

THE FACTS ON MAMMOGRAPHY – CLINICAL STUDIES

Doubts about the value of mammography first surfaced in 1991, when the *Times* of London published an article titled "Breast Scans Boost Risk of Cancer Death." Its opening line: "Middle-aged women who have regular mammograms are more likely to die from breast cancer than women who are not screened, according to dramatic new research." The study reported the results of the Canadian National Breast Screening Study (NBSS), the largest study of its kind carried out anywhere in the world. The NBSS was the first randomized, controlled clinical trial to separate the effect of mammography from the physical examination of the breast. In all other major trials, dating back to the 1960s, participants were given either mammography plus breast exams or mammography alone. The NBSS tracked 89,835 Canadian women age 40 to 49 during the period 1980 – 1988. Half were given mammograms every twelve to eighteen months. The other half were given only a single physical exam. To the surprise and chagrin of the researchers, at the end of the eight-year period, deaths among the group getting regular mammograms were "significantly higher" than in the group getting none. When the study was published in November 1992, the odds of dying of breast cancer if you had been screened were reported to be 16 percent greater than if you had not. On September 20, 2000, the thirteen-year follow-up results were published for the NBSS, involving nearly 40,000 women in their fifties. Again, no benefits were found for those receiving annual exams, and any design flaws criticized in 1992 were carefully refuted. The data confirmed that mammography is no more effective than a careful breast exam by a trained professional in detecting breast cancer in women *either* in their forties or their fifties.

In 1999, a study published in *The Journal of the American Medical Association* (JAMA) concluded that mammography offers very little life-extending benefit for women over age 69. And a Swedish study reported the same year found no significant benefit for women age 50 to 69. The breast cancer death rate dropped only one percent between 1989 and 1996 for women in that age group, despite regular mammography screening. The results were called "a shocking disappointment," since an accumulated 25 to 30 percent mortality reduction had been predicted based on the findings of eight earlier randomized controlled clinical trials conducted worldwide previously considered the "gold standard" for information about mammography. As for those eight trials, in January 2000 the British medical journal *The Lancet* published a new analysis concluding that six of the trials were flawed in a way that exaggerated mammography's benefit; and the two remaining studies (including the NBSS) found no benefit for mammography. The conclusion of *The Lancet* analysis was that "Screening for breast cancer with mammography is unjustified.... [T]he data show that for every 1000 women screened biennially throughout 12 years, one breast-cancer death is avoided whereas the total number of deaths is increased by six."

Mammography is controversial for another reason. Breast cancer incidence has reportedly increased 30 percent since the 1970s when it came into vogue, and disturbing new research blames mammography itself for at least some of the apparent increase. Mammography and biopsy are detecting "pre-cancerous" conditions that would not otherwise have turned into active cancers. That would make both the apparent incidence and the apparent cure rate go up, since the easiest cancers to cure are the ones that aren't really cancer. The disturbing part is that 30 percent of breast cancer "victims" may have been victims only of their unnecessary treatments: biopsy, surgery, radiation, and chemotherapy. Even the National Cancer Institute has conceded that mass screening may be responsible for the alarming increase (or apparent increase) in breast cancer incidence. The suspicion was strengthened by a study at Fred Hutchinson Cancer Research Centre in Seattle finding that the apparent increase in breast cancer could be explained by early detection alone.

John Gofman, M.D., Professor of Molecular and Cell Biology at the University of California at Berkeley, asserts in a 1999 book *Radiation from Medical Procedures in the Pathogenesis of Cancer and Ischemic Heart Disease* that mammography and other diagnostic X rays have contributed to the cancer epidemic in another way: medical radiation itself substantially increases cancer risk. His detailed review of the evidence suggests that this may actually be the most important cause of cancer deaths in the twentieth century.

CONVENTIONAL CANCER TREATMENT

Ironically, mammography *has* been found to be effective as an early cancer detection technique. The Canadian study found that it detected cancers earlier than physical examination alone and was more sensitive in finding smaller cancers and *in situ* carcinomas. NBSS director Dr. Anthony Miller blamed the failure of mammography to save lives not on the procedure itself but on the cancer treatment that followed the diagnoses. "Studies in animals suggested that removal of the main tumour and radiation of the immediate area affected the body's

