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Performance of ultrasonography screening for breast cancer: a systematic review and meta-analysis

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Abstract

Background

To investigate the performance of primary ultrasound (US) screening for breast cancer, and that of supplemental US screening for breast cancer after negative mammography (MAM).

Methods

Electronic databases (PubMed, Scopus, Wed of Science, and Embase) were systematically searched to identify relevant studies published between January 2003 and May 2018. Only high-quality or fair-quality studies reporting any of the following performance values for supplemental or primary US screening were included: sensitivity, specificity, cancer detected rate (CDR), recall rate (RR), biopsy rate (BR), and proportions of invasive cancers (ProIC) or node-positive cancers (ProNPC) among screening-detected cancers.

Results

Twenty-three studies were included, including 12 studies in which supplemental US screening was used after negative MAM and 11 joint screening studies in which both MAM and US were used as primary screening methods. Meta-analyses revealed that supplemental US screening could detect 96% [95% confidential intervals (CIs): 82% to 99%] of occult breast cancers missed by MAM and identify 94% (95% CIs: 88% to 97%) of healthy women, with a CDR of 2.9/1000 (95%CIs: 1.8/1000 to 3.9/1000), RR of 8.6% (95%CIs: 4.8% to 13.5%), BR of 3.9% (95%CIs: 2.5% to 5.5%), ProICof 73.9% (95%CIs: 49.0% to 93.7%), and ProNPC of 72.6% (95%CIs: 51.9% to 90.0%). Compared with primary MAM screening, primary US screening led to the recall of significantly more women with positive screening results [1.2% (95%CIs:0.4% to 1.9%), P =0.004] and detected significantly more invasive cancers [20.2% (95%CIs: 7.2% to 33.1%), P = 0.002]. However, there were no significant differences for other performance measures between the two screening methods, including sensitivity, specificity, CDR, BR, and ProNPC.

Conclusions

Supplemental US screening could detect occult breast cancers missed by MAM, while primary US screening would be considered as comparable to primary MAM screening in certain subgroup of women, but with a higher recall rate and a higher detection rate for invasive cancers.

Background

Cancer is a global public health issue in the world. In 2016, an estimated 17.2 million cancer cases and 8.9 million cancer deaths occurred worldwide [1]. For women, both the most commonly occuring cancer and the leading cause of cancer deaths and disability-adjusted life-years (DALYs) was breast cancer (1.7 million incident cases, 535, 000 deaths, and 14.9 million DALYs)[1]. Over the years, the burden of cancer has shifted from more developed countries to less developed countries [2]. Moreover, the burden is expected to grow worldwide due to the aging of the population and the adoption of lifestyle behaviors such as smoking, poor diet, physical inactivity, and reproductive changes (including lower parity and later age at first birth), particularly in less developed countries[2]. Therefore, broad prevention measures, such as cancer screening, are urgently needed to control this increasing burden, especially in less developed countries.

Mammography (MAM) has been used to screen for breast cancer since the 1970s and is now widely available in developed countries. However, in less developed counties, such as China, MAM is not easily accessible due to several barriers, including insufficient MAM equipment, inadequate insurance coverage for MAM, and widely dispersed populations [3]. Moreover, MAM has a low sensitivity in women with dense breasts [4], who could suffer a higher risk of breast cancer than those without dense breasts [5]. Worrisome research from Denmark and Netherlands showed that nearly one in every three or half of screening-detected breast cancers represents overdiagnosis, respectively [6, 7].

Recent data indicates that supplemental ultrasonography (US) screening could detect occult breast cancers missed by MAM, and primary US screening seems perform comparably to primary MAM screening [8–11]. However, systematic reviews of the performances of supplemental or primary US screening have been published only in limited studies. Moreover, among broad screening studies in which both MAM and US were used as primary screening methods, researchers just focused on the performance differences between joint screening and MAM screening alone. Limited studies investigated the independent performances of primary US screening. Therefore, we conducted this systematic review and meta-analysis to provide a global profile of supplemental US screening after MAM screening or primary US screening for breast cancers.

Methods

This meta-analysis was reported in line with the preferred reporting items for a systematic review and meta-analysis of diagnostic test accuracy studies: The PRISMA-DTA Statement (Supplementary S1) [12].

Types of studies and participants

Randomized-controlled trials (RCTs), prospective or retrospective screening cohort studies focusing on the performance of primary US screening for breast cancer or performance of supplemental US screening for breast cancer after negative MAM were included. The screening performance included the following indicators: sensitivity, specificity, cancer detected rate (CDR), recall rate (RR), biopsy rate (BR), and proportions of invasive cancers (ProIC) or node-positive cancers (ProNPC) among screening-detected cancers. The types of US included were hand-held ultrasonography (HHUS) and automated whole breast

ultrasonography (ABUS). Diagnostic studies of patients with histopathologically proven breast cancer or women with suspicious finding after initial screening were excluded. Screening studies for second cancers among women previously diagnosed with breast cancer were also excluded.

Searching strategies

A comprehensive search was conducted according to the Cochrane handbook guidelines. The American College of Radiology (ACR) developed the Breast Imaging Reporting and Data System (BI-RADS) classification for breast ultrasonography examinations starting in 2003 [13]. Electronic databases (PubMed, Scopus, Wed of Science, and Embase) were systematically searched to identify relevant studies published in English between January 2003 and May 2018. Five groups of key words were used in the searching strategies: (1) breast neoplasm, breast cancer, breast carcinoma (2) ultrasound, ultrasonography (3) screening (4) supplemental, supplementary, adjunct, adjunctive, combined, joint, primary, single, alone (5) sensitivity, specificity, detection rate, recall rate, biopsy rate. Reference lists from retrieved articles were also reviewed. Detailed searching strategies are referred to in the supplementary S2.

Selection of studies

Two authors independently screened the titles and abstracts of all selected articles to confirm their eligibility. All selected articles were analyzed by EndNote software that allows reviewers to manage articles and detect duplicate publications. When two or more articles from the same trial were selected, the article with the larger sample size, longer duration of follow-up, or the latest results was included. Any disagreement on the selection of articles was discussed and arbitrated by a third author. Details of the selection process are provided in the supplementary S3.

