk factors and improved treatment than by screening mammography.

BMJ

BMJ 2014;348:g366 doi: 10.1136/bmj.g366 (Published 11 February 2014)

RESEARCH

Twenty five year follow-up for breast cancer incidence and mortality of the Canadian National Breast Screening Study: randomised screening trial


OPEN ACCESS

Anthony B Miller *professor emeritus*[1], Claus Wall *data manager*[1], Cornelia J Baines *professor emerita*[1], Ping Sun *statistician*[2], Teresa To *senior scientist*[3], Steven A Narod *professor*[1 2]

[1]Dalla Lana School of Public Health, University of Toronto, Toronto, Ontario M5T 3M7, Canada; [2]Women's College Research Institute, Women's College Hospital, Toronto, Ontario M5G 1N8, Canada; [3]Child Health Evaluative Services, The Hospital for Sick Children, Toronto, Ontario, Canada

Abstract

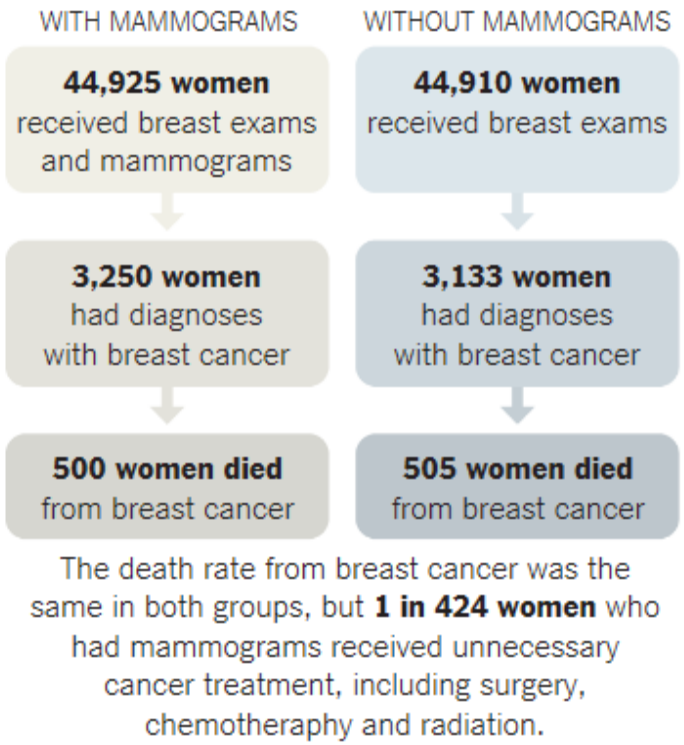
Objective To compare breast cancer incidence and mortality up to 25

Conclusion Annual mammography in women aged 40-59 does not reduce mortality from breast cancer beyond that of physical examination

The New York Times

Study Results

A large, 25-year study of Canadian women aged 40 to 59 found no benefit for women who were randomly assigned to have mammograms. FEB. 11, 2014



Source: British Medical Journal

Differenz: **117 mehr Brustkrebsdiagnosen (+Therapie)**
1 : 384

Differenz : **5 weniger Brustkrebstote**
1 : 9000

Falsche Befunde von Brustkrebs und unnötige Behandlungen:

Das Swiss Medical Board rät vom systematischen Mammografie-Screening in der Schweiz ab.

JAMA Oncology

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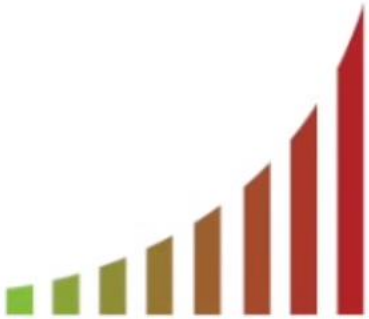
Mammography Screening and Overdiagnosis

ONLINE FIRST

Heidi D. Nelson, MD, MPH[1,2]

Conclusions and Relevance When analyzed at the county level, the clearest result of mammography screening is the diagnosis of additional small cancers. Furthermore, there is no concomitant decline in the detection of larger cancers, which might explain **the absence of any significant difference in the overall rate of death** from the disease. **Together, these findings suggest widespread overdiagnosis.**

JAMA Intern Med. 2015;175(9):1490-1491



PREVENTING
OVERDIAGNOSIS

Winding back the harms of too much medicine

Übersicht Inzidenz und Mortalität von Karzinomen USA 1975 bis 2005

SEPTEMBER 2015

National Insitutes of Health
Bethesda, Maryland USA

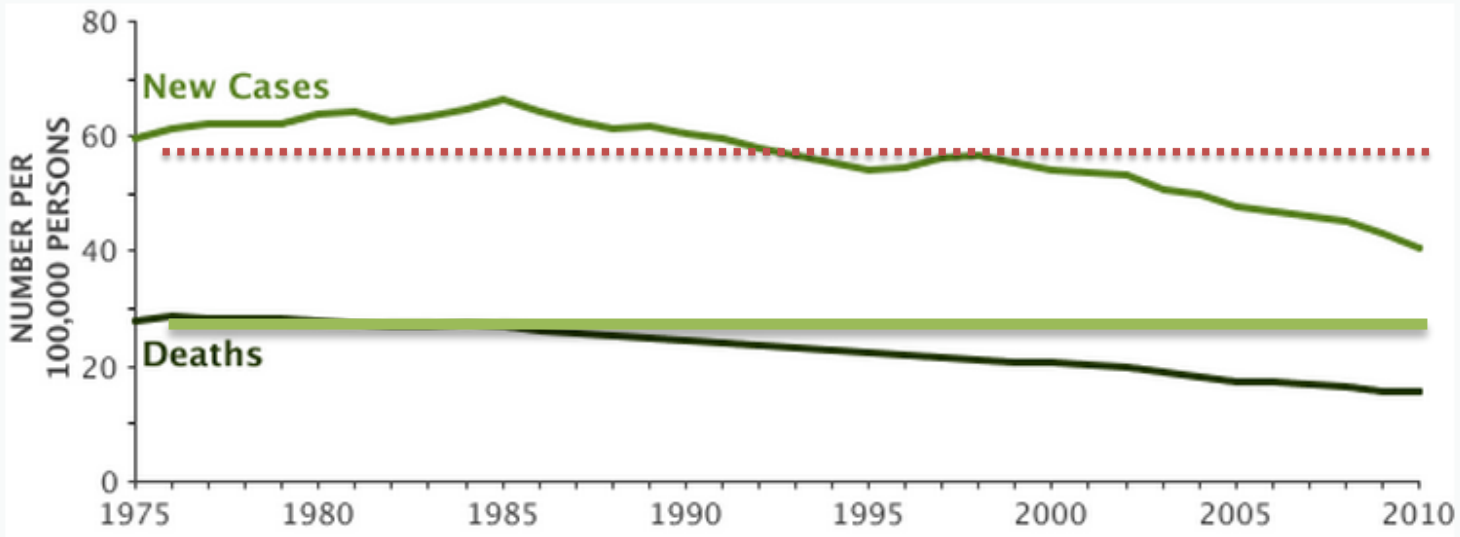
WEITER
Bridge Over Diagnosis - a parody of Bridge Over

https://www.youtube.com/watch?v=gfesuNG0-kQ

SEER Stat Fact Sheets: Colon Rectum Cancer
New Cases, Deaths and 5-Year Relative Survival

New Cases, Deaths and 5-Year Relative Survival

View Data Table



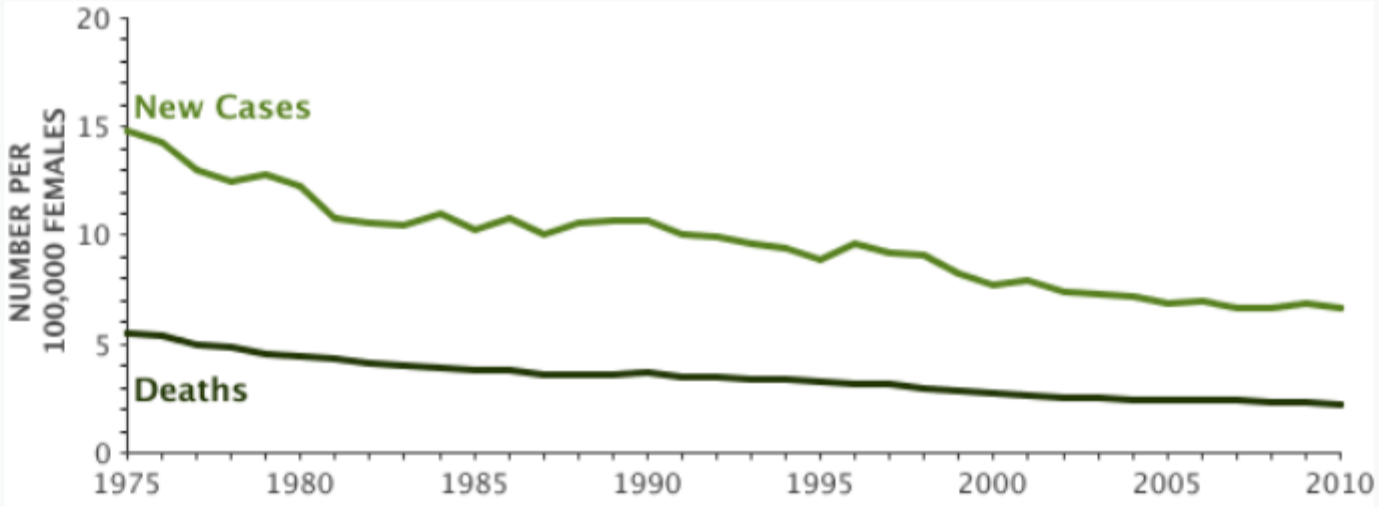
Year	1975	1980	1985	1989	1993	1997	2001	2005
5-Year Relative Survival	48.5%	51.1%	58.1%	59.9%	59.8%	61.5%	66.1%	66.1%

SEER 9 Incidence & U.S. Mortality 1975–2010, All Races, Both Sexes. Rates are Age-Adjusted.

SEER Stat Fact Sheets: Cervix uteri
New Cases, Deaths and 5-Year Relative Survival

New Cases, Deaths and 5-Year Relative Survival

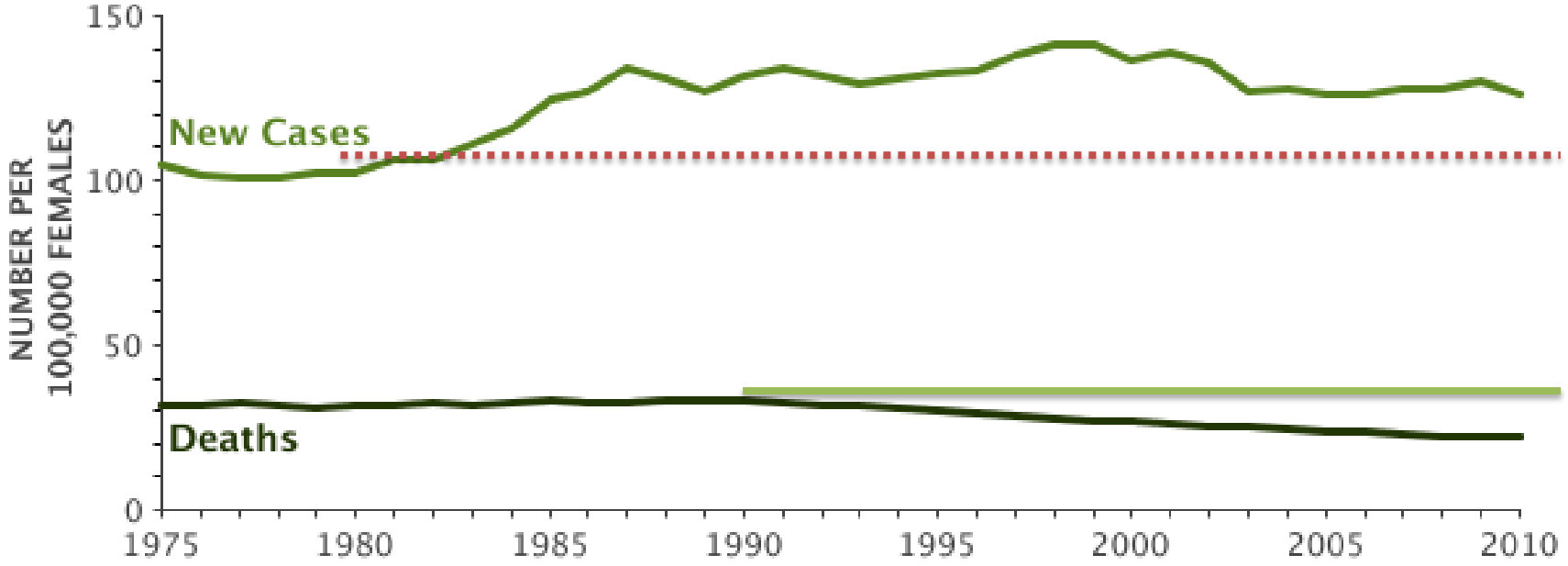
View Data Table



Year	1975	1980	1985	1989	1993	1997	2001	2005
5-Year Relative Survival	68.1%	67.9%	66.4%	71.0%	70.9%	71.6%	70.4%	68.0%

SEER 9 Incidence & U.S. Mortality 1975-2010, All Races, Females. Rates are Age-Adjusted.

SEER Stat Fact Sheets: Breast Cancer
New Cases, Deaths and 5-Year Relative Survival



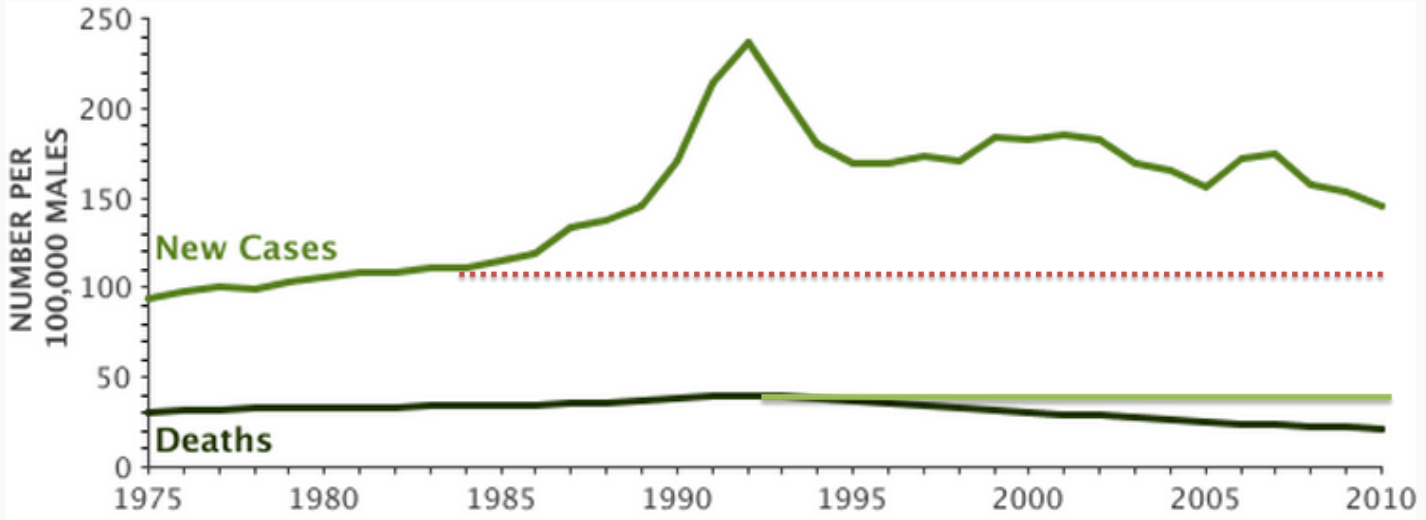
Year	1975	1980	1985	1989	1993	1997	2001	2005
5-Year Relative Survival	75.2%	74.9%	78.4%	84.3%	85.7%	88.4%	89.5%	90.5%

SEER 9 Incidence & U.S. Mortality 1975–2010, All Races, Females. Rates are Age-Adjusted.

SEER Stat Fact Sheets: Prostate Cancer
New Cases, Deaths and 5-Year Relative Survival

New Cases, Deaths and 5-Year Relative Survival

View Data Table



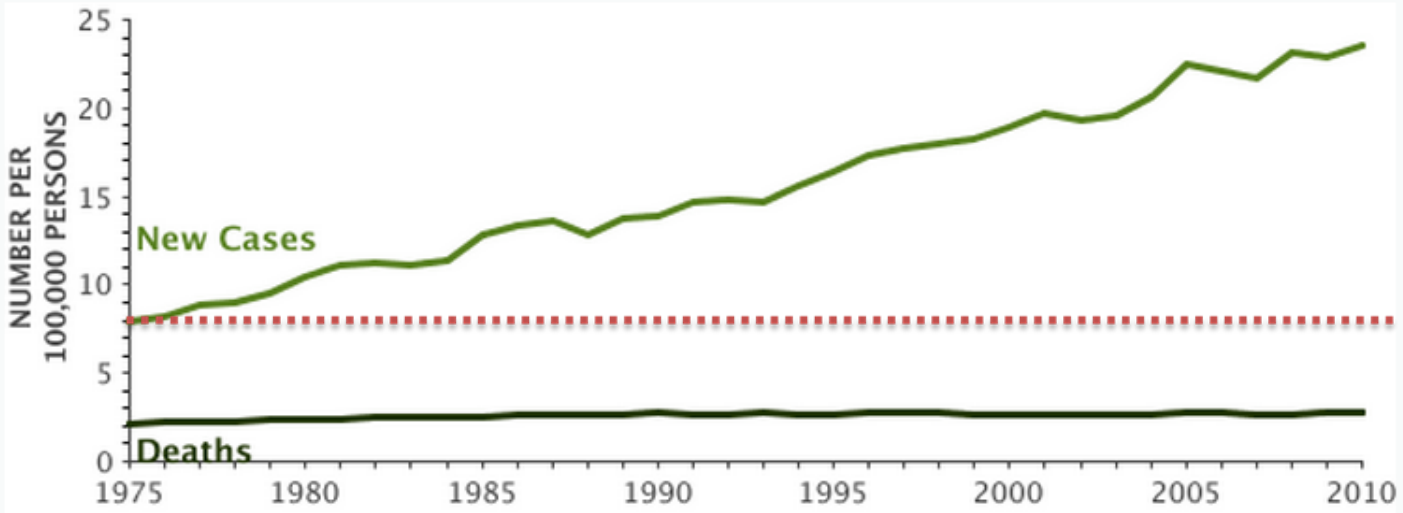
Year	1975	1980	1985	1989	1993	1997	2001	2005
5-Year Relative Survival	66.0%	70.2%	75.0%	84.4%	95.2%	97.5%	99.8%	99.6%

SEER 9 Incidence & U.S. Mortality 1975–2010, All Races, Males. Rates are Age-Adjusted.

