

**National Screening Advisory Committee (NSAC)**

**National Screening Unit (NSU)**

**Minutes Wednesday 20 October 2021**

Venue	Attendance by video conference	
Start Time	1000	
NSAC members present	Dr Karen Bartholomew Sheila Beckers Pania Coote (Chair) Professor Mark Elwood John Forman Dr Gary Jackson Professor John McMillan Dr Jane O'Hallahan (Deputy Chair) Dr Pat Tuohy	
Other attendees	<b>NSU</b> Anne McNicholas Dr Kerry Sexton Dr Jo Wall Dr Karen McIlhone	
Apologies	Dr Carol Atmore Professor Barry Borman Stephanie Chapman Gerardine Clifford-Lidstone Dr Caroline McElnay Dr Katherine Neas Dr Nina Scott	

Item	Subject and summary
1.	<p><b>Welcome, apologies and introductions</b></p> <p>The Chair welcomed attendees. It was noted the Dr Jackie Cumming's term on NSAC has ended and the Dr Katherine Neas has recently been appointed to NSAC.</p>
2.	<p><b>Declaration of conflicts of interest</b></p> <p>Conflict of interest register tabled (by email).</p>
3.	<p><b>Update on evidence for breast screening women aged 70 to 74 years</b></p> <p>BreastScreen Aotearoa (BSA) currently offers free mammography screening every two years to asymptomatic women considered at average risk of breast cancer aged 45 to 69.</p> <p>NSAC considered an evidence update for screening women aged 70 to 74 years, having last considered the topic at its April 2019 meeting, and were asked to provide their views on the conclusions drawn.</p> <p>Dr Jo Wall summarised recent research findings, updated guidance by international expert bodies and recent moves by jurisdictions comparable to New Zealand to offer screening to women aged 70 to 74 years.</p> <ul style="list-style-type: none"> <li>• <b>A small pool of direct primary studies shows that offering breast screening to women aged 70-74 years reduces mortality and morbidity</b> <ul style="list-style-type: none"> <li>○ One new observational study from Sweden provides evidence for the effectiveness of continuing to invite women to screen up to age 74 years with a statistically significant 20% lower incidence-based breast cancer mortality (95%CI 0.75-0.85).</li> <li>○ The previous studies that provided direct evidence comprise one randomised controlled trial (RCT) of women aged 70-74 years at entry, and three observational incidence-based cohort mortality studies. While the estimates for reduction of mortality from these studies are all in a favourable direction (21-24% from RCT and 4-35% from observational studies), there is some uncertainty around the estimates with wide confidence intervals and results statistically significant for only one observational study.</li> <li>○ The results from the UK Age X RCT to assess the benefits and harms of offering screening to women aged 70 years and over are anticipated in 2026.</li> </ul> </li> <li>• <b>There is limited direct evidence on the potential physical and psychological harms of screening for women aged 70-74 years.</b> <ul style="list-style-type: none"> <li>○ Recent systematic reviews supporting the European Commission Initiative on Breast Cancer Guidelines and the Canadian Task Force on Preventive Health Care have largely extrapolated evidence of harms from adjacent age groups.</li> <li>○ <i>False positives</i>: there was direct evidence from analysis of Canadian breast screening programme or registry data, with fewer false positives and false positive related biopsies in women aged 70-74 years (with less dense breast tissue) compared with younger women.</li> <li>○ <i>Overdiagnosis</i>: no direct data was available for women aged 70-74 years, with recent systematic reviews' risk assessment based on data from younger adjacent age groups.</li> </ul> </li> <li>• <b>There is greater support from international expert bodies for screening women aged 70-74.</b> <ul style="list-style-type: none"> <li>○ Two expert groups have undertaken recent systematic reviews and updated their guidelines. <ul style="list-style-type: none"> <li>○ The European Commission Initiative on Breast Cancer 2019 update recommends mammography screening in the context of organised screening programme for</li> </ul> </li> </ul> </li> </ul>

