

Cultural Differences in Breast Health

Dr. Margaret Churcher
Dr. Gloria Roldan Urgoiti

Saturday, April 14, 2018



Faculty/Presenter Disclosure

- **Speaker:** Dr. Margaret Churcher
Cultural Differences in Breast Health
- **Relationships with commercial interests:**
 - Grants/Research Support: None
 - Speakers Bureau/Honoraria: None
 - Consulting Fees: None
 - Other: None



Disclosure of Commercial Support

- This Program is funded through AHS Operational Funding.
- This Program has not received financial support.
- This Program has not received in-kind support.
- Dr. Margaret Churcher is presenting at this Program on a voluntary basis.
- **Potential for conflict(s) of interest: None**

Objectives

1. Describe which populations (especially in their panel or area) could be at risk for decreased breast cancer screening.
2. Discuss the barriers that might prevent screening in these individuals.
3. Start to develop strategies for your office/clinic to address barriers and improve breast cancer screening rates in this population.

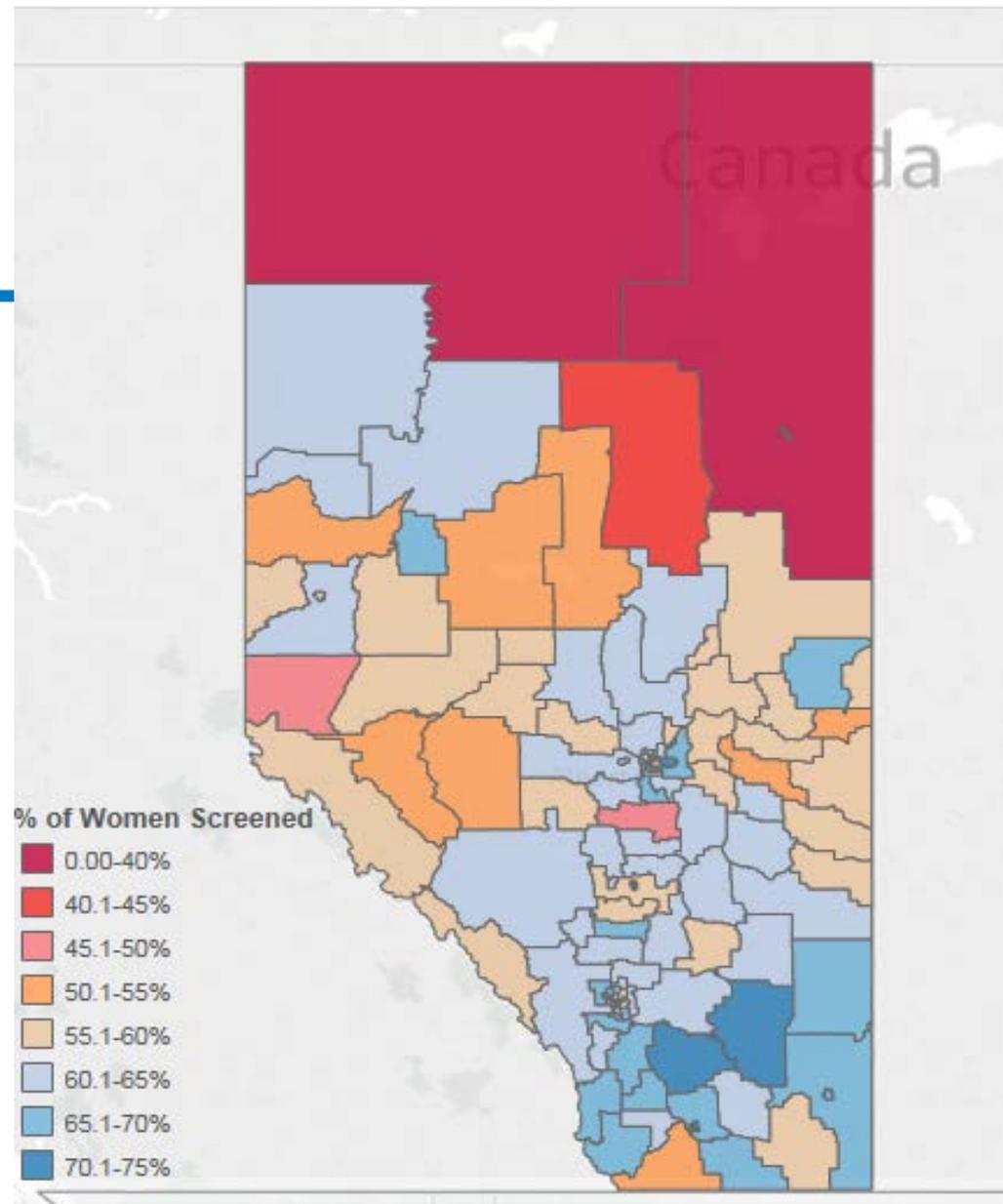
Case

- 50 yrs old female
- Recent immigrant from Pakistan
- Islamic faith
- Husband is a physician
- First time seeing you
- Hardly ever had a Pap or breast exams

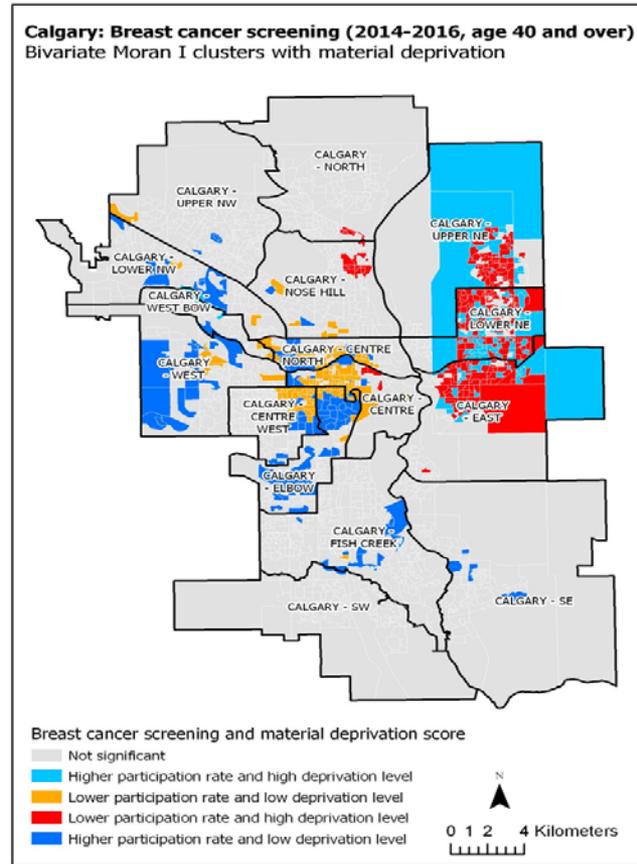
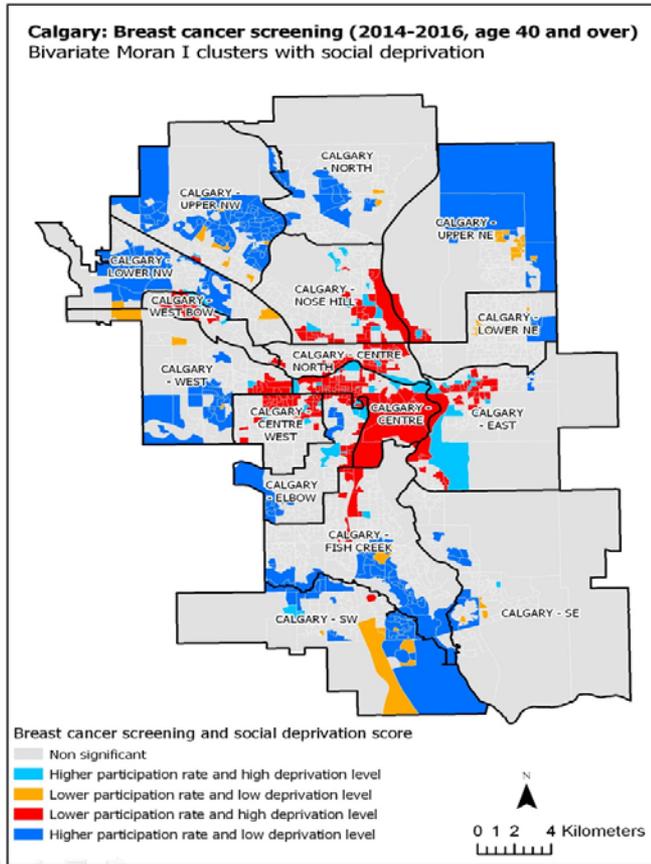
What...?

