Breast Cancer: Addressing Disparities, Improving Care

Sarina Schrager, MD, MS, *WMJ* Associate Editor

Breast cancer remains the leading cause of new cancer diagnoses among women in the United States and the second leading cause of cancer deaths, behind lung cancer.[1] As with many other chronic diseases, there is a striking racial disparity in breast cancer mortality. And although overall mortality rates from breast cancer in all women have declined over the past 20 years—likely due to expanded screening programs and advances in treatment options—racial disparities continue to exist.

White women and black women have similar rates of new breast cancer diagnoses, yet black women have an approximately 30% higher chance of dying from breast cancer.[1,2] Reasons for this disparity vary. Black women may have multiple barriers to care including lack of health insurance and poor access to mammography screening programs. In some cities, the quality of care may be erratic based on location. When diagnosed with breast cancer, black women are more likely to have a more advanced stage of disease as well as triple negative breast cancer (estrogen receptor, progesterone receptor, and HER2 receptor negative), which is harder to treat and carries a poorer prognosis.[2] All of these factors can impact survival.

Several interventions have been tried to decrease these disparities. Notably, the Metropolitan Chicago Breast Cancer Task Force, which was created in Chicago in 2008 used a comprehensive public health approach to reduce disparities in the community—previously among the highest in the country. The Task Force found a striking variability in quality of mammogram services in different parts of the city and higher uninsured rates for women of color. As an intervention, they provided free, high quality mammography, partnered with community groups to do education about breast cancer screening and ensured that all women received quality care.[3] This multipronged, public health approach reduced the disparity in breast cancer mortality between white and black women by close to half, bringing Chicago in line with data from the rest of the country.

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The paper by Kamaraju, et al[4] in this issue describes a similar intervention in Milwaukee. The authors partnered with community organizations, presented educational seminars about breast health, and provided information and transportation for women to get free mammograms through the Wisconsin Well Woman Program. They also enlisted a mobile mammography unit that enabled women to get mammography on site at the neighborhood community centers. Over a 2-year period, the project affected almost 500 women and documented significant increases in mammography rates in both women with and without insurance. The Community-Academic partnership employed a community advisory committee and used these community relationships to ensure buy-in from the community groups. In this way, the medical knowledge from the academic partner (Medical College of Wisconsin) was shared with patients in ways that they understood, in an environment where they felt comfortable. This study is a great example of an innovative method to bring health care to the community in order to improve care for underserved women.

Additionally in this issue, 2 studies focus on evidence-based care for women with breast cancer. The project reported by Hill, et al[5] describes an intervention to ensure adherence to national guidelines for women diagnosed with early stage breast cancer. The new guidelines by the National Comprehensive Cancer Network, established in 2016, do not recommend doing screening lab tests in these women. Previously, all women diagnosed with early stage breast cancer routinely had complete blood cell count and liver profile measurements. Using a multipronged intervention that targeted providers and included educa-

tion, feedback, and positive reinforcement (gift cards), the authors successfully achieved over 80% compliance with the new guidelines. This paper is an example of an effective quality improvement initiative.

Teaching residents about quality improvement (QI) is the focus of the paper by Reardon et al.[6] This paper describes the development of a successful QI curriculum for psychiatry residents. The curriculum involves a faculty development component, time to pursue projects, and linking QI projects to Maintenance of Certification within the discipline. Most of the residents who participated completed successful QI projects.

Finally, Chaudhary et al[7] evaluate the predictive power of progesterone receptor status in recurrence rates among women with ductal carcinoma in situ (DCIS). Invasive breast cancers with positive estrogen receptor status but negative progesterone status are more aggressive than those with positive estrogen and progesterone receptor status. The authors evaluated whether that subtype of tumors (estrogen receptor positive and progesterone receptor negative) was predictive of increased rates of recurrence in women with DCIS. They followed a cohort of almost 700 women for 5 years and found that progesterone receptor status did not predict recurrence rates. This information can be helpful when counseling women with DCIS about treatment options.

Breast cancer is common, and women of color continue to experience poorer outcomes after being diagnosed. This issue of the journal summarizes important research from the public health and clinical care perspectives that can help bridge the disparity gap and lead to more equitable outcomes.

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