

AN EPIDEMIOLOGY PUBLICATION OF THE OREGON DEPARTMENT OF HUMAN SERVICES

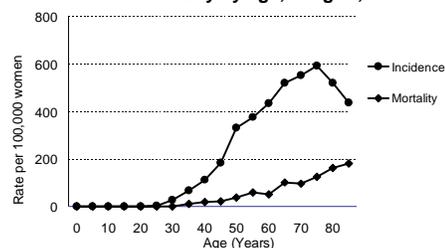
BREAST CANCER IN OREGON—UPDATE

BREAST CANCER REMAINS the most commonly reported cancer in Oregon. In 1999, the most recent year for which data are available, 3,380 cases were diagnosed. The vast majority of these cases, 3,355, were in women. In Oregon, similar to the U.S. as a whole, breast cancer is the second leading cause of cancer deaths among women (after lung cancer);¹ in 1999, 510 Oregon women died of breast cancer. In this issue of the *CD Summary*, we report on the epidemiology of breast cancer in Oregon and on mammography screening rates. We also provide contact information for the Oregon Breast and Cervical Cancer Program.

INCIDENCE AND MORTALITY

Oregon's 1999 age-adjusted incidence rate of 153.2 cases of invasive breast cancer per 100,000 women was higher than the 1998 national rate of 139.1 (latest year data are available). However, our breast cancer mortality rate was slightly lower: 26.9 deaths per 100,000 women in Oregon compared to 27.9 in the U.S. as a whole. Oregon's 1999 rates also reflect an increase in incidence of 16% (from 132.6) and a decrease in mortality of 6.3% (from 28.7) since 1996.*

Incidence and mortality by age, Oregon, 1999

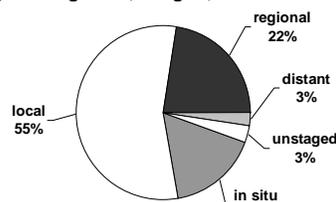


Of the known breast cancer risk factors for women, age is the most important. Approximately 80% of women with breast cancer have no known risks other than being female and growing older. The incidence of breast cancer increases as age increases. Similar to national trends, approximately 80% of women in Oregon diagnosed with breast cancer in 1999 were age 50 or older.

STAGE AT DIAGNOSIS

From 1996 to 1999, a consistent 72 to 73% of breast cancers in Oregon were diagnosed in early stages, when treatment is most successful. Over this span, in situ diagnoses, as a proportion of total cancers, increased from 14% to 17%. At the same time, localized diagnoses decreased from 60% to 55%.

Stage at diagnosis, Oregon, 1999



The proportion of cancers diagnosed in the in situ stage have increased for women in all age groups since 1996. Comparisons between the Portland metropolitan area and the rest of Oregon however, show that the proportion of cancers diagnosed as in situ is consistently higher in Portland. While early detection is increasing overall, this geographic difference may reflect disparities in access to and utilization of screening facilities.

SCREENING: BSE AND CBE

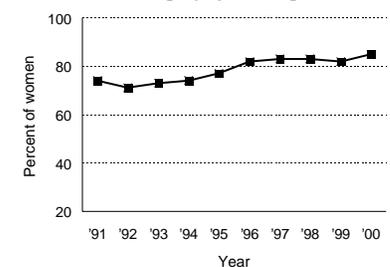
Controversy over the effectiveness of breast self-examination (BSE) has risen to the forefront in recent months, with the publication of findings from the Canadian Task Force on Preventive Health Care.² On reviewing the available evidence, the task force concluded that for women aged 40 to 69, there is "fair evidence of no benefit" from BSE as well as fair evidence for discontinuing BSE instruction. The group questioned whether BSE might in fact be harmful, in that it leads to excess work-up for false-positive results. Critics point out that these conclusions may be premature, given that the positive effects of screening often take longer to become apparent than do short-term negative effects such as excess work-up.

Regular clinical breast examinations by a health care professional and screening mammography are currently the most effective means of early detection.

SCREENING: MAMMOGRAPHY

Mammography is the best way to detect breast cancer in its earliest stages; an average of 1.7 years before a lump can be felt in a breast self-exam.³ Although controversy continues regarding the benefits of mammography for women 40–49 years of age, clear benefit has been shown for women aged 50 to 69 years. The U.S. Preventive Services Task Force recommends mammography screening every one to two years beginning at age 50 years. Routine screening of women in this age group can decrease deaths from breast cancer by up to 30%.⁴ Mammography may also be recommended for those younger women who are at higher risk.

Routine mammography in Oregon



Routine mammography increased in Oregon during the 1990s. In 1991, 74% of Oregon women ages 52–64 years reported having had a mammogram during the prior two years. In 2000, this figure increased to 85%.⁵ Oregon's rates of mammography screening are some of the highest in the country. This increase in self-reported rates suggests that higher breast cancer incidence rates may be due, in part, to a screening effect.