Data extraction

Two authors independently extracted the following data from the qualifying studies: general information (name of first author, year of publication, and country or countries where the study was performed), design of study (sample size, mean age, percent of women with dense breasts among the whole population, type of US, screening mode), performance of US, and information for risk assessment of bias (detailed information referred to in the following section). Since there was not a consistent conclusion that dense breast can be regarded as an independent risk factor of breast cancer, in order to avoid bringing ‘high risk’ labels to women with dense breasts, we collected information of dense breast as an attribute for average risk women. All data was entered into STATA 14.0 software for analysis. Any disagreements on data extracted were also discussed and arbitrated by the same third author.

Risk assessment of bias in included studies

Two investigators critically appraised all included studies independently according to the pre-specified criteria, which were adjusted from the USPSTF’s design-specific criteria and the STARD checklist for reporting diagnostic accuracy studies [14, 15]. The adjusted criteria included: (1) Included population came from a representative source population (Yes: general community women or well-defined high-risk women; No: women participants in an opportunistic screening and other undefined women) (2) Sample size was greater than or equal to 1000 (Yes/No) (3) Included studies clearly described the inclusion and exclusion criteria, and women who had a personal history of breast cancer were definitely excluded before screening (Yes/No) (4) In studies in which more than one screening method was used as the primary screening method, the readers of different screening methods were masked to each other (Yes/No) (5) All participants received US screening, or the proportion of missing data for either test was less than or equal to 5% (Yes/No) (6) US findings were interpreted according to BI-RADS criteria (Yes/No) (7) Women with positive results from index screening methods were ascertained with histopathology; and women with negative results were ascertained with a minimum 12-month clinical follow-up (reference standards) (Yes/No).

According to the above mentioned criteria, high-quality studies were defined as those meeting at least six criteria for joint screening studies and five criteria for supplemental US screening studies. Fair-quality studies meet four or five criteria for joint screening studies and three or four criteria for supplemental US screening studies. Poor quality studies were defined as those meeting less than four criteria for joint screening studies and three criteria for supplemental US screening studies. Poor studies were excluded from the review.

Data synthesis and analysis

All data were extracted with pre-specified uniform tables and recalculated with uniform methods.The corresponding authors were contacted to obtain any missing information from their studies. For these studies in which the number of ‘examinations’ rather than the number of ‘women’ as the denominator to calculate the detection rate of breast cancer, the same woman had been followed up several times, and every time they had an examination. Therefore, every woman had several examinations in these stuides. In our current study, if we changed the number of ‘women’ as the denominator to calculate the detection rate for these studies, the results would significantly be overestimated since the number of ‘women’ was significantly less than the number of ‘examinations’. Therefore, in order to follow the analysis protocol in the original studies and avoid potential overestimate in detection rate, we equate each examination with an independent woman.

The recall rate was calculated as the number of women recalled for further diagnosed examinations divided by the total number of women participated the screening. If the number of women recalled for any further diagnosed examinations was not available, the number of women with a positive result of index screening modality was used instead. The biopsy rate was calculated as the number of women recalled for pathological examination divided by the total number of women participated the screening.

The variation in different screening performances attributable to heterogeneity was measured as I^2. If the *P* value for I^2 was less than 0.1, significant heterogeneity was indicated among included trials and the random-effect model was used to combine screening performances [16]. Otherwise, the fixed-effect model was used if the *P* value for I^2 was larger than 0.1. To search for sources of heterogeneity and obtain clinically meaningful estimates, subgroup analyses were conducted according to different studies characteristics, such as sample size > 1000 (Yes/No), all women with dense breasts (Yes/No), type of US (HHUS/ABUS), and quality assessment (Yes/No), whenever possible. The package "midas" was used to combine sensitivity and specificity, to investigate whether there were potential publication biases among included studies, and to plot the summary receiver operating characteristic (SROC) curve with its 95% confidence and prediction contours [17]. The package "metaprop" was used to combine CDR, RR, BR, ProIC, and ProNPC [18]. In addition, the package "metan" was used to compare the performances between MAM and US [19].

All meta-analyses were conducted with STATA software (version 14.0). All tests were two-sided, and *P* values of less than 0.05 for all meta-analyses indicated statistical significance.

Results

Supplementary figure S3 shows a flowchart of the study selection procedure. The electronic searches yielded 1162 potentially relevant studies, of which 23 eligible studies were included in the final review [9–11, 20–39], including 12 studies in which supplemental US screening was used after negative MAM and 11 joint screening studies in which both MAM and US were used as primary screening methods.

Table 1 shows the baseline characteristics of the 23 studies. Twelve studies were conducted among women with dense breasts. Twenty studies screened women with HHUS. Twelve studies were conducted among general community women or well-defined high-risk women. Eleven studies definitely excluded women who had a personal history of breast cancer. Eight joint screening studies masked the results of primary MAM screening and primary US screening. Nineteen studies had low risk of incomplete data. Sixteen studies reported US results according to BI-RADS classification criteria. The reference standard in seventeen studies was pathologic examination combined with 12-month clinical follow-up. Finally, according to the pre-specified criteria, seven studies were of high quality, while the remaining 16 were of fair quality.

Screening accuracy for supplemental and primary US screening

Table 2 shows the original data of screening accuracy for supplemental and primary US screening among the included studies. Based on meta-analyses, supplemental US screening could detect 96% [95% confidential intervals (CIs): 82% to 99%; I^2 = 66.3%, *P* < 0.01] of occult breast cancers missed by MAM and identify 94% (95% CIs: 88% to 97%; I^2 = 99.8%, *P* < 0.01) of healthy women (Figure 1A, supplementary S4). The area under the SROC (AUC) for supplemental US screening was 99% (95CIs: 97% to 99%) (Figure 1A). No publication bias was found among these studies (*P* = 0.465).

