HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

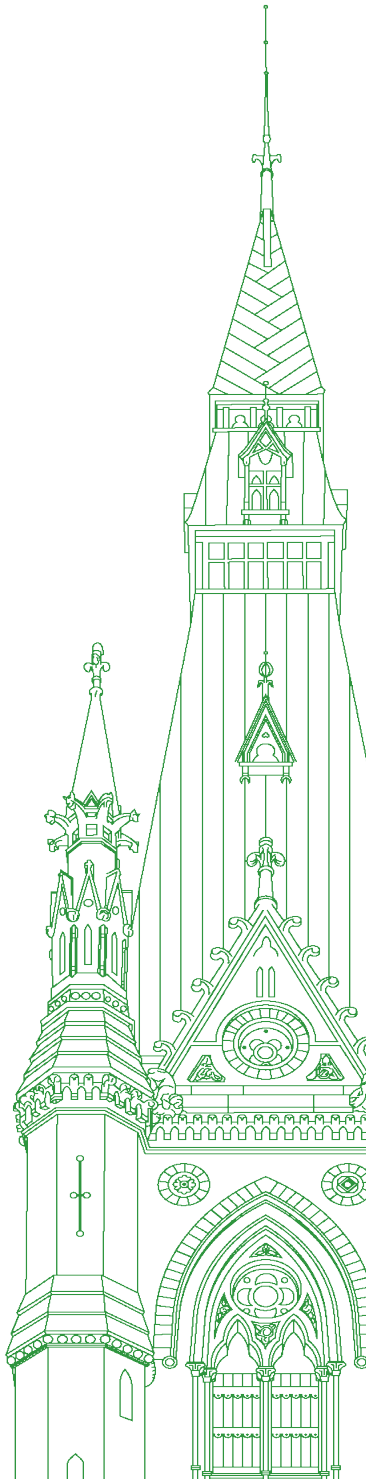
44th PARLIAMENT, 1st SESSION

Standing Committee on Health

EVIDENCE

NUMBER 122

Monday, June 10, 2024



Chair: Mr. Sean Casey

Standing Committee on Health

Monday, June 10, 2024

● (1700)

[*English*]

The Chair (Mr. Sean Casey (Charlottetown, Lib.)): I call this meeting to order.

Welcome to meeting number 122 of the House of Commons Standing Committee on Health.

Before we begin, I'd like to ask all members and other in-person participants—

[*Translation*]

Mr. Luc Thériault (Montcalm, BQ): Point of order, Mr. Chair

I'm not getting interpretation. The sound isn't loud enough. I've got the volume three quarters of the way up right now and I can't hear the interpretation.

The Chair: We're going to try to fix the problem.

Is it better?

Mr. Luc Thériault: No. I have to turn the volume up to 10 to hear. It's dangerous.

The Chair: I see.

We are going to suspend the meeting while we fix the issue.

● (1700)

_____(Pause)_____

● (1705)

[*English*]

The Chair: I call the meeting back to order.

Once again, welcome to meeting number 122 of the House of Commons Standing Committee on Health.

Before we begin, I'd like to ask all members and other in-person participants to consult the cards on the table for guidelines to prevent audio feedback incidents. Please take note of the following preventative measures in place to protect the health and safety of all participants, including the interpreters. Please use only the black, approved earpiece. The former grey earpieces must no longer be used. Please keep your earpiece away from all microphones at all times. When you're not using your earpiece, please place it face down on the sticker placed on the table for this purpose.

Thank you for your co-operation.

In accordance with our routine motion, I'm informing the committee that all remote participants have completed the required connection tests in advance of the meeting.

Pursuant to Standing Order 108(2) and the motion adopted on April 11, 2024, the committee is commencing its study of breast cancer screening guidelines.

I'd like to welcome our panel of witnesses.

We have, appearing as an individual, Dr. Michelle Nadler, breast medical oncologist and implementation scientist; representing Breast Cancer Canada, Kimberly Carson, CEO; representing the Coalition for Responsible Healthcare Guidelines, Dr. Shiela Appavoo, chair; and representing Dense Breasts Canada, Dr. Paula Gordon, volunteer medical adviser, clinical professor at the University of British Columbia.

To all of our witnesses, thank you for bearing with us. We had some technical difficulties and votes that caused the start to be delayed. We have resources until 6:30 eastern. That's when we will adjourn.

I understand Ms. Carson has another obligation that will require her to leave at 5:30, so we're going to start off the opening statements with Ms. Carson to make sure that we get it in.

Ms. Carson is here on behalf of Breast Cancer Canada.

Welcome to the committee. You have the floor.

● (1710)

Ms. Kimberly Carson (Chief Executive Officer, Breast Cancer Canada): Thank you.

Thank you very much for having me here and for the opportunity to speak on the important topic that this is.

My name is Kimberly Carson, and I'm the chief executive officer of Breast Cancer Canada.

Breast Cancer Canada is the only national organization that's clearly focused on funding breast cancer research, and we've been doing that since 1991. We advocate for more funding in breast cancer research and diagnostics and precision oncology, and certainly the task force recommendation on May 30 is of great concern to us.

Despite calls from patient advocates like me at Breast Cancer Canada and from health care providers and patients across Canada to lower the age of the systematic breast cancer screening program to 40, the task force remained with the guidelines of 50 to 75. Obviously, we have a number of research projects that go against this recommendation.

We believe that the screening should be lowered to a lower age because we know for sure that detecting it early saves lives. When it's detected early and it hasn't spread—it has not become metastatic—the five-year relative survival rate is close to 99%. Making that diagnosis at an earlier age and stage, and not delaying treatment, obviously increases the survival rate.

The other thing I would like you to consider is that there are many populations where the risk is even higher at a younger age, including Black and Hispanic women. For example, triple-negative is one of the more aggressive forms of breast cancer and tends to be at higher rates in Black and Hispanic women, and certainly younger, at 10% to 20% of the diagnoses. The other consideration is women with dense breasts, who are obviously more at risk with a delayed diagnosis and less chance of MRI screening.

All of this leads to a burden on the health care system.

There are steps we could take certainly to reduce that burden. An earlier diagnosis reduces the number of systemic treatments, the complexity of the treatments, the repercussions, the overtreatment with chemotherapy, surgery and radiation.

For patients who receive stage three or stage four therapy, their therapy will go on over a longer period of time and has a greater impact—greater disability—as opposed to women who would perhaps be diagnosed at a younger age and an earlier stage, where they could go back into the workforce or remain employed at the same time and continue to care for their families and contribute to society.

Certainly, earlier screening at the age of 40 is going to play a very important role for those health outcomes for our patients across Canada.

We also see some inequities in breast cancer screening. There are a number of provinces where the screening is at 50, which makes it inaccessible for women at a lower age, but then we see some provinces where they can self-refer into a program at a younger age.

The other thing I would add is that women need to be prompted and reminded that they're not health care professionals and it's certainly up to the task force to recommend the screening age.

The other thing Breast Cancer Canada would like to see is review in a more timely manner. There are new therapies and new novel treatments coming out. Right now, we're talking about mammography and screening, but in the future there will be things like blood tests and new technologies. We certainly would like to see that timing get a little quicker—at least once every two years—so that we would have the opportunity to take advantage of all of the new breakthroughs in technology that we have.

We have some amazing breast cancer researchers right here in Canada, and we should really be listening to what they have to say to help us provide that quality and equity across Canada and help to save more lives through breast cancer research.

Thank you very much for your time, and thanks for taking a moment to listen to me.

The Chair: Thank you, Ms. Carson.

Next is Dr. Michelle Nadler, breast medical oncologist and implementation scientist.

Welcome to the committee. You have the floor.

Dr. Michelle Nadler (Breast Medical Oncologist and Implementation Scientist, As an Individual): Thank you for the opportunity to present to the committee today, and thank you for taking the time to review an issue so important to women's health.

I'm a breast medical oncologist in Toronto. I speak with patients and their families about breast cancer every single day, and I see how this disease and its treatment impacts them. We are all committed to ensuring the best possible outcomes for women and for people with breast cancer.

