Prevention

Health (/health) DOCTORS (/TAGS/DOCTORS-1)

The Best Doctors You've Never Heard Of

JUNE 25, 2015 By MEEHAN CRIST

(/HEALTH/OSTEOPATHIC-DOCTORS#BOTTOM)

No white linoleum or fluorescent lighting here. There's classical music, dark wooden bookcases, a desk disappearing under dog-eared medical tomes. A human skeleton dangles from a metal pole; I reflexively imagine the hollow clackety-clack of jostling bones. Taking off my shoes, I stand next to a padded exam table. Dr. Daniel Shadoan places his hands lightly on my shoulders. I stand straight and breathe deep, wondering what his hands are telling him. Is my weight distributed evenly on both feet? Is one shoulder higher than the other? He asks how I'm feeling, and I say my lower back has been hurting. "Hmm,"

he murmurs. Shadoan is an osteopathic physician, or DO, and I'm about to receive a treatment known as osteopathic manual manipulation.

While DOs are often indistinguishable from MDs (they are fully licensed, and can prescribe drugs and perform surgery like an MD), their medical education is rooted in a distinctive philosophy. Like all integrative doctors, osteopathic physicians are taught to encourage the body back toward health using the least invasive measures first. What differentiates their training is this: It focuses on how the structures of our bodies are deeply linked with how healthy we are. The field was founded upon manual manipulation, a therapy designed to improve the flow of air and blood, lymphatic, and other fluids in the body to maximize self-healing mechanisms and improve the function of our brain, organs, and joints. Doctors who practice manipulation, like Shadoan, say they can help a body return to health by adjusting tissues and bones just so. Sounds like a long shot, but there may be increasingly good

reason to believe in this touch-centered medical approach.

For one thing, DOs are fast becoming a pillar of American health care. As we barrel toward an unprecedented physician shortage, they are stepping up to fill the widening gap. One in four medical students in the US are enrolled in a DO program, and this number is rising rapidly. In 1970 there were 14,000 Dos in the US; that number is expected to be more than 100,000 by 2016.

MORE: 7 Stress-Busting Yoga Poses You Need (http://www.prevention.com/mind-body/yoga-poses-relieve-stress)

DOs like Daniel Shadoan return you to health by adjusting tissues and bones.

Next time you visit your oncologist, psychiatrist, or even your primary care doctor, eyeball their credentials; you might be seeing a DO without even realizing it. Today's osteopathic doctors can be found in all medical specialties; out of 100 DOs,

fewer than five specialize in manual manipulation, the way Shadoan does. But the other 95 have been trained in it and are likely to use their hands: to diagnose you, to soothe you, to convey warmth and connection, says Boyd Buser, dean of the University of Pikeville–Kentucky College of Osteopathic Medicine. Studies from the past couple of decades show associations between touch and faster wound healing, stronger immunity, and reduced pain, suggesting that doctors who touch their patients may be able to offer more effective medical care.

Anecdotally, Buser and other physicians, MDs included, say that touch is crucial to effective diagnosis, too. In light of these notions, it's distressing that many MDs are putting their hands ever more firmly in their pockets (it's true; see why more doctors won't shake hands with you anymore (http://www.prevention.com/health/healthy-living/handshakes-and-high-fives-spread-germs-hospitals)), doing away with the physical exam entirely, and in some cases turning toward telemedicine, conducted via screens and at a distance. The oncoming wave of DOs may be poised to counter this trend, as physicians trained in the art and science of touch join their

MD counterparts in hospitals and clinics around the country.

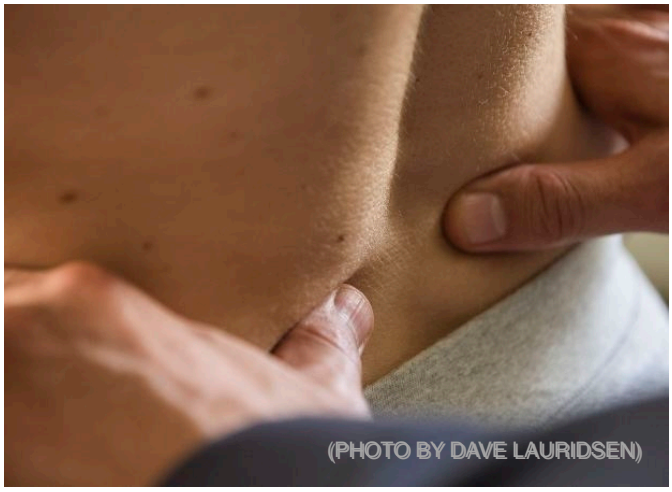
Osteopathic manipulation is most commonly used to treat joint neck, and back pain, but it also appears to offer relief from a range of medical problems.

