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A Cancer Journal for Clinicians

## **BREAST SELF-EXAM IS TOO VALUABLE TO DISCARD**

*CA Cancer J Clin* 2001;51;268-270

DOI: 10.3322/canjclin.51.5.268

**This information is current as of March 13, 2010**

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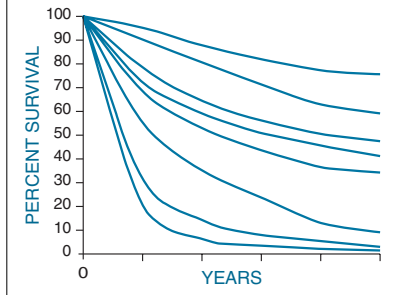
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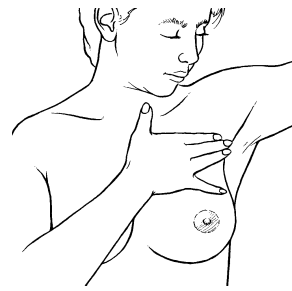




Tobacco cessation counseling ranks among the most cost-effective preventive interventions.



Physicians not always forthcoming with accurate prognosis.



BSE is a useful component of prognosis for early detection of breast cancer.



## News Briefs

### STUDY GUIDES DOCTORS ON PREVENTIVE SERVICES FOR IMPROVING HEALTH

Immunizing children against common infections tops the list of preventive interventions ranked according to a combination of clinically preventable burden of disease and cost effectiveness. However, five of the top seven are relevant to cancer prevention and/or early detection, according to a study in the July 2001 issue of the *American Journal of Preventive Medicine* (2001;21:1-9).

The study was conducted by the non-profit Partnership for Prevention, based in Washington, DC, an association of corporations, non-profit organizations, and state health departments charged with analyzing health promotion and disease prevention issues. The study was supported by the US Centers for Disease Control and Prevention and the Health Care Financing Administration.

The authors looked at 30 preventive health services the US Preventive Services Task Force recommends for Americans at average risk of disease, from birth through death. The intention, says Ashley Coffield, MPA, co-author and research fellow with Partnership for Prevention, was to produce information that would guide developers of health plans, employers purchasing health

insurance, and providers of health care to “good-value services” when they are dealing with limited time and money.

They calculated each service’s effect on clinically preventable burden of disease (CPB), a measure that reflects the disease, injury, and premature death prevented by the intervention and is expressed in quality-adjusted life years (QALYs). Based on this calculation, the authors assigned a score from one to five for each service, with a rank of five indicating the highest CPB. They then calculated the cost effectiveness (CE), defined as net cost (the cost of providing the service as recommended over a lifetime, minus the money saved by avoiding illness or injury) divided by the CPB. That, too, was assigned a score of one to five, with five indicating the most cost-effective services. The authors then ranked the services based on the sum of these two scores. Fourteen services scored seven or higher out of a possible 10. They finally looked at whether these top-scoring preventive services were available to most Americans. In eight of the 14 cases, they were not.

Among the top seven preventive services (based on their sum of CPB and CE) listed below, five (in bold type) are relevant to prevention and/or early detection of cancer:

- Vaccinate children: DTP/DtaP,

*Physicians’ counseling of patients about tobacco was nearly as valuable as childhood immunizations. The burden of disease it prevents is so great, even moderately effective counseling makes a huge impact.*

MMR, Oral polio/IPV, Hib, Hep B, Varicella.

- **Assess adults for tobacco use and provide tobacco cessation counseling.**
- Screen for vision impairment among adults aged  $\geq 65$ .
- **Assess adolescents for drinking and drug use, and counsel on alcohol and drug abstinence.**
- **Assess adolescents for tobacco use and provide an anti-tobacco message or advice to quit.**
- Screen for cervical cancer among sexually active women or  $\geq 18$  years.
- **Screen for colorectal cancer (FOBT and/or sigmoidoscopy) among all persons  $\geq 65$  years.**

In the rankings, physicians' counseling of patients about tobacco was nearly as valuable (nine) as childhood immunizations (10), says Coffield. That finding, she says, may surprise physicians and the public alike, as it initially did her, "Because most people perceive tobacco counseling as effective, but not highly effective." And in fact, tobacco counseling isn't highly effective in convincing smokers to quit, Coffield says—but because the burden of disease it prevents is so great, even moderately effective counseling makes a huge impact.