SEER Stat Fact Sheets: Melanoma of the skin
New Cases, Deaths and 5-Year Relative Survival

New Cases, Deaths and 5-Year Relative Survival

View Data Table



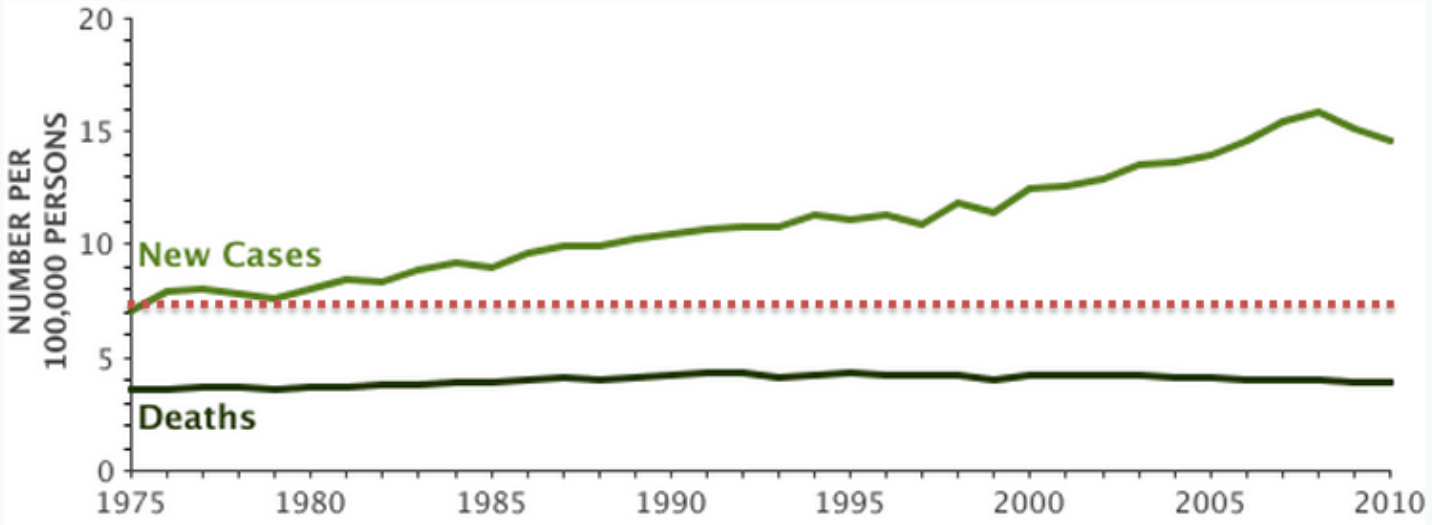
Year	1975	1980	1985	1989	1993	1997	2001	2005
5-Year Relative Survival	81.9%	83.8%	86.1%	87.6%	90.2%	89.8%	92.1%	93.1%

SEER 9 Incidence & U.S. Mortality 1975–2010, All Races, Both Sexes. Rates are Age-Adjusted.

SEER Stat Fact Sheets: Kidney and Renal Pelvis Cancer New Cases, Deaths and 5-Year Relative Survival

New Cases, Deaths and 5-Year Relative Survival

View Data Table



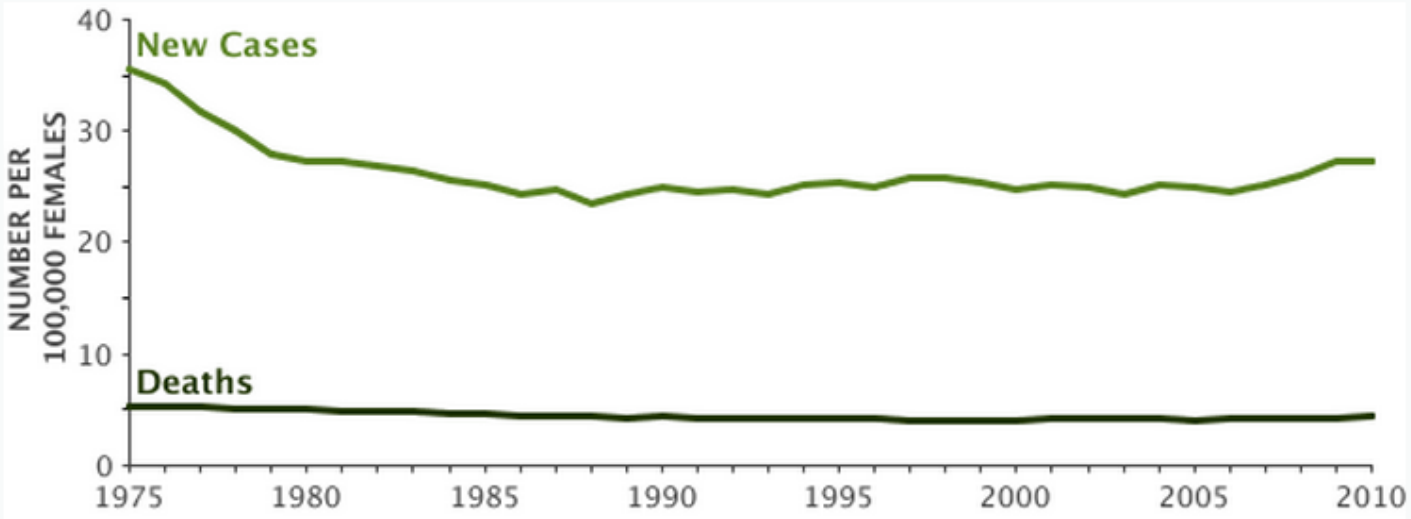
Year	1975	1980	1985	1989	1993	1997	2001	2005
5-Year Relative Survival	52.1%	54.2%	55.1%	56.3%	60.9%	61.7%	66.4%	74.5%

SEER 9 Incidence & U.S. Mortality 1975–2010, All Races, Both Sexes. Rates are Age-Adjusted.

SEER Stat Fact Sheets: Endometrium Cancer
New Cases, Deaths and 5-Year Relative Survival

New Cases, Deaths and 5-Year Relative Survival

View Data Table



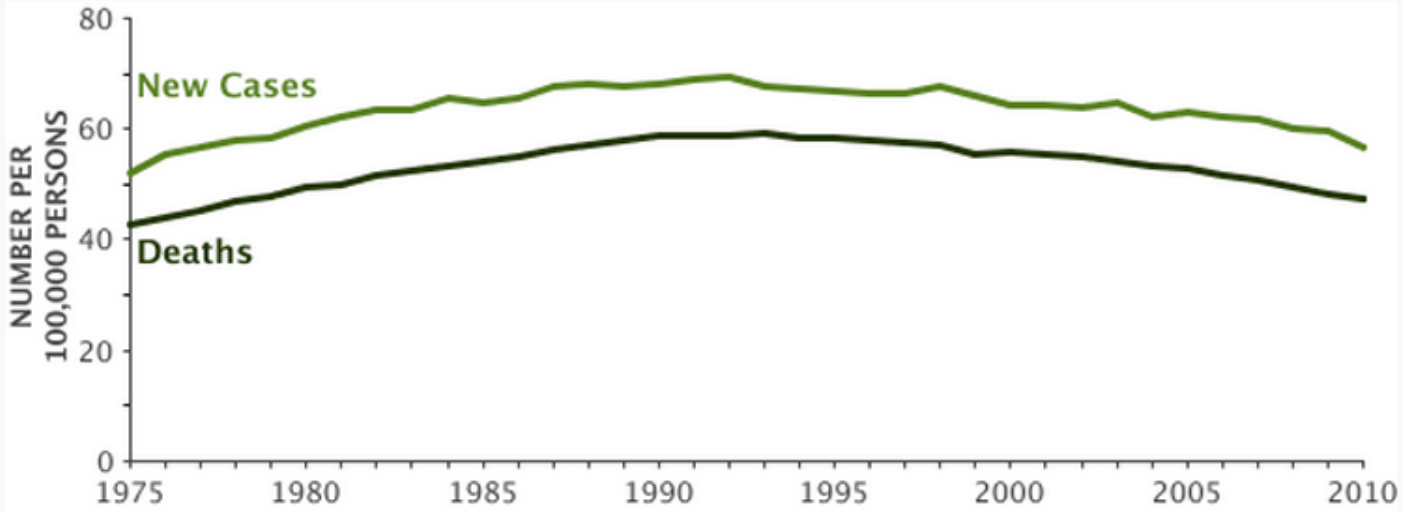
Year	1975	1980	1985	1989	1993	1997	2001	2005
5-Year Relative Survival	87.8%	79.6%	82.7%	83.2%	82.9%	84.1%	83.2%	82.8%

SEER 9 Incidence & U.S. Mortality 1975–2010, All Races, Females. Rates are Age-Adjusted.

SEER Stat Fact Sheets: Lung and Bronchus Cancer
New Cases, Deaths and 5-Year Relative Survival

New Cases, Deaths and 5-Year Relative Survival

View Data Table

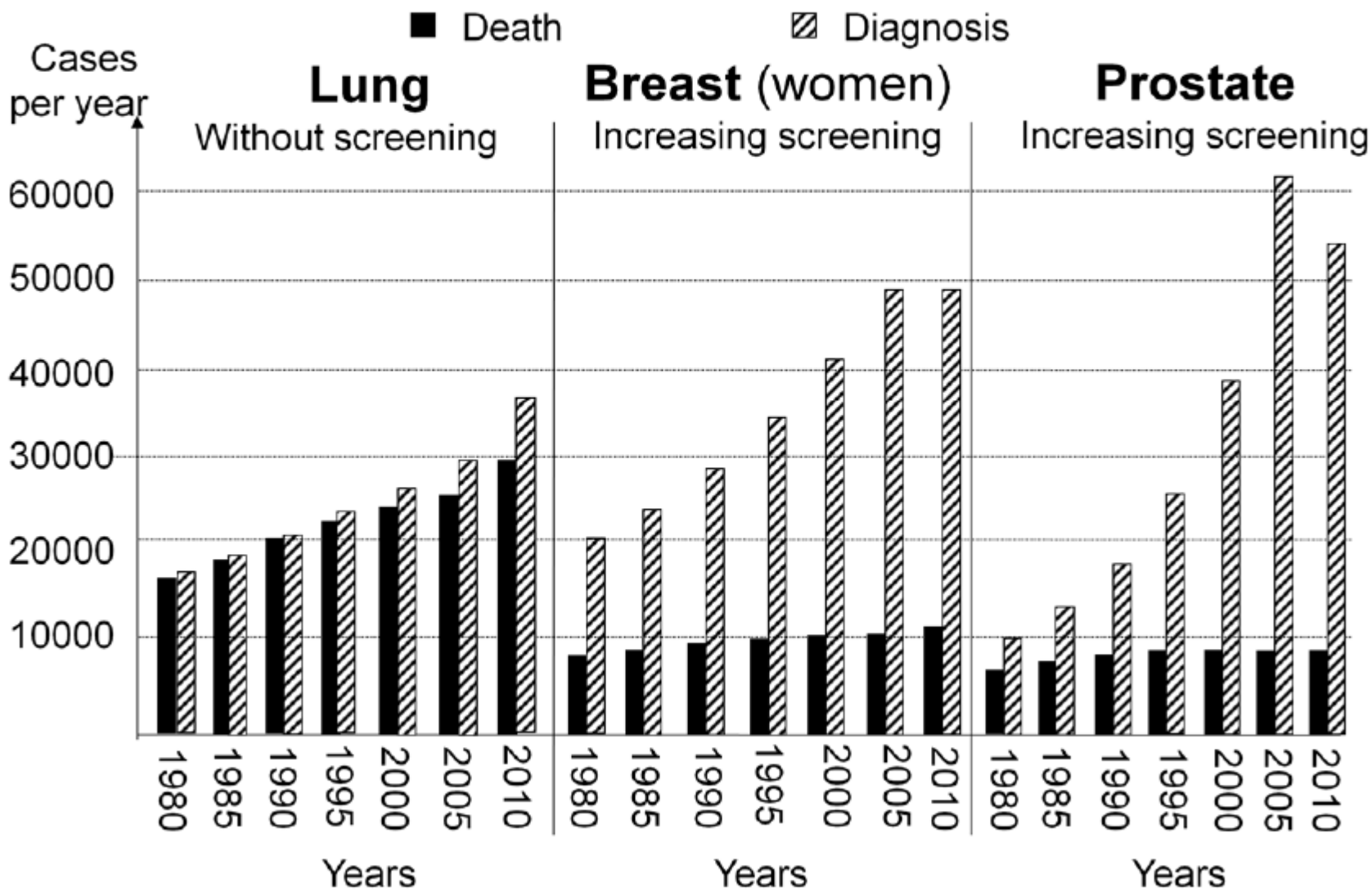


Year	1975	1980	1985	1989	1993	1997	2001	2005
5-Year Relative Survival	11.4%	12.5%	13.1%	13.4%	14.2%	14.7%	14.9%	17.3%

SEER 9 Incidence & U.S. Mortality 1975–2010, All Races, Both Sexes. Rates are Age-Adjusted.

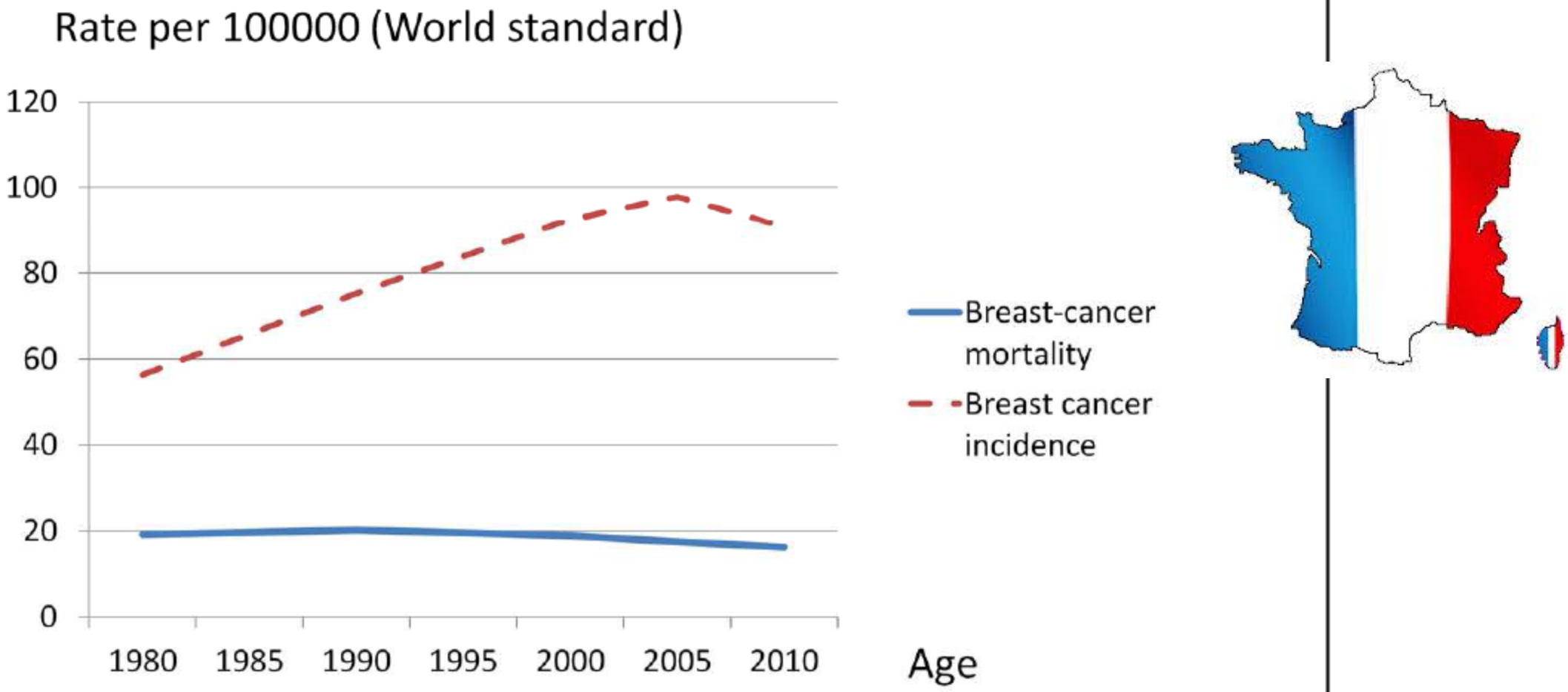
Cancer death and invasive cancer diagnosis with and without screening

Lung, breast and prostate. France 1980-2010



Breast-cancer incidence and mortality

France 1980 - 2010



Increase in incidence for early stage
Constant incidence for late stage
Four French Registries - 1990 to 2008

■ *Loire-Atlantique* ▲ *Isère et Tarn* ● *Hérault*

Standardized incidence
for 100000

← **Early stag**

← **Late stage**

Year

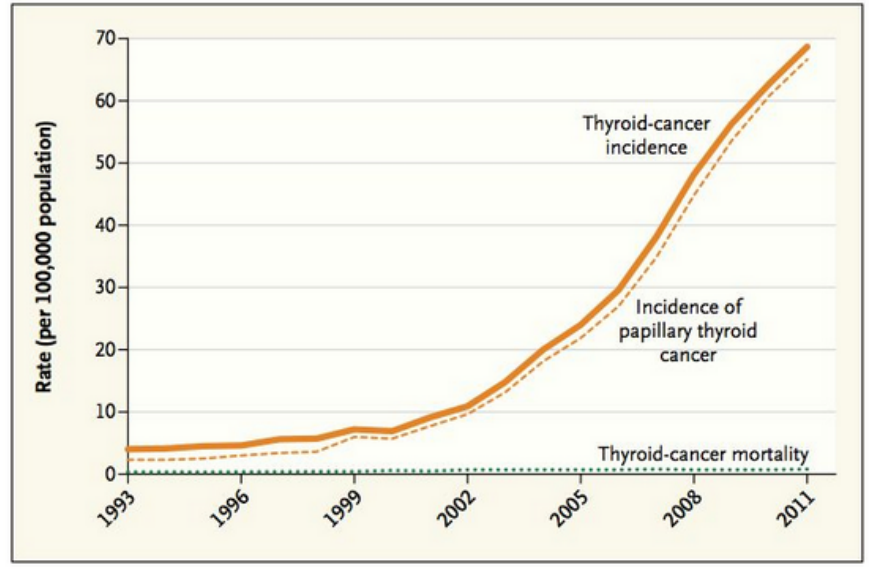
Georgia Political Review

World — November 19, 2014 at 10:04 AM

When Cancer Screening Goes Too Far: Implications of Medical Overdiagnosis

By: **Hammad Khalid**

The new face of cancer is not cancer of the lung, breast, colon, or prostate. Instead, **thyroid cancer** is now the most common cancer in South Korea, after a fifteen-fold increase in incidence over the past two decades. Although thyroid cancer rates have more than doubled since 1994 in the United States, and similar upward trends can be found in Europe, nowhere in the world has the rate of any cancer grown faster than that of thyroid cancer in South Korea.



