

X-Ray Mammograms Starting at 40? New Recommendations Fail to Warn Women of the Real Risks

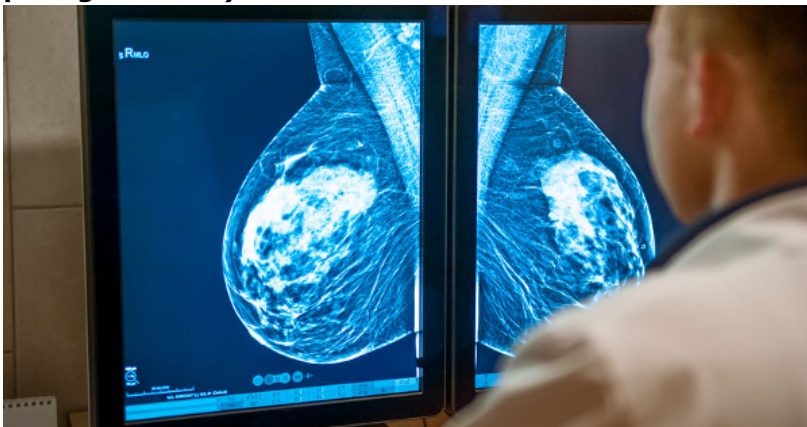
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In a move that could negatively impact the overall health of women over 40, the U.S. Preventive Services Task Force (USPSTF) released new draft recommendations on Tuesday urging all women to undergo x-ray mammography breast screenings every other year, starting at 40 instead of 50, as previous guidelines from 2016 recommended.

"Cause marketing" campaigns promoting x-ray mammography have been **running nonstop since the inception of Breast Cancer Awareness Month in 1985** ([/blog/covering-causes-breast-cancer-1985-astrazenecas-bcam-2](#)). The campaigns equate "early screening" of healthy/asymptomatic women's breasts to "breast cancer prevention," at least in the minds of those heavily influenced by **pharmaceutical and medical industry propaganda** ([/blog/dark-side-breast-cancer-unawareness-month](#)).

In fact, as the advertisement image below clearly demonstrates, the "breast cancer awareness industry" is notorious for shamelessly promoting products known to cause cancer, like junk food, soda pop, toxic cosmetics and even fracking, which requires the use of dozens of carcinogenic chemicals and **even radionuclides** ([/blog/fracking-radiation-natural-gas-industrys-worst-pr-nightmare-1](#)), resulting in environmental contamination. The industry slaps a pink ribbon on virtually any product or service willing to donate to its "cause," which never addresses the root causes of the cancer epidemic. To the contrary, it **even covers it up** ([/blog/covering-causes-breast-cancer-1985-astrazenecas-bcam-2](#)).

It is therefore no surprise that Breast Cancer Awareness Month, and all the marketing, propaganda and fundraising events that go



with it, never discusses the role that mammary carcinogens play in cancer development. This **includes exposure to the very same kinds of radiation used in x-ray mammography**.

Indeed, there are many **"hidden dangers" of mammography that every woman should know about**, ([/blog/hidden-dangers-mammograms-every-woman-should-know-about](#)) which is why we created a **database on the subject you can consult, share and use to educate yourself further here** ([/blog/hidden-dangers-mammograms-every-woman-should-know-about](#)).

Unfortunately, mainstream media, government health agencies and the medical industry foreground and even inflate the theoretical benefits of mammography without accurately representing the seriousness of its known risks. This bias violates the medical ethical principle of informed consent,

which requires patients to be informed of the true risks and benefits of an intervention, in order to make an informed choice.

New Breast Screening Guidelines Disregard the Evidence of Harm in Favor of Promoting Theoretical Benefits

