

# [Barriers to breast cancer screening and mammograms](https://assignbuster.com/barriers-to-breast-cancer-screening-and-mammograms/)

### Abstract

The mammography screening recommendations have been ambiguous and disagree with suggesting institute to institute.  Thus, it is up to women to make choices about mammogram inspection based on theirpersonal health beliefs.  This paper explores 6 published articles that report results from various research conducted on women with an averagerisk of breast cancer. These studies examined the connection between observed benefits and alleged barriers to mammography and compliance with mammography screening in women age 40 and older and among minorities.  It also discusses the latest findings and guidelines according to the American Cancer Society.  Other articles discuss their reviews to support mammogram screening for women under 50, a systemic review of the benefits and harms of breast cancer screening and factors that influence breast cancer screening in Asian countries.

## Introduction

Currently, breast cancer is one ofthe most common cancers in women and one of the chief causes of deathworldwide. (Oeffinger, Fontham, Etzioni, et al.) According to the American Cancer Society 2015, it is the leadingcontributor to cancer mortality in women aged 40 to 55.  Several risk factors increase the likelihoodof the disease occurring.  These factorsinclude: (1) aging, (2) personal history of breast cancer, (3) family historyof breast cancer, (4) history of benign breast disease, (5) menarche youngerthan 12 years, (6) nulliparous, or a first child after age 30, (7) highereducation or socioeconomic level, (8) obesity and/or high fats diets, (9)menopause after age 50, (10) lengthy exposure to cyclic estrogen and (11)environment exposure (American Cancer Society, 2015).  The cause of breast cancer is still unspecified, yet these risk factors are known to play a part in the risk of developing thisdisease.  Essentially all women can beconsidered at risk.  No successful cureor preventative methods exist, and early recognition offers the bestopportunity for decreasing morbidity and mortality.

## Literature Review

The first article that I reviewed istitled “ Benefits and Harms of Breast Cancer Screening, A Systemic Review”.  According to Myers, et al., mortality frombreast cancer has declined substantially since the 1970’s, a drop attributableto both the accessibility of screening methods, particularly mammography, and better-qualitytreatment of more advanced cancer.  Thisliterature pointed out that, although there has been stable evidence thatscreening with mammography reduces breast cancer mortality, there are a numberof possible harms, including false-positive results, which result in both needlessbiopsies and added distress and anxiety associated to the potential diagnosis ofcancer.  In addition, screening may leadto over diagnosis of cancers that may not have become life-threatening.  With their investigation in the meta-analysesof RTCs (randomized clinical trials) that stratified by age, screening womenyounger than 50 years was constantly associated with a statisticallysignificant reduction in breast cancer mortality of approximately 15% whilescreening women 50 years or older was linked with slightly greater mortalityreduction (14-23%).  In general, based ontheir research, they have concluded that “ regular screening with mammography inwomen 40 years or older at average risk of breast cancer reduces breast cancermortality over at least 13 years of follow-up, but there is uncertainty aboutthe magnitude of this association, particularly in the context of currentpractice in the United States.”

In summary, this review concludedthat among women of all ages at average risk of breast cancer, screening was relatedwith a reduction in breast cancer mortality of approximately 20%, althoughthere was ambiguity about quantitative estimates of the association ofdifferent breast cancer screening strategies in the United States.  These findings and the related uncertaintyshould be considered when making suggestions based on judgments about thebalance of benefits and harms of breast cancer screening. (Myers et al. 2015).

Mammography can pinpoint tumors toosmall to be detected by palpitation of the breast by the woman or her healthcare provider.  Early detection of breastcancer in women improves the possibility of successful treatment and thus cutsmorbidity and mortality from the disease (American Cancer Society, 2015).  Yet, there still exists an observable lack ofcompliance with the recommended screening guidelines.  According to an article in the Journal of theAmerican College of Radiology by Monticciolo, et al. (2015), they pointed outthat previous to the presentation of widespread mammographic screening in themid-1980s, the mortality rate from breast cancer in the US had stayed unaffectedfor more than 4 decades.  From 1990, the fatalityrate has fallen by at least 38%.  Considerably, this change is recognized to prompt detection with mammography.

In this next article, Miranda-Diaz, et al. (2016) studied the Hispanics Puerto Rican subjects, inner-city women anddeterminants of breast cancer screening and suggested that women with lowincomes and education were less likely to partake in mammography.  Lack of submission of breast cancer screeningtests is more prevalent among minorities. They added that Hispanic women are less likely to receive a Physician’srecommendation for breast cancer screening, therefore, it was the primaryreason for not doing a mammogram.  Otherbarriers for lack of compliance among Hispanic women and Latinas living in Californiaare lack of health insurance, age, usual source of care, having a busyschedule, fear, cost and feeling uncomfortable during the procedure.

In conclusion, the authors of thisarticle did a study that was limited by the small sample size and may not begeneralizable to the entire population of the island. In order to improvecompliance as well as educating health care providers about the importance ofreferral, a tailored health education interventions directed to describe thenature and benefit of cancer screening test needed to be put in place.

Similarly, another article statedthat early detection of breast cancer, while the tumor is still small andlocalized, provides the opportunity for the most effective treatment.(Mandelblatt, Armetta, Yabroff, et al.) According to the American CancerSociety 2015, detection guidelines recommended that women with an average riskof breast cancer should undergo regular screening mammography starting at age45 years.  Women aged 45- 54 years shouldbe inspected annually and women 55 years and older should changeover tobiennial screening or have the opportunity to begin annual screening betweenthe ages of 40 and 44 years.  The suggestedoutcome of the guideline would result in earlier detection because breastcancers found by mammography in women in their forties are smaller and moretreatable than those found by self-breast exam or clinical breast exam.  Consequently, earlier detection bymammography could save lives.