SUMMARY

The goal of screening is to detect more of the existing cancers early on, thus increasing women's chances for survival. Higher rates of mammography, greater numbers of breast cancers being detected,

* All rates are age-adjusted to the U.S. year 2000 standard. Cancer data is supplied by the Oregon State Cancer Registry, which began data collection in 1996. Registry data are lagged due to delays in cancer reporting. Some of the difference between state and national rates may be due to differences in ICD coding schemes and population files.



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and greater proportions of in situ diagnoses indicate that Oregon has made progress over the last several years. Lower mortality may reflect advances in breast cancer treatment, as well as early detection. On the cautionary side, higher incidence rates may well be due in part to better case reporting, and decreased mortality rates may be due in part to changes in death-coding schemes.

Although physicians and other health-care providers can take pride in these rates for screening and early detection, room for improvement still exists. Data from Medicare, Medicaid and HEDIS indicate wide variation in mammography screening rates. Women outside of the Portland metropolitan area may particularly benefit from reminders, support systems, and improved access to providers and screening facilities. Additional research into risk factors and prevention, as well as detection and treatment, is also clearly warranted.

THE OREGON BREAST AND CERVICAL CANCER PROGRAM

The Oregon Breast and Cervical Cancer (BCC) Program is a collaboration between public health, private health care providers and community and tribal organizations, working to increase access to screening and education for women throughout Oregon. The program is funded by the Centers for Disease Control and the Oregon and Southwest Washington affiliate of the Susan G. Komen Breast Cancer Foundation and administered by the Health Services section of the Department of Human Services.

While Oregon state law mandates insurance coverage for mammograms and Pap tests for all insurance originating in

Oregon, an estimated 11% of Oregon's population is uninsured.⁶ The BCC Program provides clinical breast exams, mammograms, Pap tests, pelvic exams and diagnostic services to uninsured or underinsured low-income women. Program objectives include an emphasis on serving women 50–64 years of age and women in under-screened racial, ethnic, and differently-abled groups. Since its inception in 1995, the BCC Program has served over 20,000 women, and 178 invasive and in situ breast cancers have been diagnosed through the program.

THANK YOU!

Those of us involved with the BCC Program are taking this opportunity to send a heartfelt *thank you* to over 2,000 physicians and health-care providers who have worked with the program over the past six years, and who have made it possible for more women to access screening services. In our follow-up survey of BCC clients, conducted during 2000, 82% rated the care they received from participating providers as the "best possible care" and 94% would return to those same providers.⁷

RESOURCES

For the following materials, contact the Oregon Breast and Cervical Cancer Program, 800 NE Oregon St. Suite 730, Portland, OR 97232. For more information, call us at 503/731-4273 or visit our web site at: <http://www.ohd.hr.state.or.us/bcc>.

- *A Woman's Guide to Breast Cancer Diagnosis and Treatment*: a 32-page booklet for women diagnosed with breast cancer or with a recommendation for a biopsy.

- *Breast Cancer Diagnostic and Follow-up Protocols*: a 25-page guide for health care providers.
- *Follow-up of Abnormal CBE and Mammographic Findings*: a self-study course for participating BCC health care providers.

Questions related to Oregon State Cancer Registry data can be directed to 503/731-4858.

REFERENCES

- 1 Oregon State Cancer Registry: <http://www.ohd.hr.state.or.us/oscar/welcome.htm>
- 2 Baxter N, Canadian Task Force on Preventive Health Care. Preventive health care, 2001 update: should women be routinely taught breast self-examination to screen for breast cancer? *Canadian Medical Association Journal*. 2001; 164 (13): 1837-46.
- 3 Centers for Disease Control and Prevention: <http://www.cdc.gov/cancer/nbccedp/info-bc.htm>
- 4 U.S. Preventive Services Task Force. *Guide to Clinical Preventive Services*, 2nd ed.
- 5 DHS Health Services analysis of Behavioral Risk Factor Surveillance System, 1991-2000.
- 6 Oregon Population Survey, 1998. <http://www.osl.state.or.us/lib/orepop/title.html>
- 7 DHS Health Services analysis of the Breast and Cervical Cancer Program Client Satisfaction Survey, 2000.

Correction

SEVERAL ANGRY FLEAS have reported errors in the table describing transmission of category A bioterrorism agents in the Oct. 19 issue. Bubonic plague is transmitted from infected rodents by fleas, and pneumonic plague is transmitted from person to person by respiratory droplets. Foodborne botulism is acquired by ingestion of preformed botulinum toxin, although terrorists might cause illness by aerosolizing the toxin for inhalation by unsuspecting victims. We regret the errors and are duly chagrined.