Kansas Behavioral Health Risk Bulletin

Kansas Department of Health and Environment

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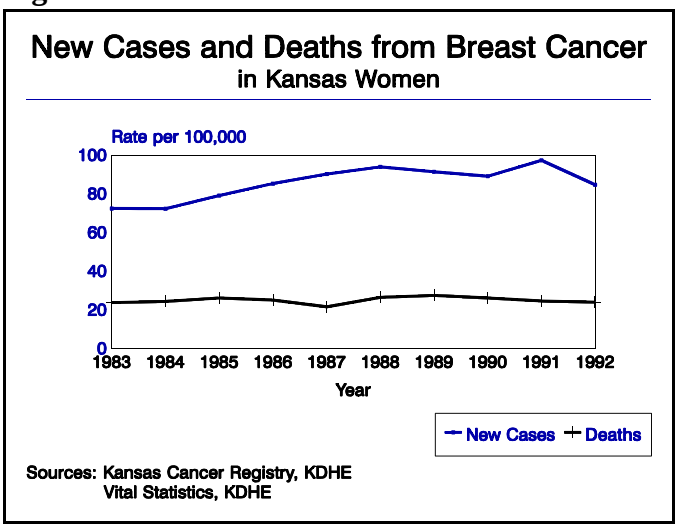
Breast Cancer in Kansas

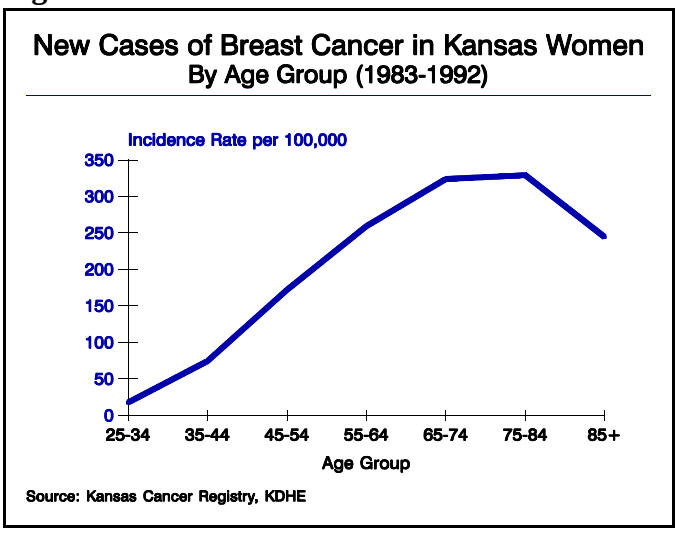
Breast cancer is the most commonly occurring cancer in Kansas women, and is second only to lung cancer as the leading cause of cancer deaths among female Kansans. Every year in Kansas over 1,100 new cases of breast cancer are diagnosed[1], and nearly 400 Kansas women die from breast cancer[2]. Although men may also be stricken with breast cancer, it is fairly rare (occuring almost 200 times more frequently among women).

Figure 1



The number of new cases of breast cancer has risen slightly over the past ten years (Fig. 1). However, over the next ten years, it is expected that the incidence rate for breast cancer will level off[3]. Despite the slight increase in the number of cancer cases diagnosed, the rate of death from breast cancer has remained stable. Less than one-third of women diagnosed with breast cancer eventually die from the disease.

Figure 2



The risk of developing breast cancer increases with age (Fig. 2). Having a close family member (mother, sister, or daughter) with breast cancer also increases a woman's risk. Other risk factors for breast cancer include hormonal factors such as early onset of menstruation, late menopause, no full-term pregnancies or first pregnancy after the age of 30. There is some evidence that synthetic hormones such as oral contraceptives[4] or hormone replacement therapy for menopausal symptoms[5] may increase the risk of breast cancer. Some experts hypothesize that a low-fat diet may be helpful in preventing breast cancer[6].

Despite knowledge about risk factors, there is currently no known means of preventing breast cancer. Early detection of breast cancer is the best method for enhancing survival from the disease. When breast cancer is detected in early stages (i.e., cancer is localized), the 5-year survival rate is 93%[7]. If breast cancer is not detected until it has spread to other organs (i.e., distant metastases), the

5-year survival rate declines to only 18%.

There are currently three methods for detecting breast cancer: mammography, clinical breast examination (CBE), and breast self-examination. Mammography is the only method that can detect lumps or lesions early - before they can be felt. Mammography can detect nearly 90% of cancerous lesions, yet mammography and a clinical breast examination together provide more certainty that if cancer exists, it will be detected[7].

