To: The Honorable Pam Beidle, Chair
Finance Committee

FROM: Emily Ambinder, MD
Pouneh Razavi, MD

DATE: March 20, 2026

RE: **UNFAVORABLE - HB1364** *Public Health – Mammograms – Arterial Calcification Notice*

Introduction

The undersigned breast radiologists at Johns Hopkins Medicine write in strong opposition to House Bill 1364, which would require mammography centers to include a standardized notice regarding breast arterial calcification (BAC) in every patient mammogram results letter. While we share the legislature's commitment to advancing women's health, we believe this legislation is premature, not adequately supported by the current evidence base, and risks undermining the primary purpose of mammography: the early detection of breast cancer.

I. Mammography Exists to Detect Breast Cancer: That Focus Must Be Protected

Screening mammography is a powerful tool for detecting breast cancer at its earliest and most treatable stages. Decades of evidence and clinical practice have refined both the technology and the reporting systems that support this singular, life-saving mission.

Requiring radiologists to systematically document and communicate BAC findings in every mammogram results letter, including in letters sent directly to patients, risks diluting that focus. Patients receiving their mammogram results may already be navigating anxiety-provoking information about breast cancer risk. Inserting mandatory language about cardiovascular disease introduces a separate and complex medical issue into a communication designed for a different purpose, and may cause confusion, unnecessary alarm, or distraction from the cancer-related findings that require their primary attention.

II. Acknowledging the Association Does Not Justify a Mandatory Reporting Requirement

We recognize that published research, including several systematic reviews and meta-analyses, has identified a statistical association between BAC and cardiovascular outcomes such as coronary artery disease, stroke, and heart failure.

A 2023 meta-analysis of 87,865 patients found pooled risk ratios ranging from 1.24 to 2.06 for various cardiovascular endpoints.[5] However, the existence of a statistical association does not, by itself, justify a population-wide legislative reporting mandate. Several critical limitations remain.

- There is no established clinical pathway for patients notified of BAC. Unlike an abnormal mammogram finding that triggers a well-defined follow-up protocol, a BAC notification lacks a clear, evidence-based next step for most patients. Notifying patients of a finding without a defined management algorithm risks generating anxiety without benefit.
- There is no validated, standardized method for quantifying or grading BAC. Unlike coronary artery calcium (CAC) scoring, which uses the well-established Agatston score, BAC assessment in mammography lacks equivalent standardization.[6] Mandating a patient notice based on an unstandardized finding risks inconsistency across institutions and readers.
- The meta-analyses themselves demonstrate high heterogeneity across studies (I^2 values of 61–77%), reflecting significant variability in study design, patient populations, BAC assessment methods, and endpoints.[5,7] This variability cautions against applying population-level findings to individual patient notifications.
- The biology of BAC is fundamentally different from coronary artery calcification. BAC represents *medial* (Monckeberg's) calcification of the arterial tunica media, whereas coronary artery disease involves *intimal* calcification driven by atherosclerosis. These are distinct pathophysiological processes, and conflating them in mandatory patient communications may be scientifically misleading.[4]
- Established cardiovascular risk assessment tools, including the Pooled Cohort Equations, the Framingham Risk Score, and CAC scoring, have robust, peer-reviewed evidence supporting their clinical use.[1,2,3] No evidence currently demonstrates that adding BAC notification to mammogram letters improves cardiovascular outcomes beyond what these validated tools already provide.

Even individual studies reporting strong associations show the limited clinical utility of BAC as a positive signal. A 2022 prospective study found that BAC had a positive predictive value (PPV) of only 55% for significant coronary artery calcification, meaning nearly half of all women notified of BAC would not have meaningful coronary disease burden. The negative predictive value (NPV) in that same study was 86.7%, indicating that the absence of BAC is more informative than its presence. A separate study examining BAC in a Scottish chest pain cohort similarly found that while BAC absence carried a high NPV for excluding significant coronary calcification, BAC presence had poor PPV. These modest and variable predictive values reinforce that BAC is not ready for mandatory population-wide patient notification

Mandating patient-facing language about BAC without an adequate framework for what patients and clinicians should do with that information risks causing harm through overutilization of testing, unnecessary anxiety, and confusion about clinical priorities.

III. Clinical Judgment, Not Legislative Mandate, Is the Appropriate Framework

Breast radiologists are trained to recognize clinically significant findings and communicate them appropriately. When a radiologist identifies extensive or notable BAC, particularly in a younger patient where such a finding may carry greater significance, it is already standard practice to document this in

the radiology report for the referring physician's consideration. This approach preserves appropriate clinical context and physician-to-physician communication.

A one-size-fits-all legislative requirement mandating a standardized patient notice for every instance of BAC, regardless of its extent, clinical context, or the patient's individual risk profile, is not appropriate. Medicine is not well served by legislative scripts that cannot account for clinical nuance.

IV. Conclusion and Recommendations

We respectfully urge the committee to oppose House Bill 1364. Our position is not rooted in indifference to cardiovascular health. It reflects our commitment to evidence-based medicine and to protecting the integrity of mammography as a primary breast cancer detection tool. Reporting requirements of this kind should be driven by clinical consensus and validated outcome data, not legislative mandate.

We appreciate the legislature's commitment to women's health and welcome the opportunity to work collaboratively toward policies that are both well-intentioned and well-supported by evidence. We respectfully request that HB 1364 not be advanced at this time.

Respectfully submitted,

Emily Ambinder, MD
Division Chief of Breast Imaging
Johns Hopkins Medicine

Pouneh Razavi, MD
Director of Breast Imaging National Capital Region
Johns Hopkins Medicine

References

1. Goff DC Jr, Lloyd-Jones DM, Bennett G, et al. 2013 ACC/AHA Guideline on the Assessment of Cardiovascular Risk: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. Circulation. 2014;129(25 Suppl 2):S49–73.

2. D'Agostino RB Sr, Vasan RS, Pencina MJ, et al. General cardiovascular risk profile for use in primary care: the Framingham Heart Study. Circulation. 2008;117(6):743–753.

3. Detrano R, Guerci AD, Carr JJ, et al. Coronary calcium as a predictor of coronary events in four racial or ethnic groups. N Engl J Med. 2008;358(13):1336–1345.

4. Abedin M, Tintut Y, Demer LL. Vascular calcification: mechanisms and clinical ramifications. Arterioscler Thromb Vasc Biol. 2004;24(7):1161–1170.

5. Koh J, Dodd JD, Murphy DJ, et al. Association between breast arterial calcifications and cardiovascular disease: a systematic review and meta-analysis. Can J Cardiol. 2023;39(12):1941–1950.

6. Osman M, Dodd JD, Hensey C, et al. Association between breast arterial calcification on mammography and coronary artery disease: a systematic review and meta-analysis. J Womens Health (Larchmt). 2022;31(12):1719–1726.

7. Pecoraro M, Laporta A, Borghetti G, et al. Is breast arterial calcification associated with coronary artery disease? A systematic review and meta-analysis. PLoS One. 2020;15(7):e0236598.