

Cervical Cancer Screening Among Minorities in the United States

Christina Nardi, MSN, FNP, Prabjot Sandhu, DNP, FNP-C, and Nancy Selix, DNP, FNP-C, CNM

ABSTRACT

Consistent use of the Papanicolaou (Pap) test is the main reason there is a decreased incidence of cervical cancer and associated mortality rates but many women are still not adequately screened. Minority women have lower screening rates and higher incidence and mortality rates than white women. Understanding minority groups' knowledge of cervical cancer and perceived barriers to screening is critical when designing interventions to increase screening rates among minority women. In this article we highlight the beliefs and barriers of African American, Hispanic, and Asian American women as well as potential interventions that can improve cervical cancer screening in these minority groups.

Keywords: barriers, beliefs, cervical cancer, health disparities, minorities

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BACKGROUND

Since the introduction of the Papanicolaou (Pap) test in the 1950s, the incidence of cervical cancer and associated mortality rates have decreased significantly in the United States.¹⁻³ In 1975, the incidence of new cases of cervical cancer was 14.8 per 100,000 persons. In 2013, that rate dropped to 6.4 per 100,000 persons.⁴ Over the past 10 years alone, rates for new cervical cancer cases have been falling at an average of 0.9% and death rates from cervical cancer have been falling, on average, 0.8% each year.⁴ These decreases are due in large part to the availability and use of the Pap test, demonstrating the importance of early, routine, and adequate screening.³

The Pap test is critical for the early detection and prevention of cervical cancer. Cervical cancer does not develop suddenly, but it starts with abnormal changes in cervical cells. These precancerous changes of the cervix are defined as cervical intraepithelial neoplasia (CIN) and are graded by severity, from CIN1 to CIN3, with CIN3 being carcinoma in situ, meaning the abnormal cells have not extended beyond the tissues of the cervix. The Pap test enables examination of the cytology to detect early cellular changes, and initiate appropriate treatment before the

progression to an invasive cervical cancer (ICC).³ Because precancerous lesions can be detected on the Pap test and treated early, most deaths from cervical cancer occur in women who have not been adequately screened.² Early detection greatly increases the 5-year survival rate for women with cervical cancer. When cervical cancer is diagnosed and is localized, meaning it is confined to the part of the body where it started, the 5-year survival rate is 91.3%. If the cancer spreads to a different part of the body it is staged as regional cancer and the 5-year survival rate is reduced to 57.4%.⁴

In addition to the Pap test, cervical cancer screening can include testing for human papilloma virus (HPV), one of the main causes of cervical cancer.^{2,3,5} For the period 2004 to 2008, it was estimated that 91% of cervical cancers were caused by HPV.⁶ HPV infection can cause temporary changes in cervical cells until it is eventually suppressed by the immune system. However, there are certain high-risk strains of HPV that can persist and lead to changes in cervical cells that develop into precancerous lesions. HPV types 16 and 18 are the 2 types that cause most HPV-related cancer, but HPV testing can also detect 12 other high-risk types of HPV.⁵ The HPV vaccine was created to help protect against cancers

caused by HPV. The vaccine is recommended for adolescents starting at age 11, in order to build immunities before they are ever exposed, and can be given through age 26.³ In 2015, 62.8% of girls and 49.8% of boys aged 13–17 had coverage with at least one dose of the HPV vaccine. These rates increased from 60% of girls and 41.7% of boys in 2014, but there needs to be continued effort to increase these rates in order to prevent cervical cancer.⁷

The United States Preventive Services Task Force (USPSTF) updated the cervical cancer screening guidelines in 2012 to reflect the importance of cytology and HPV testing (see Table). The USPSTF guidelines apply to all women with a cervix, without a diagnosis of high-grade precancerous cervical lesion, in utero exposure to diethylstilbestrol, or immunocompromised women, such as those with

Table. Summary of 2012 USPSTF Cervical Cancer Screening Guidelines^a

Population	Recommendation
Women 21-29 years	Screening with cytology only every 3 years. HPV screening is not recommended, alone or with cytology.
Women 30-65 years	Cytology (Pap smear) in combination with HPV testing every 5 years or with cytology alone every 3 years.
Women < 21 years	Screening is not recommended.
Women > 65 years who have had prior adequate screening	Screening is not recommended if prior adequate screening ^b and are not considered high risk for cervical cancer. ^c
Women who have had a hysterectomy	Screening not recommended in women who have had hysterectomy with the cervix removed and no history of high-grade precancerous lesion (CIN 2 or 3) or cervical cancer.

CIN = cervical intraepithelial neoplasia; HPV = human papilloma virus; USPSTF = United States Preventive Services Task Force.

^a Guidelines from Moyer.²

^b Adequate prior screening is 3 consecutive negative cytology results or 2 consecutive negative HPV results within 10 years before cessation of screening, with the most recent test occurring within 5 years. Routine screening should continue for at least 20 years after spontaneous regression or appropriate management of a high-grade precancerous lesion, even if this extends screening past age 65.

^c HPV infection, HIV infection, compromised immune system, in utero exposure to diethylstilbestrol, history high-grade precancerous lesion, or cervical cancer.

HIV. Prior to the release of the 2012 guidelines, the USPSTF, American Cancer Society, and American College of Obstetrics and Gynecology had varied screening recommendations. Now, these organizations jointly recommend screening with cytology every 3 years for women 21–65 years old. Women 30–65 years old can be screened every 5 years if they are screened with cytology and HPV testing. The USPSTF does not recommend screening women > 65 years old if they have had adequate screening in the past and are not considered high risk.²

Despite the known benefits of cervical cancer screening, recommendations on updated practice guidelines, and the widespread availability of the Pap test, national screening rates remain low. Healthy People 2020 has set a target goal of screening 93% of women according to the recommended guidelines.⁸ Since 1957, the Centers for Disease Control and Prevention has monitored national health with the National Health Interview Survey (NHIS), a cross-sectional household interview survey about all health topics, including the prevalence of disease and utilization of health resources, such as cervical cancer screening. The data are collected continuously throughout the year. The 2013 NHIS data indicate that only 80.7% of women 21–65 years old reported having a Pap smear within the past 3 years.⁹

Although there has been a drop in the overall incidence of newly diagnosed cervical cancers, minority populations continue to be disproportionately affected by cervical cancer.¹⁰ African American, Hispanic, and Asian American women reportedly demonstrate higher incidence and mortality rates than white women.¹ Black women account for 8.9 of 100,000 new cases and the incidence in Hispanic women is 9.4 per 100,000 cases, compared with 7.5 per 100,000 cases for white women.⁴ The NHIS data indicate that Asian American women have a lower incidence than white women, but they also have lower screening rates. In 2013, only 70.5% of Asian women were screened compared with 82.7% of white women.⁸ Screening rates also proved lower for Hispanic and African American women at 77% and 82.13%, respectively.¹¹ Cervical cancer screening rates are an important factor to examine because the

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