Breast and Cervical Cancer Screening in Marginalized Populations

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CENTER FOR COMMUNITY HEALTH INTEGRATION

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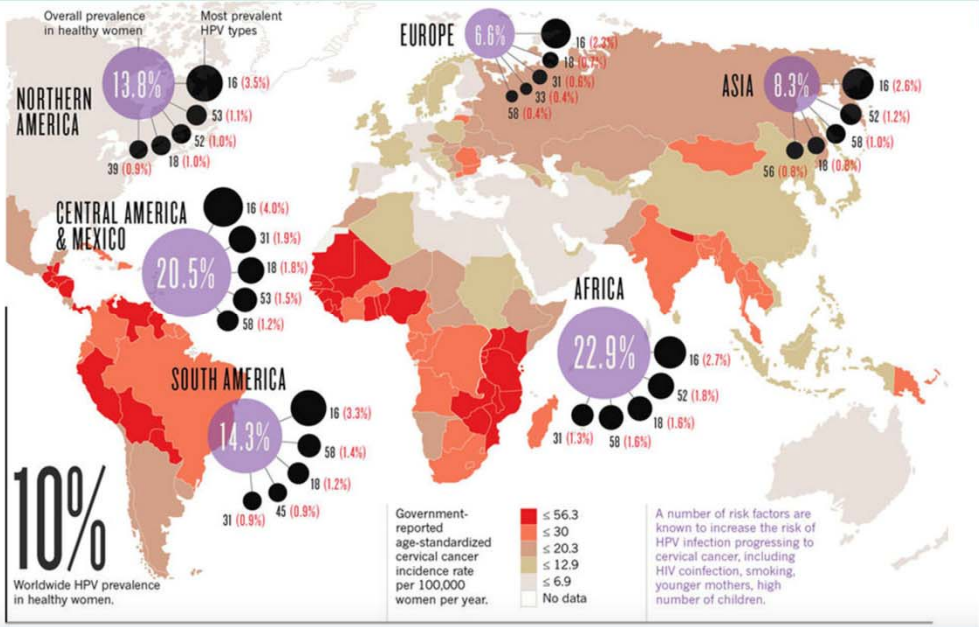
Learning Objectives

- Describe barriers that certain populations face in getting cancer screening
- Determine what community resources can address the barriers patients face in getting appropriate screening
- Cite evidence for screening recommendations for various special populations
- Formulate a plan to address a patient's concerns about screening recommendations

Disclosure

- None



Agenda

- The cancer control continuum & levels of prevention
- Brief grounding in shared language
- Breast and cervical cancer disparities: *screening and outcomes*
- Screening barriers and their root causes
- Guidance for specific populations
- Applying community resources for screening equity
- Population-specific screening evidence
- Guidance for patient-centered screening

Cancer STATS & FACTS for Ohio
BREAST CANCER

October 2021

Who Gets Breast Cancer?

In Ohio in 2018, **9,832** invasive and **1,987** *in situ* (earliest stage) breast cancer cases were diagnosed among females.

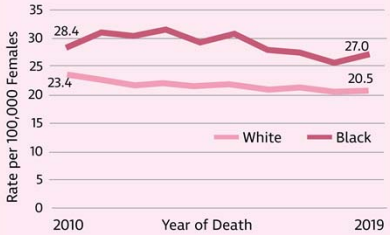
Breast cancer accounted for **29%** of all cancers in women in Ohio in 2018.

Men can also get breast cancer; **76** men in Ohio were diagnosed in 2018.

1 in 8 women in the United States who live to be age **85** will develop breast cancer.

Breast Cancer Deaths

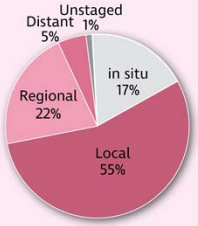
In Ohio in 2019, **1,744** deaths occurred among women from breast cancer. Overall, breast cancer death rates among women decreased **11%** from 2010-2019.



Black women have higher breast cancer death rates than white women.

Early Detection Is Important

In Ohio in 2018, **72%** of female breast cancers were diagnosed at an early stage (*in situ* and local stages combined).



Nearly **100%** of women in Ohio diagnosed with **early** stage breast cancer that has not spread **SURVIVE 5 YEARS.**

30% of women in Ohio diagnosed with breast cancer that has **spread** to distant organs **SURVIVE 5 YEARS.**

Get Screened for Breast Cancer

Regular mammograms can help find breast cancer early.

- The U.S. Preventive Services Task Force (USPSTF) recommends mammogram screening every two years for women ages **50-74** who are at average risk.
- The decision to start screening mammography prior to age **50** should be an individual one. However, women with a parent, sibling, or child with breast cancer are at higher risk for breast cancer and may benefit more than average-risk women from beginning screening in their 40s.

The *Breast and Cervical Cancer Project* offers no-cost breast and cervical cancer screenings and diagnostic testing to qualified participants. Call 1-844-430-BCCP for more information.

For more information, see the ODH Cancer Data and Statistics webpage.

Sources: Ohio Cancer Incidence Surveillance System and Bureau of Vital Statistics, Ohio Department of Health, 2021; U.S. Preventive Services Task Force.

Ohio Department of Health

https://odh.ohio.gov/know-our-programs/comprehensive-cancer-control-program/cancer-stats-an-facts-for-ohio/breast-cancer-stats-and-facts

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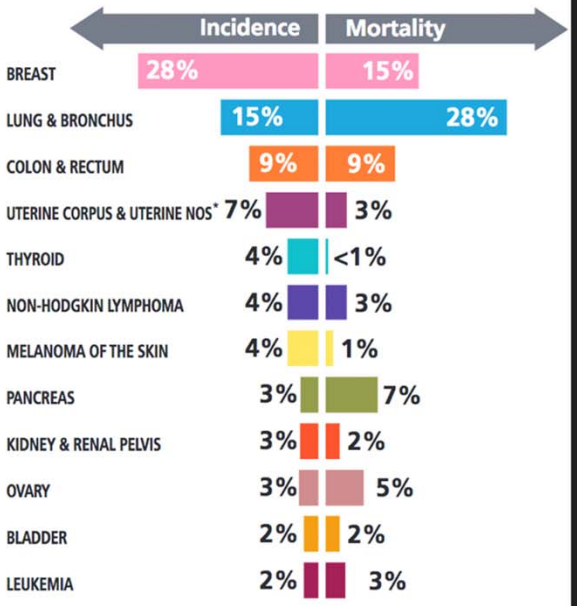
Ohio Epidemiology

Cervical Cancer	Cases	Rate (per 100,000)
Incidence	490 cases	8.1
Mortality	141 deaths	2.1