Manipulation exemplifies the traditional osteopathic approach to medical care. There is also evidence that it can help relieve lower-back pain (http://www.prevention.com/health/health-concerns/highly-effective-treatments-lower-back-pain), which is why I'm standing sock-footed in Shadoan's office, listening to classical music and concentrating on my breathing.

Shadoan asks me to lie faceup on the exam table. He rolls his stool to my right side and slides his hands under my back, palms up. There are multiple manipulation approaches, and he specializes in one known as cranial osteopathy, a sometimes controversial practice focused on the cranial bones and the tissues surrounding the brain and spinal cord. DOs like Shadoan

are particularly concerned with increasing the flow of cerebrospinal fluid, which provides nutrients, cushions the brain inside the skull, and circulates rhythmically through the brain—between the membranes that surround it and up and down the spinal column.

As Shadoan sets to work using his fingers to investigate each vertebra in my spine, he explains the DO philosophy: "Many drugs address the symptoms, not the cause. You're not sleeping, here's something to make you sleep; you're nauseated, here's something that will block your nausea response." He has intense brown eyes and a cropped beard—more East Coast intellectual than New Age spiritualist. "Medicine that treats the patient," he says, "seeks to understand why the problem is there and resolve the conditions that create that problem." When medication is necessary, Shadoan uses it. "Drugs and surgery are often a less efficient, less healthy way to deal with things," he says. "But sometimes they're necessary." If a patient needs a knee replacement or radiation therapy for cancer, Shadoan refers them to a specialist and suggests manual manipulation as a complementary treatment.



There's good evidence that osteopathic manual manipulation can relieve lower-back pain. In one randomized, controlled study, people with back pain who got OMM once a week for 4 weeks showed more improvement than those given painkillers and physical therapy alone.

His fingers work down my spine and into my right hip, then slowly down my right leg all the way to my ankle. He's checking the "movement and quality of tissues," he says, explaining that the texture and flexibility of bones, joints, muscles, ligaments, fasciae, and organs beneath his fingertips tell him a lot about my health, and what adjustments might improve it. He repositions himself to stand at the end of the table, facing my feet. He gently presses his fingertips between the tendons on the top of my right foot, and I feel an unpleasant tenderness. When he tests the same spot on the left foot, eyebrows raised at me in question, I tell him it doesn't hurt at all. He nods.

Taking my less sensitive foot in his hands, Shadoan pushes his palm flat against my sole and gently rotates the foot outward. "Does this hurt?" he asks. No. He repeats the position on my right foot. "Ow!" I yelp, recoiling slightly. Pain has just gone

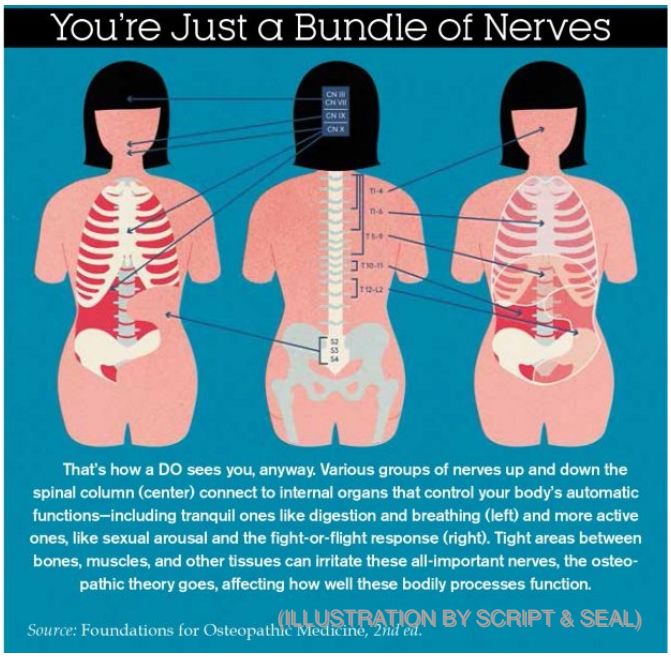
shooting up my right leg, through my hip, and into my lower back. It wasn't excruciating, but it was completely unexpected. "I thought that might be it," Shadoan nods. It's a little unsettling that he seems to know things about my body that I don't.

> "'I thought that might be it,' Shadoan nods. It's a little unsettling that he seems to know things about my body that I don't."

That ankle got injured awhile back, and Shadoan suggests that to ease the pain in my still-unhealed ankle, it's possible I'd unconsciously begun to favor that foot when I walk. This would have alleviated the discomfort in my ankle, but also would have changed how my weight was distributed throughout my body, causing my hip to twist and putting stress on my lower back, an imbalance that could strain muscles and put pressure on nerves. I have no way to test this theory, of course, but it's intriguing.