Among 11 joint screening studies, primary MAM screening could detect 64% (95%CIs: 53% to 74%; I^2 = 93.5%, *P* < 0.01) of breast cancers and identify 97% (95% CIs: 94% to 99%; I^2 = 99.9%, *P* < 0.01) of healthy women (Figure 1B, supplementary S5), respectively. Primary US screening could detect 55% (95%CIs: 37% to 71%; I^2 = 95.5%, *P* < 0.01) of breast cancers and identify 98% (95CIs: 94% to 99%; I^2 = 100%, *P* < 0.01) of healthy women (Figure 1C, supplementary S6). The AUCs for primary MAM screening and primary US screening were 88% (95CIs: 85% to 91%) (Figure 1B) and 90% (95CIs: 87% to 93%) (Figure 1C), respectively. No publication bias was found for both primary MAM screening (*P* = 0.209) and primary US screening (*P* = 0.466). No significant differences were found for either sensitivity [–10.9% (95%CIs: –29.0% to 7.2%), *P* = 0.239; I^2 = 91.8%, *P* < 0.001] or specificity [–0.2% (95%CIs: –0.9% to 0.4%), *P* = 0.510; I^2 = 96.7%, *P* < 0.001] between primary MAM screening and primary US screening (Figure 2).

Screening efficacy for supplemental and primary US screening

Table 3 shows the original data for screening accuracy for supplemental and primary US screening reported by the included studies. Meta-analyses determined that the summary CDR for supplemental US screening was 2.9/1000 (95%CIs: 1.7/1000 to 4.5/1000; I^2 = 85.2%, *P* < 0.001), with a RR of 8.6% (95%CIs: 4.8% to 13.5%; I^2 = 99.7%, *P* < 0.001) and a BR of 3.9% (95%CIs: 2.5% to 5.5%; I^2 = 98.4%, *P* < 0.001) (Figure 3).

The summary CDRs for primary MAM screening and primary US screening were 4.5/1000 (95%CIs: 3.1/1000 to 6.0/1000; I^2 = 89.6%, *P* < 0.001) and 3.7/1000 (95%CIs: 2.4/1000 to 5.2/1000; I^2 = 91.0%, *P* < 0.001), with summary RRs of 4.1% (95%CIs: 2.0% to 7.0%; I^2 = 99.8%, *P* < 0.001) and 5.3% (95%CIs: 2.5% to 9.2%; I^2 = 99.8%, *P* < 0.001), and summary BRs of 1.4% (95%CIs: 0.4% to 2.9%; I^2 = 99.0%, *P* < 0.001) and 1.9% (95%CIs: 0.8% to 3.4%; I^2 = 98.7%, *P* < 0.001) (Figure 4). Compared to primary MAM screening, primary US screening recalled significantly more women with positive screening results [1.2% (95%CIs: 0.4% to 1.9%), *P* = 0.004] (Figure 2). No significant differences were found for either CDR [–0.6/1000 (95%CIs:–1.7/1000 to 0.6/1000, *P* = 0.334; I^2 = 73.8%, *P* < 0.001] or BR [0.6% (95%CIs: –0.1% to 1.2%), *P* = 0.091; I^2 = 92.2%, *P* < 0.001] for primary US screening compared to primary MAM screening (Figure 2).

Cancer characteristics for supplemental and primary US screening

Table 4 shows the original data for cancer characteristics for supplemental and primary US screening reported by the included studies.After meta-analyses, 73.9% (95%CIs: 49.0% to 93.7%; I^2 = 66.4%, *P* = 0.007) of cancers detected by supplemental US screening were invasive cancers, while 72.6% (95%CIs: 51.9% to 90.0%; I^2 = 0.0%, *P* = 0.499) of cancers were node-positive cancers (Figure 3).

Among 11 joint screening studies, 57.1% (95%CIs: 39.8% to 73.6%; I^2 = 88.6%, P < 0.001) and 85.0% (95%CIs: 54.1% to 100.0%; I^2 = 96.2%, P < 0.001) of cancers detected by supplemental US screening and primary MAM screening were invasive cancers, while 58.0% (95%CIs: 28.0% to 85.5%; I^2 = 94.4%, P < 0.001) and 64.1% (95%CIs: 37.8% to 87.3%; I^2 = 91.1 %, P < 0.001) of cancers were node-positive cancers (Figure 4). Compared to primary MAM screening, primary US screening detected significantly more invasive cancers [20.2%, 95% CIs (7.2% to 33.1%), P = 0.002; I^2 = 74.2%, P < 0.001] but a similar number of node-positive cancers [–2.0%, 95% CIs (–13.5% to 9.4%), P = 0.729; I^2 = 57.6%, P = 0.028] (Figure 2).

Subgroup analyses

Subgroup analyses showed very similar results to those of primary analyses (Supplementary S7 and S8). In addition to results comparable to those observed in the primary analyses, lower sensitivity, higher specificity, and higher cancer detection rate were found for supplemental US screening among women with dense breasts compared to those without dense breasts (Supplementary S7). Moreover, the differences for sensitivities, specificities, and cancer detection rates between primary MAM screening and primary US screening were smaller among women with dense breasts compared to those without dense breasts (Supplementary S8).

Discussion

The U.S. Preventive Services Task Force (USPSTF) had initially reviewed the performances and clinical outcomes of supplemental US screening in women with dense breasts or negative mammography [14]. However, only two studies were included. The authors concluded that the effects of supplemental US screening on breast cancer outcomes remain unclear due to sparse good evidence [14]. In addition, Gartlehnerhad systematically reviewed the evidence investigating the joint effectiveness of screening with MAM and US compared to MAM screening alone [40]. However, this review did not investigate the performance of primary US screening. Our study is the first systematic review and meta-analysis to investigate the performance of primary US screening for breast cancer, and this is also an important up-to-date systematic review and meta-analysis investigating the performance of supplemental US screening.

The role of supplemental US screening was first addressed in ACRIN 6666 by Berg in 2008 [4]. Berg concluded that adding US screening to MAM screening would yield an additional 1.1 to 7.2 cancers per 1000 high-risk women [4]. Our analyses also found a similar additional 1.8 to 3.9 cancers per 1000 examinations. Moreover, after re-analysis of ACRIN 6666, Berg concluded that ultrasound could be used as the primary screening test for breast cancer [11]. However, up to now, there have been no consistent conclusions concerning whether US screening should be recommended as a screening test for women in the screening guidelines for breast cancer. For example, the National Comprehensive Cancer Network, the European Society of Breast Imaging (EUSOBI), the Japanese Breast Cancer Society, and the Chinese Anti-Cancer Association (CACA) supported that supplemental US screening should be recommended for women with dense breasts after negative mammogram [41–44], while no clear recommendations of US screening were suggested by the USPSTF, the American Cancer Society, the American College of Physicians, and the Canadian Task Force on Preventive Health Care [45–48].