Line graph courtesy of New England Journal of Medicine shows thyroid-cancer incidence and related mortality in South Korea from 1993 – 2011.

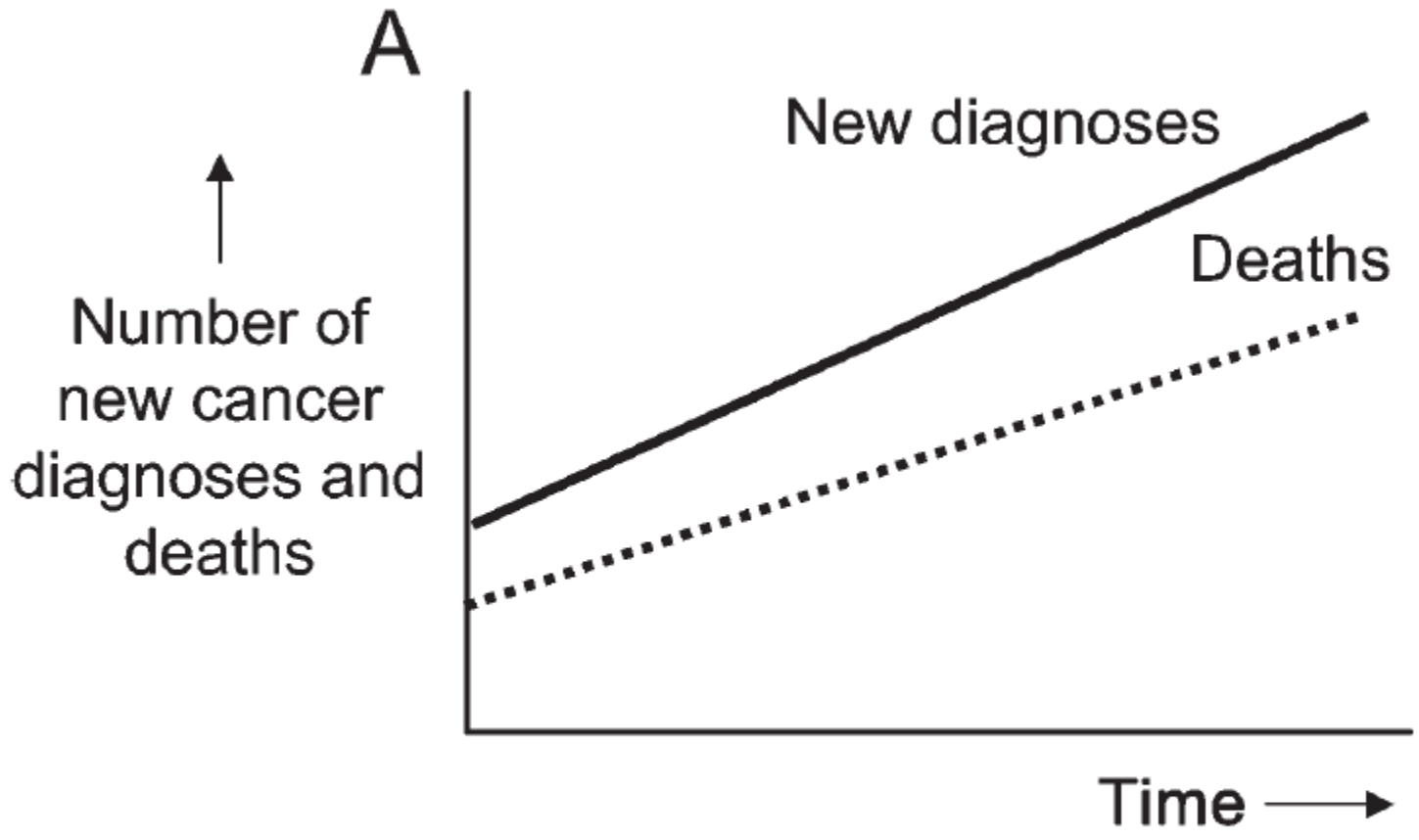
Such a sharp rise in incidence typically indicates a real increase in disease prevalence, which can be directly correlated to increased mortality rates from the disease. These significant increases are usually rationalized via biological explanations, such as a new infectious agent or novel environmental exposure to pathogens. In this case, experts have agreed that South Korea's thyroid cancer epidemic is instead a direct result of increased cancer screening.

United States University of Georgia

women's rights

Overdiagnosis in Cancer

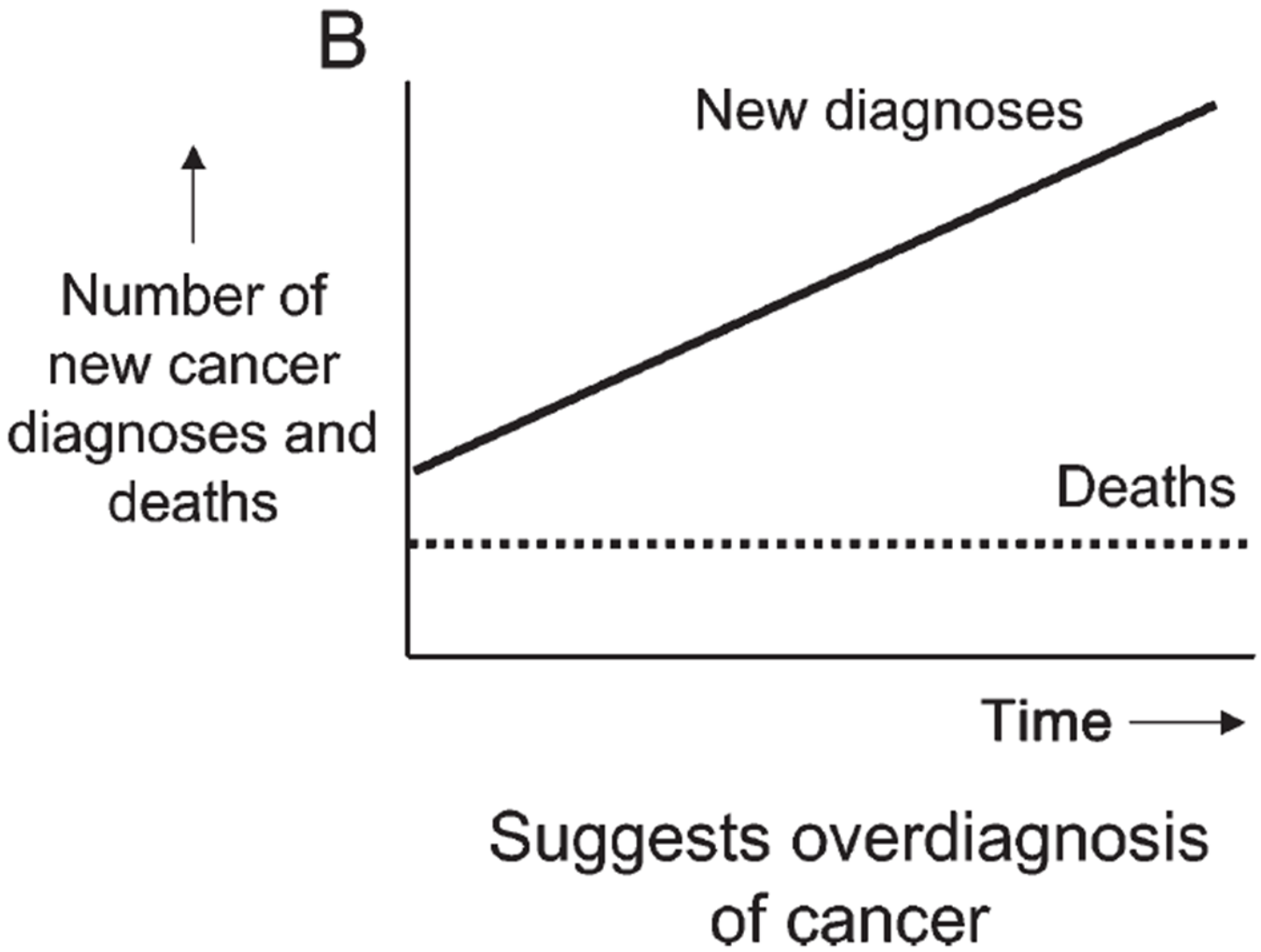
H. Gilbert Welch, William C. Black



Suggests a true increase in the amount of cancer

Overdiagnosis in Cancer

H. Gilbert Welch, William C. Black



RESEARCH CMAJ

Incidence of breast cancer and estimates of overdiagnosis after the initiation of a population-based mammography screening program

Andrew Coldman PhD, Norm Phillips MSc

Competing interests: Andrew Coldman was previously associated with the Screening Mammography Program of BC in an administrative capacity; he is currently employed by the BC Cancer Agency, which manages this program. Norm Phillips is currently employed by the BC Cancer Agency, which manages the Screening Mammography Program of BC.

This article has been peer reviewed.

Correspondence to: acoldman@bccancer.bc.ca

CMAJ 2013. DOI:10.1503/cmaj.121791

Abstract

Background: There has been growing interest in the overdiagnosis of breast cancer as a result of mammography screening. We report incidence rates in British Columbia before and after the initiation of population screening and provide estimates of overdiagnosis.

Methods: We obtained the numbers of breast cancer diagnoses from the BC Cancer Registry and screening histories from the Screening Mamm
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with nonparticipants; the second estimate compared observed and predicted population rates.

Results: We calculated participation-based estimates of overdiagnosis to be 5.4% for invasive disease alone and 17.3% when ductal carcinoma in situ was included. The corresponding population-based estimates were –0.7% and 6.7%. Participants had higher rates of invasive cancer and ductal carcinoma in situ than nonparticipants but lower rates after screening stopped. Population incidence rates for invasive cancer increased after 1980; by 2009, they had returned to levels similar to those of the 1970s among women under 60 years of age but remained elevated
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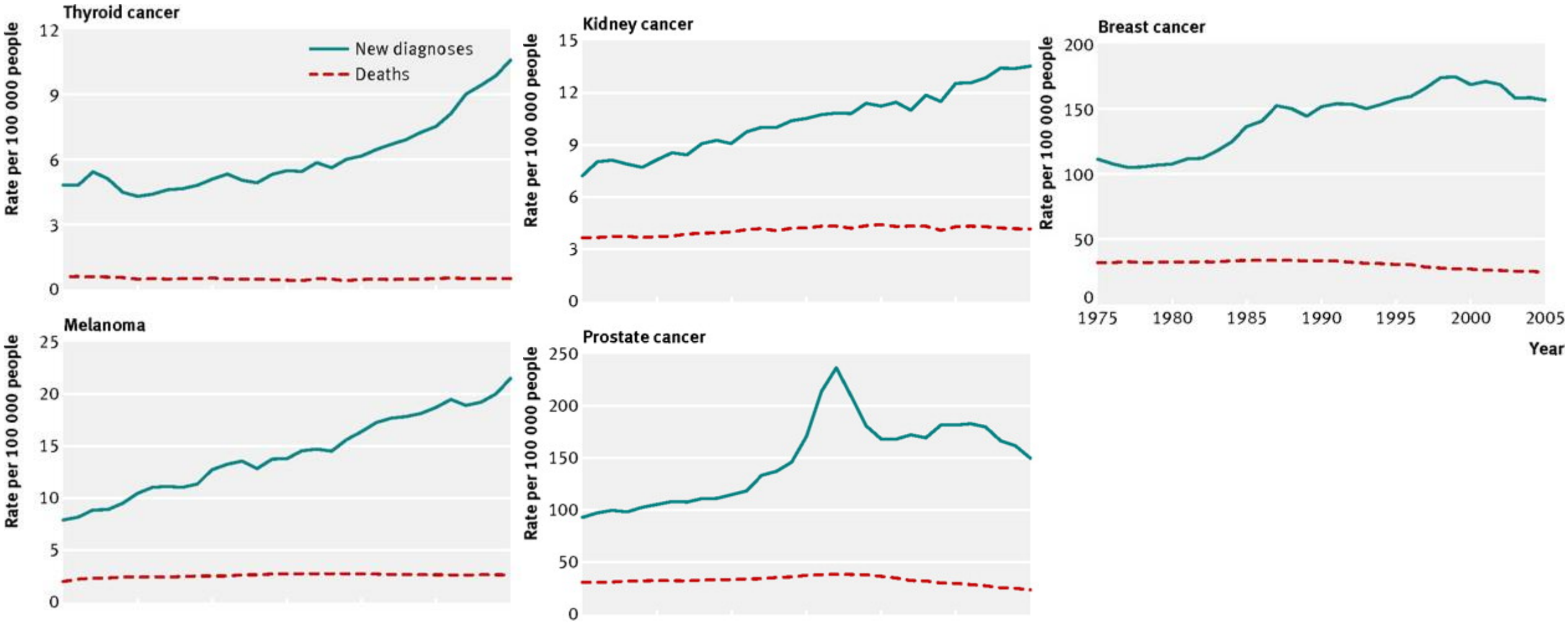
diagnosis from observational data is complex and subject to many influences. The use of mammography screening in older women has an increased risk of overdiagnosis, which should be considered in screening decisions.

The use of mammography screening in older women has an increased risk of overdiagnosis, which should be considered in screening decisions.

LESS IS MORE

- = + MEDICINE



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PLOS | MEDICINE

Essay

Using Evidence to Combat Overdiagnosis and Overtreatment: Evaluating Treatments, Tests, and Disease Definitions in the Time of Too Much

July 2014 | Volume 11 | Issue 7

Ray Moynihan[1]*, David Henry[2,3], Karel G. M. Moons[4]

1 Centre for Research in Evidence-Based Practice, Bond University, Robina, Queensland, Australia, **2** University of Toronto, Toronto, Ontario, Canada, **3** Institute for Clinical Evaluative Sciences, Toronto, Ontario, Canada, **4** Julius Center for Health Sciences and Primary Care, University Medical Centre Utrecht, Utrecht, The Netherlands

While a large part of the world's population faces the problems of underdiagnosis and undertreatment, it is apparent that a "modern epidemic" of overdiagnosis afflicts high-income countries [1], with tangible human and financial costs of the unnecessary management of overdiagnosed diseases [2,3]. While there is ongoing debate about how to best describe the problem, narrowly defined, overdiagnosis occurs when increasingly sensitive tests identify abnormalities that are indolent, non-progressive, or regressive and that, if left untreated, will not cause symptoms or shorten an individual's life. Such overdiagnosis leads to overtreatment when these "pseudo-diseases" are conventionally managed and treated as if they

Summary Points

- Overdiagnosis and related overtreatment are increasingly recognised as major problems.
- "Positive" average results from trials of treatments can mask situations where many participants at low risk of disease may receive no benefit.
- The evaluation of diagnostic tests usually involves assessing how well tests detect presence versus absence of a certain disease—rather than how well they detect clinically meaningful stages of disease.
- Changes to disease definitions typically do not involve evaluation of potential harms of overdiagnosis, and are often conducted by heavily conflicted panels.
- We offer suggestions for improving the way evidence is produced, analysed, and interpreted, to help combat overdiagnosis and related overtreatment. These include routine consideration of overdiagnosis and related overtreatment in studies of tests and treatments, and clearer stratification by baseline risk to identify treatment thresholds where benefits are likely to outweigh harms.

Preventing Overdiagnosis 2015 Highlights

SUSAN MERRELL

'We want to figure out how to do less safely.'

—Laura Esserman, a breast-cancer surgeon at the University of California, San Francisco

Laura Esserman

University of California and San Francisco, USA

Risk-Based Screening

Vollbildmodus beenden

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The Lancet Oncology, Volume 15, Issue 6, Pages e234 - e242, May 2014
doi:10.1016/S1470-2045(13)70598-9 Cite or Link Using DOI

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Addressing overdiagnosis and overtreatment in cancer: a prescription for change

Prof Laura J Esserman MD [a], Prof Ian M Thompson MD [b], Prof Brian Reid MD [c], Prof Peter Nelson MD [c], Prof David F Ransohoff MD [d], Prof H Gilbert Welch MD [e], Shelley Hwang MD [f], Prof Donald A Berry PhD [g], Prof Kenneth W Kinzler PhD [h], Prof William C Black MD [i], Prof Mina Bissell PhD [j], Howard Parnes PhD [k], Sudhir Srivastava PhD [l]

Summary

A vast range of disorders—from indolent to fast-growing lesions—are labelled as cancer. Therefore, we believe that several changes should be made to the approach to cancer screening and care, such as use of new terminology for indolent and precancerous disorders. We propose the term indolent lesion of epithelial origin, or IDLE, for those lesions (currently labelled as cancers) and their precursors that are unlikely to cause harm if they are left untreated. Furthermore, precursors of cancer or high-risk disorders should not have the term cancer in them. The rationale for this change in approach is that indolent lesions with low

We propose the term **indolent lesion of epithelial origin, or IDLE**, for those lesions (currently labelled as cancers) and their precursors that are unlikely to cause harm if they are left untreated.