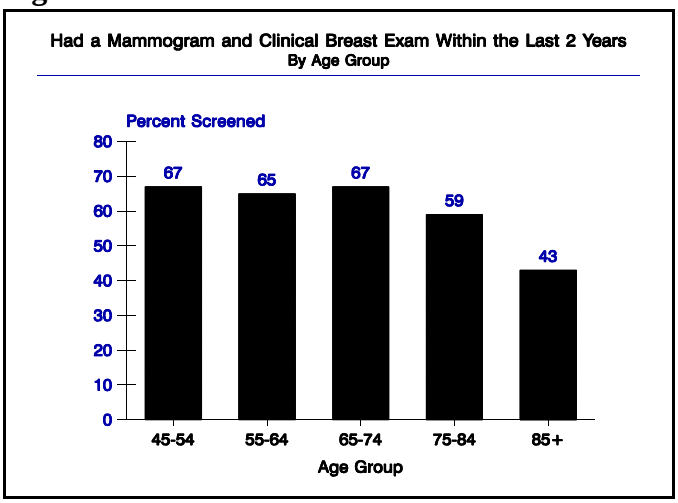
The American Cancer Society recommends that women aged 50 and over receive annual mammograms and clinical breast examinations.

In 1993 and 1994, the Kansas Department of Health and Environment, Bureau of Chronic Disease and Health Promotion, conducted the Behavioral Risk Factor Surveillance System (BRFSS) survey to assess the prevalence of health behaviors among adult Kansans (aged 18 and older) through a random digit-dialed telephone interview. Female respondents were asked "Have you ever had a mammogram (an x-ray of the breast to look for cancer)?" If the respondent ever had a mammogram, she was asked "How long has it been since your last mammogram?" To determine whether the respondent had a clinical breast examination, she was asked "A clinical breast exam is when a doctor, nurse, or other health professional feels the breast for lumps. Have you ever had a clinical breast exam?" Again, if the respondent ever had such an exam, she was asked "How long has it been since your last exam?"

This bulletin examines breast cancer screening practices among Kansas women aged 50 and over. A recent mammogram is defined as having had a mammogram within the previous two years. A recent clinical breast examination is one that was conducted within the past two years.

Overall: According to the 1993 and 1994 BRFSS survey, 69% of women 50 years of age and over had a mammogram within the last two years, and 63% had both a clinical breast examination and a mammogram within the last two years.

Figure 3



Age Group (Figure 3): The percentage of women having a recent mammogram and CBE varies significantly by age. Women in the older age groups, who have a higher risk of breast cancer, less often receive a current mammogram and CBE than younger women.

Race: White women are slightly less likely (63%) than women from other racial groups (66%) to have had a recent mammogram and clinical breast examination; however, these figures are based on small numbers of minorities. A recent survey of African American Kansans[A] indicates that 61% of African American women aged 50 and over had both a recent mammogram and clinical breast examination (unweighted data).

Education: The percentage of women having a recent mammogram and CBE does not vary by education level.

Income (Figure 4): Women with higher household income levels are much more likely to have had a current CBE and mammogram. In fact, women with annual household incomes between $35-50,000 are substantially more likely to have recent breast cancer screening as women in the lowest income group.

A The African-American Survey used breast cancer screening questions that were identical to those asked by the BRFSS survey.

Figure 4

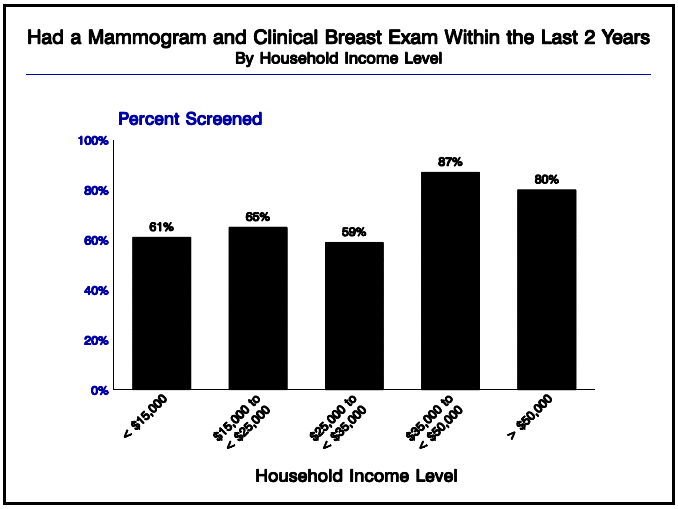
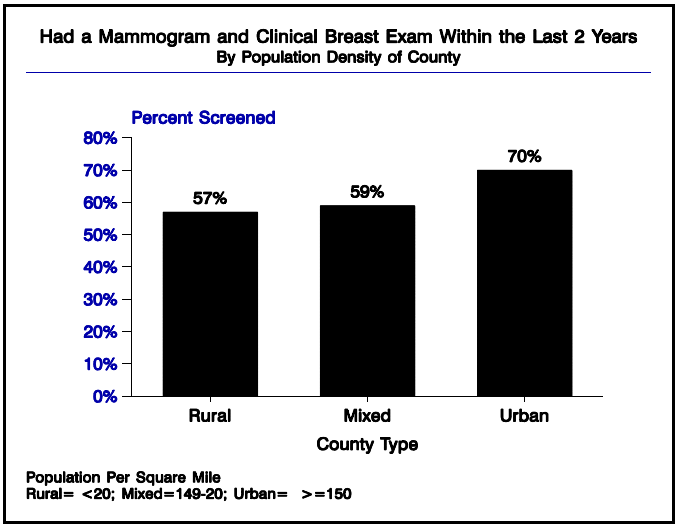


Figure 5



Marital Status: Women who are currently married or living with a partner are much more likely to have had a recent mammogram and CBE (68%) than women who were not currently married (54%).