My academic focus is in knowledge translation or guideline implementation. Through this work, I was invited to participate as a knowledge expert on the task force. The 2024 draft guidelines state as follows:

> Breast cancer screening is a personal choice.
>
> Women aged 40 to 74 should be provided information about the benefits and harms of screening to make a screening decision that aligns with their values and preferences. If someone in this age range is aware of this information and wants to be screened, they should be offered mammography screening every 2 to 3 years.
>
> This information should be accessible and shared in absolute numbers. It should include how age, family history, race and ethnicity, and breast density (if known) may impact the benefits and harms of screening.

The task force invited four experts: a medical oncologist, a radiation oncologist, a radiologist and a breast oncology surgeon. There were two to three patient partners. All provided input on the three main systematic review questions: inclusion criteria for each study, outcomes of importance and protocols. Randomized trials and observational and quasi-experimental studies were included.

The task force investigated, among others, the following outcomes: breast cancer mortality, stage distribution and treatment morbidity. We often hear about the benefits of early detection. We are told that if we can find cancer earlier, there is less chance of death from breast cancer or less intensive therapies. It might be surprising, but early detection is not always necessarily an assurance of either of these. More and more, we know that the biology of disease or how aggressive the cancer is factors into prognosis.

Outcomes of harms, including additional testing showing no cancer and overdiagnosis, were also looked at. Overdiagnosis means the biopsy-proven detection of a pre-cancer or cancer that would otherwise never have caused the individual any symptoms or problems in their lifetime. This occurs for older women and is also well documented in younger women.

All studies that met inclusion criteria and additional studies submitted to the portal were reviewed by the evidence synthesis team. The team included two radiology experts and a GP-oncologist. All studies were rated for certainty, i.e., how likely they are to represent the truth, through something called the GRADE methodology. Once the data analysis was completed, the evidence was displayed to our working group, and we reviewed and discussed the data.

In key question three, the task force undertook a systematic review related to the values and preferences for women ages 40 to 74 for screening. This showed that the majority of women aged 40 to 49 felt that the harms outweigh the benefits for screening; however, members of the task force working group agreed that there is large variability in women's values.

The task force met separately to look at the evidence in totality, looking at all included study results and comparing them. One of the criticisms of the task force is that certain studies were not considered. It is normal in the scientific method of a systematic review to question why some results are outliers compared to others. This does not mean that they are dismissed. The task force cannot base its recommendation on only one or two studies; they must look at the evidence in totality.

Everything above that I have stated are the facts as I know them. To be clear, what follows is my personal opinion.

I think it is commendable to have guidelines state specifically that personal risk factors, benefits and harms should be clearly communicated to women to inform a decision and that the decision they make should be respected.

The alternative suggested by many critical of the task force is to systematically screen all women starting at 40. I have concerns that this is not respectful to the range of values that different women hold about the benefits and harms of screening. Some women will want to screen, and others won't. Both sets of values should be respected.

I went into this process with an open mind of what the data would demonstrate. I truly believe that the task force went into this with open minds as well. The science shows us that there are both benefits and harms to breast screening. In individuals not at high risk, there is equipoise and substantial uncertainty. There is more uncertainty than the public may think.

● (1715)

Sometimes science gives us an answer we didn't expect or we don't want, but we should still listen to it. In medical practice, when there is close equipoise or uncertainty, the best thing to do is have a shared discussion with each individual patient in front of us and respect their decision.

Thank you.

The Chair: Thank you, Dr. Nadler.

Next, representing the Coalition for Responsible Healthcare Guidelines, we have Dr. Sheila Appavoo. Thank you for being with us.

You have the floor.

Dr. Shiela Appavoo (Chair, Coalition for Responsible Healthcare Guidelines): Thank you for having me.

Honourable members of the health committee, thank you for convening this important study with such urgency.

I'm Dr. Sheila Appavoo, a general radiologist with an interest in breast imaging. I chair the Canadian Society of Breast Imaging's patient engagement working group. I also founded and chair the Coalition for Responsible Healthcare Guidelines.

I speak today about my serious concerns about the recent draft guidelines issued by the Canadian Task Force on Preventive Health Care regarding breast cancer screening, which recommend against screening women aged 40 to 49.

These guidelines stand in stark contrast to those provided by the U.S. task force, the Canadian Cancer Society and the majority of Canadian provinces, all of which have recognized the need to lower the screening age to 40. The Nurse Practitioner Association of Canada has also recently withdrawn its endorsement of the similar 2018 task force guidelines.

The task force decision not to routinely screen women aged 40 to 49 is biased. This stance was seemingly predetermined. The task force leadership indicated in the media in early May 2023 that there was no need to change the Canadian guidelines. This was before the evidence review began. Lo and behold, this prophecy was fulfilled almost exactly a year later.

How does the task force come to such different conclusions from the rest of the modern world? Without the context provided by the fulsome guidance of experienced content experts, they amplify harms, such as overdiagnosis and callbacks for additional imaging, and they minimize the benefits of early detection. One rarely hears the task force discussions mentioning the lives saved or mastectomies prevented by screening.

The U.S. task force has acknowledged and acted on the increasing incidence of breast cancer and racial disparities. Canadian research has found similar trends here at home, and the Canadian task force even acknowledges higher mortality in Black women in their forties, but fails them in its guidelines by begging off on a lack of evidence and abandoning common sense and the precautionary principle.

In every racial group except white women, breast cancer starts to peak in the forties, yet the task force makes little attempt to accommodate these groups. While acknowledging the influence of race, ethnicity, family history and breast density, the task force has minimized these important individualizing issues.

One of the misconceptions of the task force is that improved life expectancy is attributable to better treatment, with an implication that treatment is a substitute for early detection. This is problematic. Women with an early-stage diagnosis are far more likely to live out their full lifespan with less of the aggressive treatment, existential dread and generational trauma of a woman and her family dealing with a late-stage cancer diagnosis. Simply put, women with smaller, less advanced tumours tend to live longer and better-quality lives, and screened women tend to have smaller tumours than non-screened women.

It has been mentioned by some task force members that screening should be limited to control costs. This is a false economy. Screening is an investment, considering the cost of modern treatment. Work done by researchers in Ottawa has demonstrated that by screening annually from age 40 to 74, Canada would save around $460 million annually. The cost of treatment far outweighs the cost of screening. We cannot afford not to screen.

If instituted, the consequences of these new task force guidelines will be dire. Many young women will potentially pay with their lives. Most provinces and territories have recognized this and have allowed self-referral for women aged 40 to 49. However, the recommendation of a primary care provider is still the strongest predictor of whether a woman will actually go for screening. As long as doctors are being given the task force message that women in their forties don't need screening, many of those women won't get access.

By continuing to make the same recommendation that the task force has made since 2011, Canada's national guideline is falling further and further behind the provinces, other countries and expert recommendations. This has led to patchwork access for women across the provinces. Unfortunately, these guideline problems are not isolated to breast screening; they are part of a pattern seen in multiple other guidelines during the past 15 years of the task force's existence.

We must not allow these guidelines to stand as they are. We must have guidelines that are informed by the latest evidence and that truly serve the best interests of Canadians. With respect, looking at its record, we must dismantle and rebuild this task force.

Thank you very much for your attention to this issue.

● (1720)

The Chair: Thank you, Dr. Appavoo.

Finally, representing Dense Breasts Canada, we have Dr. Paula Gordon.

Welcome back, Dr. Gordon. You know the drill and you have the floor.

Dr. Paula Gordon (Volunteer Medical Advisor, Clinical Professor at University of British Columbia, Dense Breasts Canada): Thank you.

Honourable health committee members, the Canadian task force understates the benefits of screening, but they are obsessed with what they call the harms. They recommend against screening women in their forties, even though women aged 40 to 49 are 44% less likely to die of breast cancer if they have mammograms. They recommend against supplemental screening for women with dense breasts, even though many more invasive cancers would be found earlier if it were used.