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	<p>asymptomatic women aged 70-74 years (conditional recommendation, moderate evidence). Their earlier guidance recommended screening to age 69 years.</p> <ul style="list-style-type: none"> <li>○ The Canadian Task Force on Preventive Health Care 2018 update made no change to their earlier 2011 guidelines. These conditionally recommend screening women aged 70 to 74 every two to three years, with the decision conditional on the relative value placed by a woman on possible benefits and harms from screening (very low-certainty evidence).</li> </ul> <ul style="list-style-type: none"> <li>● <b>There is increasing international precedence with comparable jurisdictions undertaking organised breast screening for women aged 70-74 years.</b> <ul style="list-style-type: none"> <li>○ Organised population-based screening is offered to women up to 74/75 years in Australia, all Canadian provinces (with exception of Quebec), France, Netherlands, and Sweden.</li> <li>○ Following the publication of the updated European Commission Initiative on Breast Cancer guideline in 2019, a wider range of European countries with population-based screening now have eligible screening up to age 74 years including Germany, Norway, Denmark, and Estonia.</li> <li>○ The notable exception is the UK, where women are invited up to 70 years, but can request to be screened three-yearly if 70 years or older.</li> </ul> </li> </ul> <p><b><i>In discussion NSAC members noted the following</i></b></p> <ul style="list-style-type: none"> <li>● Framing of the evidence update should lead with the research evidence (favourable but still limited for the older age group), followed by the recent general trend for international bodies and countries with population-based screening programmes to support screening women aged 70-74 years.</li> <li>● It is known that screening is effective in the younger age groups studied extensively, with the trials restricted to those aged 50-69 years for practical/logistical reasons.</li> <li>● There is no biological reason that screening would not be effective in the older age group.</li> <li>● There is no scientific evidence and no ethical reason not to extend the age range, with the issue one only of economics.</li> <li>● The original trials were 20 or more years ago and since then life expectancy has increased considerably, increasing the potential gains from screening women aged 70-74 years.</li> <li>● Evidence supports screening older age groups, and this age group are less likely to be misdiagnosed (fewer false positives).</li> <li>● While New Zealand's screening criteria need to be met to support a change in age eligibility, it is reasonable to extrapolate the benefits and harms of screening from younger age groups.</li> <li>● While waiting for the Age-X trial results, a proportionate approach akin to the UK is possible, where screening could be available to women over 70 years on their request, with individual consideration of benefit (competing health issues/clinical benefit/life expectancy). However, this approach is not viewed as equity driven, for example, the equity gap risks widening further as non-Māori non-Pacific women aged 70-74 years would likely displace bookings for younger Māori and Pacific women. An individual choice is an easier approach in Europe, less so in Aotearoa New Zealand.</li> <li>● Broader equity issues are also of concern, including: <ul style="list-style-type: none"> <li>○ there is greater benefit and equity gain from increasing screening in Māori and Pacific aged 45-69 years and that this needs to be the priority for breast screening</li> <li>○ the Māori Monitoring and Equity Group (MMEG) has previously expressed the view that the focus should be on addressing inequities that already exist in younger age groups</li> <li>○ the ongoing impact of COVID lockdowns on the BSA programme</li> <li>○ discomfort with the fairness of an extension to the BSA screening age group in the absence of other screening priorities being delivered (eg, bowel screening age extension for Māori and Pacific; and non-invasive prenatal testing (NIPT) for Down syndrome.</li> </ul> </li> </ul>

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	<ul style="list-style-type: none"> <li>• Issues related to the BSA register: <ul style="list-style-type: none"> <li>○ the current register is old and unstable so cannot incorporate an additional age group</li> <li>○ a new register is under development with completion approximately two years away</li> <li>○ any age range change requires full register functionality to provide the safety net that helps ensure women progress appropriately along the screening pathway.</li> </ul> </li> </ul> <p><b>NSAC conclusion</b></p> <p>The assessment of the evidence for screening women aged 70-74 years should be framed favourably.</p> <ul style="list-style-type: none"> <li>• While there is still limited primary direct evidence for both benefit and harms, it is biologically plausible to extrapolate benefits from younger adjacent age groups.</li> <li>• There is growing support from international expert bodies.</li> <li>• There is increasing international precedence amongst jurisdictions comparable to New Zealand</li> </ul> <p>In addition, concerns should be noted around the potential impact of age extension on equity, particularly the risk of widening the equity gap for Māori and Pacific women; and the demands on the BSA programme as it attempts to catch up screening volumes in the face of COVID pandemic impacts.</p>
4.	<p><b>Up-date on atrial fibrillation (AF) screening pilot</b></p> <p>AF screening was undertaken as part of the abdominal aortic research programme at Waitemata DHB and Auckland DHBs. NSAC considered the research findings at its 12 May 2021 meeting and concluded that AF screening does not meet the New Zealand criteria for a national screening programme.</p> <p>The research findings presented at the May 2021 meeting included that there was a lower proportion of anticoagulant prescribing three months after newly diagnosed AF than might have been expected, with Māori lower than non-Māori (40% vs 50% respectively). The reason for non-prescription of oral anticoagulants was not clear, therefore an audit was developed for further exploration.</p> <p>Karen Bartholomew presented a summary of the audit findings. These confirmed the low prescribing of anticoagulants (33%) and inadequate GP follow-up in a high proportion of cases (55.6%).</p> <ul style="list-style-type: none"> <li>• For those not on appropriate anticoagulants, a small number of important subsequent clinical events were noted.</li> <li>• The reasons for poor follow-up were not clear. Lack of knowledge of best practice guidance on AF management appeared to be part of the issue, as was management of results and follow-up.</li> </ul> <p>The research team are considering the findings for the project reporting and recommendations for extension of the programme going forward, noting:</p> <ul style="list-style-type: none"> <li>• the sub-optimal general practice management of new AF</li> <li>• that opportunistic screening in general practice without a screening programme monitoring function (follow up for anticoagulant treatment) would be problematic, particularly from an equity perspective</li> <li>• primary care education and support for best practice management is recommended.</li> </ul> <p><b>NSAC discussion included:</b></p> <ul style="list-style-type: none"> <li>• while there is no target for anticoagulant treatment of AF, 40-50% is clearly too low (80% would likely be the best achieved given context of what is seen with statin treatment)</li> <li>• clearly there is an issue related to quality of care, with avenues to address this through the College, communications, education, guidelines and further integration of CVD risk assessment tools.</li> </ul>

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	<ul style="list-style-type: none"> <li>systematic racism is evident, manifested both through structural access to primary care and medication, and personal communications.</li> </ul>
5.	<p><b>Other business</b></p> <p>HPV self-sampling study (cervical screening) update</p> <ul style="list-style-type: none"> <li>Karen Bartholomew noted that during an Auckland-metro HPV self-sampling study, women returned their swab during the current COVID lockdown, with excellent uptake of home-based self-sampling during this period. The full study results are currently being analysed.</li> </ul>
6.	<p><b>Meeting dates:</b> Next meeting likely to be during March 2022</p> <p>Meeting closed at 1100hrs.</p>