Ohio Annual Cancer Report 2019

SUMMARY OF CANCER INCIDENCE AND MORTALITY FOR 2016 AND CANCER TRENDS FOR 2007-2016

FIGURE 3 Selected Cancer Sites/Types: Average Annual Number and Percentage of New Invasive Cancer Cases and Cancer Deaths in Females in Ohio, 2009-2013[1,2]



1 Source: Ohio Cancer Incidence Surveillance System, Chronic Disease Epidemiology and Evaluation Section a
2 Figure 3 presents the top cancer sites/types among females according to incidence.
* Not Otherwise Specified
** Central Nervous System

https://odh.ohio.gov/know-our-programs/comprehensive-cancer-control-program/cancer-stats-an-facts-for-ohio/breast-cancer-stats-and-facts

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THE CANCER CONTROL CONTINUUM

FOCUS

Etiology
- Environmental factors
- Genetic factors
- Gene-environment interactions
- Medication (or pharmaceutical) exposure
- Infectious agents
- Health behaviors

Prevention
- Tobacco control
- Diet
- Physical activity
- Sun protection
- HPV vaccine
- Limited alcohol use
- Chemoprevention

Detection
- Pap/HPV testing
- Mammography
- Fecal occult blood test
- Colonoscopy
- Lung cancer screening

Diagnosis
- Shared and informed decision making

Treatment
- Curative treatment
- Non-curative treatment
- Adherence
- Symptom management

Survivorship
- Coping
- Health promotion for survivors

National Cancer Institute: https://cancercontrol.cancer.gov/about-dccps/about-cc/cancer-control-continuum

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CROSSCUTTING AREAS

Communications

Surveillance

Health Disparities

Decision Making

Implementation Science

Health Care Delivery

Epidemiology

Measurement

Adapted from David B. Abrams, Brown University School of Medicine

Early Detection through screening works!

Table 8. Five-year Relative Survival Rates* (%) by Stage at Diagnosis, US, 2011-2017

	All stages	Local	Regional	Distant		All stages	Local	Regional	Distant
Breast (female)	90	99	86	29	Oral cavity & pharynx	67	85	68	40
Colon & rectum	65	91	72	15	Ovary	49	93	75	30
Colon	64	91	72	14	Pancreas	11	42	14	3
Rectum	67	90	73	17	Prostate	98	>99	>99	31
Esophagus	20	46	26	5	Stomach	32	70	32	6
Kidney†	76	93	71	14	Testis	95	99	96	73
Larynx	61	78	46	34	Thyroid	98	>99	98	53
Liver‡	20	35	12	3	Urinary bladder§	77	70	38	6
Lung & bronchus	22	60	33	6	Uterine cervix	66	92	58	18
Melanoma of the skin	93	99	68	30	Uterine corpus	81	95	69	18

*Rates are adjusted for normal life expectancy and are based on cases diagnosed in the SEER 18 areas from 2011-2017, all followed through 2018. Rates by stage reflect Combined Summary Stage 2004+ except for testicular cancer, which is based on Combined Summary Stage 2000 (2004-2017). †Includes renal pelvis. ‡Includes intrahepatic bile duct. §Rate for in situ cases is 96%.

Local: an invasive malignant cancer confined entirely to the organ of origin. **Regional:** a malignant cancer that 1) has extended beyond the limits of the organ of origin directly into surrounding organs or tissues; 2) involves regional lymph nodes; or 3) has both regional extension and involvement of regional lymph nodes. **Distant:** a malignant cancer that has spread to parts of the body remote from the primary tumor either by direct extension or by discontinuous metastasis to distant organs, tissues, or via the lymphatic system to distant lymph nodes.

Sources: SEER*Explorer, National Cancer Institute, 2021. Available from https://seer.cancer.gov/explorer/. Testicular cancer survival by stage was calculated using SEER*Stat software (version 8.3.9), National Cancer Institute, 2021.

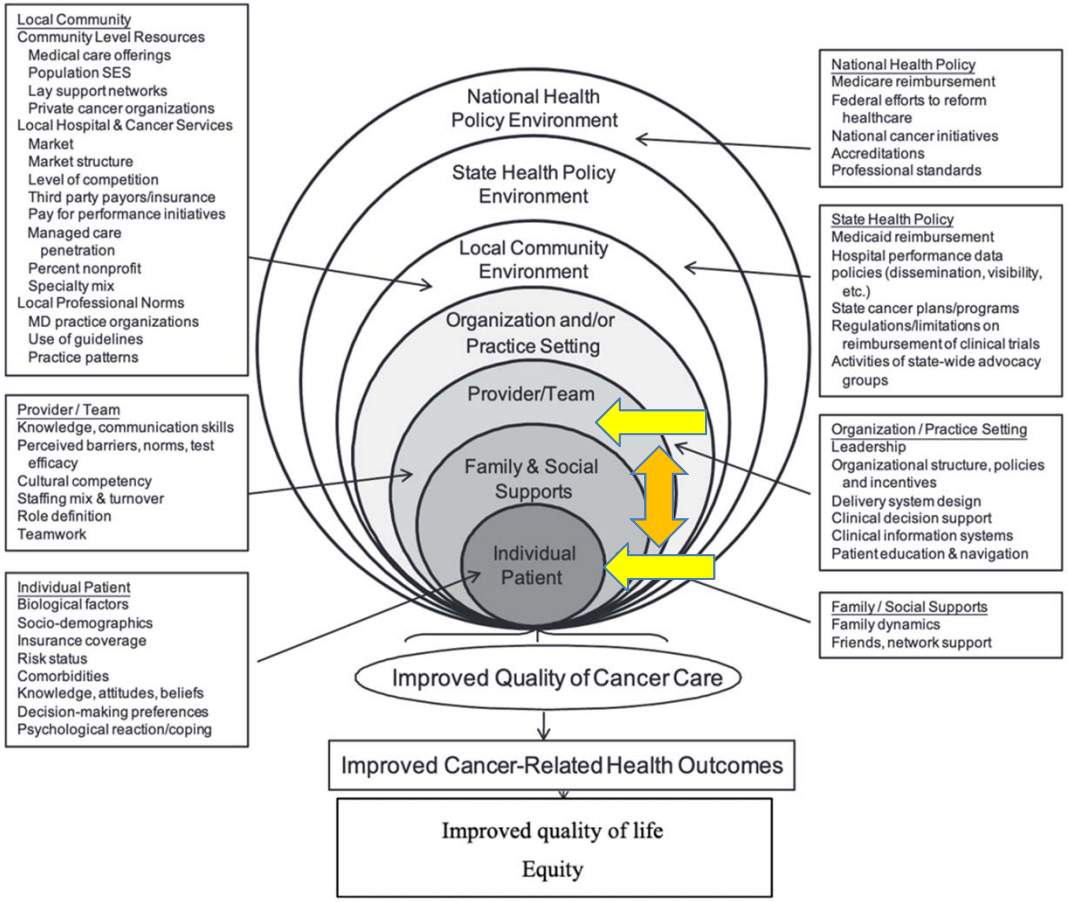
Social and Structural Determinants and Cancer

- "Poverty is a carcinogen."