Several reasons would lead to these inconsistent recommendations among current guidelines. As argued by USPSTF, sparse good evidence would be the major reason. However, as shown in our study, several high-quality studies and fair-quality studies had been conducted since 2003. Although EUSOBI supported supplemental US screening after MAM, it also addressed the concern that breast US was inappropriately suggested to be a primary screening method since primary US screening had not been shown to reduce mortality of breast cancer in the general female population. Moreover, US would lead to more biopsies and recalls than MAM [44]. In this systematic review, we did observe higher recall rates for US compared to MAM. We also observed higher biopsy rates for US compared to MAM; however, the difference was nonsignificant. This nonsignificant difference in biopsy rates between US and MAM may be due to small sample sizes, but it may also reflect no actual difference. In addition, there are several limitations of breast ultrasound that would make it inappropriate for a screening test. These include: US cannot take an image of the whole breast at once as MAM does; US cannot show microcalcifications, which would be the most common feature of tissue around a tumor; the skill level of the US operators makes a great difference in the screening results. However, as shown in our study, these concerns seemed not to cause significant differences in the sensitivity and specificity, or even in cancer detection rates and cancer characteristics (such as the proportion of node-positive cancers) between primary US screening and primary MAM screening. Moreover, lower price, larger coverage, absence of radiation effects, and lower overdiagnosis rates for US compared to MAM make US more easily accepted in China and other countries [3, 49, 50].Therefore, Chinese Anti-Cancer Association and other societies supported supplemental US screening in their guidelines.

Lastly, the following results are significant. First, we observed significantly higher RR and ProIC for primary US screening compared with primary MAM screening. Higher recall rates would be an important barrier to promote US screening. More studies are needed to investigate the factors influencing false positive caused by US screening so as to reduce unnecessary recalls. In contrast to the higher rate of detection of microcalcified cancers by MAM, detection of more invasive cancers by US would be another potential advantage compared to MAM, since we usually cannot classify invasive cancers as overdiagnosed cancers. Second, we did not observe obvious differences in the performance of supplemental US screening between women with and without dense breasts. These results further support the position that the performance of supplemental US screening would not be easily influenced by dense breasts. However, we also did not observe significantly higher sensitivity for US compared to MAM among women with dense breasts. Small sample size could be an important factor, since only three of 11 included studies recruited women with dense breasts.

Limitations

First, due to lack of evidence for reduced mortality from breast cancer, we cannot conclude that US screening would lead to a long-term benefit. Second, in addition to breast density, no studies investigated whether other risk factors (such as obesity) influenced the differences in screening performance between US and MAM. Therefore, we cannot conclude whether these different performances between US and MAM derived from confounding effects or from the actual

differences between US and MAM. Third, missing data in several important performance indexes, such as recall rate and biopsy rate, could lead to biased results. Uniform reporting guidelines for US or MAM screening studies are needed to improve comparability between different studies.

Conclusions

Current evidence suggests that supplemental US screening could detect occult breast cancers missed by MAM, while primary US screening would be considered as comparable to primary MAM screening in certain subgroup of women, but with a higher recall rate and a higher detection rate for invasive cancers. More studies are needed to investigate the long-time benefits of US screening, and to investigate the influential factors of false positive caused by US screening to reduce unnecessary recall back. Moreover, we hope that US screening for breast cancer should deserve more attention in the future, not only because US has potential less overdiagnosis and comparable performance as MAM in certain subgroup of women, but also because ultrasound is not radiated and is easier to access in low-resources areas, such as Chinese rural areas.

Abbreviations

ABUS: automated whole breast ultrasonography; BR: biopsy rate; CDR: cancer detected rate; HHUS: hand-held ultrasonography; MAM: Mammography; ProIC: proportions of invasive cancers; ProNPC: node-positive cancers; RR: recall rate; US: ultrasonography; USPSTF: the U.S. Preventive Services Task Force; EUSOBI: European Society of Breast Imaging; CACA: Chinese Anti-Cancer Association.

Declarations

Ethics approval and consent to participate

Not applicable

Consent for publication

Yes

Availability of data and materials

The datasets analysed during the current study available from the corresponding author on reasonable request.

Competing interests

The authors declare that they have no competing interests.

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Authors’ contributions

LY drafted and revised the manuscript. SW analyzed the data. LZ and CS colleted the data. YH conceived and designed the study. All authors contributed interpreted findings, and reviewed and approved the final version to be submitted.

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Tables

Table 1. Characteristics of included studies

Author, year	Country	Age, years	PerDB, %	Type of US	Sample size	Screening mode	Exclusion of BC	Blinding	Complete data	BIRADS criteria	FU, months	Quality assessm
Supplemental US screening studies												
Tagliafico, 2016[19]	Italy	51	100	HHUS	3231	Community screening	Yes	-	Yes	No	<12	Fair
Kim, 2016[20]	South Korea	NR	100	HHUS	3171	Opportunistic screening	Yes	-	Yes	No	12	Fair
Weigert, 2015[24]	United States	NR	100	HHUS	10282	Opportunistic screening	NR	-	Yes	Yes	6	Fair
Hwang, 2015[23]	South Korea	50	78	HHUS	1727	Opportunistic screening	No	-	No	Yes	12	Fair
Moon, 2015[22]	South Korea	53	64	HHUS	2005	Opportunistic screening	NR	-	Yes	Yes	24	Fair
Parris, 2013[26]	United States	52	100	HHUS	5519	Opportunistic screening	No	-	Yes	Yes	NR	Fair
Girardi, 2013[25]	Italy	51	45	HHUS	22131	Opportunistic screening	No	-	Yes	Yes	NR	Fair
Leong, 2012[30]	Singapore	45	100	HHUS	106	Community screening	No	-	Yes	No	12-24	Fair
Hooley, 2012[29]	United States	52	100	HHUS	648	Opportunistic screening	No	-	Yes	Yes	>15	Fair
Corsetti, 2011[31]	Italy	NR	100	HHUS	3356	Opportunistic screening	Yes	-	Yes	No	12	Fair
Youk, 2011[32]	South Korea	48	100	HHUS	446	Opportunistic screening	No	-	Yes	Yes	24	Fair
Brancato, 2007[34]	Italy	52	100	HHUS	5227	Opportunistic screening	NR	-	Yes	Yes	NR	Fair
Joint screening studies												
Dong, 2017[9]	China	52	44	HHUS	31918	Community screening	Yes	Yes	Yes	No	12	High
Ohuchi, 2016[10]	Japan	44	NR	HHUS	36752	Community screening	Yes	Yes	Yes	Yes	12	High
Berg, 2016[11]	United States	55	100	HHUS	2662	High-risk screening	Yes	Yes	Yes	Yes	>12	High
Shen, 2015[21]	China	46	NR	HHUS	4135	High-risk screening	Yes	Yes	No	Yes	12	High
Brem, 2015[37]	United States	53	100	ABUS	15318	Community screening	Yes	No	Yes	Yes	12	High
Huang, 2012[28]	China	46	48	HHUS	3028	Opportunistic screening	Yes	Yes	Yes	Yes	12	High
Kelly, 2010[38]	United States	53	68	ABUS	4419	High-risk screening	No	Yes	Yes	Yes	12	High
Wilczek, 2016[36]	Sweden	50	100	ABUS	1668	Community screening	Yes	No	Yes	No	24	Fair
Venturini, 2013[27]	Italy	46	55	HHUS	1666	Community screening	Yes	No	No	Yes	6	Fair
Weinstein, 2009[33]	United States	49	60	HHUS	609	High-risk screening	No	Yes	No	Yes	12	Fair
Honjo, 2007[35]	Japan	NR	NR	HHUS	3453	Community screening	NR	Yes	Yes	No	≥18	Fair