immune system so that tumours elsewhere grow faster," he said. "You may find the cancers earlier (with mammography), but the women are still going to die. *Modern treatment does not work for these early cancers.* It was, of course, the early cancers that the cancer establishment has said modern treatment does work for. The late cancers, the ones that have spread to other areas of the body, are known to be much harder to cure. It was to catch the early cancers that billions have been spent on mass screening for early detection. The statistics cited in support of cancer treatment in general are often misleading. While the National Cancer Institute (NCI) consistently claims gains in the cancer cure rate, the General Accounting Office has accused the NCI of regularly manipulating data in order to "artificially inflate the amount of 'true' progress." In 1997, statistician Dr. John Bailar III, former editor of the *Journal of the National Cancer Institute*, compared the most recent cancer mortality rates with those in 1970, just before the National Cancer Act re-leased billions of dollars for cancer research. Overall, he found, the odds of dying of cancer are 6 percent *higher* today than they were in 1970. While some battles in the cancer war have been won, they have been primarily against uncommon forms of the disease, accounting for less than 2 percent of total cancer deaths. For the major killers – including not only the hormonal cancers of the breast, ovary, and prostate but also cancers of the lung and colon – deaths have either stayed the same or increased, despite the intervention of the world's most costly and sophisticated cancer technology.

In an eye-opening 1995 book *Questioning Chemotherapy*, Dr. Ralph Moss documented the ineffectiveness of chemotherapy for prolonging life or improving its quality in the case of most cancers. He noted that the FDA defines an "effective" drug as one that achieves a reduction of 50 percent or more in tumour size over twenty-eight days. That means that to be "effective," a drug needn't be proven to extend life or improve its quality. After reviewing thousands of studies for more than fifty types of cancer, Dr. Moss concluded that in most cases the drugs do neither.' In a January 2001 update confirming his earlier statistics, Dr. Moss observed that cancer drug ads are often misleading. An ad for the cancer drug Arimidex, for example, claimed "56.1 percent survival" for breast cancer patients treated with it. What the ad was actually referring to was the two-year survival rate compared to an older drug, Megace. The median time to death for women on the newer drug was 26.7 months compared to 22.5 months for Megace, a difference that did not reach statistical significance. In either case, the patients lived only about two years after treatment, hardly the common definition of "survival." And the "control" group involved another toxic drug, not natural treatment or no treatment.

Surgery and radiation have also not been proven in controlled trials to extend life. They didn't need to be, since they were grand fathered in before the FDA's "effectiveness" requirement. Radiation can effectively shrink tumours in critical situations (when the tumour is pressing on an artery, airway, vital organ, or nerve), but long-term studies have found that it can actually shorten overall survival.

As a last resort in serious breast cancer cases, oncologists have turned to bone marrow transplants. In an article in the October 18, 1998, issue of *The New Yorker* titled "Healing Hell," Jerome Groopman, M.D., called this procedure both "the most powerful weapon in the growing arsenal against cancer" and "the most devastating treatment that the human body could be subjected to." Preliminary results reported in April 1999 of long-awaited international studies on bone marrow transplants, however, were called "a bitter disappointment." The therapy Dr. Groopman called conventional oncology's most powerful weapon against cancer was found to be no more effective in prolonging life than conventional chemotherapy, which is also only marginally effective for metastized breast cancer.

Among breast cancer drugs, the market leader is currently Tamoxifen (Zeneca's Novaldex), a synthetic estrogen compound that acts by blocking natural estrogen from binding with receptor sites in breast tissue. Roughly 1 million American breast cancer patients are now being treated with Tamoxifen, but the drug is not a cure and comes with significant side effects, including troublesome hot flashes and a significantly increased risk of blood clots, serious thromboembolic events, and uterine cancer.

Tamoxifen was recommended not only for treatment but also as a preventive measure for women at high risk for developing cancer of the breast, after it was shown to help prevent breast cancer recurrences in women already treated for the disease. But recruitment into a tamoxifen prevention trial at the University of Pittsburgh beginning in 1981 was temporarily halted following a finding that more than ten times as many women contracted cancer of the uterus in the tamoxifen group as in the control group. Despite those findings, the National Cancer Institute continued to spend millions of taxpayers' dollars giving the drug to cancer-free women already in the study, to see if it would keep them from developing the disease. A nine-year Swedish study reported in 2001 confirmed the uterine cancer risk, finding a more than fivefold increase in its incidence in women given tamoxifen, and in 1998 the World Health Organization labelled the drug a carcinogen. Zeneca kept it off the official carcinogen list only by aggressive lobbying of California state regulators.

Excerpt from

A Woman's Complete Guide to Natural Health by Lynne Paige Walker, Pharm. D., D. Hom, L. Ac., and Ellen Hodgson Brown ISBN 1-58333-155-7