  -Dr. Samuel Broder, former director of National Cancer Institute, 1985

- "When one reviews the literature, it is rather depressing to encounter the same observations, the same results, and the same conclusions and recommendations repeated over the years. Although there is not much to be found that is new, poverty continues to be rediscovered."

  -Tomatis 1992



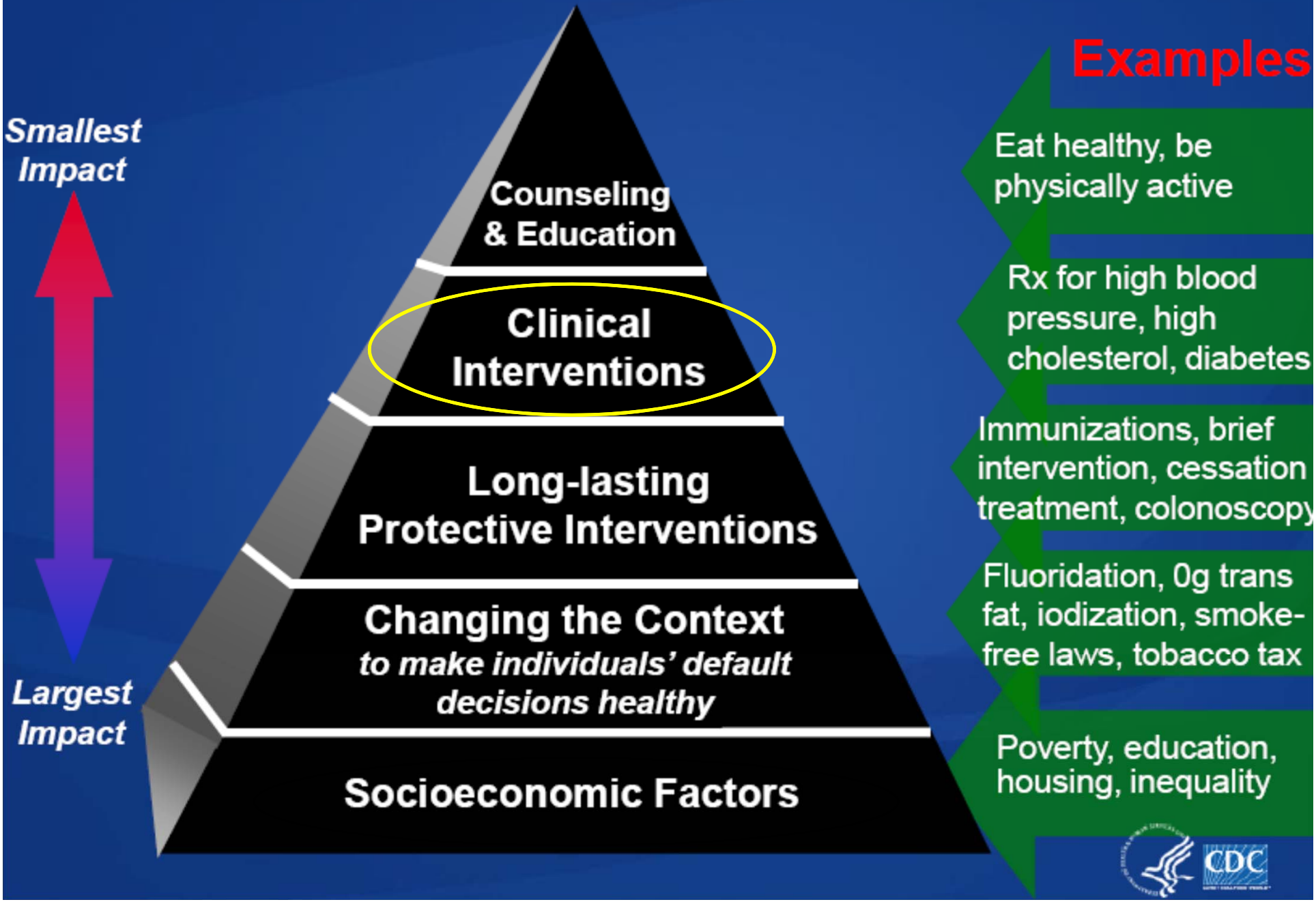
Adapted from Taplin SH, Anhang Price R, Edwards HM, Foster MK, Breslau ES, Chollette V, Prabhu Das I, Clauser SB, Fennell ML, Zapka J. Introduction: Understanding and influencing multilevel factors across the cancer care continuum. *J Natl Cancer Inst Monogr.* 2012;2012(44):2-10.