| Recommendation Summary | | |
|------------------------------|--|----------|
| Population | Recommendation | Grade |
| Women aged 50 to 74 years | The USPSTF recommends biennial screening mammography for women aged 50 to 74 years. | B |
| Women aged 40 to 49 years | <p>The decision to start screening mammography in women prior to age 50 years should be an individual one. Women who place a higher value on the potential benefit than the potential harms may choose to begin biennial screening between the ages of 40 and 49 years.</p> <p>. For women who are at average risk for breast cancer, most of the benefit of mammography results from biennial screening during ages 50 to 74 years. Of all of the age groups, women aged 60 to 69 years are most likely to avoid breast cancer death through mammography screening. While screening mammography in women aged 40 to 49 years may reduce the risk for breast cancer death, the number of deaths averted is smaller than that in older women and the number of false-positive results and unnecessary biopsies is larger. The balance of benefits and harms is likely to improve as women move from their early to late 40s.</p> <p>. In addition to false-positive results and unnecessary biopsies, all women undergoing regular screening mammography are at risk for the diagnosis and treatment of noninvasive and invasive breast cancer that would otherwise not have become a threat to their health, or even apparent, during their lifetime (known as "overdiagnosis"). Beginning mammography screening at a younger age and screening more frequently may increase the risk for overdiagnosis and subsequent overtreatment.</p> <p>. Women with a parent, sibling, or child with breast cancer are at higher risk for breast cancer and thus may benefit more than average-risk women from beginning screening in their 40s.</p> <p>Go to the Clinical Considerations section for information on implementation of the C recommendation.</p> | C |
| All women | The USPSTF concludes that the current evidence is insufficient to assess the benefits and harms of digital breast tomosynthesis (DBT) as a primary screening method for breast cancer. | I |
| Women with dense breasts | The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of adjunctive screening for breast cancer using breast ultrasonography, magnetic resonance imaging, DBT, or other methods in women identified to have dense breasts on an otherwise negative screening mammogram. | I |
| Women aged 75 years or older | The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening mammography in women aged 75 years or older. | I |

The USPSTF's latest 2023 draft recommendations.

(https://www.uspreventiveservicestaskforce.org/uspstf/sites/default/files/file/supporting_documents/breast-cancer-screening-draft-rec-bulletin.pdf)

The USPSTF's latest draft guidance recommending x-ray mammography breast screenings beginning at 40 are concerning, especially given that their previous guidance from **2016**

(<https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/breast-cancer-screening>) advised against screening women before age 50. This was due to the following concerns, which are still valid today:

"In addition to false-positive results and unnecessary biopsies, all women undergoing regular screening mammography are at risk for the diagnosis and treatment of noninvasive and invasive breast cancer that would otherwise not have become a threat to their health, or even apparent, during their lifetime (known as "overdiagnosis"). Beginning mammography screening at a younger age and screening more frequently may increase the risk for overdiagnosis and subsequent overtreatment." [bold added]

The new draft recommendations are based on a May 9, 2023, draft modeling report titled, "**Breast Cancer Screening With Mammography: An Updated Decision Analysis for the U.S. Preventive Services Task Force**

(https://www.uspreventiveservicestaskforce.org/home/getfilebytoken/uRwAnYAnc4HCNY3j3h5v_z)."

It is open for public comments until June 6, 2023, after which approval is expected. The draft report concludes:

"Conclusions: This collaborative modeling analysis suggests that several mammography screening strategies **reduce breast cancer mortality and increase life expectancy** in average-risk female persons. Strategies with biennial screening, start ages at 40 or 45, and cessation age 79 resulted in greater incremental gains in mortality reduction per mammogram compared with most strategies involving annual screening, start age 50, and/or cessation age 74. For some subgroups of female persons with higher risk of breast cancer and breast cancer death, more intensive screening resulted in judicious benefit-to-harm tradeoffs." [bold added]

While their conclusion makes bold claims for the "life saving" health benefits of starting mammography screenings at 40 years of age instead of 50, glaring flaws in both their reasoning and study design are apparent. These are explicitly acknowledged by the draft itself in the section titled "Limitations":

"We did not consider imaging modalities besides mammography, individuals at high risk of breast cancer due to genetic susceptibility, or potential risk of breast cancer due to screening-related radiation." [bold added]

In other words, the carcinogenic effects of x-ray mammography radiation on women whose breasts are screened were not considered. Neither was the well-known greater susceptibility to radiation-induced breast cancer among women who possess the so-called **breast cancer susceptibility genes - BRCA1/BRAC2 (/blog/brca-breast-cancer-gene-death-sentence)**. Together, they amount to **two very important reasons why x-mammography (performed without adequate risk assessments and stratifications) may actually create more disease and harm than it prevents.**

It should be repeated that iatrogenic illness caused by exposing the breasts of healthy women to radiation must be taken into account in any study that purports to be evidence-based. This is necessary for there to be an adequate and accurate risk/benefit analysis for recommending healthy women participate in x-ray mammography screenings starting as young as 40 years of age.

Failing this, the USPSTF's new draft's claims that earlier mammography screening would "reduce breast cancer mortality and increase life expectancy in average-risk persons" cannot be justified as an adequately "evidence-based" recommendation. Moreover, initiating the screening of healthy women **a decade earlier** would expose millions more women to increased risk of breast cancer from the diagnostic procedure itself, as will be explained in more detail below.