A massage therapist might have helpfully kneaded tight muscles near my spine; an MD might have prescribed a painkiller. Shadoan did something that felt more like a gentle untangling, what he would describe as resetting the alignment of tissues and bones so that I would bear my weight more evenly and so blood and other healing fluids

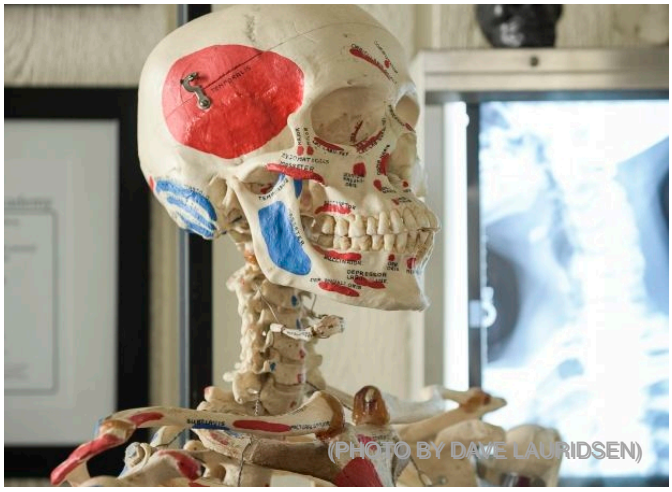
could flow unimpeded through my system again.



Although osteopathic manipulation is most commonly used to treat musculoskeletal conditions like back, joint, and neck pain, its practitioners say it offers relief from a range of medical problems, from asthma to migraines to Parkinson's symptoms. Some research bears this out. There is evidence, for example, that using manipulation to treat elderly patients with pneumonia results in shorter hospital stays and less use of medication. Other studies have suggested a link between manipulation and activity in the endocannabinoid system, the same system affected by the pain-relieving cannabis in marijuana.

MORE: Genius Natural Cures From Your Kitchen (http://www.prevention.com/mind-body/natural-remedies/easy-home-remedies-food)

But the results of studies are mixed overall, and there have been few reliable trials. This may be partly because, like treatments such as acupuncture (http://www.prevention.com/health/healthy-living/health-benefits-acupuncture), manipulation doesn't fit neatly into the scientific model of clinical testing. The gold standard is the double-blind, placebo-controlled study, in which neither practitioner nor patient knows if the person is receiving the treatment or a placebo. These studies are incredibly difficult to do on manipulation, because you have to do "sham" treatments. At best, the patient won't know if they're getting the treatment, but the practitioner will. Another reason may be cultural: The MD track has historically been better at training doctors to do research, and MDs have not been hugely motivated to do clinical trials on manipulation. Only a slim percentage of doctors practice manual manipulation, and some look on the therapy with skepticism. In recent years, there has been a push for more rigorous testing, which should eventually shed light on how and for what conditions this therapy is most effective.



DOs are taught that the very basis of health is the structure of the body.

Shadoan scoots his stool back, stands, and takes hold of my right arm. He rotates my shoulder joint, then my elbow, kneading tender points until they are no longer tender. In this, the treatment is reminiscent of a session of physical therapy, in which a therapist might find points of tension, where muscles are contracting, and press into them until the muscles release. Finding a particularly sore spot on the outside of my elbow, Shadoan moves my arm into a slightly elevated and inward-twisted position, which relieves the pain in my elbow and makes my head ache at the same time. He lowers my now-floppy arm onto the table and begins to press his fingers into my abdomen, near my belly button, while explaining how he takes all the information he's getting and "puts it into a framework of the entire body being a tensegrity system." I'm getting pleasantly woozy, which makes it hard to concentrate on what he's saying. As he pushes the heel of his palm rather forcefully into my rib cage, I breathe out, hard, then ask what he means by

"tensegrity system."

"Tensegrity is a term coined by the architect Buckminster Fuller," Shadoan says, "referring to tension and integrity. In architecture, you find tensegrity in domes, where you have a latticework of interconnected joints and supporting material stretched across them that puts tension into it to hold it, transmitting force throughout the whole thing." Early civilizations built massive pyramids and ziggurats that were simply stacked: no tensegrity. Once we mastered the concept, it allowed us to build suspension bridges and skyscrapers—buildings where the height is much bigger than the footprint.

"Like skyscrapers, humans have small feet and relatively big torsos and heads," he goes on. "Our brain monitors where the parts of the body are relative to each other and decides, OK, we need a little more tension here, a little less tension there. The brain is doing that all the time, whether we're sitting, standing, running, throwing. The number of unconscious calculations is unbelievable. An osteopathic treatment works to help the body to be more efficient in how it distributes weight and force."

