EDITORIAL

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Breast Cancer Screening: What Are the Areas for Improvement in France?

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In France, as in countries worldwide, breast cancer remains a major public health concern, with approximately 62,000 new cases and 12,000 deaths annually. Despite undeniable therapeutic advances, breast cancer treatments remain intensive and lengthy, involving surgery, radiation therapy, chemotherapy, immunotherapy, and targeted therapies in various combinations.

The prognosis for breast cancer depends on several factors, including age, disease stage at diagnosis, and breast tumor biology. Since the biological aggressiveness of cancers cannot be changed, the only ways to reduce the risk of death from breast cancer are primary prevention, women's education (1), and detection of cancer at the earliest possible stage, which is the goal of screening. The expected benefits of this screening include not only reduced mortality but also reduced treatment intensity and duration.

Following an initial phase of pilot projects launched in several French departments starting in 1989, organized breast cancer screening (OBCS) was expanded to all French departments in 2004. Women aged 50 to 74 are currently invited every two years to undergo a dual-view mammogram combined with a clinical examination and, if necessary, a breast ultrasound, with 100% of the cost covered by health insurance. Moreover, the inclusion of tomosynthesis mammography in OBCS is possible under certain conditions (2). The figure explains the French OBCS workflow in which second reading is limited to mammograms initially classified as BI-RADS 1–2.

This OBCS faces competition from so-called "individual" screening because it is conducted outside the framework established by public authorities. Compared to individual screening, the OBCS provides equal access for all women and double reading of mammograms by two radiologists (7 to 9% of cancers are identified during this second reading), and has other advantages, such as quality control of equipment (particularly dosimetry) every six months. Furthermore, prospective data collection permits precise evaluation of OBCS programs, which is not possible with individual screening. Numerous OBCS programs have demonstrated a significant reduction in treatment burden and mortality. For example, among women aged 50 to 69, invited women experienced a 23% reduction in mortality, while participating women experienced a 40% reduction. A significant reduction in mortality is also observed among women aged 70 to 74 (3).

Despite highly significant results in favor of OBCS, numerous debates and controversies surrounding this screening—particularly regarding the risks of overdiagnosis and overtreatment—continue among the public, media, and medical

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community, contributing to declining participation rates. These rates stand at approximately 44% in France. However, it has been demonstrated that, to reduce mortality rates at the population level, participation rates in this screening must be sufficiently high, exceeding 70%. Three approaches are currently being explored to increase participation rates in the OBCS in France.

First, access to OBCS in France varies widely: some regions are well-equipped with mammography units and have many radiologists, whereas in others, women face wait times of several months before they can have a mammogram and may need to travel far from their homes. This shortage of radiologists requires special attention from public authorities, and corrective proposals are needed. For example, artificial intelligence could be used to filter out cases deemed normal following an initial human review. At this stage, and based on existing studies (4), the role of artificial intelligence in OBCS has not yet been completely defined, but it may prove useful in sorting cases so that only those having a doubtful lesion are forwarded to the second reader, which would save time and improve efficiency. The MASAI study estimated a 44% reduction in workload. According to the Île-de-France Regional Cancer Screening Coordination Center, up to two-thirds of mammograms could therefore be excluded from the second reading, increasing radiologists' availability.

Secondly, socially disadvantaged or vulnerable individuals are less likely to participate in OBCS. Initiatives bring services directly to women, offering them mammograms, often via mobile screening units. However, major concerns are often raised: the absence of a radiologist in the mobile unit, the inability to perform ultrasound or core biopsies if abnormalities are detected, and the risk of loss to follow-up for women with positive test results. Moreover, it has been demonstrated that mobile screening units incur significant costs while serving a small number of beneficiaries. In this context, the implementation of so-called "aller-vers" ("Go to") initiatives has become a priority for French public authorities. This term refers to moving away from a passive, wait-and-see approach and toward active outreach to target populations. The goal is to mobilize all available resources to combat inequalities, with a focus on screening and prevention. When applied to OBCS, the concept of "aller-vers" involves "going to" the women concerned to facilitate the screening process (for example, providing free transportation to go to a radiologist, facilitating care for patients with a physical, sensory, or mental disability, or offering assistance in cases of language barriers...). Adapting communication methods with healthcare professionals and civil society, notably toward socially disadvantaged, vulnerable individuals or elderly women, will probably help increase participation rates.

Third, consideration should be given to modifying the OBCS age groups. Currently, of 23 European countries, four (Albania, Iceland, Sweden, and Türkiye) offer OBCS starting at age 40, and four others (Austria, Cyprus, Hungary, and Portugal) offer OBCS starting at age 45. Based on a review of the literature, the European Union has proposed that screening start at age 45 (European guidelines produced by the European Commission Initiative on Breast Cancer). In France, the Health Authority examines the advisability of lowering the age for OBCS to extend it to women aged 45–49 who have no risk factors other than age. The same evaluation will focus on women aged 75 to 80. The future results of MyPeBS study (5) will be also useful to validate these changes. Final decisions are expected next year.

Modernizing the French OBCS is likely to increase participation rates. In this context, it is important to take into account socio-economic inequalities; the potential benefit of artificial intelligence within the screening program, which the French authorities call for planning and regulation; and the necessity to personalize OBCS, notably age.

Footnotes

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