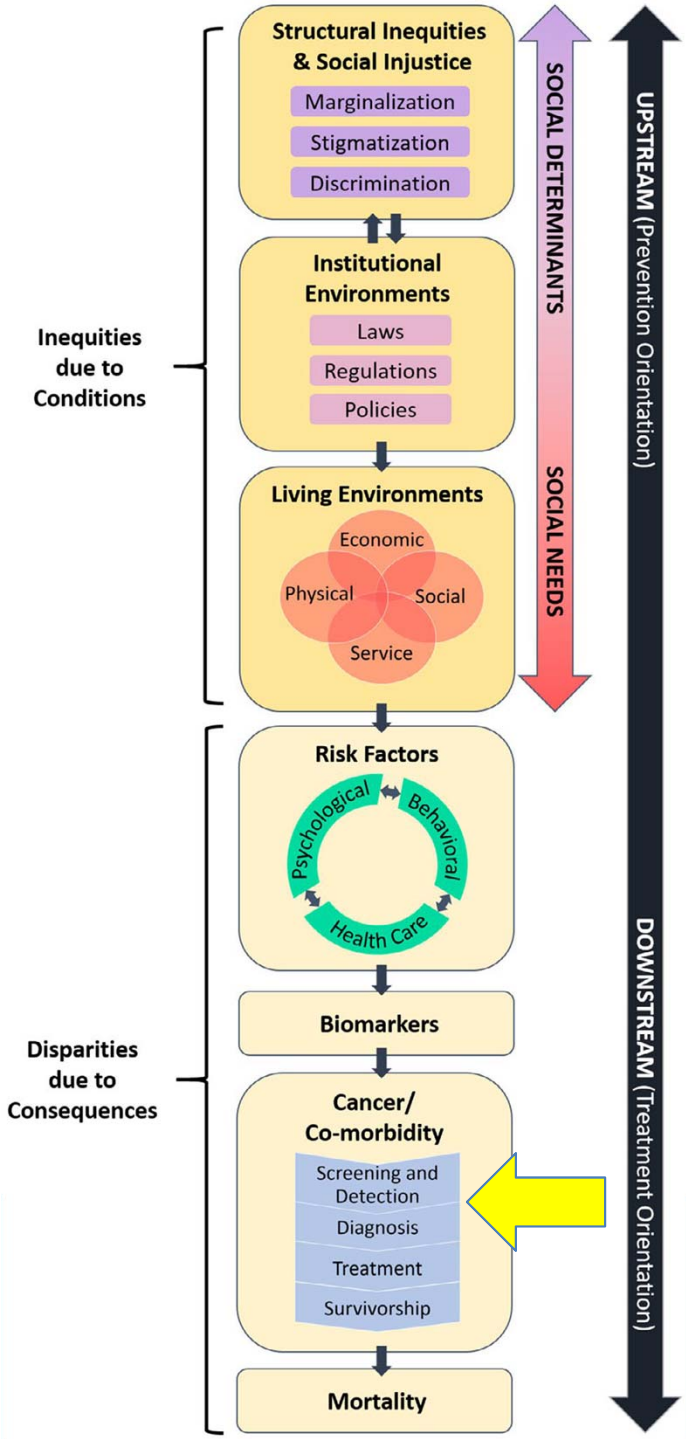
Levels of Prevention

Level of prevention	Definitions	Mode of Intervention
Primordial Prevention	Prevention of emergence or development of risk factors.	Health education Health Promotion
Primary Prevention	Prevention of disease when risk factor is present	Lifestyle modification Immunization
Secondary Prevention	Prevention of complication of disease from occurring	Early diagnosis Prompt, optimized and sustained care
Tertiary Prevention	Prevention of disability or death	Rehabilitation Disability prevention
Quaternary Prevention	Prevention of over diagnosis and treatment	Rehabilitation Disability prevention

Dutta D and Dhingra A. Quinary prevention in diabetes care. Clinical Epidemiology and Global Health. April 2021.

Factors that Affect Health





Integrated conceptual framework for understanding and addressing social determinants to advance cancer health equity

Alcaraz, KI, et al. Ca Cancer J Clin 2020; 70:31-46.

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Shared Vocabulary

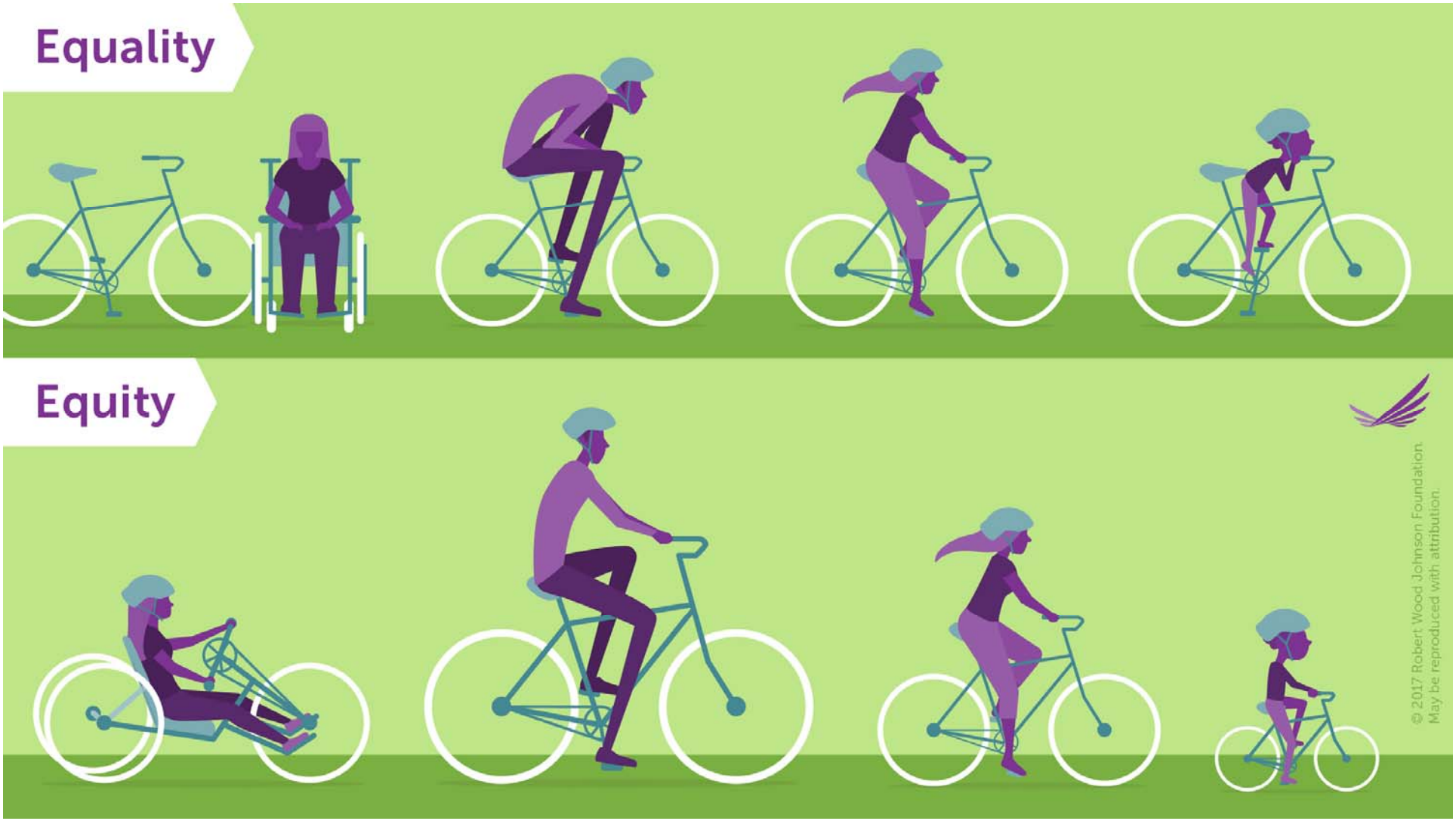
- ***Marginalized communities*** include those who have been historically excluded from involvement in our cities, as well as those continuing to face other barriers to civic participation. This includes those marginalized by factors like race, wealth, immigration status/country of origin, religion, gender identity and sexual orientation. The specific groups that are disadvantaged will also vary from one place to another, as will the degree to which they face inequality.

Adapted from https://icma.org/articles/pm-magazine/engaging-marginalized-communities-challenges-and-best-practices

Shared Vocabulary

- ***Health equity:*** Everyone has a fair and just opportunity to reach their full health potential.
- ***Health disparity***: Difference in health that is closely linked with social and economic disadvantage.
- ***Health inequity***: Difference or disparity in a health outcome that is systematic, avoidable and unjust.