PerDB, percent of women with dense breasts accounted for the whole population; US, ultrasonography; BC, breast cancer; BIRADS, Breast Imaging-Reporting and Data System; FU, follow-up; HHUS/ABUS, hand-held / automated breast ultrasonography.

Table 2. Screening accuracy for supplemental and primary US screening

Author, year	Method	Case		Non-case		Sensitivity	Specificity
		+	-	+	-	(95% CI)	(95% CI)
Supplemental US screening studies							
Tagliafico, 2016[19]	Supplemental US	23	1	65	3142	0.96(0.77-1.00)	0.98(0.97-0.98)
Kim, 2016[20]	Supplemental US	9	0	822	2340	1.00(0.63-1.00)	0.74(0.72-0.76)
Weigert, 2015[24]	Supplemental US	24	15	411	9832	0.62(0.45-0.76)	0.96(0.96-0.96)
Hwang, 2015[23]	Supplemental US	8	1	92	1626	0.89(0.51-0.99)	0.95(0.93-0.96)
Moon, 2015[22]	Supplemental US	4	0	619	1382	1.00(0.40-1.00)	0.69(0.67-0.71)
Parris, 2013[26]	Supplemental US	10	0	175	5334	1.00(0.66-1.00)	0.97(0.96-0.97)
Girardi, 2013[25]	Supplemental US	41	0	381	21709	1.00(0.89-1.00)	0.98(0.98-0.98)
Leong, 2012[30]	Supplemental US	2	0	12	92	1.00(0.20-1.00)	0.88(0.80-0.94)
Hooley, 2012[29]	Supplemental US	3	0	150	495	1.00(0.31-1.00)	0.77(0.73-0.80)
Corsetti, 2011[31]	Supplemental US	32	8	363	6821	0.80(0.64-0.90)	0.95(0.94-0.95)
Youk, 2011[32]	Supplemental US	10	1	41	394	0.91(0.57-1.00)	0.91(0.87-0.93)
Brancato, 2007[34]	Supplemental US	2	0	21	5204	1.00(0.20-1.00)	1.00(0.99-1.00)
Joint screening studies							
Dong, 2017[9]	Primary MAM	84	15	604	31215	0.85(0.76-0.91)	0.98(0.98-0.98)
	Primary US	61	38	389	31430	0.62(0.51-0.71)	0.99(0.99-0.99)
Ohuchi, 2016[10]	Primary MAM	117	85	2300	33547	0.58(0.51-0.65)	0.94(0.93-0.94)
	Primary US	143	59	2289	33558	0.71(0.64-0.77)	0.94(0.93-0.94)
Berg, 2016[11]	Primary MAM	59	52	700	6662	0.53(0.43-0.63)	0.90(0.90-0.91)
	Primary US	58	53	1012	6350	0.52(0.43-0.62)	0.86(0.85-0.87)
Shen, 2015[21]	Primary MAM	8	6	3	6913	0.57(0.30-0.81)	1.00(1.00-1.00)
	Primary US	14	0	6	6910	1.00(0.73-1.00)	1.00(1.00-1.00)
Brem, 2015[37]	Primary MAM	82	30	2219	12987	0.73(0.64-0.81)	0.85(0.85-0.86)
	Primary US	30	82	2721	12485	0.27(0.19-0.36)	0.82(0.81-0.83)
Huang, 2012[28]	Primary MAM	28	5	48	2947	0.85(0.67-0.94)	0.98(0.98-0.99)
	Primary US	24	9	19	2976	0.73(0.54-0.86)	0.99(0.99-1.00)
Kelly, 2010[38]	Primary MAM	23	34	36	4326	0.40(0.28-0.54)	0.99(0.99-0.99)
	Primary US	38	19	61	4301	0.67(0.53-0.78)	0.99(0.98-0.99)
Wilczek, 2016[36]	Primary MAM	7	4	16	1641	0.64(0.32-0.88)	0.99(0.98-0.99)
	Primary US	4	7	27	1630	0.36(0.12-0.68)	0.98(0.98-0.99)
Venturini, 2013[27]	Primary MAM	12	2	99	1553	0.86(0.56-0.97)	0.94(0.93-0.95)
	Primary US	2	12	8	813	0.14(0.03-0.44)	0.99(0.98-1.00)
Weinstein, 2009[33]	Primary MAM	6	12	25	566	0.33(0.14-0.59)	0.96(0.94-0.97)
	Primary US	3	15	66	483	0.17(0.04-0.42)	0.88(0.85-0.91)
Honjo, 2007[35]	Primary MAM	7	6	272	3258	0.54(0.26-0.80)	0.92(0.91-0.93)
	Primary US	6	7	159	3371	0.46(0.20-0.74)	0.95(0.95-0.96)

CI, confidential interval; MAM, mammography; US, ultrasonography.