Coffield says some people are surprised that mammography is midway down the list, with a combined score of six and a rank of 16th among the 30 preventive services. "Mammography is a good deal, and we ought to be doing it, but some preventive services are even a better deal than mammography," she says. "And if we pay for mammography, we ought to pay for people to stop smoking."

Among the top 14 ranked services, eight had a delivery rate to the US population of  $\leq 50\%$ . Five of these were relevant to cancer prevention or early detection:

- **Assess adults for tobacco use and provide tobacco cessation counseling.**
- Screen for vision impairment among

adults aged  $\geq 65$ .

- **Assess adolescents for drinking and drug use, and counsel on alcohol and drug abstinence.**
- **Assess adolescents for tobacco use and provide an anti-tobacco message or advice to quit.**
- **Screen for colorectal cancer (FOBT and/or sigmoidoscopy) among all persons  $\geq 65$  years.**
- Screen for chlamydia among women aged 15 to 24 years.
- **Screen for problem drinking among adults and provide brief counseling.**
- Vaccinate adults aged  $\geq 65$  years against pneumococcal disease.

Coffield calls for employers to buy insurance policies that pay for preventive services and for health insurance companies to hold providers accountable for delivering these services. "There's a big gap between covering it and providing it," she says.

#### Danger of Either/Or

American Cancer Society President Dileep G. Bal, MD, MS, MPH, says that while the study is likely to cause some physicians to rethink how they spend their time with patients, he cautions against framing health care as a pie to be cut into different size pieces, where if one piece gets larger, other pieces get smaller.

"Health care must not be characterized as a zero-sum game with the ability to quick-fix the generic problem by merely realigning priorities," says Bal.

"Moreover, the penchant to compare apples with oranges or bananas is inherent in any such modeling enterprise, because the quantification of both cost and benefit, in each intervention of interest, is understandably subject to a whole slew of qualifiers or caveats," Bal notes.

"So, without in any way diminishing this worthy attempt at trying to prioritize these clinical preventive services, I feel that to use

this prioritization directly for resource allocation decisions is premature at best," explains Bal. "Finally, it needs to be asked why these particular clinical preventive services were picked and why preventive services (that are historically under-financed) are often held to a more stringent litmus test of efficacy than other clinical interventions."

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#### PHYSICIANS NOT ALWAYS FORTHCOMING WITH ACCURATE PROGNOSIS INFORMATION

Either because they are unsure of the prognosis or think patients shouldn't know, many physicians won't tell their patients who ask—even those on their way to a hospice—how much time they might have left to live, according to a study in the June 19 issue of the *Annals of Internal Medicine* (2001;123:1096-1105).

The study involved 300 patients who had been referred by one of 258 physicians to an outpatient hospice program in the Chicago area. The physicians were interviewed by phone about the patient's prognosis and how much information they would communicate to a patient, if the patient asked.

The study authors, from the University of Chicago School of Medicine and longtime researchers on issues of caring for the dying, were surprised to discover that physicians often were not honest with these hospice patients. Co-author Elizabeth Lamont, MD, a medical oncologist and assistant professor at the University of Chicago, said she expected that physicians would have been more forthcoming, especially because these patients were close to the end of their lives.

Yet, the researchers found that 22.7% of the physicians said they would not communicate a prognosis even if asked. Thirty-seven percent said they would communicate to patients the same survival estimate they had formulated and believed to be accurate. In 40.3% of the cases physicians would "knowingly" provide an inaccurate estimate, usually a more optimistic prediction than the physician believed was true.

The researchers did not ask the study participants why they would disclose or not disclose this information.

"One thing that was interesting was that with increasing patient age, doctors were more likely to be frank," Lamont adds, which suggests that perhaps it is easier to break such news to an older person who has lived a long life.