Advancing Health Equity: https://www.aafp.org/about/policies/all/social-determinants-health-family-medicine.html


Equality
Equity
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Shared Vocabulary

- ***Social determinants of health***: conditions under which people are born, grow, live, work and age.
- ***Structural determinants of health inequities***: social, economic, and political mechanisms which generate social class inequalities in society.
- ***Cultural humility***: ability to maintain an interpersonal stance that is other-oriented (or open to the other) in relation to aspects of cultural identity that are most important to the [person].

Advancing Health Equity: https://www.aafp.org/about/policies/all/social-determinants-health-family-medicine.html
and apa.org - Hook, Davis, Owen, Worthington and Utsey (2013)

Cancer Screening Disparities

- Black people were the least likely of all races to have an **early-stage diagnosis of cancers that have a recommended screening:** in the breast, cervix, and lung. Early-stage cancers are usually less complicated to treat and have better outcomes after treatment. For example, early-stage breast cancer was diagnosed in 69% of White women and only 58% of Black women.
- Black people were the most likely of all races to have **a late-stage diagnosis of cancers that have a recommended screening.** The only **exception was for late-stage prostate cancer**, which was most likely diagnosed in American Indian/Alaska Native (AI/AN) men. Late-stage cancers have often spread and are more complicated to treat.
- People living in counties with the **highest average household income and in more populated cities** generally were more likely to have an early-stage diagnosis of cancer and less likely to have a late-stage diagnosis in the breast, cervix, or lung compared to people living in other counties. For example, early-stage lung cancer was diagnosed in 27% of people with lung cancer who lived where the average income was $75,000 a year or higher and only in 20% of people in counties where the average income was $35,000 a year or less.

The State of Cancer Disparities in the United States: cancer.org

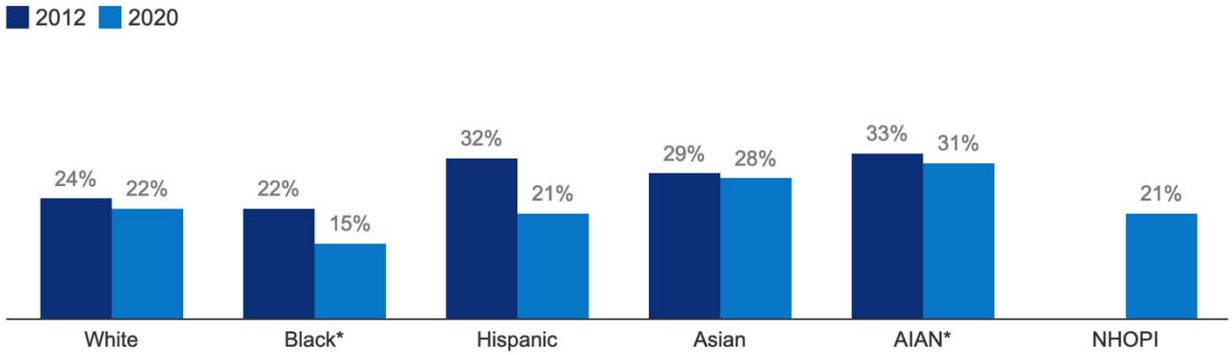
Cancer Screening Disparities: Breast

Figure 5

Percent of Females Ages 50-74 Who did not Receive a Mammogram in Past 2 Years by Race/Ethnicity, 2012 and 2020

Click on the buttons below to see data for different health screenings:

No Mammogram | No Pap Smear | No Colorectal Cancer Screening



NOTE: * Indicates statistically significant difference from White in 2020 at the p<0.05 level. AIAN refers to American Indian or Alaska Native. NHOPI refers to Native Hawaiian or Other Pacific Islander. Persons of Hispanic origin may be of any race but are categorized as Hispanic for this analysis; other groups are non-Hispanic. Data based on people who identify as female. A variety of clinical, scientific, and patient organizations make different recommendations about mammography screening. Data in this figure align with the 2016 recommendation from the USPSTF, which recommends biennial screening mammography among women ages 50 to 74. 2012 data for NHOPI do not meet minimum standards for statistical reliability.

SOURCE: KFF analysis of 2012 and 2020 Behavioral Risk Factor Surveillance System • PNG

KFF

Tong M, Hill L, Artiga S. Racial Disparities in Cancer Outcomes, Screening and Treatment. 2022. Kaiser Family Foundation.

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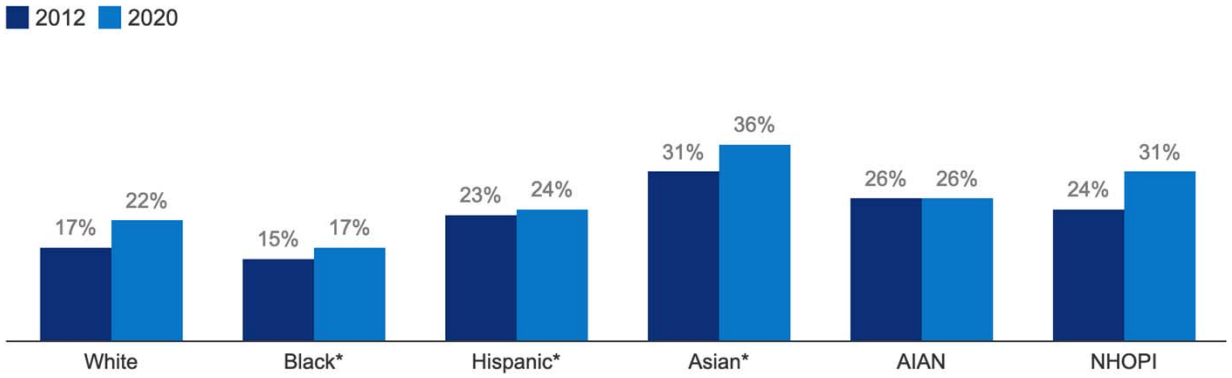
Cancer Screening Disparities: Cervical

Figure 5

Percent of Females Ages 21-65 Who Did Not Receive a Pap Smear in Past 3 Years by Race/Ethnicity, 2012 and 2020

Click on the buttons below to see data for different health screenings:

No Mammogram | No Pap Smear | No Colorectal Cancer Screening



NOTE: * Indicates statistically significant difference from White in 2020 at the p<0.05 level. AIAN refers to American Indian or Alaska Native. NHOPI refers to Native Hawaiian or Other Pacific Islander. Persons of Hispanic origin may be of any race but are categorized as Hispanic for this analysis; other groups are non-Hispanic. Data based on people who identify as female. The USPSTF recommends cervical cancer screening with Pap test every 3 years for women ages 21-65 or Pap testing every 3 years for women ages 21-29 and then Pap and HPV testing every 5 years for women ages 30-65.

SOURCE: KFF analysis of 2012 and 2020 Behavioral Risk Factor Surveillance System • PNG

KFF

Tong M, Hill L, Artiga S. Racial Disparities in Cancer Outcomes, Screening and Treatment. 2022. Kaiser Family Foundation.

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Cancer Screening Disparities – Urgency!