MORE: The Unbelievable Reason You're Short On Vitamin D (http://www.prevention.com/health/how-much-vitamin-d-you-really-need)

Shadoan has his fingers tucked into my torso and is pulling on my rib cage. My

whole body is vibrating like a plucked string.

"It's why when we treat somebody, we treat them from head to toe, whether they have a head injury or a broken ankle," he explains. "The body is trying to distribute all of our weight and keep us in balance on our tiny feet." When you're injured, suddenly other areas near the injury may have to carry more than their share, ultimately leading to problems distant from the injury. "If you twist your ankle, it's going to affect your knee, your hip, your back, your shoulder; you may get headaches. Go to an osteopath who specializes in manipulation and they'll treat the whole system." Tensegrity has been used to create and test models in fields like cell biology, but like a lot in medical care, the concept amounts to unproven theory. Nonetheless, it makes intuitive sense: Because the musculoskeletal system is intimately interconnected with the nervous system, which controls the function of all our internal organs, the theory says that adjusting structure can affect a staggering range of processes in the human body—including disease.

Whether they specialize in manipulation or not, DOs are likely to use their hands: to diagnose you, to soothe you, to convey warmth and connection. Studies show associations between touch and faster wound healing, stronger immunity, and reduced pain.

My mind is a rowboat unmoored. The oars have slipped from their locks into the water below. But I try to remember this: The human body is more like a skyscraper than a pyramid, which is why if you have a sprained ankle you can end up with headaches.

There's been much enthusiasm of late for preventive medicine, both from the government (as a feature of the Affordable Care Act) and from patients, who have been turning to integrative care in droves. This may be why so many doctors-in-training are being drawn to the growing number of osteopathic colleges—for the hands-on approach and emphasis on preventive care. Because DO schools have historically been easier to get into than conventional medical schools, however, some see them as a back door to a medical degree. But applicants' scores have been rising steadily over the

past decade, and competition for spots in osteopathic colleges is intensifying. Last year, 17,944 hopefuls applied for just over 6,200 spots.

> "When I float out of Shadoan's office, I'm breathing more deeply than I have in months."

While many MDs gravitate toward high-paying and more prestigious specialties such as cardiology and surgery (in part because they have more student debt to pay off), 60% of DOs are primary care physicians. Inspired by the social mission imparted in osteopathic med school, more than one in five practice in underserved communities, both rural and urban. And according to the American Osteopathic Association, graduating DOs are largely continuing this trend. This may be good news for a country in which the number of MDs going into primary care is plummeting, and the anticipated physician shortage will hit underserved communities hardest.

A manual manipulation treats the whole body, head included. Shadoan works the joints on both sides of the face, as well as the forehead and temples. Studies show manipulation may be good for sinusitis and chronic migraines.

At the same time the number of DOs is rising, the already hazy lines between DO and MD are getting blurred further. Last year, the Accreditation Council for Graduate Medical Education announced a plan to merge the historically separate DO and MD residency programs into a single system. This means that by 2020 all doctors in the US, whether MD or DO, will finish their medical training under one umbrella. In a press release, Stephen Shannon, the president of the American Association of Colleges of Osteopathic Medicine, said that this approach "not only streamlines but strengthens the postdoctoral process, enhancing the ability of all physicians to learn the unique characteristics of osteopathic medical practice." Whether this plays out in practice remains to be seen.

When I float out of Shadoan's office, it feels as if I'm breathing more deeply than I have

in months. The pain in my back has subsided, my arms swing loose at my sides, and my skull seems perched more squarely atop my spine. I'll feel mildly euphoric and absentminded, my whole body humming, for hours. After the initial pleasant effects, I'll be deeply sore for at least a day.

Shadoan takes all the information he gets through his fingers and puts it into a framework of the entire body.

In the short term, my back pain was relieved, an effect that has also been reported in clinical trials indicating that manipulation can lower rates of pain relapse, the use of pain medications, and missed days at work. The long-term effects of a single treatment are harder to quantify. Manual manipulation is designed to support the body's own healing mechanisms, so that you recover faster and stay healthier over time. I can't say how much faster I healed with this one treatment than I might have healed without it. Or how fast I might have healed with more regular treatments. Sometimes my

back still hurts, but I also sit hunched at a computer all day. This is why controlled studies like the one with pneumonia patients are crucial to understanding manipulation; they track a group of patients over time.

In Search of a Treatment?

To find an osteopathic doctor specializing in manipulation, search for "Osteopathic Manipulative Treatment" or "Osteopathic Manual Manipulation" at these three websites:

- American Osteopathic Association (http://osteopathic.org)
- American Academy Of Osteopathy (http://physician.academyofosteopathy.org)
- The Osteopathic Cranial Academy (http://cranialacademy.org)

Most DOs who practice manipulation encourage patients to come in every few weeks, or every few months, depending on the person's age and medical history. Get your musculoskeletal system tuned up, get your fluids flowing, they say, and your body will be more disposed toward good health. It may be that manipulation works better for some patients, and some conditions, than for others. But having more doctors who simply lay hands on their patients is good news for all of us.