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Addressing overdiagnosis and overtreatment in cancer: a prescription for change

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f Duke University, Durham, NC, USA
g University of Texas MD Anderson Cancer Center, Houston, TX, USA
h Johns Hopkins University, Baltimore, MD, USA
i Dartmouth-Hitchcock Medical Center, Lebanon, NH, USA
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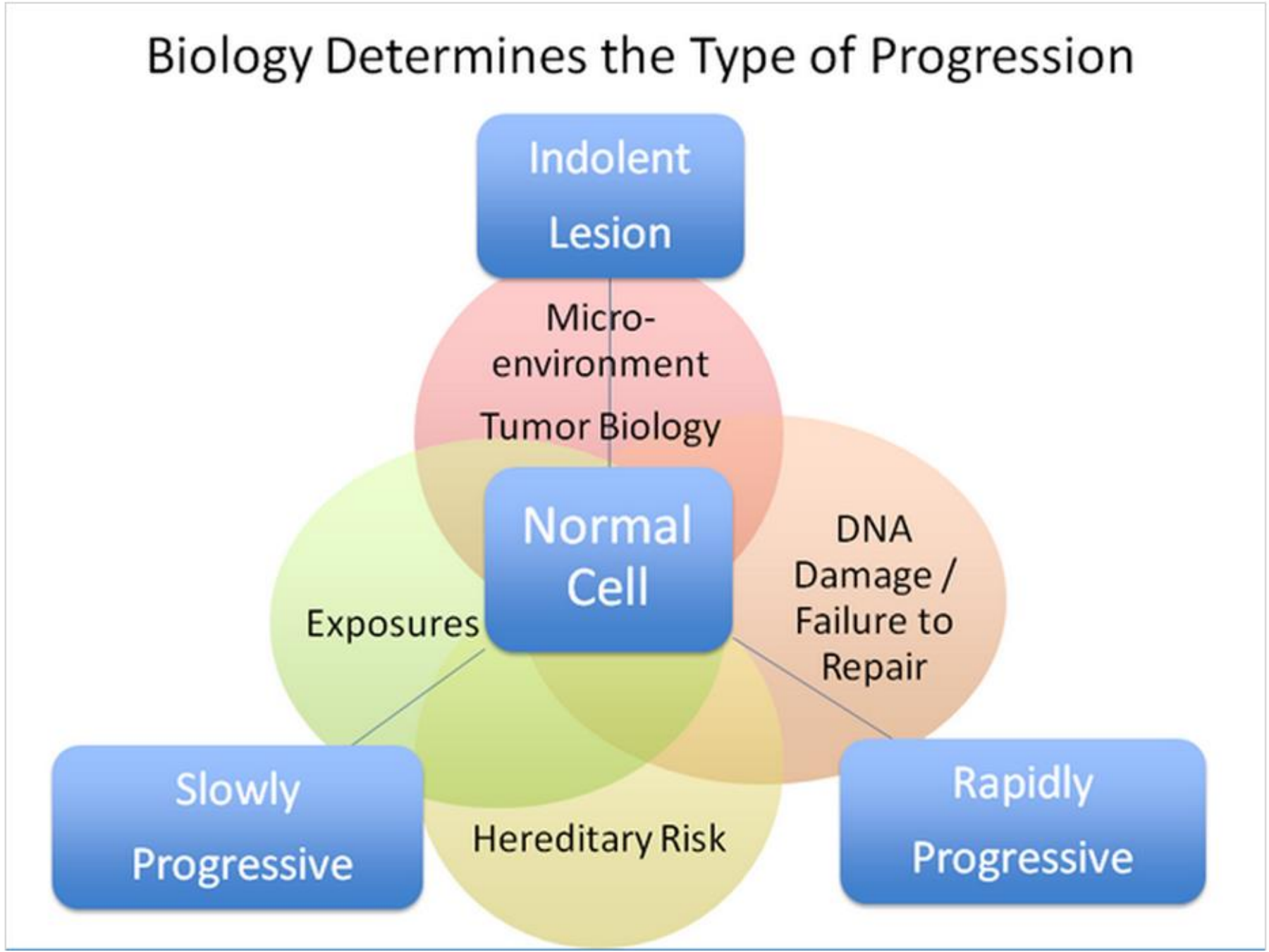
Addressing overdiagnosis and overtreatment in cancer

Elliott Foucar [a]

Mass screening for solid cancers or precancerous lesions is based on the belief that if cancers can be found early—ie, before presentation with clinical symptoms—therapy is more likely to be successful. Unfortunately, screening can also sometimes lead to the discovery of lesions that pathologists call cancer, but these diagnoses are too early—ie, they are lesions that would never progress to clinically apparent disease if simply left alone. Aggressive treatment of these lesions is the major source of patient harm that can be attributed to cancer screening, producing diagnosis survivors who are mistakenly regarded as cancer survivors. Until now, cal advocates[1] olleagues[2] propose to athologist is an autho ck of involvemer opinion-based gold readily available p e and modify haz standard of expert opinion did not adapt, becoming progressively distanced from its effect on patient populations. Experts in pathology promoted their ability to interpret cellular minutia, leaving it to non-pathologists such as Esserman and colleagues to notice the harm that these interpretations were causing to the pathologists' patients.

… discovery of lesions that pathologists call cancer, but these diagnoses are too early—ie, they are lesions that would never progress to clinically apparent disease if simply left alone …

By Laura J. Esserman, MD, MBA



Prevention and Epidemiology

Cancer Research

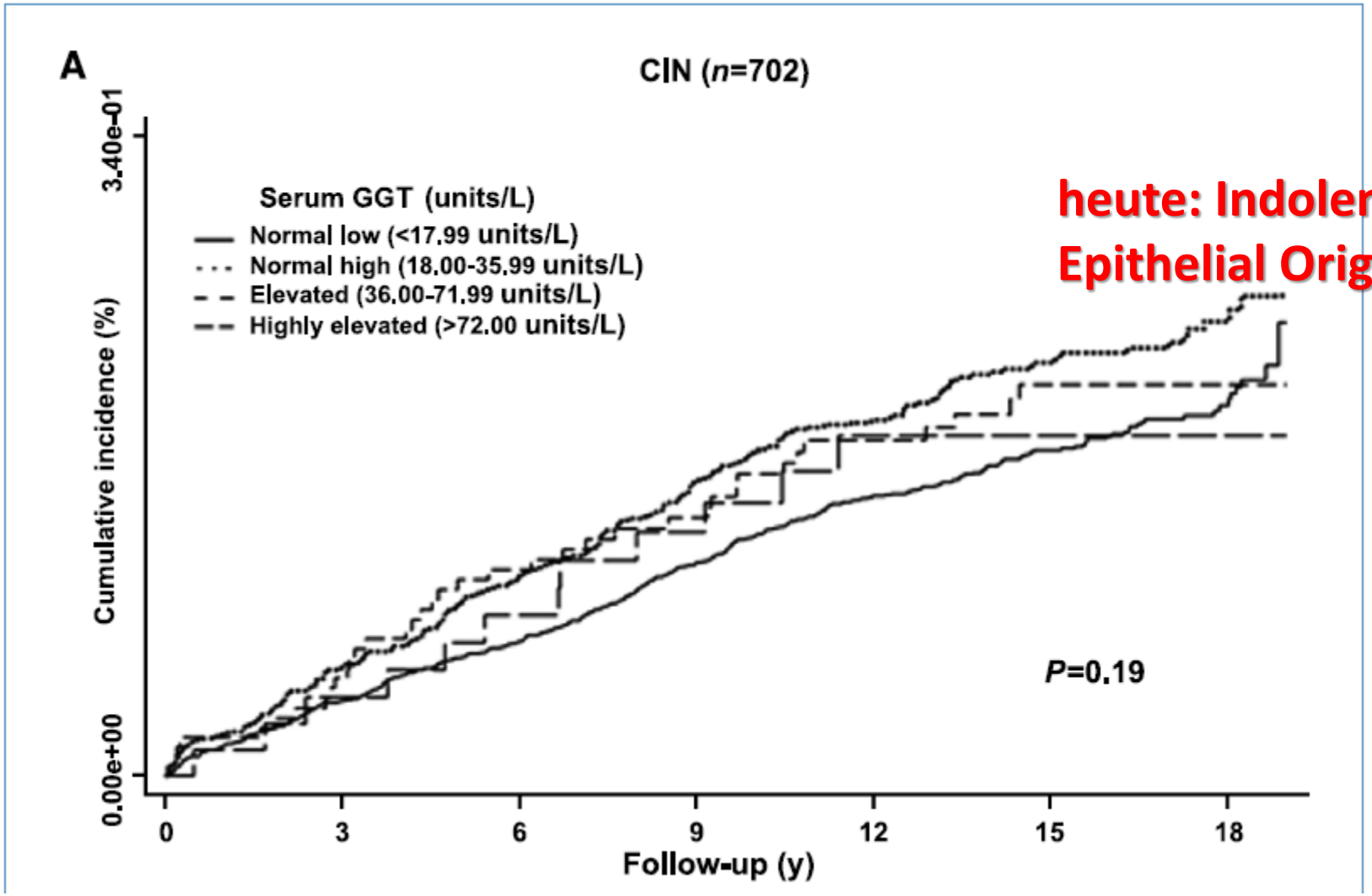
Prospective Study of the Association of Serum γ-Glutamyltransferase with Cervical Intraepithelial Neoplasia III and Invasive Cervical Cancer

heute: Indolent Lesion of Epithelial Origin - IDLE

Alexander M. Strasak[1], Georg Goebel[1], Hans Concin[4], Ruth M. Pfeiffer[5], Larry J. Brant[6], Gabriele Nagel[7], Willi Oberaigner[8], Nicole Concin[2], Günter Diem[4], Elfriede Ruttmann[3], Ulrike Gruber-Moesenbacher[9], Felix Offner[9], Alfonso Pompella[10], Karl P. Pfeiffer[1], Hanno Ulmer[1,4], and the VHM&PP Study Group

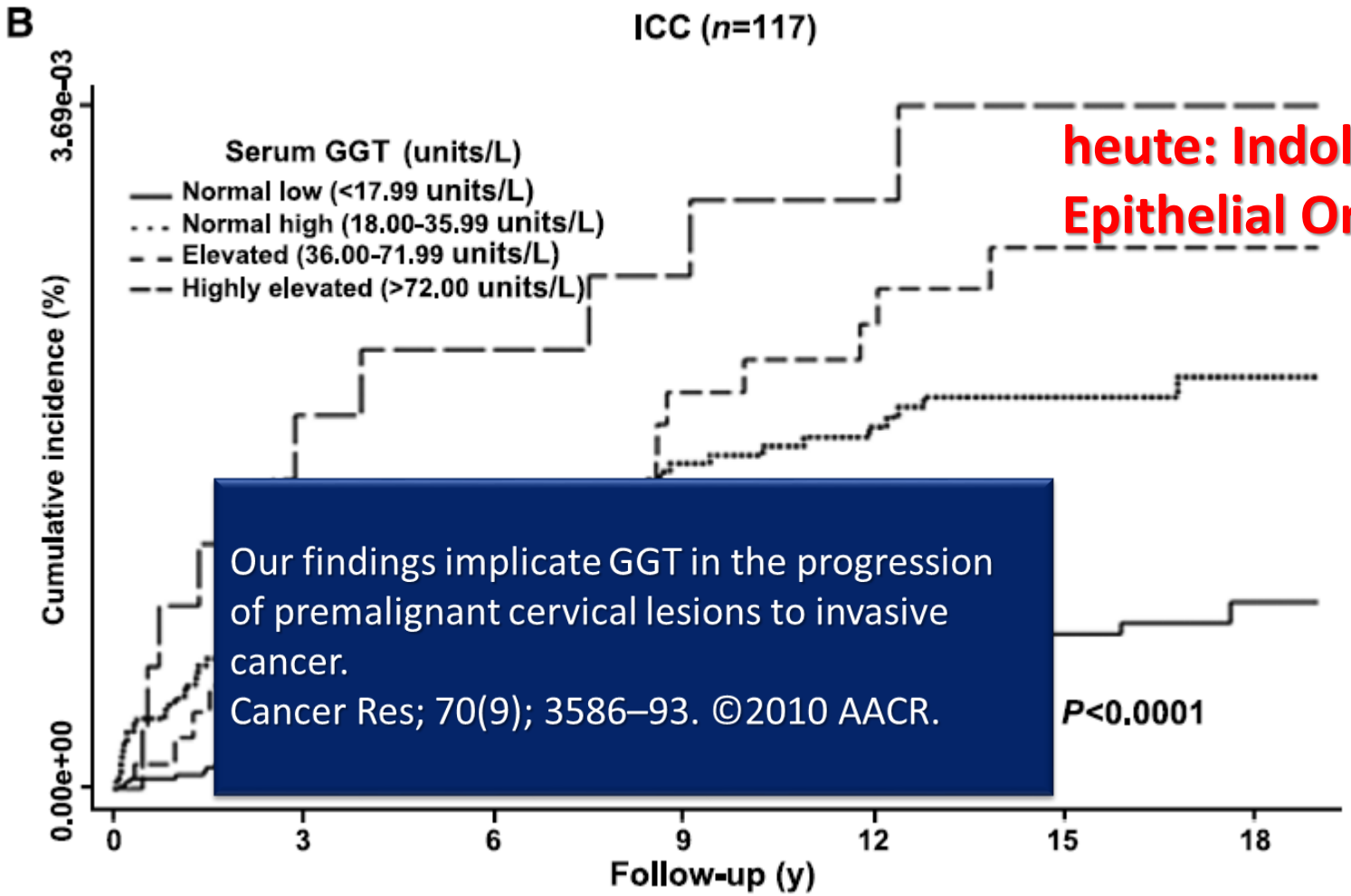
Abstract

Epidemiologic studies indicate that elevated levels of γ-glutamyltransferase (GGT), a key enzyme of glutathione metabolism, might be associated with increased cancer risk. Furthermore, preclinical studies support a role for GGT in tumor invasion and progression. However, the relationship between GGT and risks of cervical intraepithelial neoplasia III (CIN-III) and invasive cervical cancer (ICC) have not been evaluated. We investigated the association of enzymatically determined GGT in blood serum with subsequent incidence of CIN-III and ICC in a prospective population-based cohort of 92,843 women ages 18 to 95, of whom 79% had at least one gynecologic examination including Pap smear testing during follow-up. Cox regression was used to compute adjusted hazard ratios (HR) with 95% confidence intervals for the association of GGT with CIN-III and ICC. During median follow-up of 13.8 years, 702 CIN-III and 117 ICC diagnoses were observed. Compared with normal low GGT (<17.99 units/L), risk of ICC was significantly elevated for all other baseline GGT categories, with adjusted HRs of 2.31 (1.49–3.59) for normal high GGT (18.00–35.99 units/L), 2.76 (1.52–5.02) for elevated GGT (36.00–71.99 units/L), and 3.38 (1.63–7.00) for highly elevated GGT [>72.00 units/L;



heute: Indolent Lesion of Epithelial Origin - IDLE

Cancer Res; 70(9); 3586–93. ©2010 AACR.



heute: Indolent Lesion of Epithelial Origin - IDLE

Cancer Res; 70(9); 3586–93. ©2010 AACR.

January 2013 | Volume 8 | Issue 1 | e54242

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PLOS ONE

Total Serum Cholesterol and Cancer Incidence in the Metabolic Syndrome and Cancer Project (Me-Can)

Susanne Strohmaier[1], Michael Edlinger[1], Jonas Manjer[2], Tanja Stocks[3,4], Tone Bjørge[5,6], Wegene Borena[1], Christel Häggström[3], Anders Engeland[5,6], Gabriele Nagel[7,8], Martin Almquist[9], Randi Selmer[6], Steinar Tretli[10], Hans Concin[8], Göran Hallmans[11], Håkan Jonsson[12], Pär Stattin[3,13], Hanno Ulmer[1]*

1 Department of Medical Statistics, Informatics and Health Economics, Innsbruck Medical University, Innsbruck, Austria, **2** Department of Surgery, Malmö University Hospital, Lund University, Malmö, Sweden, **3** Department of Surgical and Perioperative Sciences, Urology and Andrology, Umeå University, Umeå, Sweden, **4** Institute of Preventive Medicine, Copenhagen University Hospital, Copenhagen, Denmark, **5** Department of Public Health and Primary Health Care, University of Bergen, Bergen, Norway, **6** Norwegian Institute of Public Health, Oslo/Bergen, Norway, **7** Institute of Epidemiology and Medical Biometry, Ulm University, Ulm, Germany, **8** Agency for Preventive and Social Medicine, Bregenz, Austria, **9** Department of Surgery, Skåne University Hospital Lund and Lund University, Lund, Sweden, **10** Cancer Registry of Norway, Institute of Population-based Cancer Research, Montebello, Oslo, Norway, **11** Department of Public Health and Clinical Medicine, Nutritional Research, Umeå University, Umeå, Sweden, **12** Department of Radiation Sciences, Oncology, Umeå University, Umeå, Sweden, **13** Urology Service, Department of Surgery, Memorial Sloan-Kettering Cancer Center, New York, New York, United States of America

Results: In men, compared with the 1st quintile, TSC concentrations in the 5th quintile were borderline significantly associated with decreasing risk of total cancer (HR = 0.94; 95%CI: 0.88, 1.00). Significant inverse associations were observed for cancers of the liver/intrahepatic bile duct (HR = 0.14; 95%CI: 0.07, 0.29), pancreas cancer (HR = 0.52, 95% CI: 0.33, 0.81), non-melanoma of skin (HR = 0.67; 95%CI: 0.46, 0.95), and cancers of the lymph−/hematopoietic tissue (HR = 0.68, 95%CI: 0.54, 0.87). In women, hazard ratios for the 5th quintile were associated with decreasing risk of total cancer (HR = 0.86, 95%CI: 0.79, 0.93) and for cancers of the gallbladder (HR = 0.23, 95%CI: 0.08, 0.62), breast (HR = 0.70, 95%CI: 0.61, 0.81), melanoma of skin (HR = 0.61, 95%CI: 0.42, 0.88), and cancers of the lymph−/hematopoietic tissue (HR = 0.61, 95%CI: 0.44, 0.83).

Conclusion: TSC was negatively associated with risk of cancer overall in females and risk of cancer at several sites in both males and females. In lag time analyses some associations persisted, suggesting that for these cancer sites reverse causation did not apply.

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v. 0.5

15.12.2015

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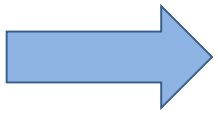
The graph below displays (up to) the top **20 years** for publications that have cited this researcher. Data is presented in ascending year order.