Breast Cancer Screening Participation

- AB rate: 62.8%
- Target: 70%



Breast Cancer Screening and Deprivation





Screen vs Symptom Detected

- How to define screen vs symptom detected?
 - CPAC definition: “cancer detected by screening”





Screen vs Symptom Detected

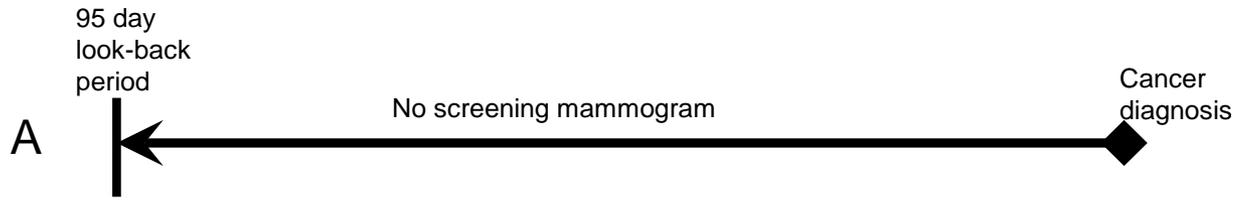
- Definition based on look-back period described in:
 - “Using administrative data to estimate time to breast cancer diagnosis and percent of screen-detected breast cancers – a validation study in Alberta, Canada”. Y. Yuan et al., 2014





95 Day Look-Back Period

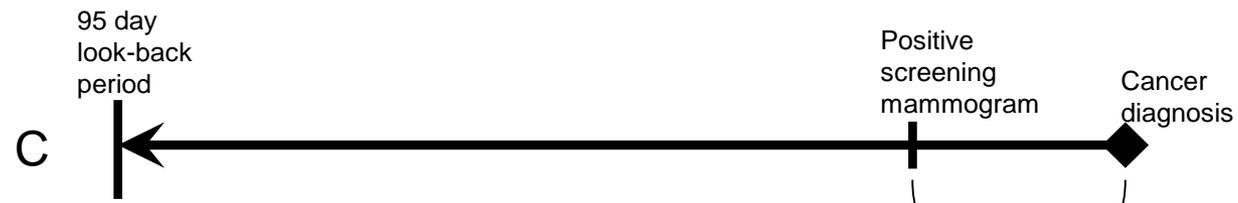
Symptom
Detected



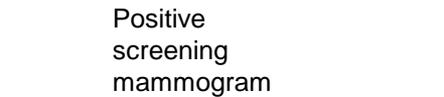
False -



Screen
Detected
(True +)