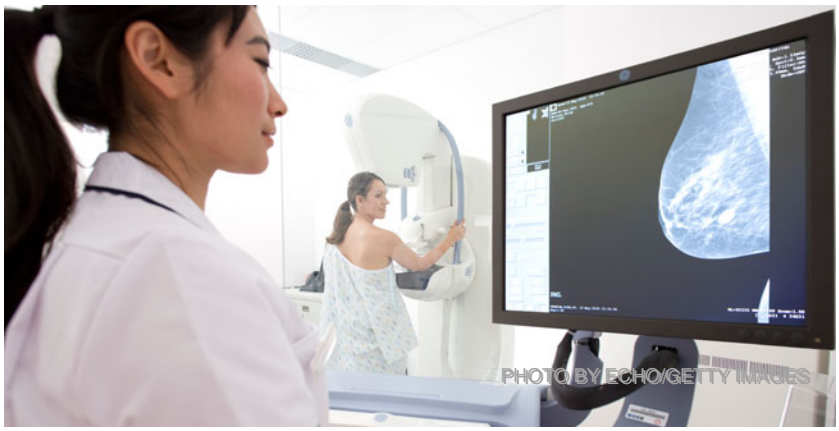
Tags: DOCTORS (/TAGS/DOCTORS-1) HEALTHY HABITS (/TAGS/HEALTHY-HABITS)

Health (/health) BREAST CANCER (/TAGS/BREAST-CANCER)

Why Getting A Mammogram May Cause More Trouble Than It's Worth

JUNE 30, 2015 By SARAH KLEIN

(/HEALTH/TROUBLE-GETTING-MAMMOGRAM-40#BOTTOM)



After a routine mammogram found that she had stage 0 breast cancer (http://www.prevention.com/health/health-concerns/how-prevent-breast-cancer), TV chef and cookbook author Sandra Lee started soapboxing.

"I don't care if my niece is only 23," she said on *Good Morning America* when she revealed her diagnosis and her plan to get a double mastectomy. "Girls in their 20s and 30s just have to know. If you're sitting at home right now watching this... get your rear end in there and get a mammogram right now."

This is singularly bad advice. There's little evidence that all women need a mammogram right now.

If you're a woman under 40, in fact, getting a mammogram is far more likely to harm your health than to help it. That's largely true for women between 40 and 49 as well.

For those 50 and up, the benefits may outweigh the risks, simply because breast cancer occurs more frequently in older women. But in all cases, mammograms are startlingly less powerful than we give them credit for. Ultimately, the decision to get screened is a personal one, and one every woman has the right to make. But there are some things we must all first try to understand:

Mammograms Just Aren't That Effective At Saving Lives.

It's a blasphemous thing to say in this pink-washed country, but it's true—and it's not even news. The American Cancer Society first started recommending mammograms to women in 1976, and screening reached its peak in 2000, when 70.4% of women 40 and up had had a mammogram in the previous 2 years. As mammography increased, so too did breast cancer diagnoses, which was exactly the idea. But what didn't change much was the number of diagnoses of late-stage breast cancer, the

significantly harder-to-treat disease that kills women. Yes, mammograms were catching a greater number of cancers, but largely they were slow-moving, potentially harmless ones. If mammos had been finding more dangerous cancers early, there would have been fewer cancers to catch at later stages. Alas, that has not happened. The annual number of deaths from breast cancer has dropped, but experts say that's largely because of improvements in treatment, not early detection. What's more, breast cancer deaths are decreasing faster among women younger than 50, who get fewer routine mammograms.

> An estimated 20% of breast cancers disappear on their own.

Mammograms are excellent at picking up on slow-moving cancers that likely aren't a threat—ones that may actually never need to be treated at all, or that are so slow moving that you'd have eventually noticed a lump while dressing or showering and ultimately had the exact same treatment and prognosis as if you'd discovered it earlier via mammogram. While they also pick up on the more virulent, fast-moving types of breast cancer, they don't necessarily lessen treatment or improve prognosis.

MORE: This Is What It's Like To Be In A Cancer Clinical Trial

(http://www.prevention.com/health/cancer-clinical-trial)

A Mammogram Probably Did Not Save Sandra Lee's Life.