I'll explain what they think the harms are. Even that term is misleading. They really are the risks or limitations.

The first is the anxiety women experience if they are recalled for additional tests after a screening mammogram and are not found to have cancer. Only about 5% of recalled women are diagnosed with cancer. That anxiety is real, but it's transient, and it pales in comparison to the anxiety a woman feels if she learns that she has an advanced cancer and that she faces the possibility of death or at least months of surgery, radiation and chemotherapy, which might have been avoided had her cancer been found earlier.

The task force gives false equivalence of this anxiety to delayed diagnosis and advanced cancer. The task force also disproportionately focuses on overdiagnosis. You just heard that this is the theoretical possibility in which a woman is diagnosed with cancer and is treated for it but dies of another cause sooner than her breast cancer would have killed her. For example, she may die of a heart attack sooner.

Overdiagnosis is much less common in younger women. They're less likely to die of other causes, and their cancers are more aggressive than are those in older women, so they grow and spread faster if untreated. In women in their forties who get breast cancer, breast cancer accounts for 91% of their deaths, but in women in their seventies, it accounts for only 48%.

Cancers do not regress if they're left untreated. They may grow quickly or slowly, but given time they will spread and kill. Doctors Wilkinson and Seely, working with Stats Canada, showed that after screening of women in their forties was stopped in response to the task force recommendations in 2011, the rate of metastatic cancer went up by 10% for both women in their forties and those in their fifties.

Overdiagnosis is only important if it leads to overtreatment. With current testing and rapidly advancing research on predicting how a given cancer will behave, oncologists can offer less aggressive treatment for some cancers, but if women choose not to be screened because of the task force's emphasis on overdiagnosis, they lose the opportunity to find their cancers early and save lives.

In their 2018 review, the task force said that the rate of overdiagnosis was 48%, based mainly on an old, flawed Canadian study that has been discredited. For the current review, overdiagnosis was 11% when that discredited study was included but only 6% when it was excluded. That 48% rate included in the decision tool created by the task force and used in shared decision-making may well have been responsible for countless deaths.

Screening is not perfect. Women should be told about the risks of being recalled and overdiagnosis, but they should not be discouraged from screening. Some members of the task force say that screening is less important because treatment is getting better, but it's not a contest. Screening and treatment are synergistic. Cancer can be treated more effectively and less aggressively when it's found earlier.

Of course, there are anecdotal studies of women with early cancer who didn't do well and women with stage three who did do well. However, it's like hearing stories about people who smoked all their lives and died at age 95 without developing lung cancer. Reliable data trumps outlier stories.

Some members of the task force claim that screening can't save the lives of women with rapidly growing cancers. That's not true. Stats Canada has shown that when triple negative cancer is detected at stage one, the five-year survival is 96%, but at stage four, it's only 7%. The stage of diagnosis does matter, and it's about more than just saving lives. Chemotherapy can often be avoided when cancer is found early. Most patients with stage one cancer don't need chemo. Most patients with stage two and higher do need it. The stage of diagnosis does matter.

Early detection also allows for less aggressive surgery—lumpectomy instead of mastectomy, sentinel lymph node biopsy versus axillary dissection. The traditional armpit surgery to sample lymph nodes leads to permanent swelling of the hand and arm in about one-third of women. The stage of diagnosis does matter.

To sum up, the science is clear: Screening finds cancer at a lower stage, improves the quality of life for women with cancer and saves more lives. The alleged harms are not reason enough to deny or discourage women from the opportunity for early detection. If screening is not offered starting at age 40, it will be inaccessible for many women. No one is going to force a woman to have screening, but she needs to have the choice whether to attend.

● (1725)

Thank you very much.

The Chair: Thank you, Dr. Gordon.

That concludes our opening statements.

We're now going to begin with rounds of questions starting with Ms. Goodridge, please, for six minutes.

Mrs. Laila Goodridge (Fort McMurray—Cold Lake, CPC): Thank you, Mr. Chair.

I want to thank all the witnesses for being here today and providing their testimony.

This is such an important study. It's wonderful that we were able to get to it so quickly, especially in light of the updated guidelines coming out, which I don't believe hit the mark by any stretch of any imagination.

Dr. Gordon, as an expert in the field, do you believe women have the capacity and capability to decide for themselves whether or not to get breast cancer screening?

● (1730)

Dr. Paula Gordon: Yes, I believe women are capable. It's patronizing for the task force to make a decision for women. If given the correct information, which is not currently in the decision tool, and given it in multiple different ways, women can make the decision for themselves. The task force plays down the benefits by using absolute numbers. They say how many women in 1,000 will benefit, for example, and they make it sound like there's not a big difference between one in 1,000 or two in 1,000. However, if you multiply that by the number of women in that age group in the country, you'll find there could be 400 to 600 fewer deaths every year in Canada if women in their forties were allowed to attend. I think women know what that means.

Mrs. Laila Goodridge: Thank you. I appreciate that.

My mom was diagnosed with breast cancer when she was 48 years old. She passed away from breast cancer at 49 years old, leaving behind four kids. I was the oldest, and that put a huge strain on all of us. If I were to have the same symptoms right now, the fact that I would have to argue with a doctor to try and get screening seems, to me, absolutely insane.

What are the benefits of early diagnosis, Dr. Gordon?

Dr. Paula Gordon: With early diagnosis, women can have better treatment that's effective. They can have a lumpectomy, for example, instead of losing a breast with a mastectomy. The way they do the lymph node staging is also less aggressive. It's called a sentinel node biopsy. Compared to the traditional method, which left about a third of women with permanent swelling in their hand and arm, with the less aggressive sentinel node biopsy, the likelihood of lymphedema is as low as 2%. They can function much better if they can avoid chemotherapy, which is possible depending on the biology and the stage of the tumour.

For some women, having chemotherapy is the worst part of breast cancer, and to be able to avoid it is a huge benefit. Then they can go to work while they're being treated and continue to care for their children and, in some cases, look after aging parents. They're contributing to the economy.

Mrs. Laila Goodridge: Thank you.

I'm now going to ask a really broad question, and it's for all of the panellists, perhaps starting with Dr. Appavoo.

If you could write screening guidelines today, what would your screening guidelines be?

Dr. Shiela Appavoo: As a matter of fact, I have notes on that.

Mrs. Laila Goodridge: Wonderful.

Dr. Shiela Appavoo: I have an opinion about everything.

What we want is to start at 25 to 30 asking a few questions of the women about family history so we know if that person needs to be on a high-risk channel to start with early in the game so that we're not finding out by accident they really should have been.... What is horrible is when we see women who get cancer and they're discovered with a late-stage diagnosis even in their thirties, sometimes even before they're eligible for screening, but once you talk to them you realize they had a really strong family history and they should have been getting screening all the way along.

Of course, I can't find my notes on this, but we would like to see annual screening from 40 until the person has under 10 years of life expectancy. That is shown, with modelling and with evidence, to save the most lives and to have the fewest treatment harms.

What we also would like to see is anybody who has dense breast tissue being offered supplemental screening with either ultrasound or MRI—most commonly ultrasound, but patients with very dense breast tissue should get MRI screening. In Europe, they're starting to do this.

That's about it.

Mrs. Laila Goodridge: Wonderful.

Dr. Shiela Appavoo: Dr. Gordon might have something extra to add there.

Mrs. Laila Goodridge: I see that Kimberly Carson has to leave.

Kimberly, could you perhaps provide us with your recommendations?

● (1735)

Ms. Kimberly Carson: Yes. Thank you so much, Laila.

Obviously, Breast Cancer Canada would like to see the age lowered to 40 for all the reasons that both the doctors recommended. I think at the age of 40, although women can make up their mind, it is about that prompt. This is what we hear from the patients every day. They say they got the letter in the mail, or their doctor said they now qualify, and then they went and had that mammogram done. It catches something at a very early stage. We speak to those patient advocates on a daily basis and we hear that frequently.