Table 3. Screening efficacy for supplemental and primary US screening

Author, year	Method	Cancer detected rate		Recall rate, %		Biopsy rate, %	
		Number	95%CI, 1/1000	Number	95%CI	Number	95%CI
Supplemental US screening studies							
Tagliafico, 2016[19]	Supplemental US	23/3231 women	7.1(4.6-10.8)	88/3231	2.7(2.2-3.4)	46/3231	1.4(1.1-1.9)
Kim, 2016[20]	Supplemental US	9/3171 women	2.8(1.4-5.6)	831/3171	26.2(24.7-27.8)	131/3171	4.1(3.5-4.9)
Weigert, 2015[24]	Supplemental US	24/10282 women	2.3(1.5-3.5)	435/10282	4.2(3.9-4.6)		
Hwang, 2015[23]	Supplemental US	8/1727 women	4.6(2.2-9.5)	100/1727	5.8(4.8-7.0)	37/1727	2.1(1.5-3.0)
Moon, 2015[22]	Supplemental US	4/2005 women	2.0(0.6-5.5)	623/2005	31.1(29.1-33.2)		
Parris, 2013[26]	Supplemental US	10/5519 women	1.8(0.9-3.4)	185/5519	3.4(2.9-3.9)	185/5519	3.4(2.9-3.9)
Girardi, 2013[25]	Supplemental US	41/22131 women	1.9(1.3-2.5)	422/22131	1.9(1.7-2.1)	422/22131	1.9(1.7-2.1)
Leong, 2012[30]	Supplemental US	2/106 women	18.9(3.3-73.2)	14/106	13.2(7.7-21.5)	14/106	13.2(7.7-21.5)
Hooley, 2012[29]	Supplemental US	3/648 women	4.6(1.2-14.7)	153/648	23.6(20.4-27.1)	46/648	7.1(5.3-9.4)
Corsetti, 2011[31]	Supplemental US	32/7224 examinations	4.4(3.1-6.3)	395/7224	5.5(5.0-6.0)	395/7224	5.5(5.0-6.0)
Youk, 2011[32]	Supplemental US	10/446 examinations	22.4(11.4-42.2)	51/446	11.4(8.7-14.8)	49/446	11.0(8.3-14.4)
Brancato, 2007[34]	Supplemental US	2/5227 women	0.4(0.1-1.5)	23/5227	0.4(0.3-0.7)	23/5227	0.4(0.3-0.7)
Joint screening studies							
Dong, 2017[9]	Primary MAM	84/31918 women	2.6(2.1-3.3)	688/31918	2.2(2.0-2.3)		
	Primary US	61/31918 women	1.9(1.5-2.5)	450/31918	1.4(1.3-1.5)		
Ohuchi, 2016[10]	Primary MAM	117/36049 women	3.2(2.7-3.9)	2417/36049	6.7(6.4-7.0)		
	Primary US	143/36049 women	4.0(3.4-4.7)	2432/36049	6.7(6.5-7.0)		
Berg, 2016[11]	Primary MAM	59/7473 examinations	7.9(6.1-10.2)	453/7473	6.1(5.5-6.6)	97/7473	1.3(1.1-1.6)
	Primary US	58/7473 examinations	7.8(6.0-10.1)	515/7473	6.9(6.3-7.5)	266/7473	3.6(3.2-4.0)
Shen, 2015[21]	Primary MAM	8/6930 examinations	1.2(0.5-2.4)	11/6930	0.2(0.1-0.3)	7/6930	0.1(0.0-0.2)
	Primary US	14/6930 examinations	2.0(1.2-3.5)	20/6930	0.3(0.2-0.5)	17/6930	0.2(0.1-0.4)
Brem, 2015[37]	Primary MAM	82/15318 women	5.4(4.3-6.7)	2301/15318	15.0(14.5-15.6)	586/15318	3.8(3.5-4.1)
	Primary US	30/15318 women	2.0(1.3-2.8)	2751/15318	18.0(17.4-18.6)	552/15318	3.6(3.3-3.9)
Huang, 2012[28]	Primary MAM	28/3028 women	9.2(6.3-13.5)	105/3028	3.5(2.9-4.2)		
	Primary US	24/3028 women	7.9(5.2-12.0)	318/3028	10.5(9.4-11.7)		
Kelly, 2010[38]	Primary MAM	23/4419 women	5.2(3.4-7.9)	59/4419	1.3(1.0-1.7)	59/4419	1.3(1.0-1.7)
	Primary US	38/4419 women	8.6(6.2-11.9)	99/4419	2.2(1.8-2.7)	99/4419	2.2(1.8-2.7)
Wilczek, 2016[36]	Primary MAM	7/1668 women	4.2(1.8-9.0)	23/1668	1.4(0.9-2.1)	11/1668	0.7(0.3-1.2)
	Primary US	4/1668 women	2.4(0.8-6.6)	31/1668	1.9(1.3-2.7)	12/1668	0.7(0.4-1.3)
Venturini, 2013[27]	Primary MAM	12/1666 women	7.2(3.9-12.9)	76/1666	4.6(3.6-5.7)	14/1666	0.8(0.5-1.4)
	Primary US	2/835 women	2.4(0.4-9.6)	87/835	10.4(8.5-12.7)	10/835	1.2(0.6-2.3)
Weinstein, 2009[33]	Primary MAM	6/609 women	9.9(4.0-22.4)	31/609	5.1(3.5-7.2)	21/609	3.4(2.2-5.3)
	Primary US	3/567 women	5.3(1.4-16.7)	39/567	6.9(5.0-9.4)	20/567	3.5(2.2-5.5)
Honjo, 2007[35]	Primary MAM	7/3543 women	2.0(0.9-4.3)	279/3543	7.9(7.0-8.8)		

Primary US	6/3543 women	1.7(0.7-3.9)	165/3543	4.7(4.0-5.4)	

CI, confidential interval; MAM, mammography; US, ultrasonography.