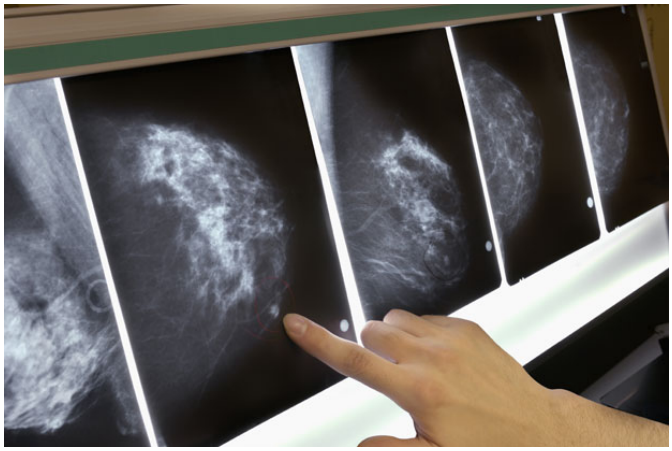
Lee's stage 0 cancer, aka ductal carcinoma in situ, generally falls into the nonthreatening-for-now category. DCIS, abnormal growth of the cells lining the milk ducts, is a diagnosis that was rarely seen before the 1980s, yet now accounts for about a quarter of all breast cancer diagnoses in the US. DCIS is confined to the milk duct; it has not yet grown in other breast tissue—and it may never.

It's impossible to know what would have happened had Lee played the odds, but "a woman would not have a risk of dying of DCIS in and of itself," says Tracy Onega, PhD, associate professor of biomedical data science and epidemiology at Geisel School of Medicine at Dartmouth. Lee chose to have a double mastectomy, which can cut the risk of ever having invasive breast cancer to about 1%, says Laura Esserman, MD, director of the Breast Care Center at the University of California, San Francisco. Surgery—whether it's mastectomy or lumpectomy—is still standard DCIS treatment, although new research questions whether it's always necessary, since it doesn't appear to improve survival in women with the lowest-grade DCIS. "We are now conducting studies to determine if women with DCIS may be carefully monitored and given preventive medicines to reverse the condition instead of

undergoing any treatment," Esserman says.

As few as 16% of cases of low-grade DCIS eventually evolve into breast cancer. Among high-grade DCIS cases, the portion is closer to 60%. Put another way, between 40% and 84% of women diagnosed with DCIS, the way Lee was, would experience zero ill effects from not treating it at all. The hope is to one day identify genetic markers that can distinguish between growths likely to become invasive and those that we can leave alone, but we don't yet have a tool to do that. (If you've been diagnosed with breast cancer, *Prevention's Ultimate Guide To Breast Cancer* (https://www.rodalestore.com/prevention/the-ultimate-guide-to-breast-cancer.html?keycode=238830) can help.)

Mammograms Can Lead To Some Pretty Bad Things.



Since medicine still can't identify which cancers are likely to morph into something lethal and which are better left alone to disappear on their own (as an estimated 20% of breast cancers are thought to do), all breast cancers that get detected tend to get treated. That amounts to a lot of

unnecessary procedures—biopsies, mastectomies, radiation, and chemo—for women whose lives would have been healthy and long without them.

Another highly common byproduct of regular mammograms: false positives, in which a woman gets called back for additional imaging or biopsies after a mammogram. While dealing with frayed nerves and increased medical bills seems like small potatoes once a woman learns that—*whew!*—she doesn't actually have cancer, new research shows that women who had false positives faced emotional consequences years after they were given the all-clear, including feeling anxious, dejected, and even less attractive.

> In 2013, the Swiss Medical Board reviewed the evidence supporting mammography screening and arrived at a startling conclusion: Do away with it.

Sandra Lee Probably Didn't Need A Mammogram—And You Might Not Either Until You Turn 50.

At 48, Lee is in the highly controversial 40 to 49 age bracket at the center of the decades-old debate over mammography. Some of the various medical organizations that give screening recommendations make

the case for yearly mammos for all women starting at age 40 and continuing as long as they are in good health. Others recommend starting at 50 and getting the test only every other year until age 74. (None recommend mammograms for the average woman under 40.) Based on the existing science, women in Lee's age group stand to be harmed more than they stand to benefit from a regular mammogram, albeit at a lesser rate than women under 40.

In 2009, the United States Preventive Services Task Force, a government-funded panel of medical experts charged with reviewing scientific evidence on disease prevention—basically the deciders of what's considered good, science-backed medicine in the US—gave a C grade to the evidence supporting regular screening before age 50. By their estimation, mammos before 50 don't do a whole lot of good. Now, under pressure from outraged mammogram advocates like the American Cancer Society and the American College of Radiology, the task force has softened the recommendations, advising women to talk to their doctors about the best time to start breast cancer screening.