Insurance Coverage: Women with any form of health insurance, including public sector programs, had a recent mammogram and CBE more often (64%) than women with no form of health care coverage (30%).

Proximity to Health Care: Women who live in counties where a large proportion of residents travel to non-adjacent counties for a hospitalization (i.e., did not receive hospitalization, if necessary, in their own county or a neighboring county) are less likely to have had a recent mammogram and CBE (50%) than women living in counties located in closer proximity to their health care source (66%).

Population Density[B] (Figure 5): The size of the community in which the woman lives affects breast cancer screening rates. Seventy percent of urban women, 59% of women living in mixed urban and rural counties, and 56% of rural women had a recent mammogram and CBE.

Conclusions: According to the information provided by the 1993 and 1994 BRFSS surveys, many Kansas women are not receiving routine clinical breast examinations and mammograms. Furthermore, some women who receive either a mammogram or a clinical breast examination do not receive both procedures. The following groups are less likely to have recent breast cancer screening than other groups:

* Women aged 75 or older
* Women with lower household incomes
* Women who were not currently married or living with a partner
* Women with no insurance coverage
* Women living a long distance from their health care providers
* Women living in rural areas

B Population density is calculated by taking the total population of a county divided by the total number of square miles in the county. For the purpose of this analysis, an urban county has a pop. density $ 150 persons per square mile. A mixed county has a pop. density of 20 - 149 persons per square mile. A rural county has < 20 persons per square mile.

Recommendations: The following recommendations are made to increase the number of women receiving a current mammogram and clinical breast examination:

1. Encourage mammography facilities and physicians to offer women both mammograms and clinical breast examinations, rather than only one service.
2. Educate women about the importance of receiving routine mammograms, clinical breast examinations, and self-breast examinations.
3. Offer free screening tests to low-income women who have no other method of paying for such services[C].
4. Encourage health care providers to work with mammography facilities and community groups to enable women to receive cancer screening tests even though the women may live a distance from the screening facility.
5. Empower local partnerships to identify and overcome barriers to cancer screening in their communities.

Healthy Kansans 2000 Objectives (Table 1): The Healthy Kansans 2000 objectives for breast cancer are:

1. Reduce the age-adjusted death rate for breast cancer to no more than 18.8 per 100,000 women.
2. Increase to 80% the proportion of women aged 40 and over who have ever received a clinical breast examination and a mammogram.
3. Increase to 60% the proportion of women aged 50 and over who received a mammogram within the last two years.
4. Increase to 100% the number of mammograms performed in Kansas by facilities which meet quality standards set forth in the Mammography Quality Standards Act (MQSA).
5. Increase to at least 50% the proportion of primary care providers who provide their patients with screening, counseling, and immunization services recommended by the US Preventive Services Task Force.

Table 1: Breast Cancer-Related Objectives

	Kansas Baseline	Healthy Kansans 2000 Objective
Breast Cancer Age-Adj Death Rate per 100,000 Women	21.8 (1990)	18.8
Proportion of Women Aged 40+ Having Ever Recieved a CBE and a Mammogram	65.5% (1992)	80%
Proportion of Women Aged 50+ Who Received a Mammogram Within the Last 2 years	53% (1992)	60%
Proportion of Mammograms Performed Which Meet MQSA Quality Standards	N/A	100%
Proportion of Primary Care Providers Meeting USPSTF Preventive Services Guidelines	N/A	50%

References:

1 Kansas Cancer Registry, 1992.
2 KDHE, Vital Statistics.
3 Miller, B.A., et al (eds.) SEER Cancer Statistics Review: 1973-1990. National Cancer Institute. NIH Pub. No. 93-2789, 1993.
4 Malone, K.E., Daling, J.R., and Weiss, N.S. (1993) "Oral Contraceptives in Relation to Breast Cancer." Epidemiologic Reviews, 15(1): 80-97.
5 Brinton, L.A. and Schairer, C. (1993) "Estrogen Replacement Therapy and Breast Cancer Risk." Epidemiologic Reviews, 15(1): 66-79.
6 Willett, W.C., et al. (1992) "Dietary Fat and Fiber in Relation to Risk of Breast Cancer. An 8-Year Follow-Up." Journal of the American Medical Association, 268(15): 2037-2044.
7 Miller, B.A., et al (eds.) op. cit.
8 Baines, C.J. (1992) "Physical Examination of the Breasts in Screening for Breast Cancer." The Journals of Gerontology, 47 (Special Issue): 63-68.

For additional information contact the BRFSS Program Coordinator by writing to the address below or call (913) 296-1207.