In terms of providing them with the opportunity to be screened at the age of 40, and certainly profiled as to whether they should even be screened at a younger age because of family history, we would definitely be advocating for that and for asking the task force to please lower that age to 40.

Certainly, when we have more technology available in the future, we'll have a better opportunity to offer more technology and more treatment options for women at a younger age.

The Chair: Thank you, Ms. Carson and Ms. Goodridge.

Next we have Ms. Kayabaga for six minutes, please.

Ms. Arielle Kayabaga (London West, Lib.): Thank you, Mr. Chair.

I also would like to extend many thanks to our witnesses.

Perhaps I can start with Ms. Carson, because I know she has to leave us soon.

In your opening remarks, you talked about Black and Hispanic women and the disparities in breast cancer and early screening for them. Do you think there's sufficient data available to be able to make any suggestions on practices for Black, Hispanic and indigenous women?

Ms. Kimberly Carson: I think there's a lot of research data. There is perhaps some shortage of some data in Canada due to the fact that we haven't always tracked ethnicity. We do now. Certainly, to the south of us there are a number of research studies. I would encourage the task force to take a look at those.

I think we need to pay more attention moving forward as well. We certainly see the risks in Black and Hispanic women at a younger age with certain types of breast cancer, the triple-negative, as I mentioned. I would like to see, as we were talking about earlier, the opportunity for women to have that profile done with their family doctor or their primary caregiver if they are at higher risk. Is there a family history? Are they at a higher risk because of the ethnicity as well?

Those all should be added in together. Perhaps even at the age of 30 they should be looked at.

Ms. Arielle Kayabaga: Last year, in February 2023, a report came out, which I think the CBC reported on. The study found that members of Black communities were less likely to get screened for cancer. As a result, they have increasing mortality rates.

What are the best practices for making decisions about screening in situations where we know there's a community that is likely to have a higher rate of death because of less access to screening?

Perhaps Ms. Carson could quickly answer and then Dr. Gordon.

Ms. Kimberly Carson: Certainly.

I don't think they have less access to screening. I think we need to do everything to encourage every woman who has access to be screened. I also believe there should be an opportunity for women of Black and Hispanic descent to have a more in-depth review of their family history and the opportunity to be encouraged to screen.

Again, if we have the screening and detection lowered to the age of 40, would that catch more cases? Would they have that availability to say, oh, this something I'm supposed to get done at the age of 40 as opposed to waiting until the age of 50?

Ms. Arielle Kayabaga: This is actually through a study that was released last year. It is proven that they have less access to screening.

I'll go to Dr. Gordon to see what she has to say. She looks like she has a lot to say on this.

Dr. Paula Gordon: Thank you.

The first point I want to make is about family history, as you've heard a couple of times. It's very important that everyone understand that—sit down for this one—85% of women who get breast cancer have no family history. Women are at increased risk if they do, but that's not the only risk factor. The other omission has been that Black, Asian and Hispanic women especially are at risk of developing cancer younger, but there are other groups who are at high risk, like Ashkenazi Jewish women.

The reason that mortality is so terrible in Black women is that they're at a much higher risk of getting these rapidly moving triple-negative cancers. For that reason, Black women are 40% more likely to die if they do get breast cancer.

Those are the aggressive, fast-moving cancers. The way to find them as early as possible is not only to do the mammogram every year, but if a woman has dense breasts—and that's more common in Black women—they should also get supplemental screening. Whether that's with ultrasound or MRI should depend on their actual risk level, which can be determined with online risk calculation tools that are easily accessible with just a few questions.

A Black woman with dense breasts and a family history is probably going to be at a high enough risk to justify not only screening her younger, but screening her more often and with better technology, like MRI.

● (1740)

Ms. Arielle Kayabaga: Dr. Nadler, did you also want to add some comments?

Dr. Michelle Nadler: Thank you.

Just to clarify, the overall incidence of breast cancer in the Black community is less than average, but it does occur younger and the prognosis is poorer, as you said.

I also want to reach out to Laila and say that I'm absolutely so sorry that this happened to you. What we don't know is whether screening would have changed that outcome or not. We simply don't know. Screening helps some people, but it doesn't help everybody.

A second point—

Ms. Arielle Kayabaga: Thank you.

I have a short amount of time, so I just want to get through some of my questions.

In December 2023, Dr. Anna Wilkinson told the committee “non-white women—Black, indigenous, Chinese, South Asian, and Filipina—have a peak age of breast cancer diagnosis in their forties, while white women have a peak age in their sixties”.

How and why are racialized women differently affected by breast cancer?

The Chair: Dr. Gordon, I'm sorry she didn't leave much time for a response. Be as concise as you can possibly be, please.

Dr. Paula Gordon: They're at risk because their cancers aren't found earlier because they're not screened starting at age 40. They deserve the same opportunity of early detection as Caucasian women. Everybody should be screened at age 40, but absolutely, racialized women deserve their cancers to be found as early as Caucasian women's.

The Chair: Thank you, Dr. Gordon.

[*Translation*]

Mr. Thériault, you have the floor for six minutes.

Mr. Luc Thériault: Thank you very much, Mr. Chair.

Dr. Gordon, we hear that overdiagnosis creates a lot of unnecessary stress, in addition to triggering other types of interventions, such as biopsies, that can sometimes complicate things. It's important to have an accurate measure of overdiagnosis to determine whether the benefits outweigh the harms.

Do you consider overdiagnosis to be a barrier to routine screening for women 40 to 49 years old?

[*English*]

Dr. Paula Gordon: You're quite right. Overdiagnosis is only important if it leads to overtreatment.

Overdiagnosis actually applies to real cancers. These are not false positive. These are cancers that have been diagnosed on a biopsy.

From that point, the patient is referred for care to a surgeon, to an oncologist or to a radiation therapist. Then her treatment has to be tailored to her. If that woman has advanced heart disease and her life expectancy is short, she will not be treated with the same aggressiveness as a young woman who's in very good health.

We have to screen to find the cancers. Then once we find them, the treatment is decided based on the individual patient, not only the characteristics of the cancer, but the patient's general health, how much treatment she can tolerate and how likely it is that the treatment is going to help her in the long run.

To say that we shouldn't screen because of overdiagnosis means we'll never find those cancers, even the ones that could be treated, even the more lethal ones, and especially the ones in younger women. As I explained, they're less likely to have heart disease and be at risk of dying of a heart attack, so if we do find their cancers, they tend to grow faster and they need to be treated. That's not overtreatment.

● (1745)

[*Translation*]

Mr. Luc Thériault: Do you think overdiagnosis has been overdiagnosed in the literature, Dr. Gordon?

[*English*]

Dr. Paula Gordon: There is confusion between overdiagnosis and what a false positive is. The term “false positive” is incorrectly used by the task force. It's pejorative to refer to something abnormal on a mammogram that needs additional tests as a false positive. Yes, 95% of those turn out to be negative and the patient is reassured that everything is fine. There's a big difference between that, which is not a cancer, and overdiagnosis, which is.

Overdiagnosis, as I said, is not a reason to deny screening to younger women. It's not even a reason to deny screening to older women, unless they're very sick. As long as a woman is healthy with a life expectancy of 10 years, it's reasonable to offer her screening because, if we can find a small cancer, sometimes it can be treated very easily, even with just a hormonal medication or a small operation—not do all the other stuff like radiation and chemotherapy. It's in the hands of the doctors who are treating her to use their skill to decide how much treatment to offer her.

[*Translation*]

Mr. Luc Thériault: The U.S. Preventive Services Task Force recommends screening starting at age 40 to save lives. It even indicates that 19% more lives could be saved. The Canadian task force, however, is sticking with age 50 and over.

How do you explain the differences in the analysis of research results? Are results in Canada so different from those in the U.S., Dr. Gordon?

[*English*]

Dr. Paula Gordon: First of all, the mortality reduction possible with screening depends on what kinds of studies you look at.