But the research hasn't changed: For mammograms to save the life of one woman between 40 and 49, nearly 2,000 women in that age range have to be screened regularly over 10 years. Meanwhile, by conservative estimates, 20 of those women will have a biopsy, a mastectomy, radiation, or chemo treatment

for cancers (http://www.prevention.com/health/health-concerns/everyday-cancer-prevention-tips) that never would have progressed, and 1,200 will receive a false positive.

Early Detection Is An Oversold Promise.

If Lee had decided to begin mammography screening at age 50, she might have discovered nothing whatsoever; maybe she would have been one of the lucky one-fifth of women whose cancer disappears without treatment. Or perhaps by then it might have progressed to highly treatable stage 1 or stage 2 breast cancer, Onega says. Breast cancer treatment has evolved to eliminate some of the importance of screening, she adds, because we've come so far in successfully treating this disease in its early stages. That's to say, catching breast cancer early with a routine mammogram may make no difference in a woman's prognosis or treatment, compared with catching it when she notices a lump. Early detection isn't the hero; it's treatment that actually

saves lives.

It Wouldn't Be Crazy To Skip Out On Mammograms Entirely...

Veneta Masson, a 71-year-old nurse practitioner in Washington, DC, had her last mammogram at the age of 56. After reviewing the scientific literature, Masson decided there wasn't enough benefit to regular screening to warrant the risks, and she opted out—for good—even though her sister had been diagnosed with breast cancer in her early 40s and later died of the disease in 1997. "It's this search for answers and 20 years of experience caring for women...that led me to decide that I could no longer endorse the tests as routine screening measures for me or any other woman," she wrote in the journal *Health Affairs* in 2010. "Breast cancer is just as treatable and just as deadly regardless of screening. I've opted out of routine screening."

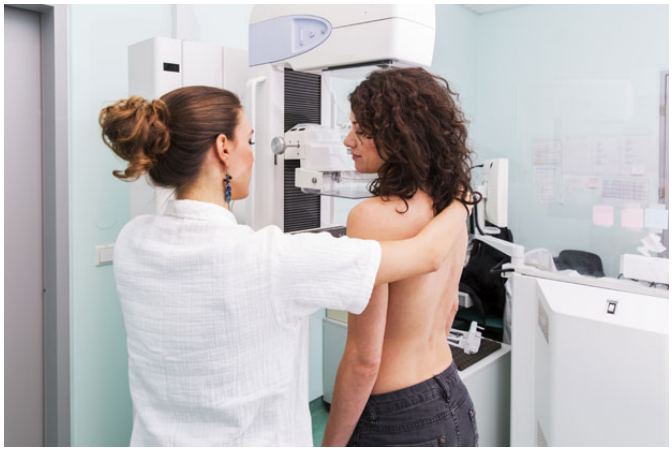
> It all comes down to that one life saved per 2,000 women, over 10 years of screening. Odds are it won't be yours, but if it were?

This is so not-crazy, in fact, that entire governments are starting to get on board with the idea. In 2013, the Swiss Medical Board reviewed the evidence supporting mammography screening and arrived at a startling conclusion: Do away with it. The

board's final recommendation was that no new awareness-raising initiatives would be launched to support mammography screening and that existing programs would be phased out over time.

MORE: The 8 Most Preventable Cancers—And How To Slash Your Risk (http://www.prevention.com/health/most-preventable-cancers)

...But It's Understandable To Want To Get Them Anyway.



Of those 2,000 women screened every year for 10 years, 6 will still lose their lives to breast cancer. That's compared with 7 lives lost among a group of 2,000 similar women who were never screened. That amounts to one life saved in the screening group—and hundreds of lives altered, sometimes permanently, by unnecessary treatment and false positives.

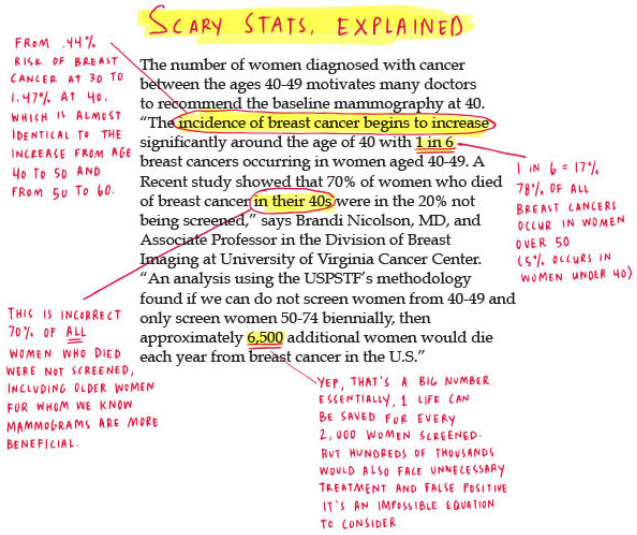
It all comes down to that one life. Odds are it won't be yours, but if it were? That small fraction of a percent would matter to you and everyone who knows you. So who can blame Lee for wanting to have removed the breasts that presumably came to represent

her cancer risk? This is an emotional choice. "Some women will think, 'Fine, I'll do whatever it takes, I'm not going to die of breast cancer,' " Onega says. And how can we judge them for that when any of us might do the same?