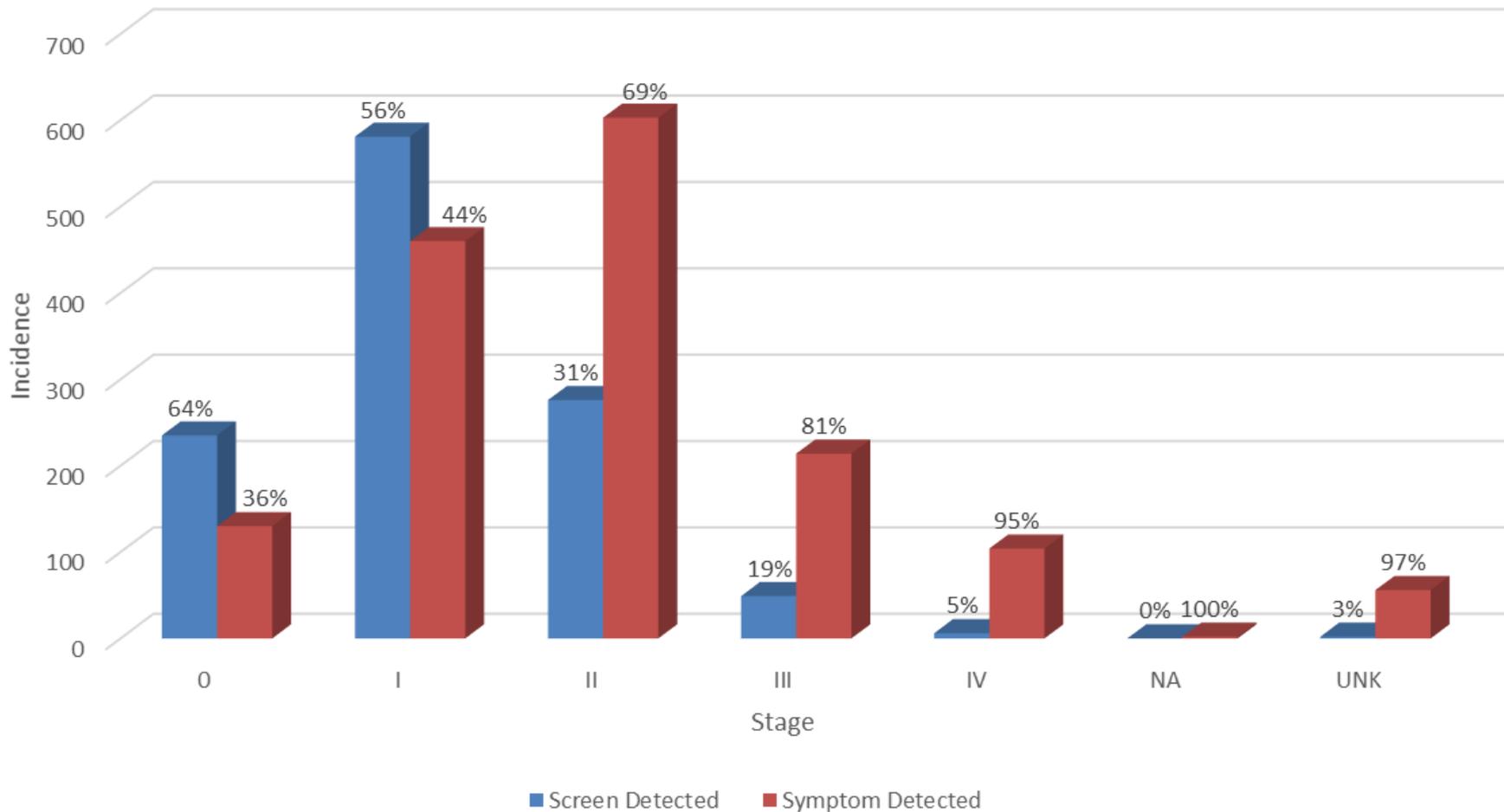


Positive
screening
mammogram





Screen Detected and Symptom Detected Breast Cancer by Stage





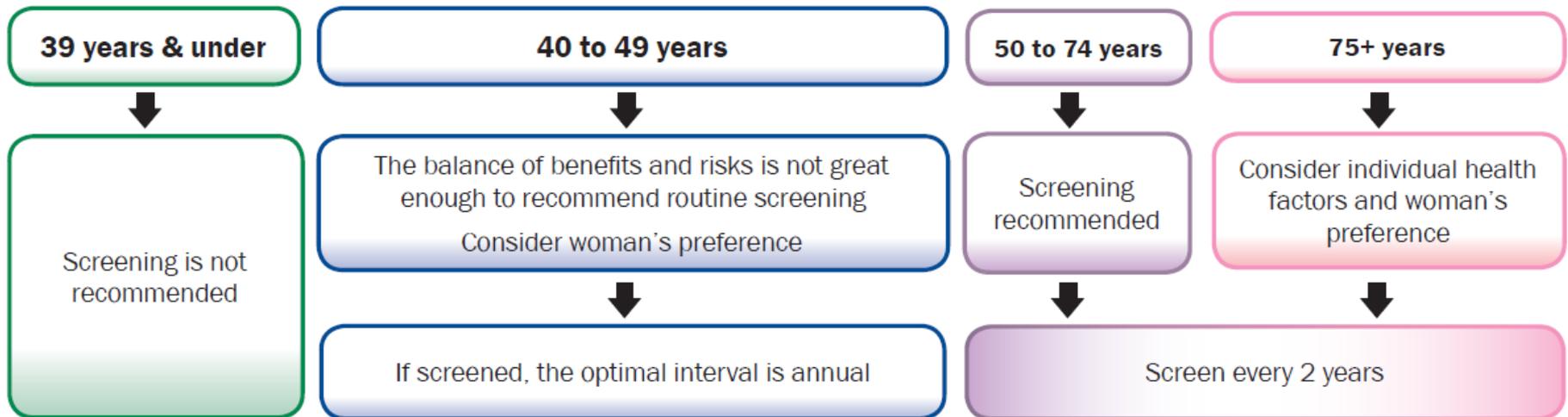
Limitations

- Low participation rate in screening
- Under screened populations
- Some not screening regularly
- Screening → Symptom VISIT: if a symptom is mentioned at screening, the assessment may be changed to diagnostic
 - Measure intent to screen

Clinical Practice Guidelines (CPGs)

AVERAGE RISK POPULATION: RECOMMENDATIONS

Use Mammography for Screening



Breast augmentation, breast reduction, sex-reassignment: As above