There's one kind of research called a randomized trial, where you have a control group and a study group. Then there's observational data. Screening has been under way in Canada since 1988. We know from observational data—not randomized trial data—that women in their forties are 44% less likely to die of breast cancer if they have screening. If you rely just on the randomized trials, which are now 40 to 60 years old.... They were done at a time when mammograms were X-ray film that we read on a light box. Now they're done digitally on computers with lots of enhancements that make them more accurate. If you look at just the randomized trials, the mortality reduction was only between 15% and 20%.

The task force this time included observational studies in addition to the randomized trials, using the grade system you heard about earlier. What they did is prioritize the older studies and downgrade the importance of the observational studies. In fact, if you look at all the observational studies, not just the Canadian one, you'll find that the mortality reduction from mammography alone is in the range of 53% fewer deaths. Yet, because of the task force's overemphasis on anxiety from recalls and overdiagnosis, they concluded that the harms of screening outweigh the benefits.

The Chair: Thank you, Dr. Gordon.

[*Translation*]

Thank you, Mr. Thériault.

[*English*]

Mr. Julian, go ahead, please, for six minutes.

Mr. Peter Julian (New Westminster—Burnaby, NDP): Thank you, Mr. Chair.

Thank you to our witnesses.

I am looking at appendix A, which is a summary of the task force’s findings on the benefits and harms of breast cancer screening. I see a chilling absence of empathy. When you look at their own figures, they show that screening 1,000 people, ages 40 to 49, prevents one breast cancer death, while no screening means two people will die from breast cancer. In other words, the number of people per 1,000 who die from breast cancer would be cut in half. When you think of the number of Canadian women in that age group—not 1,000 Canadian women but 2.5 million—we're talking about saving, just by a rough calculation, over 3,000 lives. That's more than the number of people who died in the World Trade Center attack.

I simply don't understand this chilling absence of empathy, that a task force could put out these recommendations knowing that what they're doing is sentencing 3,000 Canadian women to death.

I thank all of our witnesses for their testimony today.

I want to start with you, Dr. Appavoo.

Does that sound right to you, the number of lives that could be saved if these task force recommendations were simply set aside and we started screening at 40?

● (1750)

Dr. Shiela Appavoo: Over the 10 years, absolutely.

In fact, the modelling calculations are between 400 and 600 per year. We talk about that being, if you can imagine, a jumbo jet full of women going down every year, based on the guideline recommendations not to screen.

You're absolutely right. I think there's an emphasis on using absolute numbers only from the task force. It actually states that they recommend only using absolute numbers, not saying, “You'd save 50% of your patients,” or “If I got breast cancer, I'd be 50% less likely to die if I were screening regularly.” They don't want us to say it that way. They want to say it as one in 1,000, because it makes it seem like a much smaller number.

Frankly, that's a manipulation technique, in my opinion. It is a well-known manipulation technique to try to control the narrative by controlling the way information is delivered.

I think both types of numbers should be used. In fact, I think more than those two types of numbers should be used.

You're absolutely right. For an individual woman who gets breast cancer—and it's very common, as we know—the benefit of mammography is huge. Most people don't get it. You can minimize it by talking about absolute numbers, but if you are that woman who gets it, it makes a huge difference to you.

It's just playing roulette not to screen. You're just hoping you don't get breast cancer, but if you do, you missed your opportunity.

Mr. Peter Julian: Thank you for your answer.

I just do not understand how any person could sign what is a death warrant for thousands of Canadian women with such alacrity without any feeling at all. All the witnesses have been very clear about this. The primary people who are impacted are indigenous, Black, Asian, Filipina and Hispanic women. Is it systemic racism driving this? There is absolutely no justification for these recommendations when they know that thousands of Canadian women die as a result of these recommendations. What is it? Is it systemic racism that is contributing to them putting forward recommendations that are a death warrant for so many Canadian women?

Dr. Shiela Appavoo: I am reluctant to use the word “racism”, but sometimes you have to call a spade a spade. There is a systemic form of racism involved in over-weighting these ancient RCTs that were performed on a group, 98% of which were white women.

When you put those at the top of the evidence hierarchy or the top of the pyramid, you are systematically leaving out every other race. Women who are white have a peak in breast cancer in their fifties to sixties. Every other race that's not white gets their peak in their forties. In this question, we are specifically focused on women screening in their forties. Every race other than white has been excluded in their highest level of evidence. Yes, there's a systemic form of racism there.

I was dismayed to see in the guideline that they acknowledge there is a higher mortality rate for Black women. Black women have a slightly lower chance of getting breast cancer, but when they do, they are 40% more likely to die of breast cancer. They acknowledge that, but they put them in the average-risk category, which is the category where they don't get screened in their forties, or there's no strong recommendation for them to screen in their forties. You have this double whammy of people being more likely to die if they get breast cancer and being in a group that is under-investigated, understudied, so you have this systemic form of racism. I don't call it personal racism. I'm sure there's no intent to be racist, but if you disregard these racial imbalances in the research, then you have entered systemic racism.

● (1755)

The Chair: Thank you, Mr. Julian.

Thank you, Dr. Appavoo.

Next is Ms. Vecchio for five minutes.

Mrs. Karen Vecchio (Elgin—Middlesex—London, CPC): Thank you very much, Chair.

I want to go back to Dr. Appavoo.

We know that many Canadians don't have doctors. It's about 25% in the city of Ottawa, from what I understand.

When a woman goes to her doctor—if she has a GP—what is it that ignites getting something done? Do they have to ask for it? Must there be a referral? Is there a screening where they actually look at the family history? What does screening really look like at stage one?

Dr. Shiela Appavoo: It varies from province to province.

For example, in Dr. Gordon's province of B.C., women in their forties don't need a requisition to screen. They can go and screen, but they're not necessarily encouraged to screen, whereas there's probably.... If it's similar to Alberta, you have about 60% of women in the target age group—so 50 and up—who will screen.

In the 40 to 49 age group, about 20% of those women will screen. They're allowed to self-refer, but their doctors don't push them to do it. When I say push, I mean encourage them, have the discussion or just say, “You should do this, if you want.”

In other provinces where.... I think in Ontario you have to have a requisition to screen. In Alberta, you do at 40, as well, if you want to screen. It requires that the family doctor be motivated to want to screen that patient. The family doctors very often—not all of them—take strong leadership from the task force. If the task force is saying not to screen, the doctor is going to say not to screen.

Time after time.... I work with a patient engagement group for the Canadian Society of Breast Imaging. Several, if not most, of the patients on the panel had asked for a screening mammogram at 40 and were told that, no, they didn't need it, that the task force said they didn't need it, and then within a few years, they showed up with a late-stage cancer.

Mrs. Karen Vecchio: We know that, in certain sections, if a woman has not borne a child or has not gone through a full pregnancy, that may be one of the reasons or may be one of the screenings. To me, it just seems so simple for stage one. You sit there and think about how you haven't had a child yet or haven't nursed, so perhaps screening before 40 or screening after 40 would make sense.

That's why I'm thinking that it could be such a simple thing if you're just able to go through it at the very first step, because we know of the full-term pregnancies....

You said, or it could have been Dr. Gordon, that 85% of women do not have a history of breast cancer in their family. When we're looking at trying to do this testing, what kinds of things would they be looking at? Is it a blood test for screening, or would they be looking at a genetic issue?

Dr. Shiela Appavoo: Our recommendation is that everybody screen at 40 because your biggest risk is being female. Then the second biggest risk is getting older. It's very difficult to predict.

There are some people you have a better chance of predicting, such as if they have a very strong family history or if they've had radiation to the chest before 30. There are some people for whom you know you're going to have to work harder and get them into MRI. You're going to have to dig a little deeper and make sure that you really screen them hard.

However, the average woman walking around without a family history is still at risk for breast cancer, and because that is the vast majority of women, that is also the vast majority of breast cancers.

Mrs. Karen Vecchio: Thank you so much.

I'm going to Dr. Nadler because, to me, all of the work that you've done here is what we're questioning today. We're saying to look at these guidelines because not everybody agrees with them.