If zero American women between 40 and 49 were screened (in reality, about 60% in that age group are screened), that one avoidable death per every 2,000 women would amount to more than 11,000 additional breast cancer deaths over 10 years. That alone is enough to convince a lot of reasonable people that screening is worth it for all women 40 and up. If you're willing to think about it beyond that, here's the impossible equation to consider: If all women ages 40 to 49 were screened, those 11,000 lives would be saved, but at least 220,000 women would experience life-altering, unnecessary treatment and approximately 13 million would receive false positives. The enormity of those numbers is impressive; still, how can you weigh one lost life against many lives forever altered? You can't. So the debate rages on.

This *Prevention* article is clearly not the last word. You, the reader, will undoubtedly continue to encounter scary stats about the risks of not being screened at 40 to 49—or even younger. In fact, the paragraph below just came in to *Prevention's* offices as part of another reported story about mammograms. But our edits reveal the way these stats can be construed to seem more

scary than they actually are:



OK, OK. So What Should You Do Now?

Here's one thing to remember when thinking about your own situation: Many, many cases of breast cancer are treated exactly the same way whether they were caught early via a mammogram or caught by a woman who found a lump in her breast. Skipping out on mammograms if you're under 50 is unlikely to increase your risk of ending up with late-stage breast cancer.

Importantly, this pertains only to women with normal breast cancer risk. The average woman has about a 1 in 8 lifetime chance of ever being diagnosed; about 12.4% of women get the disease. For many of those women whose risk is higher because of genetics or other circumstances, the benefits of starting screening earlier actually outweigh the harms.

Breast cancer risk is most commonly

calculated using what's called the Gail Model (http://www.cancer.gov/BCRISKTOOL), which takes just a minute or two to fill out. It will tell you your 5-year risk of developing breast cancer and your lifetime risk, and compare those to the average risk. The tool takes into consideration known risk factors for breast cancer, like current age, when you started menstruating, when you first gave birth (if ever), family history of breast cancer, personal history of breast biopsies, and race. While that's relatively comprehensive, it still doesn't make the decision of whether to start mammography before 50 easy or clear-cut.

As we wait for refinements to this very sticky decision-making process, communication is a good place to start, Onega says. "'Talk to your doctor' isn't a very satisfying answer to many women," she says, but a doctor can help a woman navigate her known risk factors, which can better inform her decision and help her clarify what her own values and preferences are when it comes to screening.

When you're having that conversation, there are a few things to consider:

- Your personal likelihood of a false positive based on your age and breast cancer risk. Women who undergo regular screening for 10 years starting at age 50 have about a 61% chance of having a false positive (see more stats below). Keep in mind, too, that

between 7 and 10% of women who experience a false positive get a biopsy, which can hurt, be highly stressful, cost money, and still find nothing.

- The percentage of women with your risk at your age who do end up having breast cancer and how many will die from it
- Whether you have dense breasts (http://www.prevention.com/health/mamogram-frequently-asked-questions) and whether they are "extremely" or "heterogeneously" dense, the two types of breast density that increase your breast cancer risk.
- The stats, based on your age:

The Future Of Mammograms Looks Personal

There's clearly room to improve mammography—or at least the process of deciding who gets it and when, says Kirsten Bibbins-Domingo, MD, PhD, vice-chair of the USPSTF. If the task force is going to leave the pre-50 screening decision up to a woman and her doctor, there needs to be a more precise way to determine her personal risk.

MORE: Fight Colon Cancer, Diabetes, And High Cholesterol With...Leftover Pasta? (http://www.prevention.com/food/health-benefits-resistant-starch)

Fine-tuning the process of predicting a woman's breast cancer risk can help her and her doctor decide how big a benefit she stands to gain from early screening,

Bibbins-Domingo says. Scientists are working to pinpoint what factors put women in their 40s at higher or lower risk. A project across the University of California's Athena Breast Health Network, called the WISDOM trial, is enrolling 100,000 women in a 5-year study comparing annual mammography screening with a risk-based approach. "Hopefully what we'll learn is which risk factors are the most impactful when it comes to screening recommendations, and who is at risk for what kind of cancer," Esserman says. "We're trying to get away from that blanket recommendation that applies to everyone, because we know that it doesn't work for all women. We don't treat all breast cancer the same, so we shouldn't screen for it this way either."

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