Table 4. Cancer characteristics for supplemental and primary US screening for breast cancer

Author, year	Method	Proportions of invasive cancers, %		Proportions of node-positive cancers, %	
		Number	95%CI	Number	95%CI
Supplemental US screening studies					
Tagliafico, 2016[19]	Supplemental US	22/23	95.7(78.1-99.9)	13/21	61.9(38.4-81.9)
Kim, 2016[20]	Supplemental US	7/9	77.8(40.0-97.2)		
Weigert, 2015[24]	Supplemental US	10/22	45.5(24.4-67.8)		
Hwang, 2015[23]	Supplemental US	7/8	87.5(47.4-99.7)	6/7	85.7(42.1-99.6)
Moon, 2015[22]	Supplemental US	2/4	50.0(6.8-93.2)	1/2	50.0(1.3-98.7)
Leong, 2012[30]	Supplemental US	1/2	50.0(1.3-98.7)		
Hooley, 2012[29]	Supplemental US	2/3	66.7(9.4-99.2)	2/2	100(15.8-100)
Joint screening studies					
Dong, 2017[9]	Primary MAM	14/83	16.9(9.5-26.7)	49/68	72.1(59.9-82.3)
	Primary US	7/83	8.4(3.5-16.6)	34/68	50.0(37.6-62.4)
Ohuchi, 2016[10]	Primary MAM	73/116	62.9(53.5-71.7)	54/113	47.8(38.3-57.4)
	Primary US	111/140	79.3(71.6-85.7)	89/141	63.1(54.6-71.1)
Berg, 2016[11]	Primary MAM	41/59	69.5(56.1-80.8)	47/59	79.7(67.2-89.0)
	Primary US	53/58	91.4(81.0-97.1)	50/58	86.2(74.6-93.9)
Brem, 2015[37]	Primary MAM	51/82	62.2(50.8-72.7)	2/48	4.2(0.5-14.3)
	Primary US	28/30	93.3(77.9-99.2)	2/27	7.4(0.9-24.3)
Kelly, 2010[38]	Primary MAM	17/23	73.9(51.6-89.8)		
	Primary US	35/38	92.1(78.6-98.3)		
Wilczek, 2016[36]	Primary MAM	5/7	71.4(29.0-96.3)		
	Primary US	4/4	100(39.8-100)		
Venturini, 2013[27]	Primary MAM	8/12	66.7(34.9-90.1)	1/5	20.0(0.5-71.6)
	Primary US	2/2	100(15.8-100)	1/2	50.0(1.3-98.7)
Weinstein, 2009[33]	Primary MAM	3/6	50.0(11.8-88.2)	3/3	100(29.2-100)
	Primary US	3/3	100(29.2-100)	3/3	100(29.2-100)
Honjo, 2007[35]	Primary MAM	3/7	42.9(9.9-81.6)	3/3	100(29.2-100)
	Primary US	5/6	83.3(35.9-99.6)	4/4	100(39.8-100)

CI, confidential interval; MAM, mammography; US, ultrasonography.

Figures

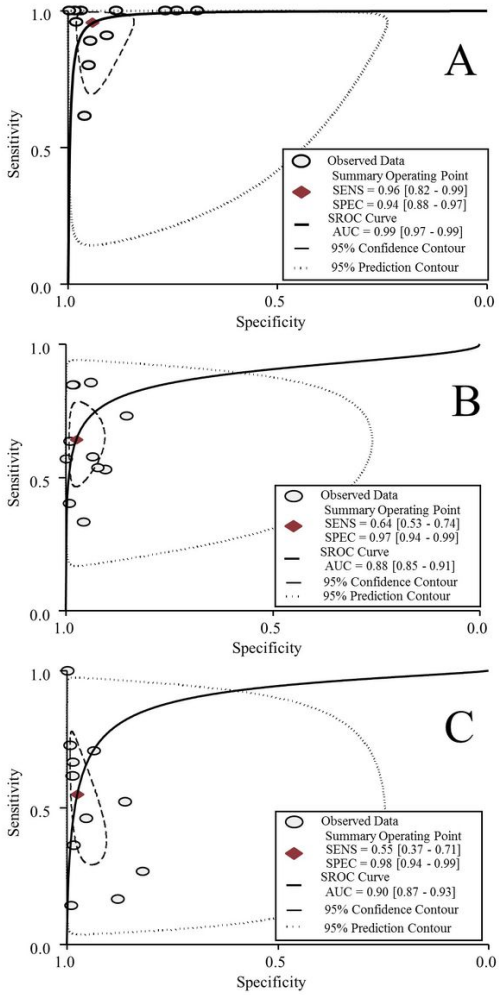

Figure 1

Summary receiver operating characteristic (SROC) curve for supplemental US screening (A), primary MAM screening (B), and primary US screening (C) for breast cancer.

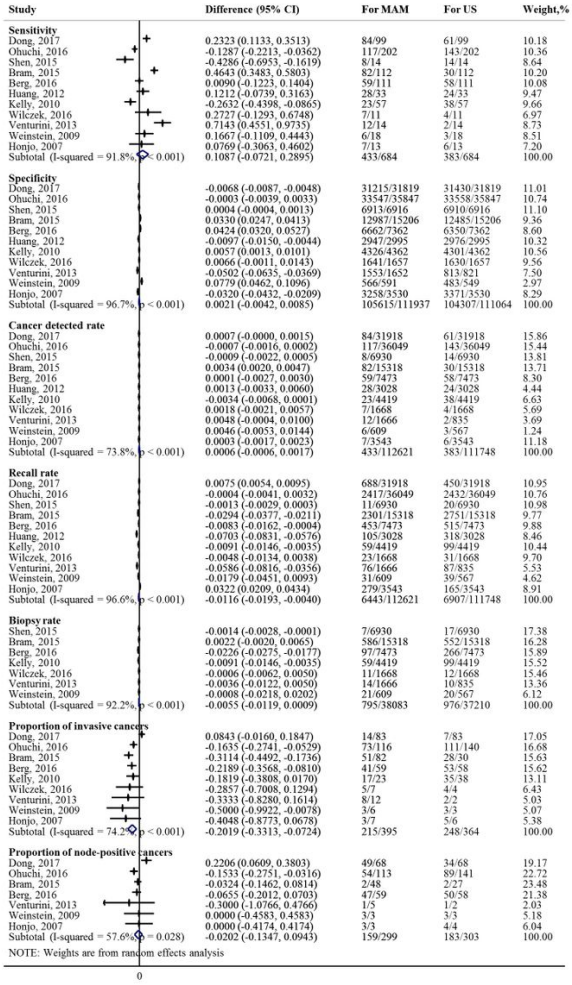

Figure 2

Comparisons on the performances for primary MAM and US screening for breast cancer.