According to an article by KathyBoltz, Ph. D. (2013), amid the 609 definite breast cancer deaths, 29% were includingwomen who had been screened with mammography, while 71% were among unscreenedwomen.  In tally, her investigation foundthat of all breast cancer deaths, only 13% happened in women aged 70 years orolder, but 50% occurred in women under 50 years old. Her studies were done tosupport mammogram screening for women under age 50.  In the meantime, Dr. Cady, MD, Professor ofSurgery of Harvard Medical School in Boston, Massachusetts, and his teammatesset out to deliver complete information on the value of mammography screeningthrough a technique called “ failure analysis”. Such evaluations look backward from the time of death to determine theconnections at diagnosis, rather than looking forward from the start of astudy.  Only one other failure analysisrelated to cancer has been published to date. In this evaluation, invasive breast cancers analyzed at PartnersHealthCare hospitals in Boston between 1990 and 1999 were followed through2007.  Facts for the study compriseddemographics, mammography use, surgical and pathology reports, and recurrenceand death dates.  The article also statedthat the study showed a dramatic shift in survival from breast cancerassociated with the introduction of screening. In 1969, half of the women diagnosed with breast cancer had died by 12. 5years after diagnosis.  Between the womenwith aggressive breast cancer in this review who were spotted between 1990 and1999, only 9. 3% had expired.  “ This is aremarkable achievement, and the fact that 71% of the women who died were womenwho were not participating in screening clearly supports the importance ofearly detection,” said co-author Daniel Kopans, MD, also of Harvard MedicalSchool.

The study of the “ perception ofbreast cancer risk and screening effectiveness” was studied by Black, Nease,& Tosteson (1995).  The purpose ofthe study was to determine how women 40-50 years of age perceive their risk ofbreast cancer and the effectiveness of screening and how these perceptionscompare with estimates derived from epidemiologic studies of breast cancerincidence and randomized clinical trials of screening. A random sample of 200women, age 40-50 years old who had no history of breast cancer was chosenthrough the computerized medical records of Dartmouth-Hitchcock Medical Center.  Thirty-nine percent had an annual familyincome of $50, 000 to $100, 000, and 62% had at least a college education.  The subjects received the questionnaire inthe mail which asked questions pertaining to breast cancer risk and screeningeffectiveness.  Seventy-three percentresponded with a complete questionnaire. The results showed that the women overestimated their probability ofdying of breast cancer within ten years by more than twenty times.  When asked about their relative riskreduction from breast cancer screening, they overestimated by six times.  These results are based on assuming a 10%relative risk reduction from cancer screening. Eighty-eight percent of the subjects agreed that the benefits toscreening mammography outweighed the barriers. The generalizability of this study is very limited because of thispopulation is better educated and of higher income than the general U. S. population of women of the same age range. Also, the subjects’ breast cancer risk was not precisely known, and theeffectiveness of modern screening mammography is unknown.  The limitations also include thequestionnaire which has not been previously tested.

The last article is a literaturereview of “ factors influencing breast cancer screening in Asian countries.”  Studies done by Ahmadian and Samah (2012), found that breast cancer arises in the younger age group of Asian women, 40 to49 years old compared to the other Western counterparts, where the peakprevalence is realized between 50 to 59 years. According to multiple sources and authors, in Singapore, Malaysia, Iran, Thailand, Pakistan, and Arab women in Palestine, more than half of new cases ofbreast cancer were diagnosed in women below the age of 50 years and in advancedstages III or IV.   Schwartz et al. (2008), discovered that breastcancer screening activities among Asian women living in their native countryare low and mammography screening in Middle Eastern countries are also low.  Analyses of the information have shown thatonly 23% of Turkish people testified having at least one mammogram.  Fewer women about 10. 3% in the United ArabEmirates had mammography, which was attributed to poor knowledge of breast cancerscreening and infrequent offering of screening by healthcare workers (Schwartzet al., 2008)  In conclusion of thisarticle, the authors stated that in order to improve women’s participation inbreast cancer prevention programs/ screenings, especially among the at-risksubgroup, the intervention strategies should be tailored to their knowledge andsocio-demographic factor.  The approachesaccepted should also take into account the women’s emotional and ethnic mattersin order to support lifelong mammography screening practice for Asian peoplewhich is based on hypothetical interventions. In addition, healthcareprofessionals working with Asian women should cautiously tackle the misapprehensionssuch as worry about mammogram devices and fatalism. (Ahmadian & Samah, 2012)

## Conclusion

In summary, after reading and reviewingthe 6 related articles pertaining to breast cancer and mammogram screening forwomen under 50, I have concluded that there are both pros and cons, benefitsand harms, perceived benefits and alleged barriers, and compliance factors thataffect women worldwide.

Breast cancer has claimed millionsof lives throughout the world and women should be encouraged to be mindful ofand to consider their family history and medical history with a physician to determineif early detection is a warrant.  If thewoman has an average risk of developing breast cancer, the American CancerSociety supports a discussion of screening around the age of 40 years.  According to the guideline, ACS recommendsthat women be provided with information about risk factors, risk reduction, andthe benefits, limitations, and harms associated with mammography screening.  While it is recognized that there is abalance of risks and benefits to the mammogram, women should be provided withguidance so that they can make the best choice about when to start and stopscreening and how frequently to be screened for breast cancer.  So, if you or your loved ones have an averagerisk of breast cancer and over 40 years old, would you prefer to have a checkuponce a year or once every two years? This is rather a personal choice but with early detection, the benefitof mammogram will prove to outweigh the risk and could possibly save your life.

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