Overdiagnosis: Plague of Fee-for-Service Health Systems

September 11, 2017 By Mike Barr

A conference in Quebec gave me an excuse to escape to our northern border and French Canada for a little summer break. It was the fifth year for “Preventing Overdiagnosis: Winding Back the Harms of Too Much Medicine,” an annual convening of clinicians, academic types, health policy experts, medical journal editors, medical students, and the concerned public, launched at Dartmouth College in 2013 following a series of provocative articles in the British Medical Journal. Conditions often overdiagnosed, according to the initial report, include COPD, bone fragility, aortic aneurysm, mammography, mild hypertension, pre-diabetes, gestational diabetes, low mood, ADHD, predementia, thyroid cancer, chronic kidney disease, pulmonary embolism and PCOS.

More recently the BMJ campaigners have been joined by no other than The Lancet, JAMA and the National Cancer Institute, which in 2014 labeled cancer overdiagnosis “a major public health concern.” Overdiagnosis, for the record, is defined as “diagnostic labelling of abnormalities or symptoms that are indolent, non-progressive or regressive, and that if left untreated will not cause considerable distress or shorten the person’s life.”

To this day I haunted by the memory of a young woman who came to see me at the school clinic after being given a diagnosis of DCIS: ductal carcinoma in situ. Not only was she convinced she had cancer (and was scheduled to begin chemotherapy), but because she had also been warned the chemo could leave her sterile she was rushing to harvest as many eggs as she could to freeze them for the future. Talk about your medical nightmare.

Little did she (or I) know at the time, the National Cancer Institute had that very year launched a working group on cancer overdiagnosis, and was preparing to publish its recommendations. Chief among them? That “premalignant conditions such as DCIS” needed to be renamed to remove any reference to cancer, “just as many lesions detected during breast, prostate, thyroid, lung and other cancer screenings should be classified not as cancerous or even pre-cancerous but as IDLE: indolent lesions of epithelial origin.” As a result of the prevailing 19th century views of cancer, one prominent oncologist noted, some 50,000 women in the US each year are wrongly diagnosed as having cancer-- and treated for it, 20,000 of whom undergo mastectomy, increasingly bilateral. I can only imagine the psychological distress and collateral illnesses that ensue.

The overdiagnosis folks, likely because they have their hands full already, don’t really get into the the tsunami of inappropriate surgical procedures sweeping the land-- the total hip, total knee

replacements, the hysterectomies, the Cesarians, the cholecystectomies-- and the harm they cause. It’s not only the squandered resources and recovery time, but many of these -ectomies leave the “-ectomized” (or in the case of a C-section, the microbiome and therefore immune system of the neonate who eventually grows to become a toddler, a teenager and an adult) with lifelong limitations that aren’t completely explained or understood a priori.

They do, however, directly address the phenomenon (that in my experience is driven by Big Pharma and the guidelines writers on their payrolls, although this may be improving slightly) of what I like to call disease definition creep. How “when to treat” thresholds for certain blood markers (think cholesterol, glucose, creatinine to name just the most common) have all conveniently crept in the direction that would put more customers in the drug companies’ pockets. No surprise here then when it was announced that a recent review of clinical practice guidelines in the U.S. found that for 10 of the 16 guidelines studied the definition of what constitutes disease had been expanded.

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