The age of physicians themselves also played a part in the level of disclosure. Older physicians with more years of practice experience were less likely to be honest with patients (either giving more pessimistic or optimistic estimates than they believed themselves) and more likely to give no information, even when asked. This might be because they were trained in an era when few cancer patients were told their true diagnosis or prognosis, Lamont says.

#### Physicians' Estimates Overly Optimistic

The researchers also compared patients' actual survival with their physicians' estimate and the prognostic information the physician said he or she would provide to the patient. On average, physicians told patients their survival estimate was 90 days when their "honest" prediction was really 75 days, and the patients survived only 26 days. Thus, the typical patient survived only one-third as long as their physician led them to believe they would.

#### Advice to Patients

Although she believes failing to be truthful with patients is wrong, Lamont adds that the lack of disclosure isn't being done out of malice toward patients. "Patients should realize that their doctors care tremendously about them and that probably affects how much information they give them," she says.

If patients want to know, they should explicitly ask their physician for prognosis

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*If patients want to know, they should explicitly ask their physician for prognosis information and tell why they want to know.*

information, and perhaps, tell the physician why they want to know. For example, if the family is planning a wedding and the patient wants to attend, he or she would want to know when to schedule it, she says. “Let them know there are things you want to do,” she notes.

It also might be helpful for people with advanced cancer to acknowledge that an exact prediction of longevity is not always possible, and that they ask the physician for an approximation or average expectancy, Lamont adds. “Ask the physician what’s the longest and the shortest time you might have left; ask what is the range,” Lamont says.

#### Value of Accurate Information

Lamont also notes that, perhaps more importantly, having an accurate sense of how long a patient might live will help determine which treatments to pursue, avoiding those that might be futile if the end of life is near.

Lamont says she hopes that further research will strengthen physicians’ ability to accurately predict a patient’s survival. When this occurs, physicians should be more willing to discuss their predictions for patient longevity, but they also may need training on how to break bad news to patients.

Robert C. Young, MD, a medical oncologist and president of the Fox Chase Cancer Center, believes that physicians today have an obligation to be straightforward with patients who ask for a specific estimate of their prognosis. First, he notes, they need to listen carefully to the patient’s actual desires. Young agrees with Dr. Lamont that many patients depend on accurate prognostic information to make plans and schedule things they want to do before the end of their life.

“For example, patients may want to speak with important people in their life one more time,” Young, who is president-elect of the American Cancer Society, explains. “If their prognostic estimates are too optimistic, they may miss that opportunity. Although all patients in this study had already been referred to a

hospice program, an accurate estimate of prognosis is important in helping patients enter such programs at the right time. If the estimate is too favorable, patients may be referred too late and may not benefit from the hospice program as much as they might have.

“The essential struggle for all physicians in this situation is the absolute inability to predict precisely when any individual patient will die,” Young says. “We can be fairly accurate when talking about percentages or probabilities but not about individual patients.”

Lamont says, “A lot of doctors believe a positive attitude helps patients, but I think we need to change the focus of our optimism from having a day longer to having a day better. Patients and families who are prepared for the end of life can experience it with more peace and dignity.”

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#### BREAST SELF-EXAM IS TOO VALUABLE TO DISCARD

Breast self-exam (BSE) is a useful component of programs for early detection of breast cancer and should not be discontinued, says an American Cancer Society expert responding to a *Canadian Medical Association Journal (CMAJ)* article that suggested that the practice does more harm than good.

“There is considerable evidence suggesting a benefit to the use of BSE,” says Robert Smith, PhD, director of cancer screening for the American Cancer Society (ACS).

#### CMAJ Article Suggests BSE Not Useful

Authors of the *CMAJ* article (2001;164:1837-1846) call for an end to routine teaching of BSE to women aged 40 to 69, saying that studies on the topic suggest BSE and BSE education do not reduce deaths, but increase unnecessary biopsies and anxiety.