I want to come back to you and ask you specifically whether there is anything that is done when you're talking about this—knowing, for instance, if a person hasn't had a child.... Is there something that would initiate some sort of screening for anybody under the age of 50 if they've not yet had a child?

Dr. Michelle Nadler: The task force recommendations say that any woman who is 40 is eligible for a mammogram as long as she is informed, and they actually say that if she's informed and would like a mammogram starting at 40, she ought to have one.

The task force does not control access. If across Canada we need to open up access, then the task force guidelines would be fine with that, as long as women are informed.

Mrs. Karen Vecchio: I absolutely appreciate that.

Dr. Nadler, we know, though, that here in Ontario, for instance, you would need to have some sort of referral.

● (1800)

Dr. Michelle Nadler: You won't anymore, not as of the fall of this year, fall 2024.

Mrs. Karen Vecchio: Are there any provinces where you still need a referral, or are they all referral-free now so that you can go directly and have breast screening?

Dr. Michelle Nadler: I believe there are still two or three that require referrals, but that could be changed. It is not the mandate of the task force to control access to care.

Mrs. Karen Vecchio: I absolutely understand.

Dr. Michelle Nadler: The task force's mandate is that women be informed.

I'm sorry. Go ahead.

Mrs. Karen Vecchio: No, I absolutely agree with you.

You only have four seconds—I'm sorry—but with regard to informing people, what does that education look like if we're saying that guidelines are somewhat different?

Dr. Michelle Nadler: Do you want me to answer, or is there no time?

Mrs. Karen Vecchio: I don't know if you have time.

The Chair: She does.

Give a brief answer.

Dr. Michelle Nadler: Thank you.

All of the best available evidence on communication does suggest to communicate in absolute numbers. For example, there was a scare many years ago where we thought that the oral contraceptive pill doubled or increased the risk of a blood clot by 100%, but really, it took it from about one in 7,000 to two in 7,000.

I don't think we would ask family doctors to use that 100% increase in blood clots from a birth control pill. We would ask them to give the absolute numbers so that women can make their own informed choices. Whatever choice they make about screening—informed in absolute numbers—should be respected, and however the access wants to be for that, the task force doesn't mind so long as the woman is informed.

The Chair: Thank you, Dr. Nadler.

Next we go over to the Liberals with Madam Brière.

I understand that you're going to be sharing your time with Ms. Sidhu.

You have the floor, Madam Brière.

Mrs. Élisabeth Brière (Sherbrooke, Lib.): Thank you, Mr. Chair.

Thank you to all of our witnesses.

[*Translation*]

I will be speaking to Dr. Gordon.

According to the expert committee, more cancer does not mean there needs to be more screening. We should be focusing on why it has become more prevalent.

Do you not think we could do both, that is, screen for cancer while finding out why it's more prevalent?

[*English*]

Dr. Paula Gordon: If I understand your question, you're asking why breast cancer is getting more common in younger women. I don't think anybody knows the answer.

One that was proposed that seems to make sense to me was, especially during the pandemic, there was greater consumption of alcohol. We know that alcohol is a carcinogen and is related to breast cancer risk as well as risks of other cancers.

For another example, we don't know why women are starting to menstruate younger. We know that lifetime exposure to estrogen is a risk factor for breast cancer, and women who start their periods younger and go through menopause later are at a higher risk for breast cancer. We've certainly seen that the age of onset of periods has become younger. It's not uncommon for girls as young as nine to get their periods now. It used to be that age 12 to 13 was the most common average.

I'm not an expert in this subject, but I've read that maybe it's because the girls who are young now, women my age, hopefully didn't smoke and drink during their pregnancy like our mothers did, and they're much better nourished. Maybe that's why they're starting their periods earlier, and maybe that's contributing to increasing rates of breast cancer.

There's a bunch of theories out there. At the end of the day, I don't think anybody really knows why it's happening.

[*Translation*]

Mrs. Élisabeth Brière: Thank you.

Dr. Appavoo, we know that, starting at age 40, women who have been given the information can decide to be screened. However, we know that not all women have a family doctor. That's the case in Quebec, at least.

Do you think that's a barrier to accessing screening?

[*English*]

Dr. Shiela Appavoo: If I understand your question, you're asking if not having a doctor is an obstacle to access. That's absolutely the case, especially in provinces where you need a requisition to get the screening mammogram.

In Alberta, fortunately, we've moved it down to age 45 when they get invited and can self-refer, but if you want to get in at 40, you need a requisition at least for the first one. If you don't have a doctor or if your doctor believes the task force and does not want to write a requisition, there's a big barrier right there. Yes, that's a huge barrier for a lot of women.

Mrs. Élisabeth Brière: Thank you.

Dr. Michelle Nadler: Just to clarify, if that family doctor followed the guidelines, they should refer for screening. Guideline care is to respect a woman's choice.

● (1805)

The Chair: Thank you.

Ms. Sidhu, you have just under two minutes.

Ms. Sonia Sidhu (Brampton South, Lib.): Thank you to all of the witnesses.

I would like to share the concerns about the findings of the task force. I'm glad that our witnesses are here with us to provide more clarity.

I would also like to follow up on my friend Ms. Vecchio's question.

Dr. Gordon, we can start with you, but any witness is welcome to add their feedback.

Earlier we heard about the importance of a primary care physician and their referral. Could the witnesses talk to this committee about the difference in the outreach to women across provinces and territories to inform them of the importance of the screening education campaign? Are there letters being sent out? Is there a notification system? Help us to understand.

Dr. Paula Gordon: Every province does its own thing.

Our screening program in British Columbia was the first in Canada in 1988. When we started, all women got a letter of invitation on their 40th birthday, and women were allowed to attend annually starting at 40 and going all the way through. It has gradually deteriorated over the years. We're striving for mediocrity instead of being the leaders now in B.C.

Now there is no letter, so if a woman happens to have seen something in a women's magazine and asks her doctor, it will depend greatly on what her doctor says. Now a woman in B.C. does not need a requisition. She can self-refer as long as she has the name of a physician to give. Sadly, only 25% of eligible women in their forties are having screening in British Columbia.

We know of examples, and because I volunteer with Dense Breasts Canada, which deals not just with dense breasts but works to get equitable access to screening across the country, we know of so many cases, as you heard from Dr. Appavoo, when a woman asked and even begged for a requisition, and her family doctor said, “No. That's not what we do here. You don't need one until you're 50.”

I give credit to the task force. As you heard from Dr. Nadler, it has changed it a bit this year. It still says it doesn't recommend it, but it's made it much clearer, from what I've read so far, that if the patient wants it, she should have it and the doctor should give her a requisition. That was not as clear when the 2018 guidelines came out. It was in the fine print, further down in the article. We even know of patients in British Columbia, where they don't need a requisition, if a woman asks her family doctor, she might be told not to bother until she's 50.

The Chair: Thank you, Dr. Gordon.

I'm sorry, Dr. Nadler. We're well past the time. Hopefully, somebody will come back to this topic.

[*Translation*]

Mr. Thériault, you have the floor for two and a half minutes.

Mr. Luc Thériault: Thank you, Mr. Chair.

Dr. Nadler, the results of a scientific research study you participated in were published in 2022. In the publication, it states that obstacles to individualized breast cancer screening include knowledge of risk factors and risk assessment tools. It also mentions that doctors had difficulty identifying breast cancer risk factors outside family history, such as reproductive factors, ethnic origin or breast density, and that some doctors were lacking the skills to calculate overall breast cancer risk.

The draft recommendations of the Canadian Task Force on Preventive Health Care would suggest not routinely screening with mammography. The suggestion is that women should be given information on the benefits and harms of screening so that they can make decisions in line with their values and preferences.

In this context, do you think that doctors' lack of knowledge of the risk factors and risk assessment tools, as you mentioned in your research, can influence women's decisions and prevent them from making an informed decision?

[*English*]

Dr. Paula Gordon: Are you addressing me?

