**Peer Reviewer Comments**

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| **No.** | **Reviewers’ comments** | **Authors’ responses** |
|  | **Reviewer 1** |  |
| 1. | What is the role of breast ultrasound in screening? The author can mention it in the paper | Ultrasound is not a primary screening tool for breast since it lacks both sensitivity and specificity. It is often used in conjunction with mammography to rule out benign breast diseases such as cysts and fibroadenomata. |
| 2. | The author refers to two large population-based studies in Russia and Shanghai in the last para of the first page. He has to provide a reference for this. | [The same reference as the Cochrane review cited.] |
| 3. | On page 2 para 4 last line the author makes a statement that the cost of pursuing false positives – emotional and financial – are large. This can be explained in greater detail as it is relevant to the ethics of this discussion | False positive mammography tests have to be followed up with more specific testing such as a biopsy. The emotional cost of waiting till the results are negated is high as also the financial costs of further testing. There are also a subset of women who will undergo definitive procedures like a mastectomy only to find out that there is no malignancy. |
| 4. | The role of the media has been mentioned. This should be clarified. How is it relevant to breast cancer screening? | The media can play a large role in highlighting the risks of mammography screening and, in the Indian context, point out that there needs to be an established system in place for managing women who are diagnosed with cancer. In the absence of such, screening mammography is a futile exercise. |
| 5. | There are 3 million breast cancer patients, if we go by the reported assumptions. What are the costs of missing them, costs over time for 12 studies? Are they less than the costs of screening + the costs of treatment? What is the harm of not having the programme? Can one person’s opportunity be withheld to benefit 9 women from having a false positive diagnosis and psychological distress, and another 90 women from being subject to 12 regular check-ups? Cancer worry in unscreened persons can be a distress too.  [Hilgart JS, Coles B, Iredale R. Cancer genetic risk assessment for individuals at risk of familial breast cancer. Cochrane Database of Systematic Reviews 2012, Issue 2. Art. No.: CD003721. DOI: 10.1002/14651858.CD003721.pub3] | The same answer as above: the continuum of care that is needed is sorely lacking in India. |
| 6. | The main argument the author makes against breast cancer screening in LMICs is that of cost intensiveness in terms of infrastructure, human resources and quality assurances, and needs to be elaborated further to develop an ethics angle to this article. Arguments of resource allocation and justice need to be teased out by the author to make this manuscript relevant to the readership of an ethics journal as opposed to a general surgery journal. | Agreed but I am not qualified to comment. l lack the background expertise. I will leave it to the reader to fill in the gaps. I think they are apparent. |
| 7. | Writing this paper from a clinician’s perspective – the clinicians dilemmas is great. However, statements on screening as a public health strategy need to draw up on more systemic and policy issues. For instance, the health system in India has been that of visualizing women’s health largely as maternal health and family planning – that the health system is looking beyond these to other women’s health issues can be regarded as a welcome change. | As above |
|  | **Reviewer 2** |  |
| 1. | We need studies evaluating the clinical examination as a tool, as per recommendation of WHO, in resource poor environments. There are no well -organized studies in this area, and current trend of mass screening with mammography draining resources in a situation where treatment is denied because of lack of access and resources, cannot be ethically justified. Screening of high risk population i.e. those with positive family history or genetic predisposition, with mammography is being justified by world literature but this again requires studies based on populations like ours. The author of the manuscript is in favor of this cohort being screened. An interesting article on Pink ribbon campaign <https://eluxemagazine.com/magazine/pink-ribbon-scandal-a-campaign-of-neglect/> | I hold on to the contention regarding screening indications. The article cited is from a general readership magazine. |
| 2. | There are clearly ethical issues in using screening as a tool in isolation, without being able to provide treatment to those who are flagged by the screening process. This would be an angle that the manuscript could further expand upon. | See above. |
| 3. | The challenge is to make a moral argument for forgoing a potentially available screening process because the state cannot provide treatment to those who test positive. Embedding equity throughout the breast cancer care continuum (in quality and access) should be the real focus moving forward —http://www.wellesleyinstitute.com/health/focusing-on-equity-in-breast-cancer-car. One would have liked this manuscript to expand in this area. | See above |