“We’re not trying to discourage women from being aware of their breasts and reporting any abnormality they find immediately to their doctors; those would be changes they find in

dressing or bathing or during sexual relations,” notes the study’s first author, Nancy Baxter, MD. “But what happens with BSE education is they don’t find those, they find benign lumps they wouldn’t find otherwise.”

#### Many Experts Disagree

The co-author of an accompanying editorial in *CMAJ* says there is insufficient evidence to support abandoning BSE.

“Our view is that the recommendation [that BSE not be used or taught] is premature,” says Larissa Nekhlyudov, MD, of Harvard Medical School’s department of ambulatory care and prevention. “The data they’re basing their recommendations on are still incomplete. Women should be taught how to perform BSE, and should discuss it with their doctors. However, they should also be aware of its limitations.”

In their editorial, Nekhlyudov and co-author Suzanne W. Fletcher, MD, agree that clinical trials of BSE have not found that the practice influences breast cancer mortality. But they note several aspects of the trials that limit their relevance to the issue of BSE in North America:

- Short follow-up time would limit the ability to detect any benefit.
- Lower breast cancer prevalence in the populations studied would reduce the ability to measure any mortality reduction.
- Uncertainty regarding standards of care for women diagnosed with breast cancer in these populations might limit any benefits of early detection.

Smith agrees that it is important to consider limitations of available data. He says, “Measuring the efficacy of BSE is extraordinarily difficult, and these challenges are magnified if you try to draw conclusions from countries with different underlying breast cancer rates, breast cancer awareness, and access to state of the art screening and treatment.”

Smith asks, “Is the experimental group actually practicing BSE? Is the control group

not examining their breasts? How do physicians respond to women’s report of a palpable mass? Is state-of-the-art treatment available? Most important, was the average size of diagnosed tumors in the population so large that a BSE intervention could be expected to measurably reduce tumor size through earlier detection? Finally, attempting to measure differences in the breast cancer death rate associated with BSE would likely require a study with 10 or more years of follow-up.”

#### ACS Recommends Three-Part Screening

Current ACS recommendations are that BSE be performed monthly beginning at age 20, as one part of a three-part program that also includes mammography and clinical breast examination. Because mammography and clinical breast examination have the greatest impact on reducing breast cancer mortality, they receive the most emphasis in ACS public awareness messages and allocation of program resources. Women are warned against relying on BSE alone.

“Breast self-exam can help with early detection of the small number of breast cancers found in the under 40 age group,” Smith says. “Although these women should have a clinical breast exam every three years, BSE can reasonably be expected to help detect some cancers that reach a palpable size during this interval. After 40, we should not expect much added benefit from BSE if compliance with mammography is high.

“As mammography utilization has increased during the past two decades, the percentage of breast cancers women find themselves has decreased,” Smith notes. “But we do expect that BSE can provide a safety net for some women whose breast cancers weren’t picked up by their last mammogram or clinical breast exam.”

The authors of the Canadian report raised the issue of harms associated with BSE, which include anxiety when doing the exam and diagnostic work-ups, including biopsies in some instances, for masses that are not cancerous. Smith admits that although false

positives are a reality in any early detection program, the data are not that clear that BSE contributes to an excess of false positives.

“More to the point, research has shown that women understand that false positives are an inevitable part of a larger program to detect breast cancer early in order to save lives,” Smith explains. “We should do whatever we can to reduce avoidable biopsies, but we should not presume on women’s behalf that these harms are intolerable in the context of the benefits of early detection.”

“The bottom line is that early detection of breast cancer is better than later detection, and

BSE most likely contributes to early detection,” says Smith, “although in this day and age that contribution is likely less for women 40 and older than it was 10 or 20 years ago.”

Nevertheless, “BSE is a prudent thing to do; it’s worth the time and effort to teach and to use,” Smith summarizes. “There may be a better and more efficient way for providers to teach BSE and breast awareness, and perhaps, that should be revisited. At the same time, it’s important for clinicians to emphasize the limits of what can be accomplished through BSE, and the far greater importance of mammography and clinical breast examination.”

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—The Editors