[*Translation*]

Mr. Luc Thériault: My question was for Dr. Nadler.

[*English*]

Dr. Michelle Nadler: Thank you.

It's important to note that a primary care provider can engage in shared decision-making with a woman without knowing the exact lifetime risk she has. That being said, it is important for a family doctor to assess a woman's risk factors—I agree with all the other experts here—because that primary care provider needs to know if that woman is even at an average risk. If she's at an average risk, these guidelines apply to her, and the guidelines say she should have a choice.

If the woman is at a higher than average risk, there is a completely separate screening recommendation that doesn't even fit within these guidelines. It is correct that some primary care physicians could use extra support in learning about risk factors and calculating lifetime risk, and separately, that is outside of the scope of these guidelines. Some of the work I do is in helping to create tool kits and support primary care providers to do this.

I think first and foremost, the most important thing is that one can still have a shared care discussion if one has determined that the woman is of average or slightly above average risk, which the task force clearly defines in these updated guidelines, and which is an improvement from the 2018 guidelines.

● (1810)

The Chair: Thank you, Dr. Nadler.

Thank you, Monsieur Thériault.

Next is Mr. Julian, please, for two and a half minutes.

Mr. Peter Julian: Thank you very much, Mr. Chair.

I appreciate all our witnesses being here.

Unfortunately, because of the time constraints, at the end of my two and a half minutes, I'll be moving a motion to adjourn.

I wanted to come back to Dr. Appavoo and then ask Dr. Nadler and Dr. Gordon the same question.

You mentioned in your testimony, Dr. Appavoo, that it is important to look to dismantle and rebuild the task force. Very clearly, the task force is not responding certainly to the needs of Canadian women or certainly to the needs of racialized women in the health care system.

How important is it to dismantle and rebuild it, and what should the steps be to actually accomplish that?

Dr. Shiela Appavoo: Thank you for asking that.

Quickly, one of the reasons I think there should be a complete dismantling and rebuilding is that this problem is not just isolated to breast. Breast is sort of the tip of the iceberg. Multiple other screening guidelines in cancer and non-cancer fields have similar reactions from experts and are similarly concerning. As one gastroenterologist told me in an email regarding the colorectal screening guidelines, people are going to die.

Unfortunately, there is no accountability structure. Because it's at arm's length, there's no way to fix the guidelines that are wrong, and there's no way to update any sooner than they feel like updating, so we have guidelines sitting there that are very outdated, dating back to 2012 and 2013.

Ultimately, we can make any fix to any individual guideline we want, but the problem will happen again and again and again, because the problem is fundamental to the structure and the accountability of the task force. I think that, ultimately, there are many national and international guidelines that are well accepted. Experts in the fields can guide you to use a better guideline in the interim while we restructure the guidelines—

Mr. Peter Julian: My time has expired—

Mrs. Laila Goodridge: I have a point of order.

Mr. Peter Julian: —so I'll move a motion to adjourn.

The Chair: We had a point of order just before you moved your motion, Mr. Julian.

Go ahead with your point of order, Ms. Goodridge. Then we're going to deal with the motion.

Mrs. Laila Goodridge: Thank you, Mr. Chair.

I appreciate the fact that the member wants to end our meeting early. Women's health is something that is greatly understudied in this country. We have an opportunity here with witnesses, and we have time for another round of questions, and this is absolutely inappropriate.

The Chair: Ms. Goodridge, that is absolutely not a point of order, and a motion to adjourn is not debatable, which is what you were trying to do through the back door.

Is it the will of the committee to adjourn the meeting?

Mrs. Laila Goodridge: I request a recorded division.

(Motion negatived: nays 10; yeas 1)

The Chair: Next up on the speakers list is Ms. Goodridge, please, for five minutes.

Mrs. Laila Goodridge: Thank you, Mr. Chair.

It's interesting. My initial anticipation as I read through the guidelines was how it was considered that women did not have the ability to make decisions and that somehow the feeling of anxiety trumped living. As someone who has dealt both with the anxiety of being sent out of my community and with getting additional testing as a result of dense breasts, the anxiety that really keeps me up at night is the anxiety of wondering whether I will live to see my children grow up, not the anxiety surrounding a test.

My question is for you, Dr. Gordon.

What advice would you have if you could draft new screening guidelines for Canada?

● (1815)

Dr. Paula Gordon: First of all, I need to explain that it is well known that a percentage of women, perhaps around 10% plus or minus are going to be recalled. It is known that women are much less anxious if they're prepared ahead of time and if they're told that this could happen. It's most likely to happen on their first screening mammogram, because there are no priors to compare to. Women need to be told, just as they need to be informed about the possibility of overdiagnosis, so they're prepared.

For my wish list, I'll start with what Dr. Appavoo said, that all women should be assessed for risk early in life, perhaps at around the age of 30. Then all average-risk women who don't need to be screened younger because of increased risk would be able to start at 40. They should be able to self-refer without a requisition from their physician. They should be able to go annually, at least when they're premenopausal, because that's when hormones cause breast cancers to grow faster, and ideally annually until they don't have 10 years of life expectancy left.

We have loads of data to show that's how you save the most lives, the most years of life, and how you get to offer the least aggressive therapy.

Women should be told after they have their screening mammogram what their breast density is. We've only just now, after seven years of lobbying, finally got pretty much every province and territory on board to tell women their breast density. Up until 2018, no woman in Canada was being told their breast density. Why? We were told that it was because we were going to make them anxious.

When men have high blood pressure, we tell them they have high blood pressure because it's a risk and they need to know information about their own health. Women deserve to know their breast density because of the two associated risks.

From there, any woman with category C or D—those are the women with dense breasts—should have access to supplemental screening because, when a woman has dense breasts, there's a risk that her cancer might not be seen on her mammogram. That supplemental screening with either ultrasound or MRI can find many of those cancers.

Finally, women should be able to continue having screening beyond age 74 until their life expectancy is less than 10 years. For most women, that's age 80. At age 75, according to Stats Canada, a healthy woman has a life expectancy of 13 years, and at age 80, it's 10 years.

That's my wish list for screening.

Mrs. Laila Goodridge: Thank you.

I appreciate that you brought up extending it past 74. I had a number of women after I brought this forward who brought that to my attention, and it was something that was a constraint to them, especially when they were healthy.

Dr. Appavoo, we have an audience here today. We have people who are tuning in and paying attention to this health committee meeting. What recommendation would you have to the women who are listening?

I have about 30 seconds.

Dr. Shiela Appavoo: My recommendation is to start screening at age 40. If you need a requisition from your family doctor, and your family doctor is reluctant to write the requisition.... I know that now the task force guideline states that women should be allowed to have screening if they want to. I know that a lot of doctors talk their patients out of it because of that overdiagnosis, anxiety and all these paternalistic ideas about why women shouldn't be screened, and they discourage it, and they talk their patients out of it.

Go in and don't let yourself be talked out of it. Make sure that you start at 40 and go every year, as Dr. Gordon says, during premenopause.

Mrs. Laila Goodridge: Thank you.

Now I would like to move a motion, Mr. Chair:

> That, in relation to the committee's order of reference of Wednesday, May 29, 2024, concerning Bill C-368, An Act to amend the Food and Drugs Act (natural health products):
>
> (a) the sponsor be invited to appear during the first hour of the committee's meeting on Thursday, June 13, 2024;
>
> (b) other witnesses, to be proposed by the parties, appear during:
>
> (i) the second hour of the committee's meeting on Monday, Thursday, June 13; and
>
> (ii) the first hour of the committee's meeting on Monday, June 17, 2024;

(c) all amendments be submitted to the clerk of the committee no later than 4:00 p.m. on Friday, June 14, 2024;

(d) clause-by-clause consideration of the bill be taken up during the second hour of the committee's meeting on Monday, June 17, 2024, provided that, at the later of the conclusion of that second hour or 5:30 p.m. that day, if the committee has not completed clause-by-clause consideration:

(i) all remaining amendments submitted to the committee shall be deemed moved;

(ii) each recognized party shall be allotted no more than five minutes for each of the remaining amendments and clauses;

(iii) the committee shall not adjourn until it has disposed of the bill; and

(e) the Chair and clerk be instructed to seek the House resources necessary to implement the terms of this motion.