Research shows that the overall rate of cancer screening is lower among Black, Hispanic, Asian, and AIAN populations compared to their White counterparts. However, screening patterns vary across screening types, and people of color are more likely than White people to receive certain types of cancer screening. Data suggest that the COVID-19 pandemic contributed to decreases or delays in cancer screening, which may have exacerbated disparities in cancer screening.

Tong M, Hill L, Artiga S. Racial Disparities in Cancer Outcomes, Screening and Treatment. 2022. Kaiser Family Foundation.

Breast Cancer Disparities: Outcomes

Table 9. Incidence and Mortality Rates for Selected Cancers by Race and Ethnicity, US

Incidence, 2014-2018	All races/ ethnicities	Non-Hispanic White	Non-Hispanic Black	Asian/ Pacific Islander	American Indian/ Alaska Native†	Hispanic/ Latino
All sites	449.0	466.0	455.0	294.5	452.6	348.3
Male	487.9	501.3	529.2	295.3	477.3	370.2
Female	423.0	442.8	405.3	297.9	438.5	339.2
Breast (female)	126.9	132.5	127.1	98.8	110.5	96.3
Colon & rectum*	36.5	36.1	42.6	29.0	49.2	32.8
Male	42.1	41.5	50.4	34.4	55.8	39.2
Female	31.6	31.3	37.1	24.6	43.9	27.6
Mortality, 2015-2019						
All sites	152.4	157.2	178.6	96.4	161.4	109.7
Male	181.4	186.2	221.4	113.2	193.2	132.2
Female	131.1	135.4	152.1	84.2	138.1	93.9
Breast (female)	19.9	19.9	28.0	11.7	17.8	13.7
Colon & rectum	13.4	13.4	18.1	9.3	17.4	10.8
Male	16.0	15.8	22.7	11.1	21.3	13.7
Female	11.3	11.3	14.8	7.9	14.4	8.5

Cancer Facts & Figures 2022 - Cancer.org

Cervical Cancer Disparities: Outcomes

Table 9. Incidence and Mortality Rates for Selected Cancers by Race and Ethnicity, US

Incidence, 2014-2018	All races/ ethnicities	Non-Hispanic White	Non-Hispanic Black	Asian/ Pacific Islander	American Indian/ Alaska Native†	Hispanic/ Latino
Uterine cervix	7.7	7.2	8.8	6.1	10.8	9.6
Mortality, 2015-2019						
Uterine cervix	2.2	2.0	3.4	1.7	3.1	2.5

Rates are per 100,000 population and age adjusted to the 2000 US standard population and exclude data from Puerto Rico. All race groups are exclusive of Hispanic origin. *Colorectal cancer incidence rates exclude appendix. †Data are based on Purchased/Referred Care Delivery Area (PRCDA) counties and are not comparable to previous years due to the new exclusion of Hispanic ethnicity to improve accuracy. Mortality estimates for American Indians and Alaska Natives are underestimated because Indian Health Service-linked data are not publicly available.

Sources: Incidence – North American Association of Central Cancer Registries (NAACCR), 2021. Mortality – National Center for Health Statistics, Centers for Disease Control and Prevention, 2021.

Cancer Screening…A Process

- Understanding utility and agreeing to test
- Order placed if done outside clinician office
- Arriving at screening test location
- Completion of test
- Return of result
- Management of abnormal results

Multi-level Approaches Needed

- *Individual:* Clinician knowledge of evidence and skills in cultural humility, patient resource needs, identification and stratification of risk (including sexual organs at birth, genetic risk)
- *Microsystem*: Office based system facilitators for orders, result follow-up, linking uninsured with coverage, EHR tools, clinician assessment and feedback, practice screening data, PDSA improvement cycles
- *Macrosystem*: Policy around health insurance, culture of valuing prevention

Facilitators of Cancer Screening

- Health insurance
- Clinician recommendation in context of trusted relationship
- Shared decision-making with clinician
- Perceptions of cancer screening
- Gender differences in screening behaviors/norms
- Geographic location
- Future orientation

Tong M, Hill L, Artiga S. Racial Disparities in Cancer Outcomes, Screening and Treatment. 2022. Kaiser Family Foundation.
Research in progress – Gullett H, Snyder B, Stange K, Zyzanski S.

Barriers to Cancer Screening

- Lack of facilitators on previous slide
- Social determinants of health, such as transportation
- Inconvenient
- Beliefs about cancer
- Misinformation about test and/or available options
- Mistrust of clinicians and health system
- Complexity of health care system
- Fear

Reducing Barriers

- Pragmatic Starting Points:
  - Prioritize cancer screenings in clinical practice
  - Proactive population-based outreach
  - Transportation assistance
  - Flexible hours
  - More locations
  - Less paperwork
  - Standing orders
  - Patient navigation

Implementation Tools for Clinicians

- Screening practice guidelines
  - Breast: USPSTF, American Cancer Society, ACOG
  - Cervical: USPSTF, ASCCP
- Training in cultural humility
  - Tools for inclusive, patient-centered care
- Courses in diversity, equity and inclusion
  - Focus on understanding history, bias, root of mistrust in heathcare
  - Tools for allyship

Implementation Tools for Clinicians/Practices

- CDC Reducing Structural Barriers Guide – cdc.gov
- Evidence-based intervention Planning Guides - cdc.gov
  - Patient reminders
  - Reducing structural barriers
  - Clinician reminders
  - Clinician assessment and feedback
- National Colorectal Cancer Roundtable Risk Assessment and Screening Toolkit – adapt for breast and cervical screenings
- American Cancer Society toolkits and patient information

