Strang Cancer Prevention Institute
Dedicated to Promote Cure by Early Detection and Research to Prevent Cancer since 1933

Prevention

Breast Cancer Awareness Month October 2018

Shared Decision Making in Breast Cancer Screening

For most of their lives, women think of mammograms when they think of cancer screening. Most women believe that screening is important and expect to discuss them at annual medical visits. In turn, PCPs know most patients over 50 should get them, and many providers are evaluated by whether their patients undergo screening. This newsletter focuses on shared decision making about mammography and the **Strang Screening Trial**, our randomized trial of educational interventions for providers about screening. We also studied how doctors and patients talk, and what they hear, when they discuss screening. We briefly review the **US Preventive Services Task Force (USPSTF)** mammography recommendations and then some early lessons from the screening trial.

The Strang Screening Trial was a cluster-randomized trial of two educational supports for PCPs for cancer screening discussions: 1) A printed tool (color-coded recommendations by patient age and other characteristics) for breast, cervical, colorectal, lung and prostate cancer screening; and 2) "Academic detailing" (educational outreach) to support elements of shared decision-making, including benefits, harms and the role of patient choice. Because the physician and patient completed surveys immediately after the visit, we learned much about what they understood, believed and heard (and didn't hear). We describe some of what we learned below.

Mammography Screening Recommendations: US Preventive Services Task Force (USPSTF)

AGE

50-74 years: Screen. High certainty of moderate net benefit or moderate certainty of moderate to substantial net benefit (USPSTF B rating). The most recent meta-analysis found a 20% survival benefit for the entire age group, although it varies by age group (see age 40-49 below).

40-49: Individual Decision taking into account patient circumstances and values regarding risks and benefits. (USPSTF C rating) The recent meta-analysis found a nearly identical survival benefit of about 15% for women 40-49 and 50-59. However, because breast cancer incidence increases rapidly, starting at age 40, the trade-offs are less favorable for younger women: fewer early cancers to detect and treat, greater chance of false-positive tests and overtreatment. As a result, the number needed to screen to prolong one life is about 1900 for women in their 40's vs. 1340 for women in their 50's. Of course, indicators of higher risk, such as a family history of breast cancer or a germline BRCA mutation, shift the balance heavily toward early screening.

75 years or older: Insufficient evidence to determine net benefits. (USPSTF I rating) Most of the survival benefit primary benefit starts 10 years or more after screening. There, older age, particularly after age 75, reduces the survival benefit of screening. In addition, older women have slower-growing breast cancers than young women and have more illnesses that are life-threatening or make aggressive cancer treatment less attractive (e.g., dementia or advance heart or lung disease). Screening trials have not been done in older women.

FREQUENCY

Biannual (vs. annual). Benefits are about the same, with less than half the false-positive and overdiagnosis of annual screening. Longer intervals (studied up to 33 months) reduce the benefit.

NEWER IMAGING TESTS: New guidance being formulated.

Digital vs. film: More expensive, benefits uncertain.

MRI: More sensitive, more false positives and overdiagnosis, uncertain impact on survival.

The Strang Screening Trial

The Strang Screening Trial is a cluster-randomized trial of two educational supports for PCPs for cancer screening discussions: 1) A printed tool (color-coded recommendations by patient age and other characteristics) for breast, cervical, colorectal, lung and prostate cancer screening; and 2) "Academic detailing" (educational outreach) to support elements of shared decision-making, including benefits, harms and the role of patient choice. Because both physician and patient completed **surveys immediately after the visit**, we learned more than any other study about what they understood, believed and heard (and didn't hear). **Patients surprisingly often reported screening discussions differently** from their doctors**.** We describe some of what we learned below.

Patients and doctors reported screening discussions Women more accurately recall discussions about mammography than about colorectal screening, even older women. Agreement between doctor and patient about whether mammography was discussed: 86% to 100% vs. 63% to 93% for colorectal cancer screening.

Doctor-patient agreement on whether the doctor recommended screening was worse, especially for women 70 and older, but better than for colorectal screening. Agreement between women 70 and over and their doctor about the recommendation was 82% for mammograms vs. 53% for colorectal cancer. Using the kappa statistic to adjust for chance agreement (even if doctor and patient simply flip coins to decide, sometimes they will agree), agreement was fair for mammography (kappa = 0.39) but nonexistent for colorectal screening (kappa = -0.07).

Shared decision-making improved communication. If the doctor recalled any element of shared decision-making (stating the arguments for screening, arguments against or simply stating that the patient had a choice), agreement about the doctor's recommendation sharply increased, from 60% (kappa = 0.00, or no agreement) to 80% (kappa = 0.60%, or good agreement). **Perhaps the difference between a lecture and a conversation is better communication, and better care.**

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The Strang Cancer Prevention Cookbook

Reduce your Risk for Cancer by Eating a Healthy Diet!

Root Vegetable Mashed Potatoes

10 Servings

The blend of autumn root vegetables is nutrient rich and contains only half the fat and calories of traditional mashed potatoes

I medium rutabaga (about 1 ½ pounds) peeled and cut into 1-inch cubes
3 medium turnips (about 1 pound), peeled and cut into 1 ½ -inch chunks
¼ teaspoon salt
4 large white potatoes (about 2 ½ pounds) peeled and cut into 1 ½ inch chunks
1 ½ cups warm 2% milk
2 tablespoons unsalted butter
Salt and freshly ground black pepper

Place the rutabaga and turnips in a large saucepan, cover with cold water and add the salt. Bring to a boil, then reduce the heat and simmer for 30 minutes. Add the potatoes and cook until the vegetables are tender when pierced with a knife, 10 to 15 minutes. Drain the boiled vegetables and transfer them to a large bowl.

Heat the milk in a small saucepan on the stove or microwave Using an electric mixer, begin creaming the rutabaga, turnips and potatoes white slowly pouring the warm milk into the bowl (use only as much milk is needed to make the puree creamy and light). Beat in the butter and season with salt and pepper to taste. Serve hot.

Calories 174 Protein 5g Carbohydrates 30g Fat 4g Cholesterol 10mg Dietary fiber 3g Saturated fat 1g
Major sources of Potential cancer fighters: Phytochemicals: glucosinolates, plant polyphenols (flavonoids phenolic acids), alliumn compounds,

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