I have a bilingual copy that I can circulate to members of the committee.

Thank you, Mr. Chair.

● (1820)

The Chair: Feel free to circulate it; however, the motion that you just presented does not touch the issue at hand and the committee has not been provided with 48 hours' notice. I therefore rule it out of order.

Mrs. Laila Goodridge: Mr. Chair, it is effectively a slight amendment to the motion that was put on notice on June 3 by my colleague, Dr. Ellis. It just updates the dates. Otherwise, it is identical.

If you would prefer, I could amend the original motion, but I thought this was cleaner and simpler.

The Chair: Your only option now is to challenge the chair because there are two issues.

Number one, if you were moving Dr. Ellis's motion, you couldn't because you aren't Dr. Ellis. Number two, the motion that you moved is not identical, so it requires 48 hours' notice, which hasn't been given.

The motion is out of order. Unless there's a challenge forthcoming, we're going to move to Dr. Hanley, please, for five minutes.

Mrs. Laila Goodridge: I will ask for unanimous consent of the committee to move the motion.

The Chair: Does Ms. Goodridge have unanimous consent to move the motion that has not been put on notice?

There is no unanimous consent.

We'll go to Dr. Hanley, please, for five minutes.

Mr. Brendan Hanley (Yukon, Lib.): Thank you.

I want to thank all the witnesses and I want to thank Ms. Goodridge for bringing this study into a priority lineup. It is an extremely important study and very timely.

Dr. Gordon, you're a very compelling witness, I have to say.

Most of my five minutes will be probably devoted to just drilling down on a few issues.

Can you talk to me about interval cancers and their relative importance?

Having been versed in this over many years, you might say that the traditional thinking is that aggressive cancers do not lend themselves to screening because almost by definition they appear between screening intervals and often the younger the woman, the more aggressive the cancer. This applies to other types of cancers of course, which is maybe one of the limitations of screening.

Maybe you could clarify what you think of that based on what we know today, especially with the technology that we have today.

Is this becoming a more outdated phenomenon?

Dr. Paula Gordon: Let me just define this for the others.

An interval cancer is one that turns up after a woman's last mammogram was read as negative. It's usually found as a lump. Interval cancers are more often the aggressive ones, the HER2-positive and so on. They are the rapidly growing cancers. They often present larger—already spread to the lymph nodes—than screen-detected cancers and they do have a worse prognosis.

There are two categories of interval cancers. There are the ones we just mentioned, which are the rapidly growing cancers. Even when you look at her recent mammogram, she didn't have dense breasts and she had the easy kind of mammogram to read, but it really wasn't there. It developed so fast that, let's say, her mammogram was negative, six months later she has another mammogram when she shows up with this lump and, oh my goodness, there's a lump that's easy to see on her mammogram. That's one kind. That's the kind that just grew so fast that it wasn't there on the mammogram. The other kind of interval cancer is the one that was there when she had her mammogram, but it was hidden in her normal dense tissue.

Breast density refers to the amount of breast tissue—glandular and fibrous tissue, but let's just call it breast tissue—compared to fat. All women have both in their breasts, but the proportions vary tremendously. Someone's breasts are all fat and then some have a little bit of dense tissue, some have more and then there's the highest category of dense tissue where there's hardly any fat and it's all dense tissue.

The reason that's important is that normal, dense breast tissue on a mammogram is white and fat is black. All lumps, including cancers, are white. If a woman has a fatty breast, it's a dark gray or black-looking mammogram and even the smallest little white cancer jumps out at you like a star in the sky.

If a woman has a very dense breast and it's all white, you're going to miss even a big cancer. In fact, 50% of cancers are missed in the densest tissue.

I'm going to let you get a word in edgewise.

● (1825)

Mr. Brendan Hanley: I have less than two minutes left, but I appreciate the fulsome explanation.

I want to focus on the U.S. and the way the recommendations are now in the U.S. preventive task force versus Canada.

You do acknowledge that we have included observational studies in the Canadian guidelines for the first time, but also that they are weighted differently from clinical trials. There's almost a time consideration because clinical trials, almost by definition, are older. The RCT has always been the gold standard of trials.

Do you see there is a process that is happening differently in the U.S. versus Canada? Should we be looking at processes that are potentially different, to emulate the U.S.? I'd also note that the U.K. has not changed from 50. As far as I know, the U.S. is perhaps one of the first to include the 40.

Dr. Paula Gordon: What the U.S. did differently from Canada was that they took greater weight of the data showing an increasing incidence in younger women and the incidence of breast cancer in racialized women. But the Americans didn't get it perfect either. They're only saying to screen every two years. They clearly don't weight the harms to the extent that our task force does.

Mr. Brendan Hanley: Dr. Nadler, we won't have time for you to speak to this. If you're able to table a response to that, to the difference between the U.S. approach and the Canadian approach, I think that would be very useful.

Am I out of time, Chair?

The Chair: Did you want to give Dr. Nadler a chance to respond?

Mr. Brendan Hanley: Yes. Thank you.

The Chair: Dr. Nadler, please take 30 seconds to offer your perspective. If that's not enough, feel free to follow up in writing.

Dr. Michelle Nadler: Thank you.

The incidence change in Canada was different from the incidence in the United States. That may be one reason.

Dr. Paula Gordon explained the difference in the two types of interval cancers. It's important to understand, exactly as Dr. Gordon said, that this is why screening doesn't help for some interval cancers. The more aggressive ones appear between screens. Although screening does help for some, it doesn't help for all.

Another important thing about interval cancers or detecting cancer early is that we don't necessarily know that screening will change the outcomes. This is something called length-time bias. A more slowly growing cancer will sit and wait and not present as a lump until a screen. A more aggressive cancer will show up in between screens. Obviously, when we look back at retrospective studies, it looks like screening catches all the very slow-growing cancers and it looks like all the fast-growing ones are in people who don't have screening, but that's because they're fast, and they show up as interval cancers. That's called length-time bias. It's a very important bias. We don't dismiss studies because of it, but we always have to think that this bias is there. The task force has to look at all of that data as systematically and as methodically as possible.

Finally, with regard to the U.S., they actually acknowledge in their guidelines that the recommendation doesn't actually improve EDI, or equity and diversity. They actually say in their guidelines that starting everybody at 40 doesn't actually improve the disparities.

We all call for more research in that area.

The Chair: Thank you, Dr. Nadler.

I'm sorry, Dr. Gordon. We have reached—

Mr. Brendan Hanley: Mr. Chair, perhaps Dr. Gordon could submit her reply.

The Chair: Yes.

Mrs. Laila Goodridge: Could we get unanimous consent to get an answer from Dr. Gordon on that?

The Chair: Is everybody okay to extend this a little bit?

Some hon. members: Agreed.

The Chair: Dr. Gordon, go ahead. Everybody wants to hear from you.

Dr. Paula Gordon: I'll be quick.

Yes, what Dr. Nadler says is true, but we do know that the size and the nodal status still matter even for aggressive tumours. In fact, sometimes it matters even more. As I said, the five-year survival rate for stage one triple-negative cancer is 96%. Stage 3 is 47%.

We also use modelling. It's not all about anecdotal cases of some women who didn't benefit. It's true that not all women will benefit to the same extent as others, but if you don't screen, you don't find the cancer in the first place to know whether it is high grade or not.

● (1830)

The Chair: I would like to thank all our witnesses for being with us here today and for being so patient as we worked through several challenges that interrupted and delayed your testimony. Your expertise is evident. We are extremely grateful that you were here with us to kick off this study and for the depth and breadth of information that has been provided. Thank you so much for being with us.

Is it the will of the committee to adjourn the meeting?

Some hon. members: Agreed.

The Chair: Thank you.

We're adjourned.