Top: Authors | Research Areas | Countries/Territories | Institutions | Map | Years |

Anzahl der Zitationen von Publikationen von und mit aks-Daten

Überdiagnose vermeiden - Lösungsansätze

- Bewusstsein: schaffen
- Wissenschaft: Versuch der Klärung
- Semantik: nur Krebs als Krebs bezeichnen:
  kein carcinoma in situ,
  keine intraepitheliale Neoplasien
- Bildgebung: für Gesunde Schwellwerte erhöhen
- Histologie: bessere prognostische Parameter entwickeln
- Lebenserwartung: berücksichtigen
- Screening: mehr Risiko-, weniger Massenscreening



PROCAM-Schnelltest

Alter:
68 Jahre

Geschlecht: Männlich | Weiblich

Diabetes mellitus / BZ >= 120 mg/dL: Nein | Ja — ? Hinweis

Zigarettenrauchen (zur Zeit): Nein | Ja — ? Hinweis

Familienanamnese positiv: Nein | Ja — ? Hinweis

Systolischer Blutdruck:
130 mmHg

Gewicht:
90 kg

Körpergröße:
177 cm

Antihypertensive Therapie: Nein | Ja

Herzinfarktrisiko: 12.26%**

PROCAM-Schnelltest

Der PROCAM-Schnelltest basiert auf der PROCAM-Studie und gilt für Frauen und Männer im Alter von 20 bis 75 Jahren zur Ermittlung des Risikos für einen Herzinfarkt innerhalb der nächsten 10 Jahre.

Bei einem Ergebnis im gelben oder roten Bereich (Herzinfarktrisiko über

Breast Cancer Risk Assessment Tool

An interactive tool to help estimate a woman's risk of developing breast cancer

Last modified date: 05/16/2011

- Get Started with the Risk Tool
- About the Tool
- Breast Cancer Risk Factors
- Download Source Code

Page Options

Print Page

Quick Links

The Breast Cancer Risk Assessment Tool is an interactive tool designed by scientists at the National Cancer Institute (NCI) and the National Surgical Adjuvant Breast and Bowel Project (NSABP) to estimate a woman's risk of developing invasive breast cancer. See About the Tool for more information.

The Breast Cancer Risk Assessment Tool may be updated periodically as new data or research becomes available.

Risk Tool

(Click a question number for a brief explanation, or read all explanations.)

1. Does the woman have a medical history of any breast cancer or of ductal carcinoma in situ (DCIS) or lobular carcinoma in situ (LCIS) or has she received previous radiation therapy to the chest for treatment of Hodgkin lymphoma? Select

5 Year Risk of Developing Breast Cancer

- This woman (age 52): 1.2%
- Average woman (age 52): 1.4%

Explanation

Based on the information provided (see below), the woman's estimated risk for developing invasive breast cancer over the next 5 years is 1.2% compared to a risk of 1.4% for a woman of the same age and race/ethnicity from the general U.S. population. This calculation also means that the woman's risk of NOT getting breast cancer over the next 5 years is 98.8%.

Lifetime Risk of Developing Breast Cancer

- This woman (to age 90): 9.6%
- Average woman (to age 90): 10.8%

Explanation

Based on the information provided (see below), the woman's estimated risk for developing invasive breast cancer over her lifetime (to age 90) is 9.6% compared to a risk of 10.8% for a woman of the same age and race/ethnicity from the general U.S. population.

These results are based upon the following answers:

SITEMAN CANCER CENTER®
BARNES-JEWISH HOSPITAL • WASHINGTON UNIVERSITY SCHOOL OF MEDICINE
A National Cancer Institute Comprehensive Cancer Center

Your Disease Risk

THE SOURCE ON PREVENTION

Cancer
Chronic bronchitis
Diabetes
Emphysema
Heart disease
Osteoporosis
Stroke

my results: No Results Yet

Cancer

This interactive tool estimates your risk of cancer and provides personalized tips for prevention. Anyone can use it, but it's most accurate for people age 40 and over who have never had any type of cancer.

Take a few minutes to answer some questions and find out your risk. It doesn't tell you if you'll get cancer or not, but it does tell you where to focus your prevention efforts.

Choose a cancer:

Bladder
Breast
Cervical
Colon
Kidney
Lung

8 ways to prevent disease

What is...?

- Prevention
- Risk
- A Screening Test

How to...

- Estimate Risk

Community Action

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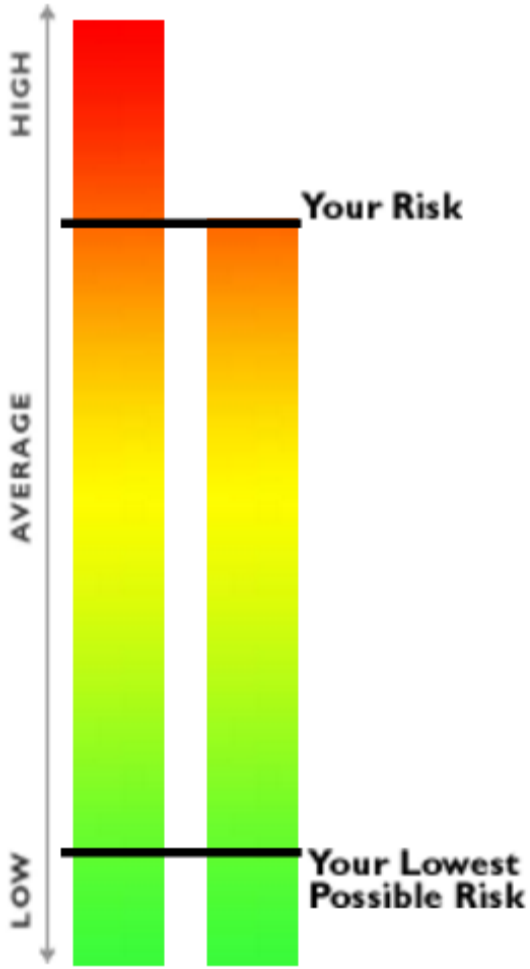
Siteman Cancer Center at Barnes-Jewish Hospital and Washington

Your Risk Is Much Above Average



What makes up my risk?

Watch Your Risk Drop

You have **7** things you can do to lower your risk. To see what your risk could be, click on a box and watch your risk drop.

- [x] Eat less than 3 servings of red meat a week. [Tips]
- [ ] Get screened for colon cancer regularly. [Tips]
- [x] Increase your physical activity. Work towards at least 30 minutes a day. [Tips]
- [x] Achieve and maintain a healthy weight. [Tips]
- [x] Take a single aspirin (325 mg tablet) 4 to 6 times a week. But check with your doctor first! [Tips]
- [ ] Take a calcium supplement or eat more dairy foods regularly. [Tips]
- [ ] Take a multivitamin every day or nearly every day. [Tips]

Keep up the good work!

You are already doing these things to stay healthy:

- You usually drink less than 2 servings of alcohol a day. [More]

Breast cancer

- Breast cancer statistics
- About breast cancer
- Awareness
- Your risk and breast cancer
- Diagnosis
- Treatment
- Living with breast cancer
- Life after breast cancer
- Breast Cancer in Men
- Ralph Lauren Pink Pony Seeding Grants

Calculate your risk

About this calculator

This user-friendly, interactive calculator is intended for use by **women who have not had breast or ovarian cancer**. It will help you to gain a good understanding of your level of risk for breast cancer compared to another woman of your age group. National Breast Cancer Centre* has based the questions in this calculator on the most important risk factors for breast cancer based on an up-to-date review of international evidence.

The calculator only takes a few minutes to complete, and the relevant risk factor is explained at each stage.

It is important to remember that the results of this calculator are not a guarantee of your risk levels, and that all women are at risk for breast cancer, no matter what their risk category. Some women at increased risk never develop breast cancer, and some women at low risk may develop the disease.

** In February 2008, National Breast Cancer Centre (NBCC), incorporating the Ovarian Cancer Program, changed its name to National Breast and Ovarian Cancer Centre (NBOCC). In July 2011, NBOCC amalgamated with Cancer Australia to form a single national agency, Cancer Australia, to provide leadership in cancer control and improve outcomes for Australians affected by cancer.*

Begin the calculator

You may have come to OncoLink searching for information for your friend or family member who has a diagnosis of cancer. At the same time you may be wondering about your own risk of cancer. Why them? Could it be me? What can I do differently to lower my risk of developing cancer?

The following questionnaire is comprehensive and asks about your habits, lifestyle and health history. Please be aware that your answers will be kept private. We do not ask for your name, address or date of birth. The more accurately you answer the questions, the more complete your What's My Risk? profile will be.

Begin Questionnaire

The Prostate Cancer Risk Calculators – including the 'future risk' calculator

Risk Calculator 1 – the general health calculator is a starting point, looking at family history, age and any medical problems with urination.

Risk Calculator 2 – the PSA risk calculator looks at the levels of prostate specific antigen (PSA) in patient's blood to help predict whether further investigation is required.

Risk calculator 3 predicts the chance of a positive sextant biopsy in a man who has never been screened; and also assesses the degree of aggressiveness.

Risk calculator 3 + DRE assessment predicts more accurately the chance of a positive sextant biopsy, compared to only assessing a patient's PSA value (RC 2), but without the necessity of a TRUS. An additional feature is the prediction of a high grade or advanced prostate cancer.

Contact Information

Monique Roobol
Risk Calculator Administrator

info@prostatecancer-riskcalculator.com

Your Feedback

Tell us what you think about the risk calculators and what your experience has been.

We would welcome your feedback.

Cancer Risk Check

By completing Cancer Risk Check, you are taking a major step toward a healthier lifestyle. This questionnaire will determine specific actions you can take to lower your chances for developing cancer.

Before you begin, gather as much information as you can about your personal and family health history. This might include results from previous colonoscopies or Pap tests, or information about diseases you've had in the past. You'll also need to know if any family members have had certain kinds of cancer or genetic conditions that make cancer more likely.

While completing Cancer Risk Check, look for these icons that will link to documents and videos where you can learn more.

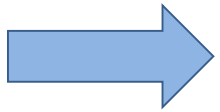
After answering the questions, you will receive your Cancer Risk Check profile. Your profile will outline healthy behaviors and cancer screening recommendations specific to you and your lifestyle. You may want to come back and complete a new Cancer Risk Check profile every so often, as your risk factors will change over time.

Once you obtain your Cancer Risk Check profile, print it out for future reference. MD Anderson cares about confidentiality and your privacy. Your data is not retained by us and once you leave the website, your profile will no longer exist.

Next


MORE PRECISION
HIGH RISK
LESS PRECISION
LOW RISK

Überdiagnose vermeiden - Lösungsansätze

- Bewusstsein: schaffen 
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- Lebenserwartung: berücksichtigen
- Screening: mehr Risiko-, weniger Massenscreening

Sir Muir Gray

Chief knowledge officer of the

National Health Service

All screening programs
do harm;
some can do good as well

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ANALYSIS

Why cancer screening has never been shown to "save lives"—and what we can do about it

The claim that cancer screening saves lives is based on fewer deaths due to the target cancer. **Vinay Prasad and colleagues** argue that reductions in overall mortality should be the benchmark and call for higher standards of evidence for cancer screening

Vinay Prasad *assistant professor*[1], Jeanne Lenzer *journalist*[2], David H Newman *professor*[3]

[1]Division of Hematology and Medical Oncology, Knight Cancer Institute, Oregon Health and Science University, Portland, OR 97239, USA ; [2]New York, USA; [3]Department of Emergency Medicine, Icahn School of Medicine at Mount Sinai, New York, USA

Despite growing appreciation of the harms of cancer screening,[1-3] advocates still claim that it "saves lives."[4] This assertion rests, however, on reductions in disease specific mortality rather than overall mortality.

reductions may be offset by deaths due to the downstream effects of screening.

Underpowered studies lead to uncertainty and assumptions of benefit rather than scientific evidence of benefit. In the 30 year

Cancer screening

Do the harms outweigh the benefits?

By **Will Stahl-Timmins**

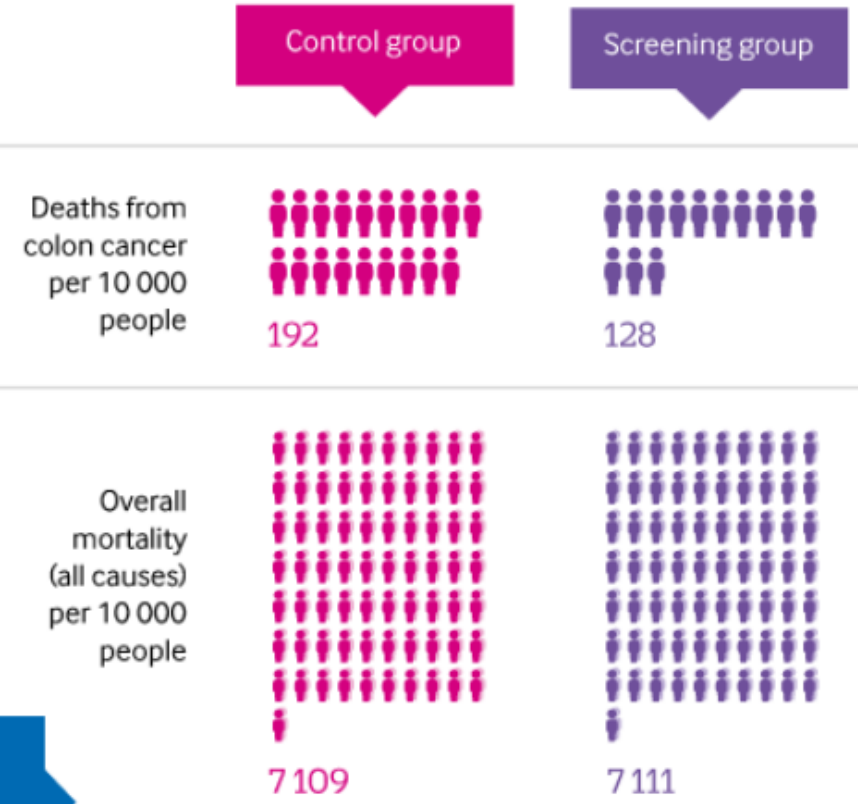
Harms vs benefits

Many trials report that cancer screening can save lives through early detection and treatment. However, screening tests can also lead to false-positive results, and aggressive treatment can cause harm to people that would not otherwise have been affected.

In their recent Analysis article for The BMJ, Prasad, Lenzer and Newman argue that too many trials focus on measuring only the outcomes related to one specific condition in the short term. They suggest that measuring all-cause mortality better represents the true impacts of screening.

The Minnesota Colon Cancer Control study

30-year follow-up of fecal occult blood testing in 46 551 people.



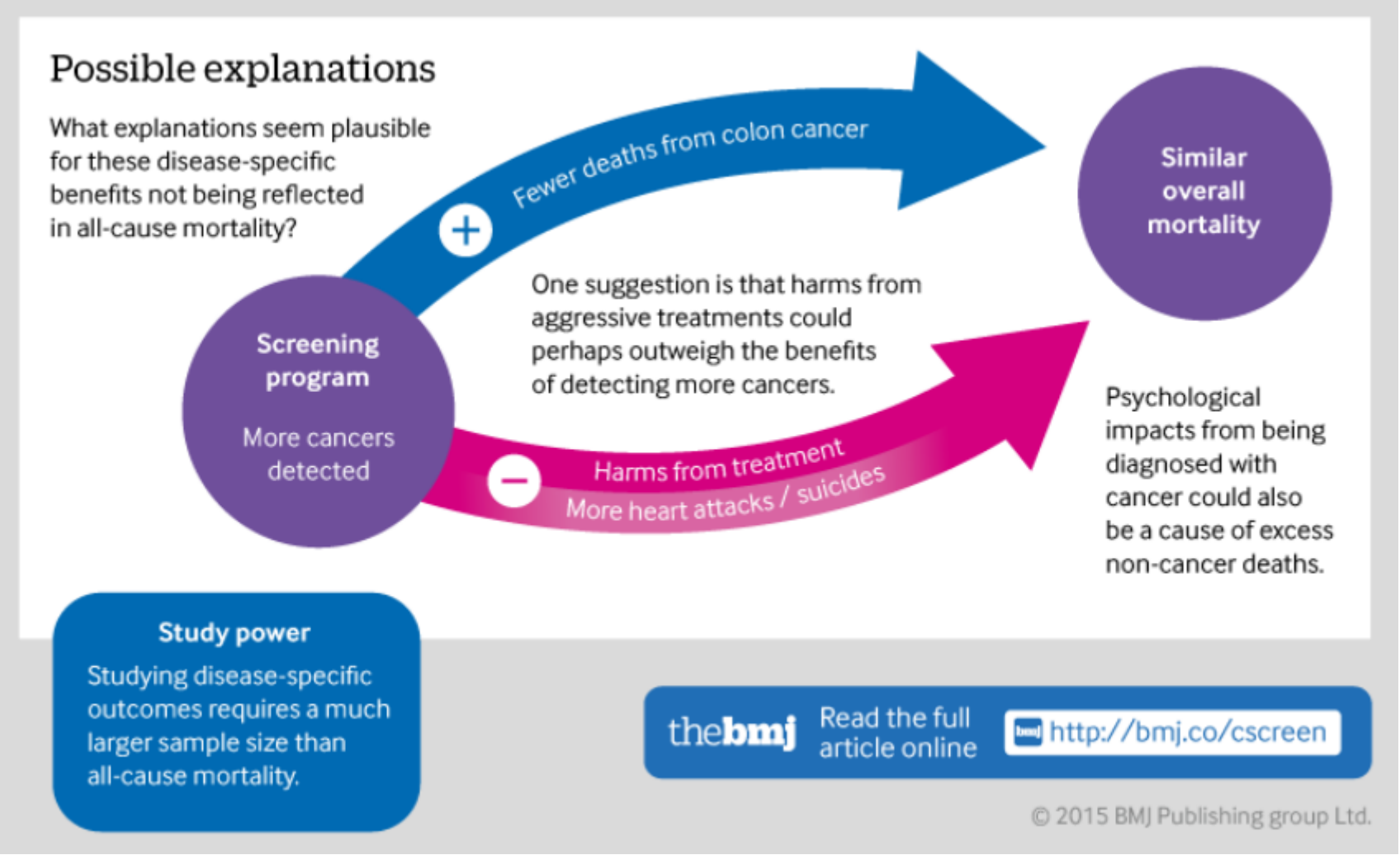
In this study, for example, fewer people died from colon cancer when screened, but overall mortality rates over the 30-year follow-up were equivalent to the control group.