Screen Out Cancer - cdc.gov
Cancer.org
Nccrt.org

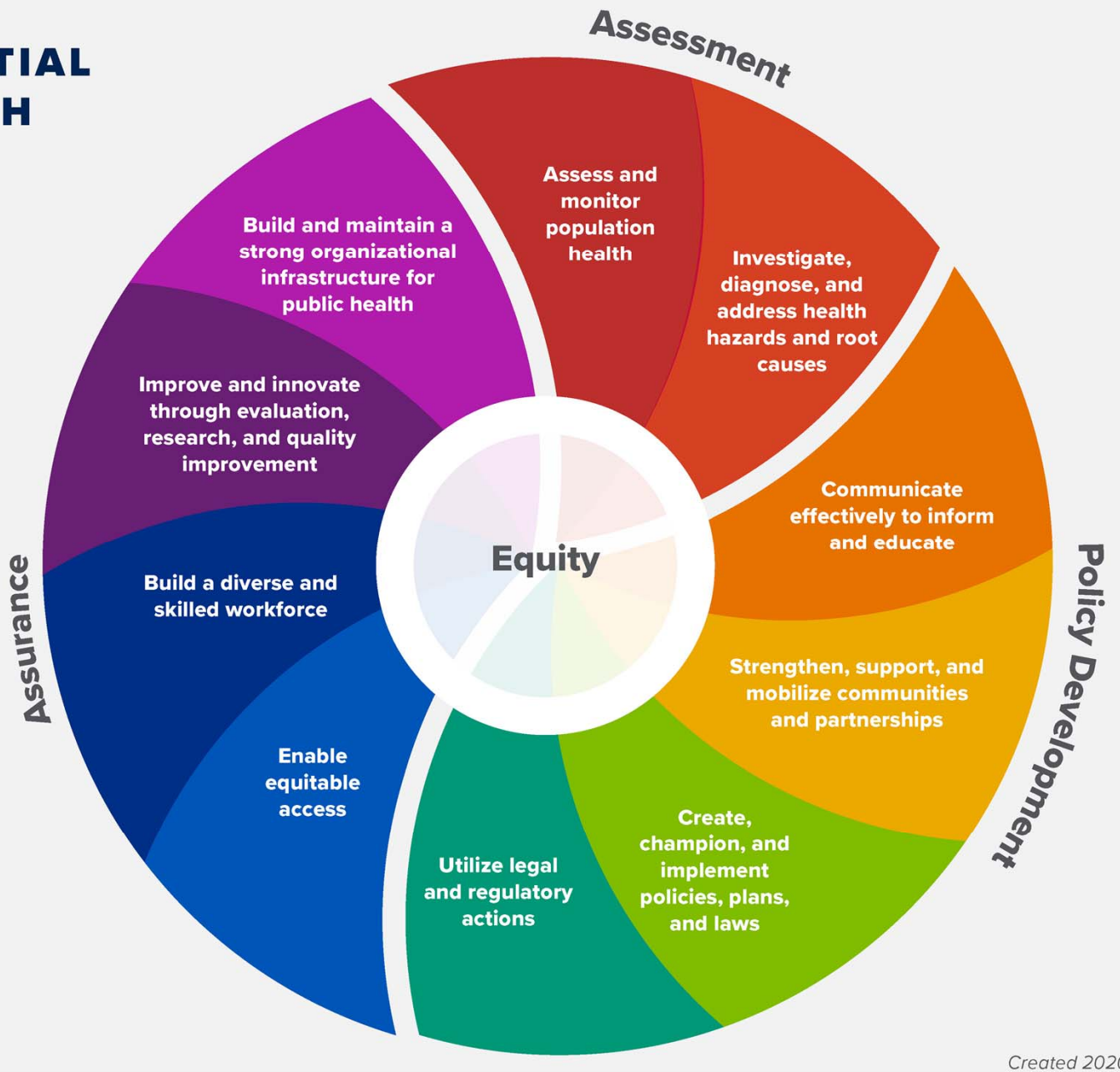
Community of Support

- Public Health
  - Local
  - State
    - Ohio Department of Health – BCCP and 4 others
  - Federal
    - CDC – NBCCEDP, NCCP, NPCR
- Not-for-profit and philanthropic organizations
  - Non-clinical advocacy groups
  - Clinical entities
  - Community-based research
  - Professional organizations
    - OAFP, ASCCP, ACOG
  - Cancer-focused
    - Komen, American Cancer Society

THE 10 ESSENTIAL PUBLIC HEALTH SERVICES

To protect and promote the health of all people in all communities

The 10 Essential Public Health Services provide a framework for public health to protect and promote the health of all people in all communities. To achieve optimal health for all, the Essential Public Health Services actively promote policies, systems, and services that enable good health and seek to remove obstacles and systemic and structural barriers, such as poverty, racism, gender discrimination, and other forms of oppression, that have resulted in health inequities. Everyone should have a fair and just opportunity to achieve good health and well-being.



Created 2020

Specific Populations

- Uninsured/underinsured
- Racial and ethnically historically marginalized populations
  - Black and American Indian & Alaska Native
- LGBTQ+
- Medically vulnerable
- Refugees, including language access
- Geography
- Disability status
- Survivors of interpersonal violence/sexual trauma
- Breast cancer in people with male sexual organs at birth

Considerations for LGBTQ+ Populations

About health insurance coverage, doctor-patient relationships, and cancer screening:

- Compared to heterosexual, cisgender people, LGBTQ people **are more likely to be unemployed, uninsured, lack access to health care, and delay health care**—including care that's critical to help prevent cancer and screen for it.
- Regardless of their sexual orientation, people whose health care providers knew their sexual orientation were **more likely to have been encouraged to get cancer screenings** compared to people whose providers didn't know their sexual orientations.
- Lesbian women were the only subgroup that was **less likely** than heterosexual women to be encouraged to receive cancer preventive care, such as HPV vaccinations and Pap tests.
- Lesbian women are less likely than heterosexual women to have a Pap test, and when they are tested, **the result is more likely to be abnormal**.

