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Cervical cancer screening after 50: near extinction?☆

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ABSTRACT

Objectives: The objectives of this study were to determine the prevalence and predictors of Pap smear screening among women aged 50 years and older.
Study design: This cross-sectional study was conducted at two large urban health centres in Selangor. A total of 515 women aged 50 and older were recruited.
Results: The mean age of the respondents was 58.83 ± 7.05, with a range of 50– 83 years. The prevalence of Pap smear screening was 39.22% (n = 202). From the multivariate analysis, Pap smear screening was significantly associated with health care provider advice (adjusted odds ratio (AOR) = 18.75; 95% CI = 8.30, 42.37); tertiary (AOR = 11.26; 95% CI = 1.50, 84.68) and secondary education level (AOR = 9.47; 95% CI = 1.43, 62.84); use of contraception (AOR = 2.90; 95% CI = 1.48, 5.69); heart disease (AOR = 0.22; 95% CI = 0.05, 0.97); and worry about Pap smear results (AOR = 0.20; 95% CI = 0.09, 0.42).
Conclusion: The prevalence of Pap smear screening in the older women is unsatisfactory. Health care provider advice, education level, use of contraception, heart disease and worry about Pap smear results were predictors of undergoing Pap smear screening in this study population.
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Introduction

Cervical cancer was the third most common cancer among women in 2007. Cervical cancer incidence rates increase with age after the age of 30 years. According to the National Cancer Registry Report, there has been a 10% increase in the incidence of cervical cancer in women aged 50–60 years (20–30% incidence rate per 100,000 population), with peak incidence occurring between the ages of 65 and 69 years [1]. In Nigeria, the prevalence of cervical intraepithelial neoplasia (CIN) was 13.0% in elderly patients aged 50 years and older [2]. In Ontario population–based registry study, over 80% of women aged 50 years or older with high-grade lesion or carcinoma did not have Pap smear screening or had an abnormal test result in the past four years [3]. "The incidence and mortality rate of cervical cancer were higher in developing countries because of ineffective screenings, lack of knowledge of its benefits among women and unsustainable screening advocates" [4].

The National Cervical Cancer Guidelines 2003 recommends that all sexually active women age between 20 to 65 years should undergo Pap smear screening annually for two consecutive years, and if the Pap smear is normal on both occasions, they can continue the screening test once every three years [4]. The widely practiced opportunistic screening may not be as effective for reducing cancer rates compared to an organised programme.

Accurate rates of Pap smear rates in recent years are unknown, as there is no Pap smear registry in Malaysia. However, the majority of Pap smears are performed through public healthcare services. Even with the presence of a nationwide opportunistic cervical cancer screening programme, the screening rate nationwide remained low (43.7%) in 2006; however, this was an increase from 26% in 1996 [4]. Compared to developed countries, Malaysia's Pap smear uptake is low [5].

Chronic diseases in women aged 40 years and older have been found to be associated with decreased uptake of Pap smear screening. It has been suggested that having a chronic disease makes cancer screening relatively less likely [6]. Chronic diseases, such as cardiovascular disease, share common risk factors, such as obesity, poor diet quality, inactivity and smoking, with breast and other cancers. Hence, screening in patients with cardiovascular disease is especially important [7,8]. The majority of 50-year-old women may refrain from cervical screening because the risk of

☆ This study was conducted in Gombak, Selangor, Malaysia.
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HPV among elderly women is minimal [9]. However, in areas with poor uptake of cervical cancer screening, Pap smear screening remains important and relevant.

A few predictors of cervical cancer screening have been identified. One study identified these predictors as being married with children, having knowledge of cervical cancer symptoms, receiving relevant information regarding cervical cancer from health personnel or campaigns, and being engaged in family planning [10]. Similarly, another study identified age and marital status as variables significantly associated with history of Pap smear screening [11].

There have been a few common barriers identified in several studies [12,13]. Hoque [12] mentioned that fear of the procedure and being healthy were barriers, while Yanikkerem et al. [13] documented lack of awareness, being uncomfortable with the procedure and not knowing where to go for a Pap smear as common barriers. Furthermore, other barriers, including pain and discomfort, were also associated with Pap smear screening.

