

Direct Interactive Public Education by Breast Radiologists About Screening Mammography: Impact on Anxiety and Empowerment

SA-CME

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Abstract

Purpose: Anxiety has been called a “harm” of screening mammography. The authors provided direct, interactive education to lay audiences and measured these sessions’ impact on anxiety and any increased understanding of breast cancer screening.

Methods: Academic breast radiologist provided seven 1-hour sessions of structured lectures and question-and-answer periods. Lay language and radiologic images were used to discuss disease background, screening guidelines, and areas of debate. One hundred seventeen participants (mean age, 45 ± 15 years) completed voluntary, anonymous, institutional review board-approved pre and postsession questionnaires relating their attitudes regarding screening and the impact of the sessions. Results are summarized descriptively.

Results: Mean reported anxiety regarding screening (on a scale ranging from 1-5; 1 = no anxiety) was 2.5 ± 1.3. Anxiety was attributed to unknown results (56.4%), anticipation of pain (21.8%), known risk factors (14.5%), general uncertainty (12.7%), waiting for results (9.1%), possibility of more procedures (3.6%), and personal breast cancer history (3.6%). Ninety-seven percent reported that immediate results would lower anxiety (78% of those women indicated a 75%-100% decrease in anxiety); 93% reported that radiologist consultation with images would lower anxiety (75.6% indicated a 75%-100% decrease in anxiety). After the lecture, women reported (on a scale ranging from 1-5) increased understanding of the topic (4.7 ± 0.6), encouragement to screen (4.6 ± 0.7), and reduced anxiety (4.0 ± 1.1). Ninety-seven percent to 100% provided correct responses to these questions: rationale for screening in the absence of family history, recall does not equate to cancer diagnosis, benefit of prior films, and continued importance of physical examination.

Conclusion: Attendees of radiologist-provided direct public lectures reported decreased anxiety and improved knowledge regarding screening mammography. The resultant reduced anxiety (“harm”) and educational empowerment help enable informed decision making and may promote screening attendance.

Key Words: Screening mammography, direct public education, breast radiologists, anxiety, informed shared decision making

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INTRODUCTION

Much of the debate surrounding screening mammography centers on the age of onset of screening and the optimal screening interval. In November 2009, the United States Preventive Services Task Force (USPSTF) announced revised guidelines for average-risk women that limited

routine screening to biennial mammography for women 50 to 74 years of age. The USPSTF recommended “against routine screening mammography in women aged 40 to 49 years” [1]. It cited significant “harms” of “false-positive” test results and “anxiety” as justification that outweighed the acknowledged evidence of two important points: (1) screening annually confers greater mortality reduction than does biennial screening, and (2) women 40 to 49 years of age do benefit from screening comparably with older women [2]. In a much less publicized amendment, the USPSTF stated that “the decision to start regular, biennial screening mammography before the age of 50 years should be an individual one and take into account patient context, including the patient’s values

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regarding specific benefits and harms” [3,4]. Presumably health care providers are expected to initiate shared decision-making processes, but it is unclear at what age or how this should occur, in the context of efficient clinical visits that likely address many other health topics as well.

Subsequent to the 2009 USPSTF recommendations, the AMA and the American College of Obstetricians and Gynecologists (ACOG) revised their recommendations to more strictly align with the American Cancer Society (ACS) guidelines, which reaffirmed annual screening for average-risk women from age 40 years and for as long as they are in good health. Therefore, any women who obtain primary medical care from physicians who abide by the AMA guidelines or from gynecologists will likely have the opportunity to discuss the screening debate. This may not be true for women who receive primary care from physicians or other health care workers who rely solely on the USPSTF’s recommendations. Survey-based studies of providers reveal low rates of offering screening to women 40 to 49 years of age [5,6]. The USPSTF 2015 draft recommendations as of this writing again mention, but do not mandate, discussing mammography with women younger than 50 years and do not mention discussing an annual screening interval with women of any age.

This highlights the need for women to become sufficiently and independently informed about screening mammography to have, and to initiate if necessary, the conversation with their providers. Women may be unable to fully follow the complex ongoing debates, and clinicians may be underprepared to handle the breadth and depth of the ensuing questions. Even if both were prepared and capable, not all women seek routine medical care to receive, or prompt, the shared decision-making discussion. Print media in widely available women’s magazines are variable in their handling of this topic, whereas educational materials from medical sources may have limited reach to only those women who are already patients.

Important strides to disseminate information directly to the public have been made since October 2013, with website, television, and radio announcements of the Mammography Saves Lives campaign, which is jointly sponsored by the ACR, the Society of Breast Imaging, and American Society of Breast Disease. There is literature supporting health care workers providing patient education for medical topics such as diabetes, hypertension, and cholesterol [7-11], but there is a paucity of data describing lay public outreach by breast radiologists on this cancer screening topic that defines their medical expertise.

To proactively address this knowledge gap, we implemented direct and interactive public education of women

about screening mammography. The goals were to promote understanding of and to help reduce anxiety about mammography, with the hope to ameliorate a “harm” as emphasized by the USPSTF. In this study, we describe these direct lay audience educational sessions and assess the sessions’ impact on attendees’ reported anxiety and any increased understanding of screening mammography.

METHODS

Our prospective, HIPAA-compliant study was approved and granted a waiver of the requirement for written informed consent by our institutional review board. A dedicated breast radiologist at a major urban academic medical center provided seven 1-hour long sessions, live and in person, composed of a formal lecture and a question-and-answer period. These were conducted in June, August, and October, 2013 at the following: medical center-sponsored evening symposium at an outpatient site and a daytime event at an affiliated community hospital that served predominantly minority populations; daytime suburban community events at a public library and as a panelist for an ACS community outreach program (different states); urban corporate offices of a major bank and a major law firm as guest speaker for their “Lunch and Learn” programs; and an evening lecture series at a private university alumni club. Attendees, including men, were invited via any and all means of publicity per usual for each venue and event type. These included internal electronic communication for corporate and private groups, newspapers, flyers, brochures, mail, and e-mail as applicable. No fees were charged for attendance.

Using plain language, word slides, and pertinent radiologic images and schematic diagrams, the structured and comprehensive PowerPoint (version 2010; Microsoft Corporation, Redmond, Washington) lectures presented disease background, age-incidence rates, the relative pros and cons of various screening recommendations, and areas of debate, with intent to explain them in their proper context. The role of radiologists among all breast specialists was explained and illustrated during the lecture and question-and-answer session. Lecture content included but was not limited to defining terms and concepts of screening versus diagnostic breast imaging exams; “false positive” imaging or clinical breast exam results; call-back or recall rates and what the patient might experience during diagnostic workups (e.g. diagnostic mammography and breast ultrasound); breast density; biopsy types and the retrospectively-determined “unnecessary” biopsy; and the medical self-auditing

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