Charlton B. Cancer Disparities Research Highlights – ACS; cancer.org

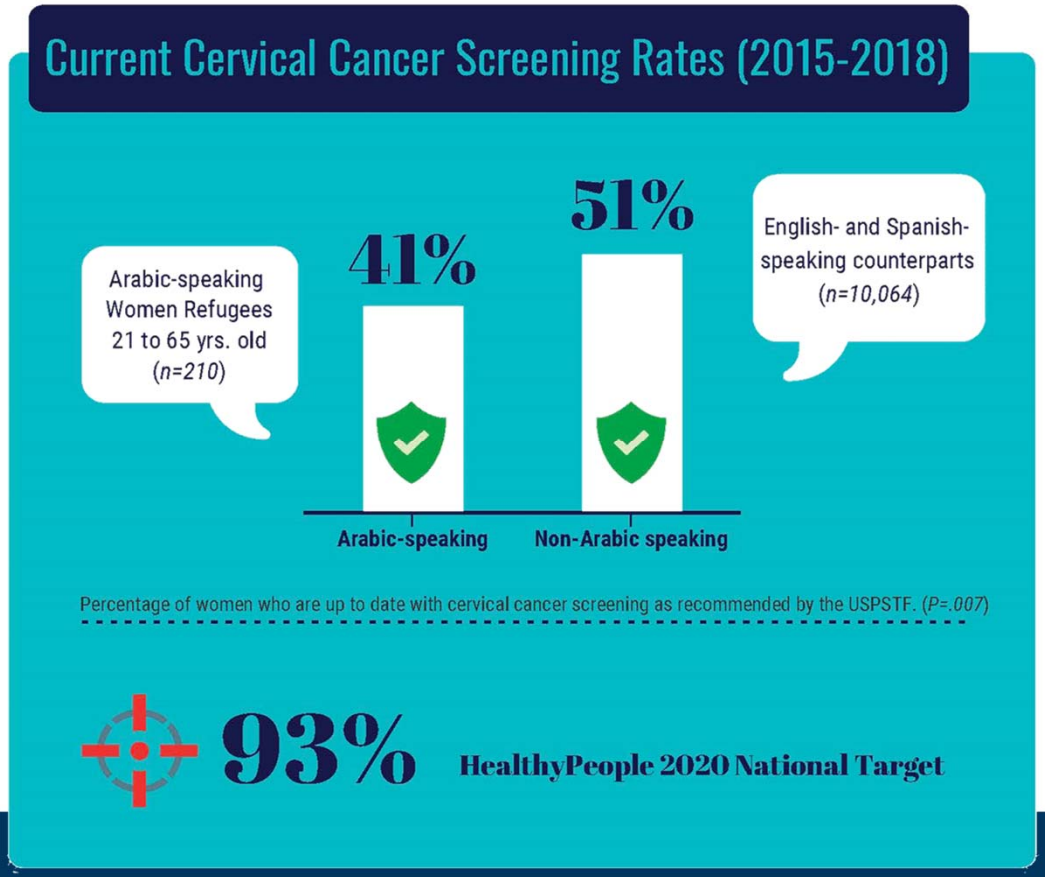
Considerations for LGBTQ+ Populations

About mammograms:

- Compared to Black heterosexual women, Black bisexual women were more likely than to have had a mammogram in the last year. In fact, **Black bisexual women had the highest prevalence of having a mammogram.**
- No differences were found between the receipt of a mammogram between Black lesbian women and Black heterosexual women or between Latina, lesbian women and Latina, heterosexual women.

Charlton B. Cancer Disparities Research Highlights – ACS; cancer.org

Considerations for Newcomer Populations



AlAbdulKader A, Golembiewski M, Gullett H. Cervical Cancer Screening among Arabic-speaking women.

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When asked about barriers:

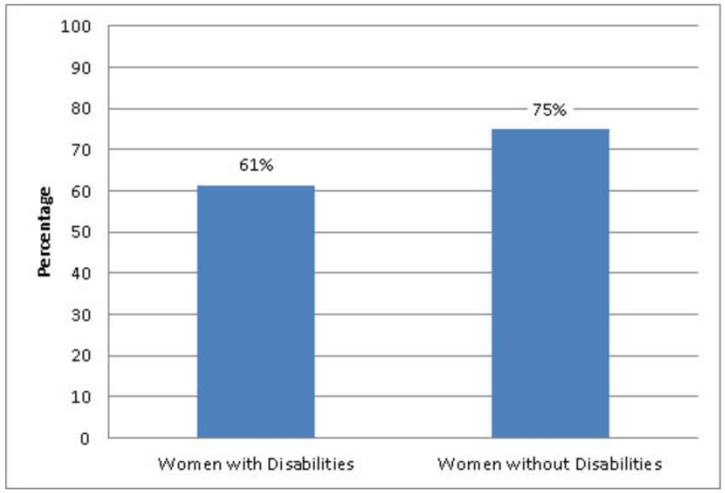
- Participants overall felt supported and gave huge credit to NFP team!
- Fear of cancer: “you’ll get what you talk about or look for.”
- No mention of religious belief as a barrier.

When asked about facilitators:

- Out of respect for doctors, their advice often perceived as “order”.
- Family Hx mentioned as a strong motivator.
- Provider’s gender: almost all participants were established with female PCPs, by choice.

Considerations for Disability Status

Percentage of U.S. Adult Women 50-74 Years of Age Who Received a Mammogram During the Past 2 Years, By Disability Status – 2010 National Household Interview Survey(NHIS)*



View Larger

* CDC/NCHS. National Health Interview Survey Data, 2010.[3]

Screening Evidence for Men

Current national organization recommendations for screening men at high risk of breast cancer.

Organization	Recommendations
American Cancer Society	• Careful breast exams might be useful for screening men with a strong family history of breast cancer, or with BRCA mutations • Screening men for breast cancer has not been studied to know if it is helpful
American College of Radiology	• None
American Society of Breast Surgeons	• None
American Society of Clinical Oncology	• None
National Comprehensive Cancer Network	For BRCA positive men: • Education regarding signs and symptoms of cancer • Breast self-exam training and education starting at age 35 years • Clinical breast exam, every 12 months, starting at age 35 years • Limited data support imaging in men

Woods R, *et al*. Image-based Screening for Men at High Risk for Breast Cancer: Benefits and Drawbacks. Mar 2020. Clin Imaging

Risk factors for male breast cancer

Risk Factor		Relative Risk of Malignancy
Genetic	BRCA1 mutation	20x [16,29]
	BRCA2 mutation	80x [16,29,78]
	CHEK2*1100delC mutation	4–10x [79,80]
	PALB2 mutation	Minimal [36]
Demographic	Age	Average age = 67 years [6]
	Family history of breast cancer	First degree relative: 1.9x Mother and sister: 10x [41]
	Personal history of male breast cancer	30–112x [42–44]
	Black race	1.3x [45]
	Ashkenazi Jewish	1.8x [47]
Hormonal	Klinefelter syndrome, XXY	16–19x [49–51]
	Gynecomastia	5–10x [49,51]
	Obesity	1.4–2x [41,49]
	Increased serum estradiol	2.5x [81]
Environmental	Radiation exposure	1–2x (diagnostic/therapeutic radiation) [55] 15x (atomic bomb survivors) [54]

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Benefits and drawbacks of image-based screening for men at high-risk for breast cancer

Benefits	Drawbacks
• Mammography in males confers a high sensitivity, specificity, and negative predictive value • Lifetime risk for specific populations of males may approach the average risk for women • Earlier detection of a disease that frequently presents as locally advanced	• No established screening regimen • No current data to support the practice of routine screening • Increased costs associated with screening for a low prevalence disease • Radiation exposure

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Considerations for Patient-Centered Screening

- Essential to prepare patient for what to expect
- Ensure language services are provided
- Use of inclusive language
  - Example: person with cervix
- Foster context in which patient is in control of the screening experience
  - Example: sexual assault survivor speculum insertion, honoring request for female clinician

Transcarebc.ca
https://studentaffairs.psu.edu/csgd/explore-lgbtq-resources/identity-based/gender-terms

High Yield Take Home Points

- Multi-level approaches are necessary to address different types of barriers
- Individual and community trust are essential and earned over time through intentionality
- Accessibility – Bring screening to the neighborhood!
- Help with obtaining insurance
- Partnership with trusted ambassadors
- Befriend your local health department
- Clinician recommendations make a difference
- Ensure up-to-date knowledge on cancer screening recommendations
  - USPSTF, ACS, specialty societies (ex ASCCP, ACOG)
- Consider the impact of future paradigm on cancer screening and control counseling
  - Time horizon can be impactful in screening discussions

Thank you!

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"If you have come to help me, you can go home again. But if you see my struggles as a part of your own survival, then perhaps we can work together."

–Lila Watson,
an Aboriginal Woman from Australia

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