Planting the Seed of Radiation-Induced Breast Cancer Through Mammography

It has been known since 2006 that x-ray mammography carries with it unique radiobiological risks for carcinogenesis. A paper published in the *British Journal of Radiobiology*, titled **"Enhanced biological effectiveness of low energy X-rays and implications for the UK breast screening programme (/article/recent-radiobiological-studies-have-provided-compelling-evidence-low-energy-x)"**, revealed the specific type of radiation used in x-ray-based breast screenings is far more carcinogenic than previously believed:

"Recent radiobiological studies have provided compelling evidence that the **low energy X-rays as used in mammography are approximately four times - but possibly as much as six times - more effective in causing mutational damage than higher energy X-rays**. Since current radiation risk estimates are based on the effects of high energy gamma radiation, **this implies that the risks of radiation-induced breast cancers for mammography X-rays are underestimated by the same factor.**" [bold added]

In other words, the radiation risk model used to determine whether the benefit of breast screenings in asymptomatic women **outweighs their harm, underestimates the risk of mammography-induced breast and related cancers by 400% to 600%**. The authors of the study continued:

"Risk estimates for radiation-induced cancer - principally derived from the atomic bomb survivor study (ABSS) - are based on the effects of high energy gamma-rays and thus the implication is that the risks of radiation-induced breast cancer arising from mammography may be higher than that assumed based on standard risks estimates."

Consider that medical radiation associated with both diagnostic technologies such as x-ray mammography and **therapeutic technologies such as radiotherapy (/article/radiotherapy-may-result-enrichment-highly-malignant-cancer-stem-cells-breast-c)** may contribute to the immortalization of benign or low-risk tumor cells that otherwise would not possess tumor-forming capabilities or a metastatic phenotype.

For instance, a 2012 study published in *Stem Cells* showed that the radiation used in x-ray mammography was capable of **"radiation-induced reprogramming of breast cancer cells, (/article/radiation-induced-reprogramming-breast-cancer-cells)"** which included enriching the number of breast cancer stem cells (BCSCs) in a radiation exposed

tissue culture (BCSCs are the most malignant and dangerous of the cell types found in any abnormal breast tissue diagnosable as "cancer").

The fact that x-ray mammography may convert non-malignant tumor cells into highly malignant breast cancer stem cells speaks to how the unintended, adverse effects of so-called "preventive" breast screenings may include planting the seeds of cancer malignancy into what would otherwise be healthy or low-risk tissues in healthy women. This would not happen if they were left alone and simply did self-assisted or practitioner-assisted lump checks and/or watchful waiting.

To learn more about the **downside of x-ray mammography, consult our database here (/anti-therapeutic-action/x-ray-mammography)**. You can also read my previous article on the topic: **How X-Ray Mammography Is Accelerating The Epidemic of Cancer (/blog/how-x-ray-mammography-accelerating-epidemic-cancer)**

An Epidemic of Breast Cancer Overdiagnosis and Overtreatment Harming Women

Perhaps even more significant a problem than the radiobiological harms of x-ray mammography itself, is the widely recognized, yet still largely underreported, problem of overdiagnosis and overtreatment of women whose mammography results show abnormalities (e.g., breast calcifications) that are, in fact, not cancer or are not likely to progress to cancer.

Yet, the results are labeled as cancerous and therefore treated with aggressive approaches such as surgery (lumpectomy and mastectomy), chemotherapy, radiation and lifelong follow up treatment with pharmaceutical hormone blockers.

Famously, Peter Gøtzsche, the former leader of the Nordic Cochrane Center, and author of *Mammography Screening: Truth, Lies and Controversy*, recommended against mammography in a 2013 Cochrane review titled **Screening for breast cancer with mammography** (https://www.cochrane.org/CD001877/BREASTCA_screening-for-breast-cancer-with-mammography), for the following reasons:

"The authors conclude that the harms of regular mammography screening outweigh the benefits. The researchers state that if mammography screening reduces breast cancer mortality by fifteen percent and overdiagnosis and overtreatment is at thirty percent, then for every two thousand women invited for screening throughout ten years, one will avoid dying of breast cancer and ten healthy women will be treated unnecessarily due to the screening. That means that ten times more women will be overdiagnosed and overtreated than will be appropriately diagnosed and treated. Also, from those two thousand women, at least two hundred will experience psychological trauma based on false positive results."

Overdiagnosis and overtreatment is most apparent in the case of **ductal carcinoma in situ (DCIS) (/disease/breast-cancer-ductal-carcinoma-situ)**, a mostly benign breast abnormality detectable through ectopic calcifications that show up on x-ray mammograms, and which is sometimes described as "stage zero breast cancer." A **2019 study (https://aacrjournals.org/cebp/article/28/8/1316/72053/Incidence-of-Ductal-Carcinoma-In-Situ-in-the)** on the topic provides background on the origin and prevalence of DCIS today:

"The introduction of mammographic screening in the early 1980s has led to a dramatic increase in the detection of ductal carcinoma in situ (DCIS) over the past three decades (1, 2). In the United States, more than 50,000 women are diagnosed with DCIS each year and DCIS accounts for an estimated 18%-25% of the total number of newly diagnosed breast tumors (3)."