Most studies have described the Pap smear screening practices among women of reproductive age. In view of the limited local literature on screening uptake among older women, it is prudent to investigate their Pap smear screening practices further. The objectives of this study were to determine the prevalence and predictors of Pap smear screening among women aged 50 years and older in an urban area in Malaysia.

Materials and methods

Two urban health centres in Gombak, Selangor district, were chosen for study inclusion. The Gombak district was chosen because it is an urbanized area in Selangor. A cross-sectional study was conducted between February and April 2014. Ethical approval (600-RMI (5/1/6/01)) was obtained from the Ethics Committee of Universiti Teknologi MARA (UiTM), Malaysia.

Using Power Sample software version 21, an estimated sample size of 432 participants was obtained. Considering a 10–20% nonresponse rate, the final sample size needed was calculated to be 500. A pilot study was conducted to test the reliability and validity of the questionnaire prior to study initiation. The questionnaire was pre-tested with health staff and underwent a minor modification at the end of the pre-testing. In this modification, the questions were modified slightly to make the language simpler and easier to understand.

Married women aged 50 years and above who can understand Malay or English language were included in the study. Respondents were briefed on the purpose of the study, and interview duration was approximately 10 min. A random sample of 515 women was generated. Written consent was obtained from each participant. All the respondents were assured that their responses and participation were confidential. The information from the respondent was collected using face-to-face interview between the researcher and a structured and validated questionnaire.

The questionnaire consisted of two parts. The first part collected the respondents' sociodemographic (ethnicity, age, highest education level, employment status, and categories of employment) and medical history information family history of cervical cancer; body mass index (BMI); contraceptive history; history of menopause; number of chronic diseases, including heart disease; hypertension and diabetes; Pap smear screening history and lastly, history of advice from a health care provider to receive Pap smear screening. The second part of the questionnaire consists of eight items reflecting perceived barriers related to Pap smear that included: painful, worry about results, embarrassment, cost, lazy/not bothered, no partner permission, working commitments and family commitments. BMIs of 18.5–24.9 kg/m^2 were considered normal weight, BMIs of 25.0–29.9 kg/m^2 were considered overweight and BMIs >30.0 kg/m^2 were considered obese, according to the Malaysian Association for the Study of Obesity Parameters [14].

Data were screened for missing data, outliers and normality. Descriptive statistics (frequency, percentage, and means) were performed. Raw percentages were calculated. Univariate and multivariate logistic regression tests were used to identify significant predictors for Pap smear screening. P values <0.05 were regarded as

Table 1
Socio-demographic factors of respondents and the univariate analysis (N = 515).

	Perform Pap smear screening		Crude odds ratio (95%CI)	P-Value
	No n (%)	Yes n (%)		
Ethnicity				
Malay	191 (55.8)	151 (44.2)	Reference	
Chinese	56 (68.3)	26 (31.7)	0.59 (0.35,0.98)	<0.01
Indian	63 (73.3)	23 (26.7)	0.46 (0.27,0.78)	<0.01
Others	3 (60.0)	2 (40.0)	0.84 (0.14,5.11)	0.85
Education				
No formal education	58 (96.7)	2 (3.3)	Reference	
Primary	136 (77.3)	40 (22.7)	8.53 (2.00,36.47)	0.004
Secondary	96 (45.5)	115 (54.5)	34.74 (8.27,145.95)	<0.001
Tertiary	23 (33.8)	45 (66.2)	56.74 (12.70,253.38)	<0.001
Marital status				
Married	229 (56.8)	174 (43.2)	Reference	
Divorced/widowed	87 (77.7)	25 (22.3)	0.53 (0.12,2.36)	0.40
Employment status				
Employed	68 (53.1)	60 (46.9)	Reference	
Not employed	245 (63.3)	142 (36.7)	0.66 (0.44,0.98)	0.04
Categories of employment				
Housewife	222 (66.1)	114 (33.9)	Reference	
Self-employed	33 (71.7)	13 (28.3)	0.77 (0.34,1.51)	0.44
Non-professional	23 (56.1)	18 (43.9)	1.52 (0.79,2.93)	0.21
Professional	12 (29.3)	29 (70.7)	4.71 (2.32,9.57)	<0.001
Others	23 (45.1)	28 (54.9)	2.37 (1.31,4.30)	<0.01

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