Shaukat A et al. Long-Term Mortality after Screening for Colorectal Cancer. *N Engl J Med* 2013; 369: 1106–14. DOI: 10.1056/NEJMoa1300720

Analysis

Why cancer screening has never been shown to "save lives"—and what we can do about it

BMJ 2016 ; 352 doi: http://dx.doi.org/10.1136/bmj.h6080 (Published 06 January 2016)
Cite this as: *BMJ* 2016;352:h6080



thebmj

BMJ 2016;352:h6967 doi: 10.1136/bmj.h6967 (Published 6 January 2016)

EDITORIALS

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Full disclosure about cancer screening

Time to change communication from dodgy persuasion to something straightforward

Gerd Gigerenzer *director*

Harding Center for Risk Literacy and Center for Adaptive Behavior and Cognition, Max Planck Institute for Human Development, Berlin, Germany

Communication about cancer screening is dodgy: benefits are overstated and harms downplayed. Several techniques of

in a fall in overall cancer mortality (which includes cancer specific mortality). Because the base rate of overall cancer

J Natl Cancer Inst. 2015 Nov 18;108(3).

Recognizing the Limitations of Cancer Overdiagnosis Studies: A First Step Towards Overcoming Them.

Etzioni R1, Gulati R2.

1Division of Public Health Sciences, Fred Hutchinson Cancer Research Center, Seattle, WA (RE, RG). retzioni@fredhutch.org.
2Division of Public Health Sciences, Fred Hutchinson Cancer Research Center, Seattle, WA (RE, RG).

Numerous studies have attempted to quantify the number of breast cancers that would never have been diagnosed in the absence of screening. Unfortunately, results are highly variable across studies and there is considerable disagreement about both the frequency of overdiagnosis and the validity of different methodologic approaches.

Mammographie-Screening: 1 - 50% Überdiagnosen

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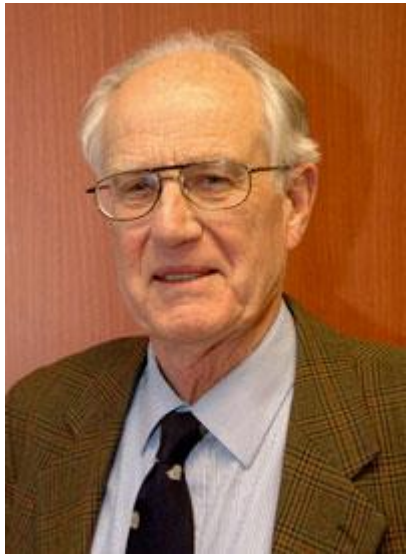
- Screening: mehr Risiko-, weniger Massenscreening

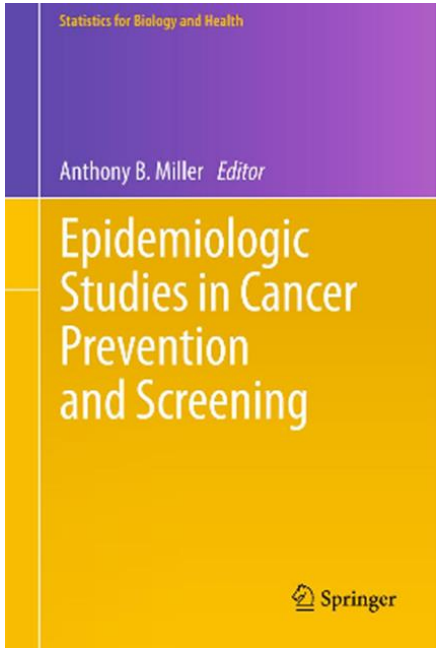
The problem of over-diagnosis



ANTHONY B. MILLER

Published — Thursday 13 November 2014

Efforts to develop new, more sensitive screening tests are thus likely to do more harm than good, as they increase the rate of over-diagnosis, without improving outcomes among women with aggressive cancers.



It is time to recognize that breast-cancer screening does not save lives — and to focus on the strategies that will.

Anthony B. Miller, MD, FRCP, FRCP (C) Prof. Emeritus, Epidemiology, Dalla Lana School of Public Health, University of Toronto

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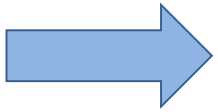
- Histologie: bessere prognostische Parameter entwickeln 
- Lebenserwartung: berücksichtigen
- Screening: mehr Risiko-, weniger Massenscreening

The Overdiagnosis of Cancer: Pathologic Profiling

Otis W. Brawley, MD, MACP, FASCO, FACE

Chief Medical and Scientific Officer
American Cancer Society
Professor of Hematology, Medical Oncology,
Medicine and Epidemiology
Emory University
Atlanta, Georgia, USA

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Of Screen Detected Cancers

- Estimates:
  - 10 to 20% of radiologically detected lung cancers
  - 0 to 50% of mammographically detected invasive breast cancers
  - ?% of Ductal Carcinoma In Situ breast tumors
  - 40- 60%% of ultrasound detected thyroid cancers
  - 60% of PSA detected prostate cancers

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Is Breast Cancer Overdiagnosis Also Nested in Pathologic Misclassification?[1]

Catherine Colin, MD, PhD
Mojgan Devouassoux-Shisheboran, MD, PhD
Francesco Sardanelli, MD

During the past 4 decades, mammography has been transformed from a diagnostic test for symptomatic women to a screening test for women at average risk for breast cancer within defined age ranges. The "do not delay" message for early asymptomatic breast cancer detection is now lessened by concerns regarding detrimental effects of screening, such as false-positive findings, overdiagnosis, and overtreatment. A large number of articles on

cancer during their life, revealing a prevalence DCIS of about 10%–15% (6–8).

Since the introduction of percutaneous image-guided biopsy, particularly the use of stereotactic core-needle biopsy of microcalcifications, surgical biopsies have become extremely uncommon in the past 2 decades. No significant difference in intraductal lesion classification was demonstrated when vacuum-assisted percutaneous biopsies and surgical biopsies were compared,

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Winding back the harms of too much medicine

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Following successful conferences in Dartmouth in 2013, the University of Oxford in 2014 and the NIH in 2015, we are pleased to announce the dates for the 2016 international Preventing Overdiagnosis conference, to be held in Barcelona. Registration is now open, details on abstract submission will follow soon. Innovations to the conference program Incorporating feedback from ... Read More....

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http://www.preventingoverdiagnosis.net/

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PERSPECTIVE

Reducing Diagnostic Errors — Why Now?

Dhruv Khullar, M.D., M.P.P., Ashish K. Jha, M.D., M.P.H., and Anupam B. Jena, M.D., Ph.D.

N Engl J Med 2015; 373:2491-2493 | December 24, 2015 | DOI: 10.1056/NEJMp1508044

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

This article was published on September 23, 2015, at NEJM.org.

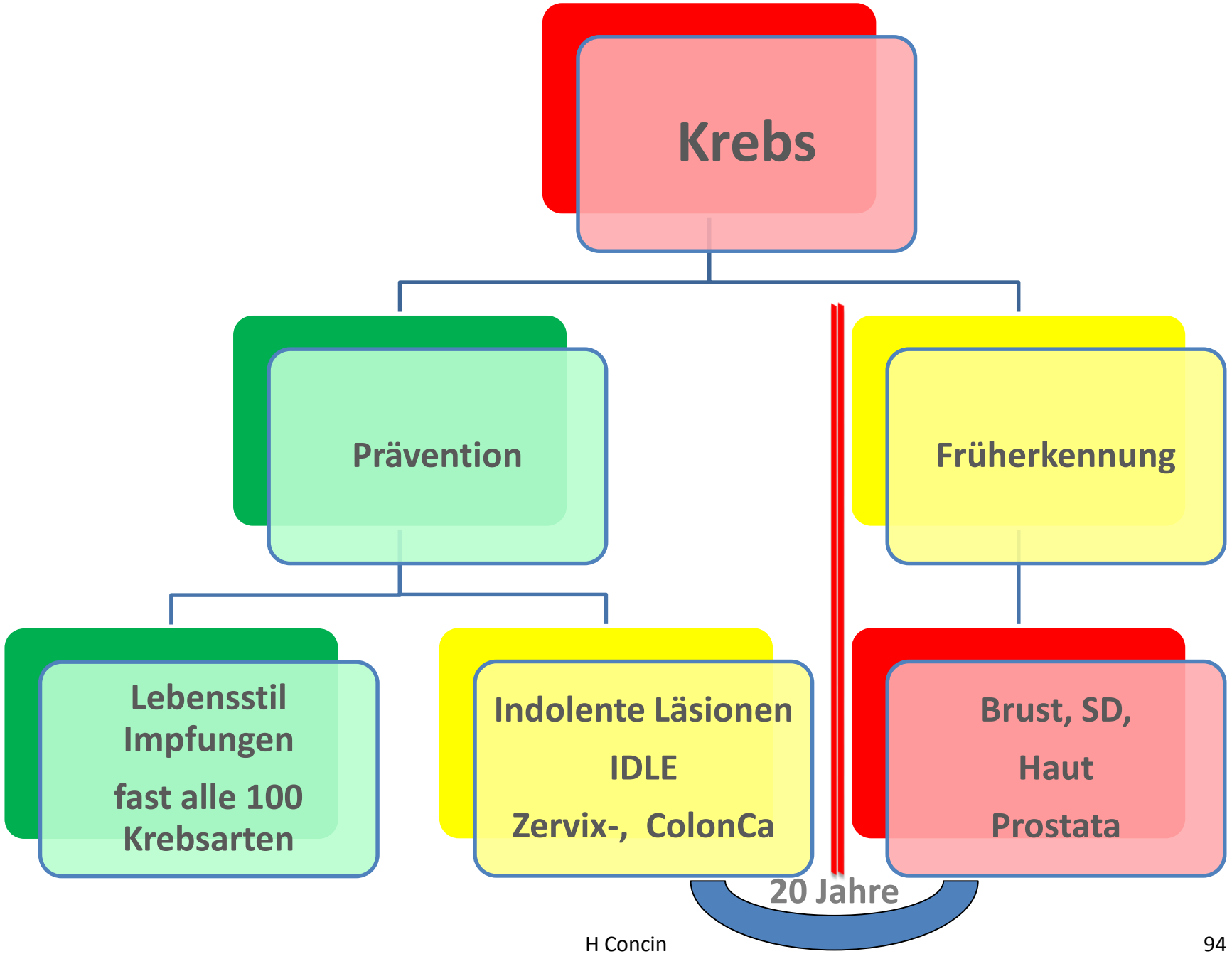
SOURCE INFORMATION

From the Department of Medicine, Massachusetts General Hospital (D.K., A.B.J.), the Division of General Internal Medicine, Brigham and Women's Hospital (A.K.J.), the Veterans Affairs Boston Healthcare System (A.K.J.), the Department of Health Policy and Management, Harvard School of Public Health (A.K.J.), and the Department of Health Care Policy, Harvard Medical School (A.B.J.) — all in Boston; and the National Bureau of Economic Research, Cambridge, MA (A.B.J.).

Mit Medikamenten die Gesunde gesund erhalten
kann man viel mehr Geld machen
als mit Medikamenten die Kranke gesund machen

RCGP Royal College of General Practitioners

Dr Iona Heath MA BChir MRCP FRCGP CBE, President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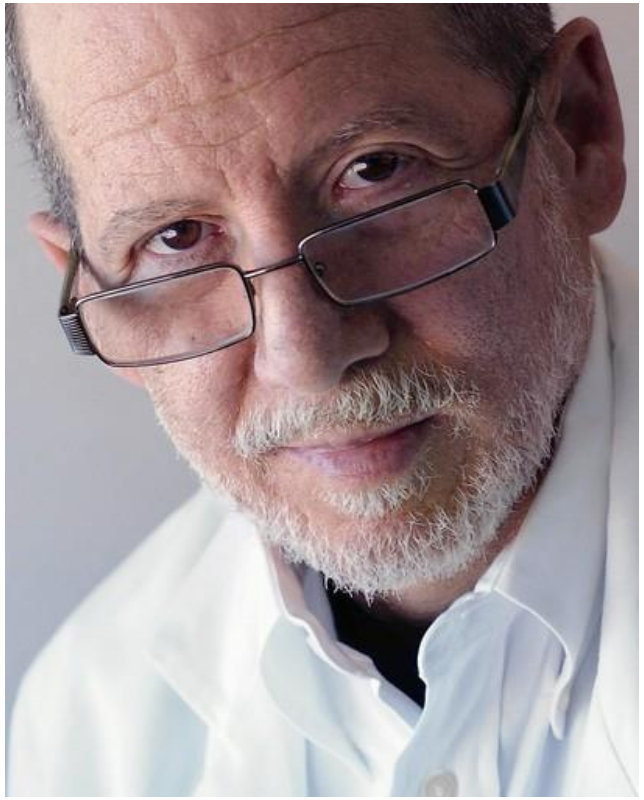
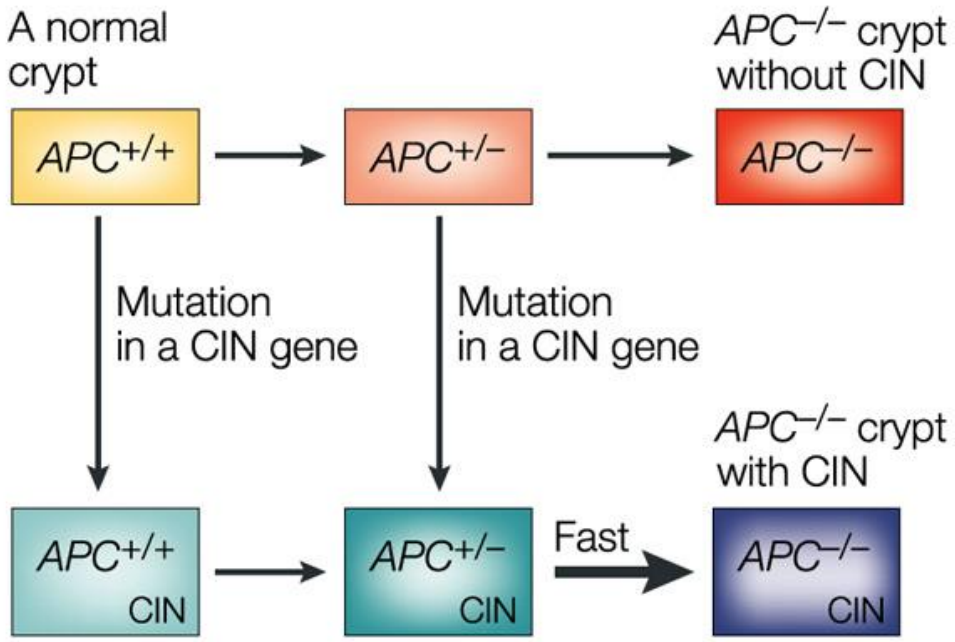
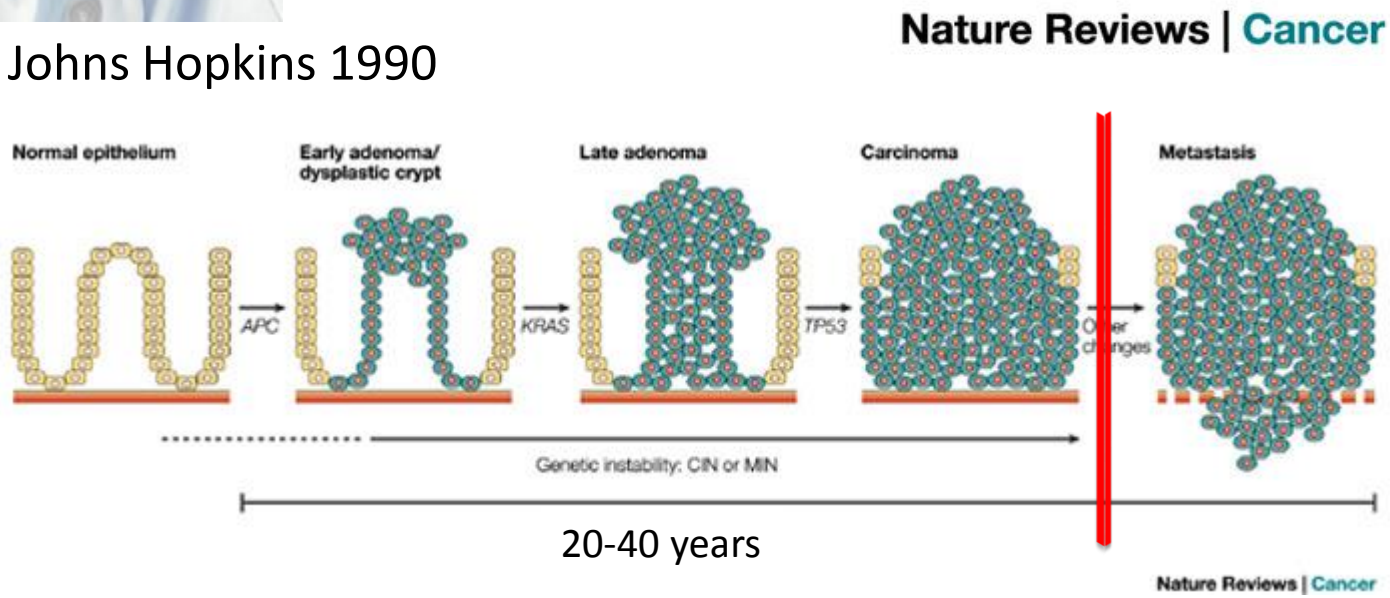


Bert Vogelstein, Johns Hopkins 1990





Die American Board of Internal Medicine (ABIM) Foundation hat im Jahr 2012 die sogenannte Choosing Wisely Initiative gestartet. Diese Initiative überzeugte bis heute mehr als 60 US-amerikanische medizinische Fachgesellschaften davon, sogenannte Top-5-Listen zu erstellen. Diese von Ärzten selbst entwickelten Listen präsentieren medizinische Maßnahmen, bei denen Überversorgung stattfindet.

Wie kann „Choosing Wisely" auch in Deutschland Schule machen?

Strech: Überversorgung, das Thema von Choosing Wisely, existiert in nicht unerheblichem Ausmaß auch in Deutschland. Ob die Choosing Wisely Initiative auch in Deutschland Schule machen kann und sollte, wurde in den letzten zwei Jahren in verschiedenen Workshops mit Ärzten, Patientenvertretern und weiteren Akteuren diskutiert. Die grundsätzliche Idee hinter dieser Initiative und die Tatsache, dass Ärztinnen und Ärzte hierbei die treibende Kraft sind, wurde von allen Beteiligten sehr begrüßt. Die Workshops brachten aber auch Anregungen für praktische und konzeptionelle Ergänzungen zur nordamerikanischen Choosing Wisely Initiative:

Eine der verbreitesten Krankheiten ist die Diagnose.