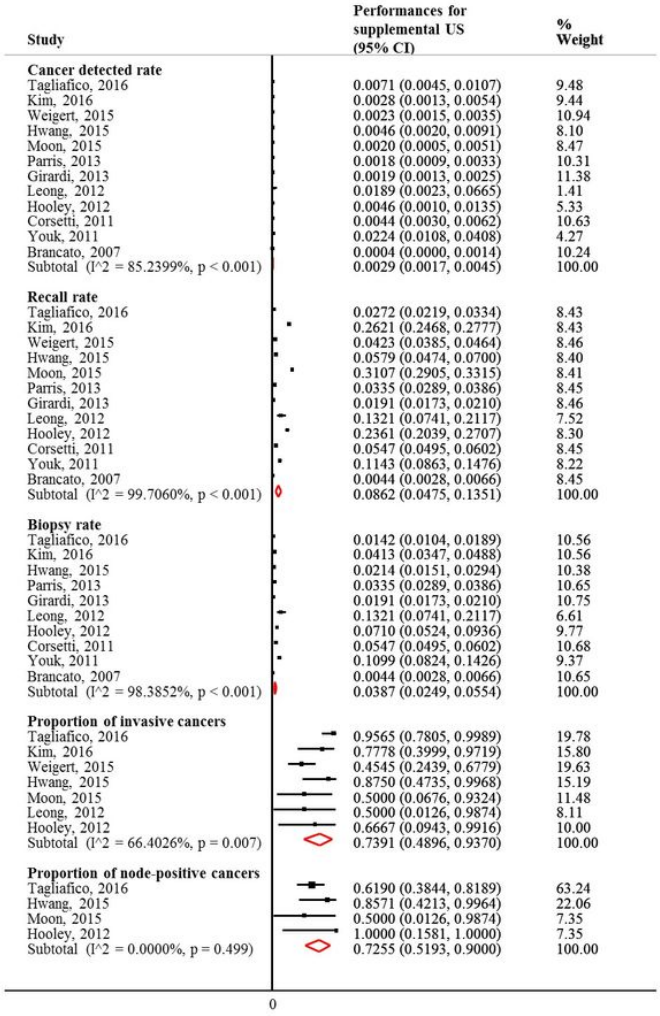

Figure 3

Screening efficacy for supplemental US screening for breast cancer.

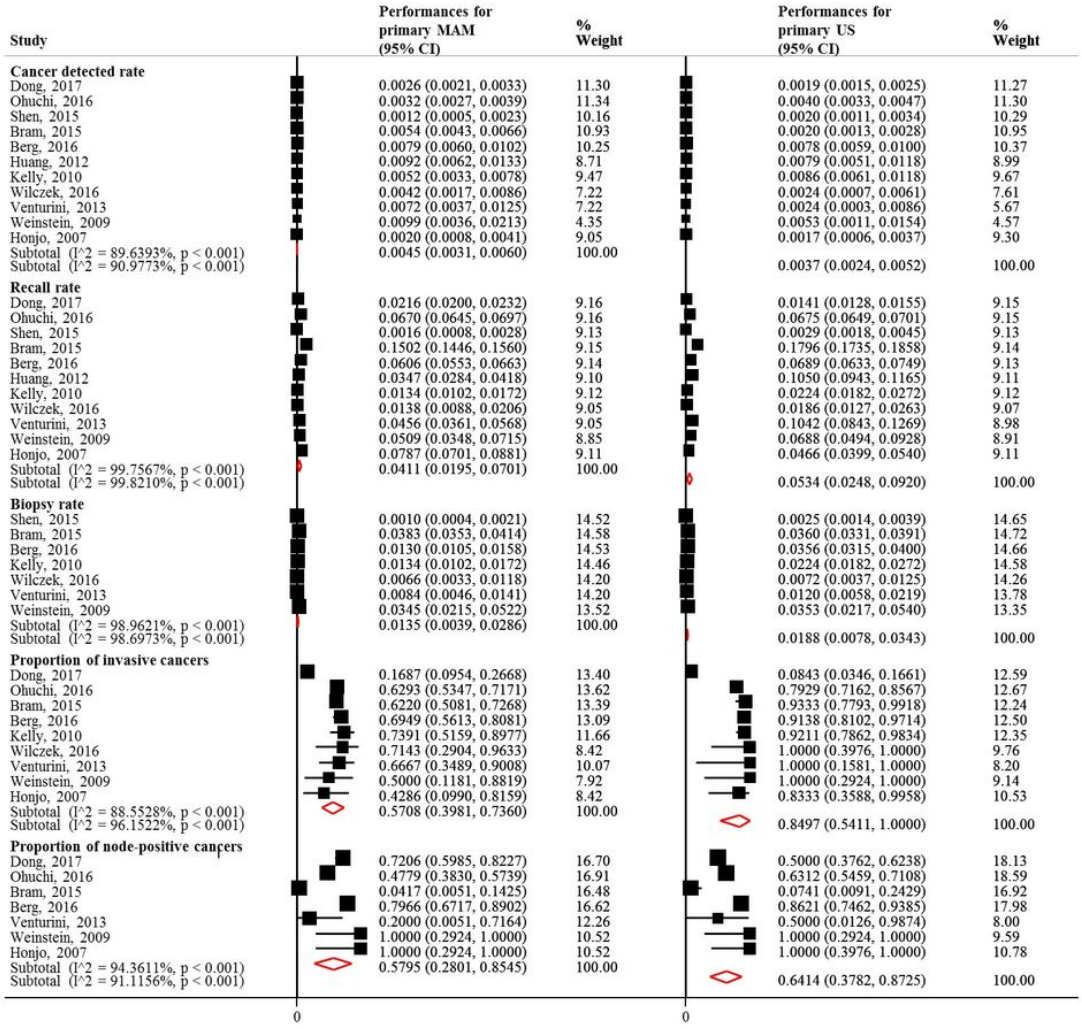

Figure 4

Screening efficacy for primary MAM and US screening for breast cancer.