Over the past 40 years, **DCIS diagnoses (/blog/30-years-breast-screening-13-million-wrongly-treated)** have resulted in well over 1.5 million women having their breasts either surgically altered or removed. In 2013, a National Cancer Institute-commissioned panel's report **published in JAMA online (http://jama.jamanetwork.com/article.aspx?articleid=1722196)** confirmed that so-called "low-risk

lesions" like DCIS, and even high-grade prostatic intraepithelial neoplasia (HGPIN), should no longer be labeled "cancer."

Despite this, and to the misfortune of countless women since the publication of the 2013 report, it takes many years, and even decades, for changes in scientific and medical knowledge to filter down to academic institutions and the manner in which doctors practice medicine (the so-called standard of care). This means that, still today, many women are needlessly losing their breasts and being treated aggressively with chemotherapy and radiation for DCIS diagnoses that may have been better off left untreated.

This is a topic that is still regularly being discussed and researched, with an article published last month in Breast Cancer Research and Treatment titled, **Should low-risk DCIS lose the cancer label?**

(<https://pubmed.ncbi.nlm.nih.gov/37074481/>), addressing this ongoing controversy and whether or not to remove the word "cancer" from the diagnostic label of low-risk DCIS.

What Happened to First, Do No Harm?

The problem with overdiagnosis and overtreatment is still hotly contested, for obvious reasons. If it is true that earlier and more aggressive mammography screenings are resulting in an epidemic of cancer diagnoses and treatments in those who actually have no breast disease, the psychological harms of these unnecessary interventions can be devastating and life-threatening, if not sometimes fatal.

Moreover, the medical establishment rarely takes responsibility for the iatrogenic harm it does; to the contrary, it will often label iatrogenic harms associated with overdiagnosis/overtreatment as new disease entities, or attribute the decline to the patient's "cancer." The end result is the victim (the patient's body) is blamed, and the medical system evades liability. You can learn more about this by reading my article on the topic: **'Oops... It Wasn't Cancer After All,' Admits The National Cancer Institute/JAMA** (</blog/oops-it-wasnt-cancer-after-all-admits-national-cancer-insitutejama>)

A recent **Los Angeles Times** article (<https://www.latimes.com/science/story/2023-05-09/expert-panel-that-sparked-mammogram-controversy-now-says-tests-should-start-at-40>) reporting on the USPSTF's new draft guidelines published critical commentary from Dr. Otis Brawley, a Johns Hopkins oncologist and cancer epidemiologist:

"Even many experts can't come to grips with how many cancers are caused by mammogram screening and how many deaths are diverted by that screening," said Brawley. People who carry genes that predispose them to some cancers may be particularly vulnerable to radiation-induced mutations, he said. "But that's not a trade-off that's been explored with strong research," he added."

It is worth noting that in the USPSTF's latest draft (pg. 19) the majority of the models they used found the number of overdiagnoses (the number of women unnecessarily treated) exceeded the number of (theoretical) deaths averted:

"Among the five models that included DCIS as well invasive breast cancer, three models found that **the overall number of overdiagnosed cases exceeded the number of breast cancer deaths averted** (Models E, M, and W)". [bold added]

Ultimately, the USPSTF's latest draft guidelines are coming from a very weak and highly contested evidence-base, and are biased against the fundamental medical ethical principle of "do no harm."

Given the epidemic-level role that overdiagnosis and overtreatment play, as well as the well-known problems that false-positives, unnecessary biopsies and other related iatrogenic factors play, it behooves the USPSTF to do more research on these confounding factors before providing draft guidelines to the world. They are suggesting women throw caution to the wind and prioritize aggressive approaches where a more gentle and watchful waiting oriented strategy could result in better outcomes.

There are also radiation-free alternatives to x-ray mammography such as **thermography (/therapeutic-action/thermography)**, which deserve to be explored, as they may provide a more effective approach to "early detection," enabling patients to understand the physiological conditions directly related to diet, lifestyle, toxicant burden, mindset and related modifiable factors that underlie the metabolic abnormalities associated with both benign and

malignant breast abnormalities. You can learn more about thermography **here (/blog/thermography-key-early-detection-breast-cancer)**.

To learn more about breast cancer and diet, environmental exposures, and both conventional and natural approaches, visit our database on the topic of **breast cancer**.
(/disease/breast-cancer)



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