(Karl Kraus)
1874 - 1936

gutezitate.com

Editorial

Overdiagnosis and breast cancer screening

Nick E Day

The Institute of Public Health, University of Cambridge, Cambridge, UK

Corresponding author: Nick E Day, nick.day@srl.cam.ac.uk

Published: 30 August 2005
This article is online at http://breast-cancer-research.com/content/7/5/228
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Breast Cancer Research 2005, **7**:228-229 (DOI 10.1186/bcr1321)

See related review by Moss in this issue [http://breast-cancer-research.com/content/7/5/230]

Screening for breast cancer is now routinely performed in most countries where the disease is common. The benefits of screening have been established and are generally accepted. However, screening does have the potential for harm, the most important aspects of which are overdiagnosis and after extended follow-up. In these trials, screening yielded no benefit but generated considerable harm.

Lesions that are detected at screening but which would not have surfaced clinically in the lifetime of the individual

UNIVERSITY OF TORONTO
DALLA LANA SCHOOL OF PUBLIC HEALTH

Health Sciences Building, 155 College Street

Toronto, ON, M5T 3M7, Canada

February 17, 2012

To whom it may concern

I am writing in support of the application by Prof. Dr. med. Gabriele Nagel, MPH for funds to evaluate the organized mammography screening program in Vorarlberg. Given the increasing uncertainty of the validity of many of the randomized screening trials conducted in Sweden which have largely been the basis for the initiation of breast screening in many countries, it is critical that programs such as those in Vorarlberg where data are available that enable linkage of the records of screened women with breast cancer incidence and mortality data be carefully conducted. Prof. Nagel and her colleagues have proposed an innovative cohort study that will permit such an evaluation. An important contribution of their proposal will be to determine the extent to which regular clinical breast examinations impact on the outcome of mammography screening, and the relevance of risk factors such as obesity and diabetes.

I have known Dr Nagel since I spent 1999-2003 as Head of the Division of Clinical Epidemiology of Deutsches Krebsforschungszentrum, Heidelberg, and I have a high opinion of her expertise and experience. I have agreed to provide advice and assistance to Dr Nagel and her colleagues during the course of this project

Sincerely

Anthony B. Miller, MD, FRCP,

Professor Emeritus

Director, Canadian National Breast Screening Study

Cancer Res Treat. 2015 Dec 28 [Epub ahead of print]

Responses to Overdiagnosis in Thyroid Cancer Screening Among Korean Women.

Lee S[1], Lee YY[2], Yoon HJ[2], Choi E[1], Suh M[2], Park B[2], Jun JK[1,2], Kim Y[2], Choi KS[1,2].

•[1]Graduate School of Cancer Science and Policy, Goyang, Korea.
•[2]National Cancer Control Institute, National Cancer Center, Goyang, Korea.

RESULTS:
Prior awareness of overdiagnosis in thyroid cancer screening was 27.8%. The majority of subjects intended to undergo thyroid cancerscreening before and after receiving information on overdiagnosis (87% and 74%, respectively)

CONCLUSIONS:
Women in Korea appeared to be less concerned about overdiagnosis when deciding whether or not to undergo thyroid cancerscreening.

"Österreicher sind Weltmeister beim Im-Spital-Liegen"

Die Presse

Die Presse

Von Christian Höller
vor 17 Std.

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In Österreich liegen die Gesundheitskosten über dem OECD-Schnitt. Was ist der Grund?

Artur Wechselberger: Die OECD kritisiert seit Jahren, dass das österreichische Gesundheitssystem zu spitalslastig ist. Wir haben zu viele Spitalsbetten. Die Österreicher sind Weltmeister beim Im-Spital-Liegen. Die Spitalsträger handeln nach dem Motto: Jedes gefüllte Bett ist ein bezahltes Bett.

Werden zu viele Menschen ins Spital geschickt?

Ja, denn das Hauptproblem besteht darin, dass die Krankenkassen für die Spitäler nur eine bestimmte Pauschale zahlen. Für den Rest kommt der Steuerzahler auf. Die niedergelassenen Ärzte werden von den Krankenkassen nach ihrer Leistung bezahlt. Daher halten die Krankenkassen die Ausgaben im niedergelassenen Bereich bewusst niedrig. Damit schiebt man die Patienten bewusst in den teuren Spitalsbereich.

CA: A Cancer Journal for Clinicians

CA CANCER J CLIN 2015;00:00–00

Cancer Statistics, 2016

Rebecca L. Siegel, MPH[1]; Kimberly D. Miller, MPH[2]; Ahmedin Jemal, DVM, PhD[3]

Each year, the American Cancer Society estimates the numbers of new cancer cases and deaths that will occur in the United States in the current year and compiles the most recent data on cancer incidence, mortality, and survival. Incidence data were collected by the National Cancer Institute (Surveillance, Epidemiology, and End Results [SEER] Program), the Centers for Disease Control and Prevention (National Program of Cancer Registries), and the North American Association of Central Cancer Registries. Mortality data were collected by the National Center for Health Statistics. In 2016, 1,685,210 new cancer cases and 595,690 cancer deaths are projected to occur in the United States. Overall cancer incidence trends (13 oldest SEER registries) are stable in women, but declining by 3.1% per year in men (from 2009-2012), much of which is because of recent rapid declines in prostate cancer diagnoses. The cancer death rate has dropped by 23% since 1991, translating to more than 1.7 million deaths averted through 2012. Despite this progress, death rates are increasing for cancers of the liver, pancreas, and uterine corpus, and cancer is now the leading cause of death in 21 states, primarily due to exceptionally large reductions in death from heart disease. Among children and adolescents (aged birth-19 years), brain cancer has surpassed leukemia as the leading cause of cancer death because of the dramatic therapeutic advances against leukemia. Accelerating progress against cancer requires both increased national investment in cancer research and the application of existing cancer control knowledge across all segments of the population. **CA Cancer J Clin 2016;00:000-00.** **© 2016 American Cancer Society.**

Keywords: cancer cases, cancer statistics, death rates, incidence, mortality, survival, trends

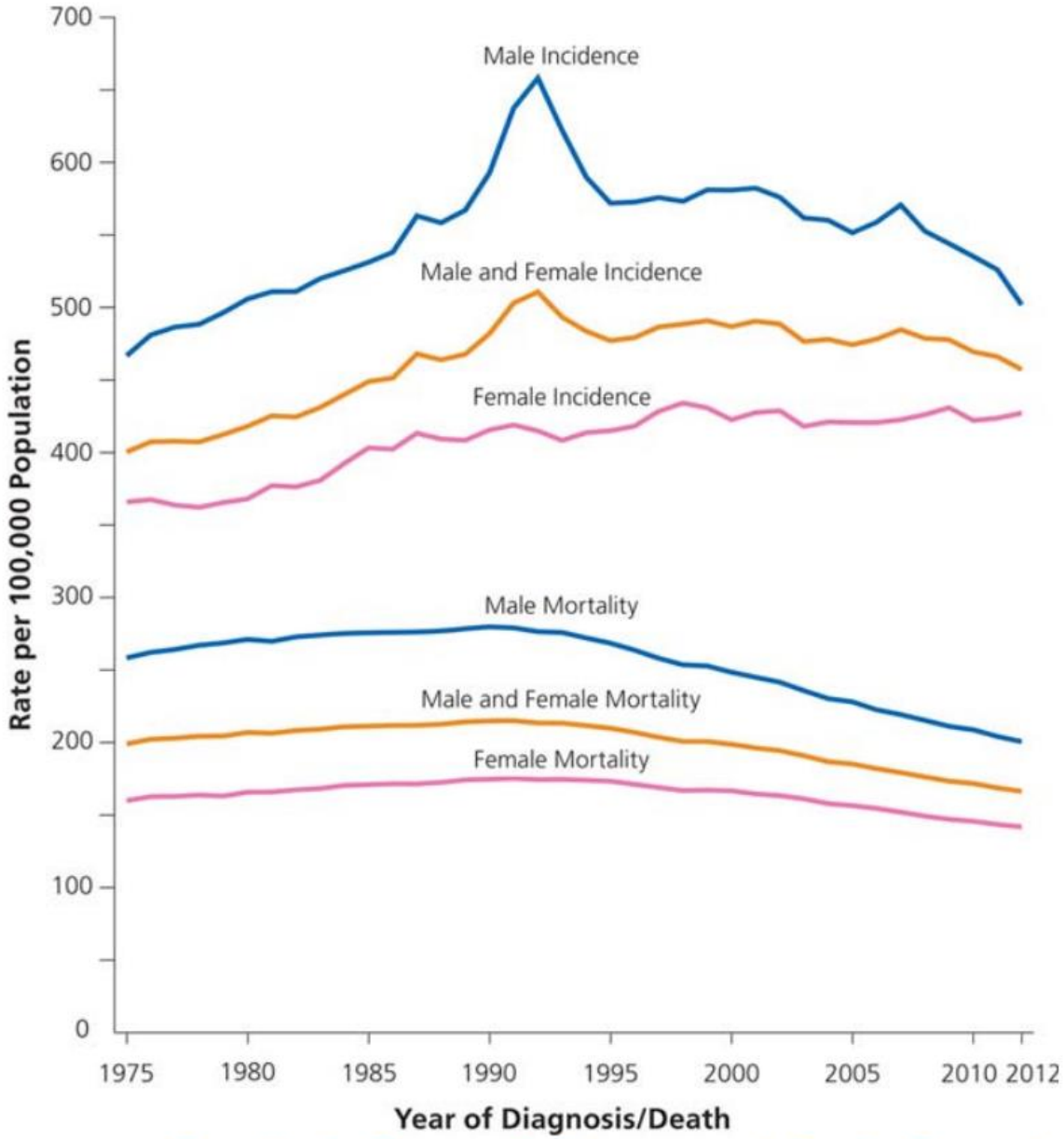


FIGURE 2. Trends in Cancer Incidence and Death Rates by Sex, United States, 1975 to 2012.

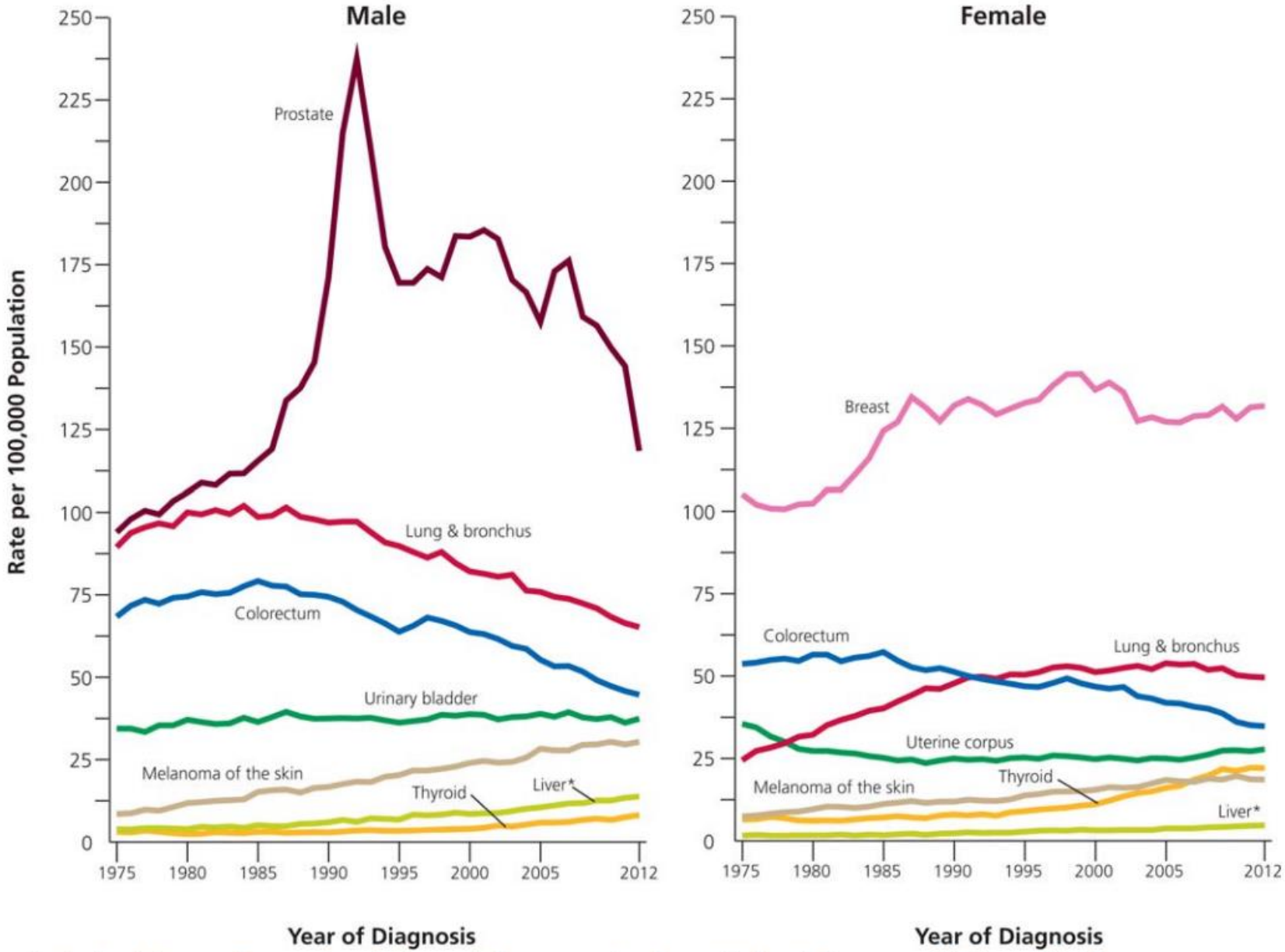


FIGURE 3. Trends in Incidence Rates for Selected Cancers by Sex, United States, 1975 to 2012.

Rates are age adjusted to the 2000 US standard population and adjusted for delays in reporting.

*Includes intrahepatic bile duct.

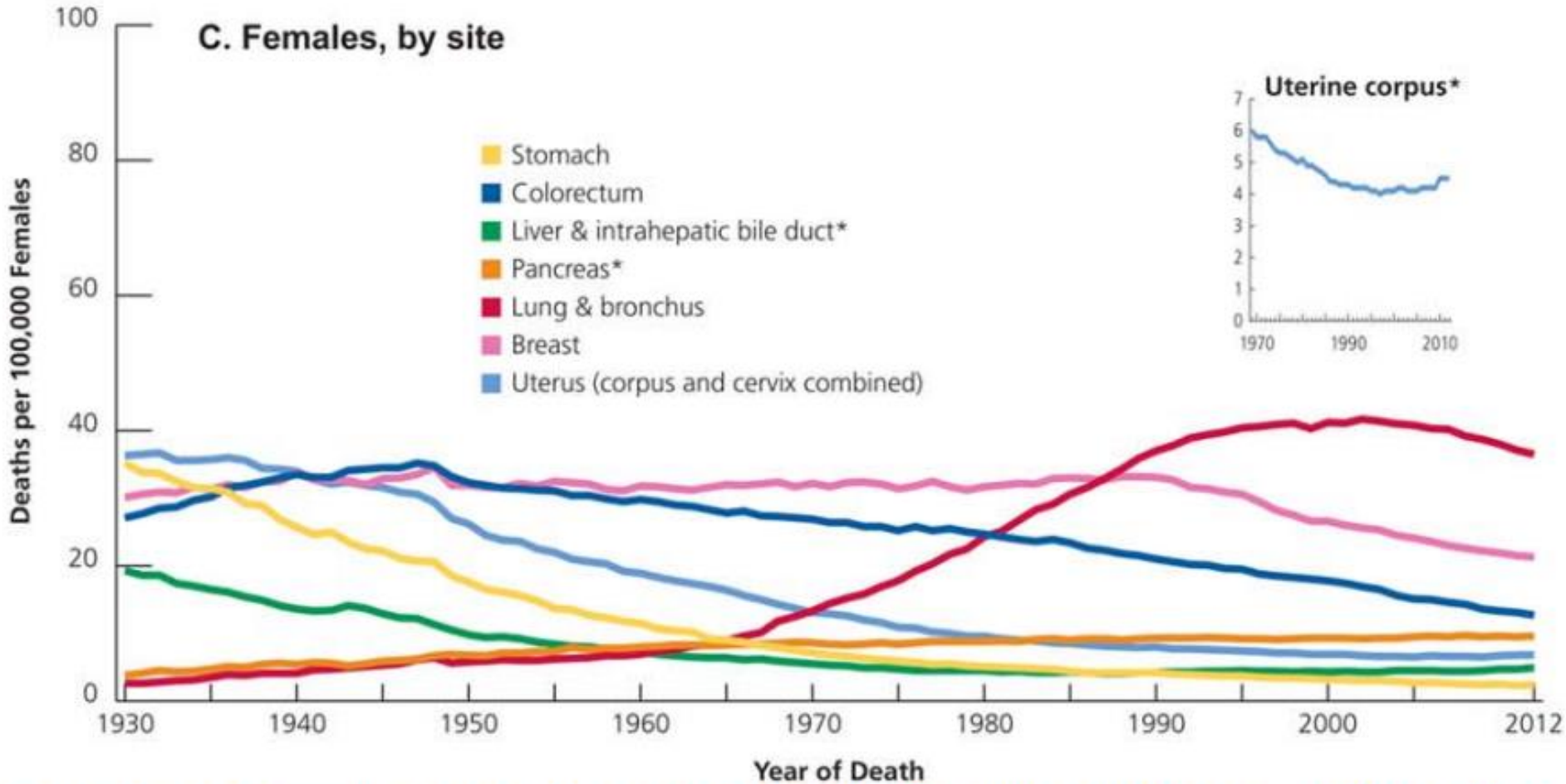


FIGURE 8. Trends in Death Rates Overall and for Selected Sites by Sex, United States, 1930 to 2012.

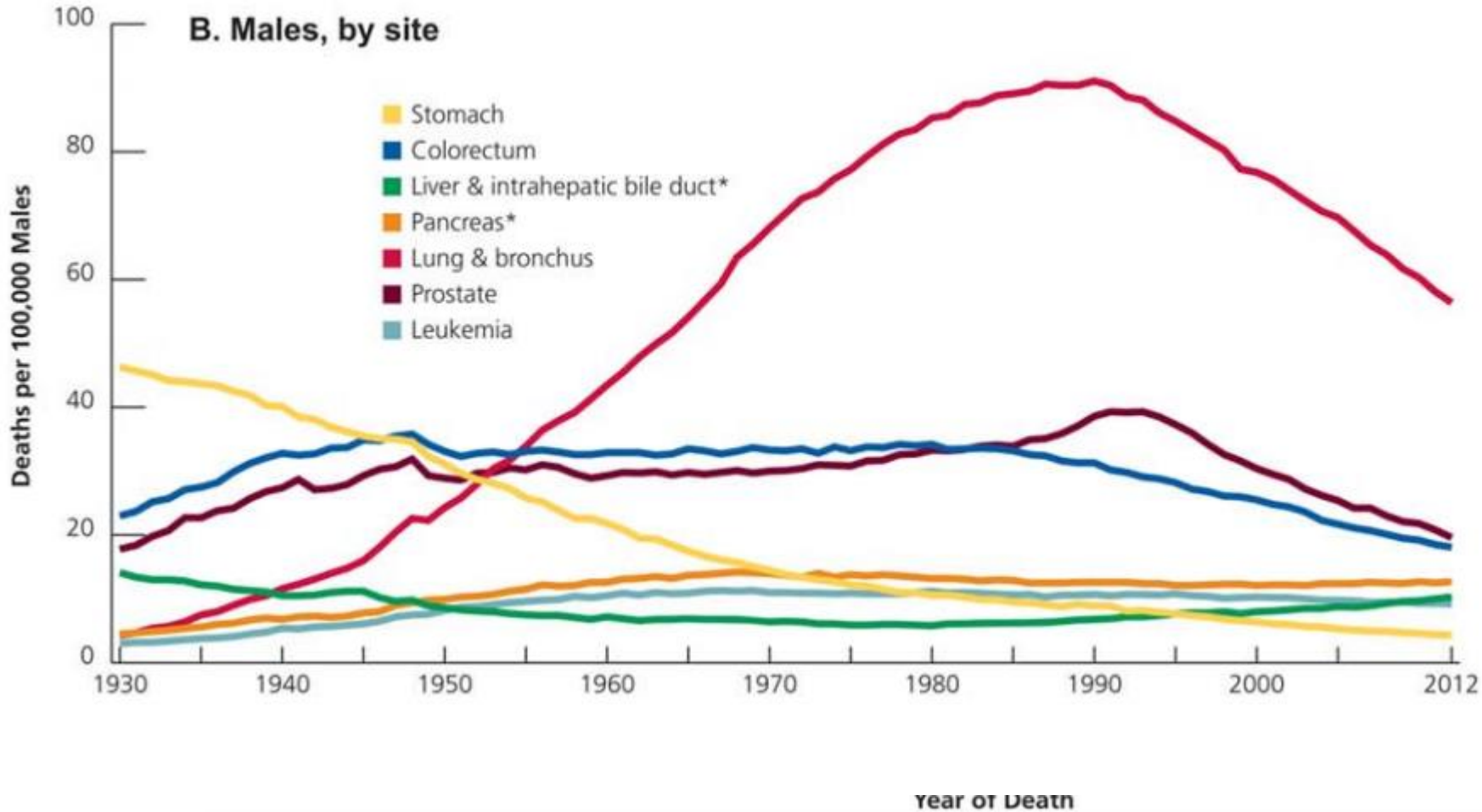


FIGURE 8. Trends in Death Rates Overall and for Selected Sites by Sex, United States, 1930 to 2012.

The National Cancer Act of 1971

SUMMARY

Senate Bill 1828 - Enacted December 23, 1971 (P.L. 92-218)

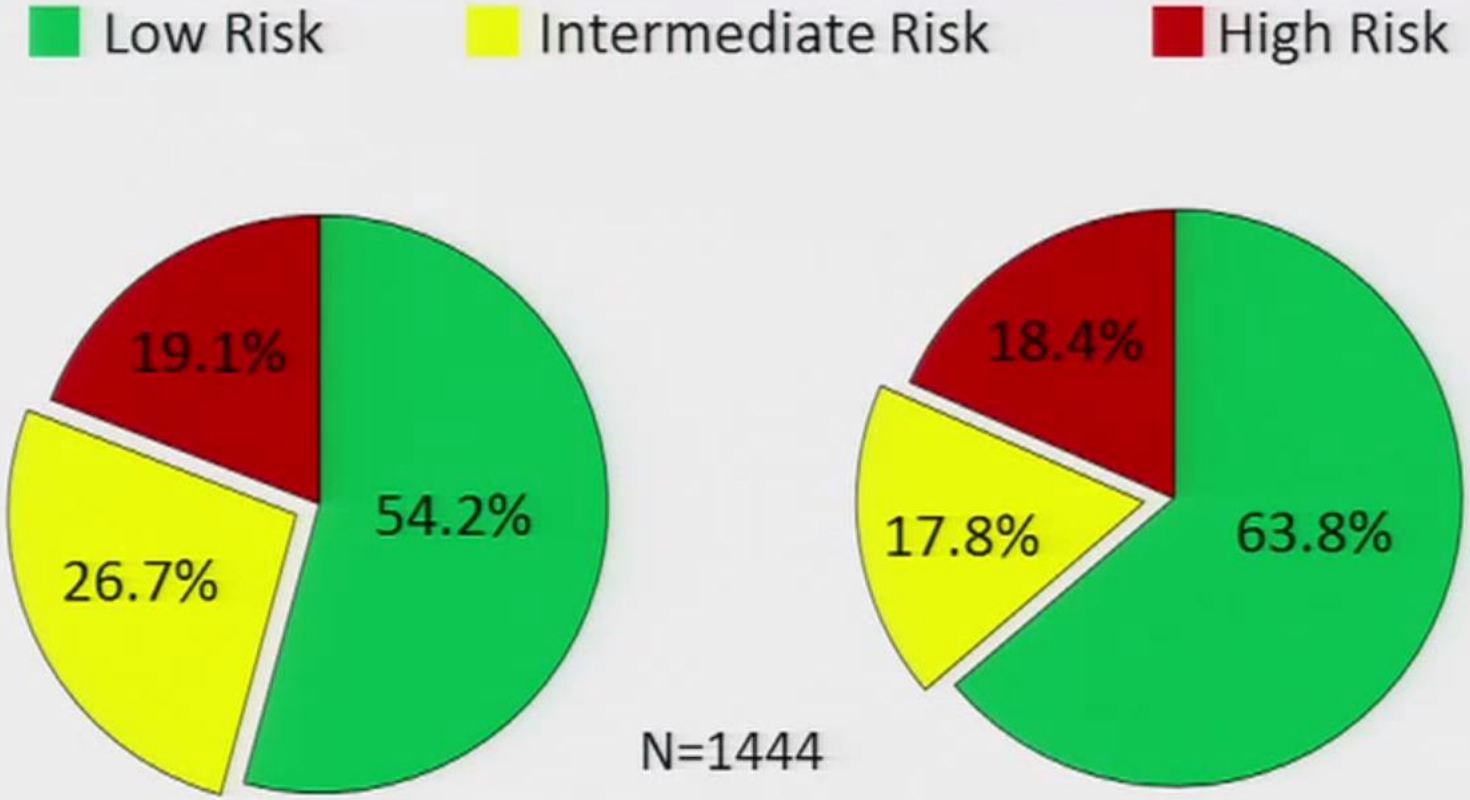
This bill strengthened the National Cancer Institute in carrying out the national effort against cancer by creating the National Cancer Program. It mandated the following:

- The Program be developed by the NCI director with the advice of the National Cancer Advisory Board (NCAB), a presidentially appointed committee of 18 members, including both distinguished scientists and laypersons from the general public. The NCAB also has 12 ex-officio members from other government agencies.
- A three-member panel, the President's Cancer Panel (PCP), review the Program by holding

On This Page

Majority of Node-Negative Patients today are Classified as Low Risk

54-64% depending on scoring



Tang G, et al. JCO. Oct 2011; 1-8.

RSPC, Recurrence Score Pathology-Clinical; RS, Recurrence Score

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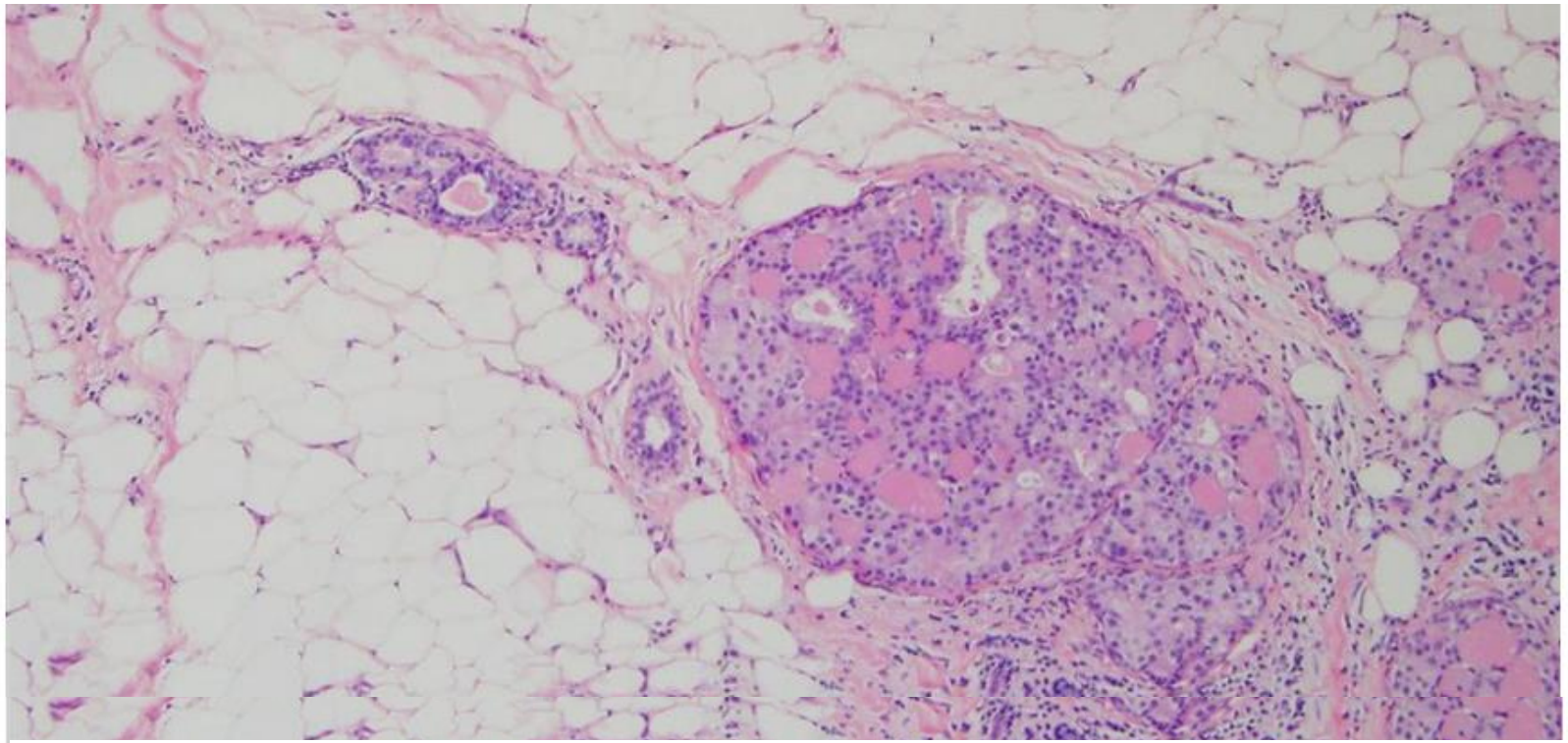
JOURNAL REPORTS: HEALTH CARE

Some Cancer Experts See 'Overdiagnosis,' Question Emphasis on Early Detection

Debate Among Doctors Looks at Whether Zealous Screening Leads to Overtreatment



Early detection has long been seen as a powerful weapon in the battle against cancer. But some experts now see it as double-edged sword.

Zwei konträre Welten
Diagnostik und Screening

- **Völlig unterschiedliche Philosophien, Strategien und**

- **Zielsetzungen**

- Viele Kliniker neigen dazu eine gesunde **Zielpopulation**
- nicht nur zu **„screenen“**
- sondern auch zu **„diagnostizieren“**

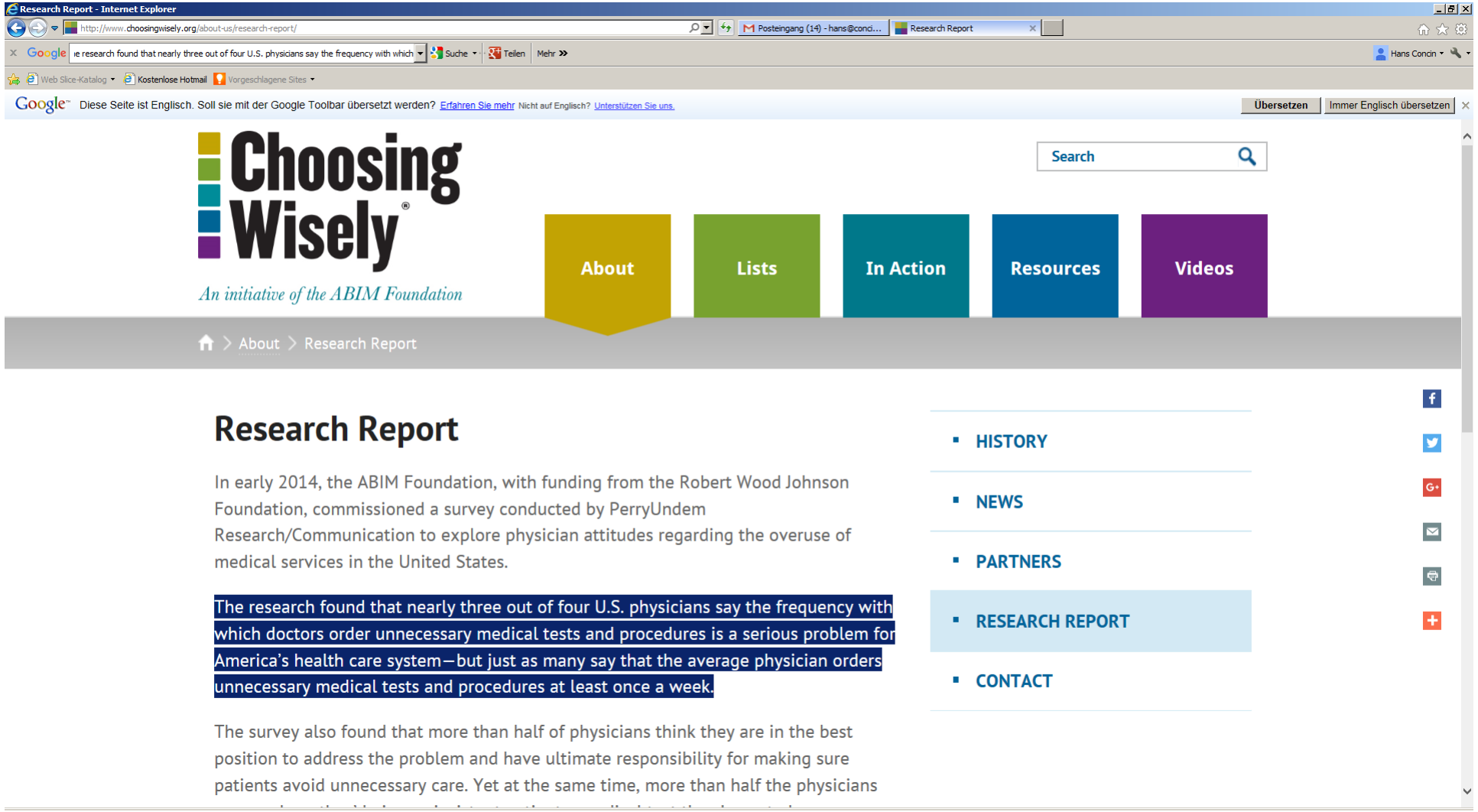
- Daher fordern viele internationale Screeningexperten und Epidemiologen z.B. der WHO, dass

- klinisch tätige Ärzte vom Screening ausgeschlossen sein sollen!

- **Diagnostik**
  - Abklärung eines symptomatischen **individuellen Patienten**
  - Angestrebt wird eine **sichere Diagnose oder Ausschluss** einer Erkrankung
  - **Viele** diagnostische Methoden
  - **Hohe Kosten sind akzeptiert**
  - **Arzt verdient**

- **Screening**
  - Filterung einer **gesunden Ziel-Population**
  - Angestrebt wird eine **Risikoevaluation**
  - Keine Abklärung benigner Befunde
  - **Ein** Einzeltest
  - **Niedrige Kosten**
  - **Hohe Frequenz**

- **Diagnostik**
  - **Vertrag** Arzt / Patient / Soz.Vers.
  - Vorteile für das symptomatische **Individuum**
  - Auch **seltene und nicht relevante** Erkrankungen
  - Kranke sollen gesund werden
  - **Ärztliche** Entscheidung / informed consent
- **Screening**
  - **Vertrag** Programm / Proband
  - Vorteile für die **Population** aber mit potentiellen Nachteilen für das gesunde Individuum:
  - falsch pos. Verdacht
  - Überdiagnose
  - falsch neg. Befund
  - Nur **häufige und relevante** Erkrankungen
  - Gesunde sollen nicht krank werden
  - **Politische** Entscheidung, Probandin entscheidet über die Teilnahme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ie research found that nearly three out of four U.S. physicians say the frequency with which
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Choosing Wisely
An initiative of the ABIM Foundation
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Research Report
In early 2014, the ABIM Foundation, with funding from the Robert Wood Johnson Foundation, commissioned a survey conducted by PerryUndem Research/Communication to explore physician attitudes regarding the overuse of medical services in the United States.
The research found that nearly three out of four U.S. physicians say the frequency with which doctors order unnecessary medical tests and procedures is a serious problem for America's health care system—but just as many say that the average physician orders unnecessary medical tests and procedures at least once a week.
The survey also found that more than half of physicians think they are in the best position to address the problem and have ultimate responsibility for making sure patients avoid unnecessary care. Yet at the same time, more than half the physicians
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AWMF

Arbeitsgemeinschaft der Wissenschaftlichen Medizinischen Fachgesellschaften e.V.

Manual

Entwicklung von Empfehlungen im Rahmen der Initiative Gemeinsam Klug Entscheiden (GKE)

Version 1.0 vom 15.09.2015 (Konsultationsfassung)