Note presence of implants in history section of mammography requisition form

Clinical Breast Exam (CBE): Do not use for screening. Consider as part of physical exam

Not recommended for routine screening: MRI, ultrasound, tomosynthesis, thermography, breast self-examination



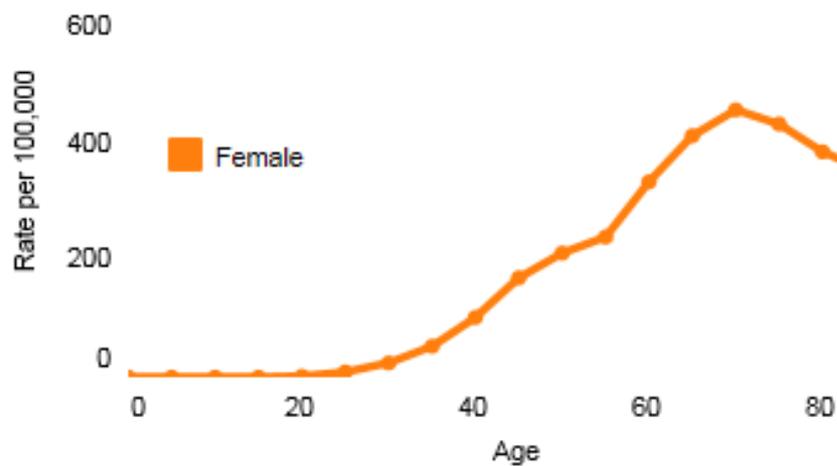
CPGs – Key Discussion Points

1. Initiate discussion about screening mammography with women of the appropriate age, including potential benefits and risks of mammography
2. Encourage breast awareness
3. Discuss modifiable risk factor(s)

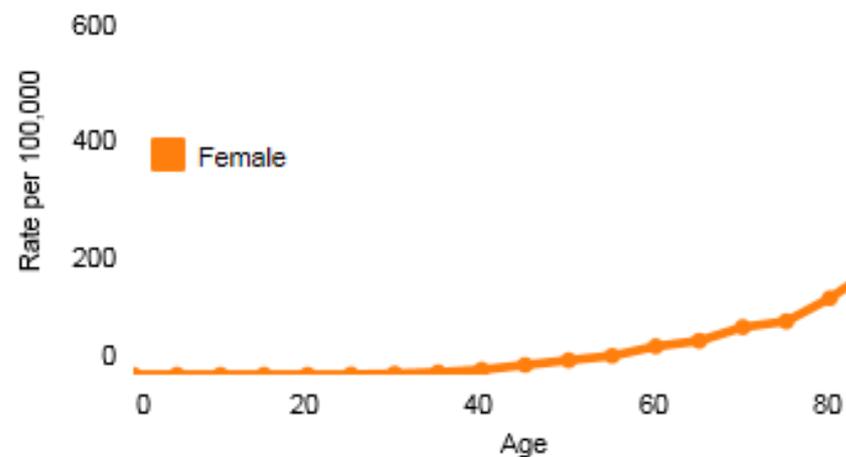


Age-Specific Rates

Incidence

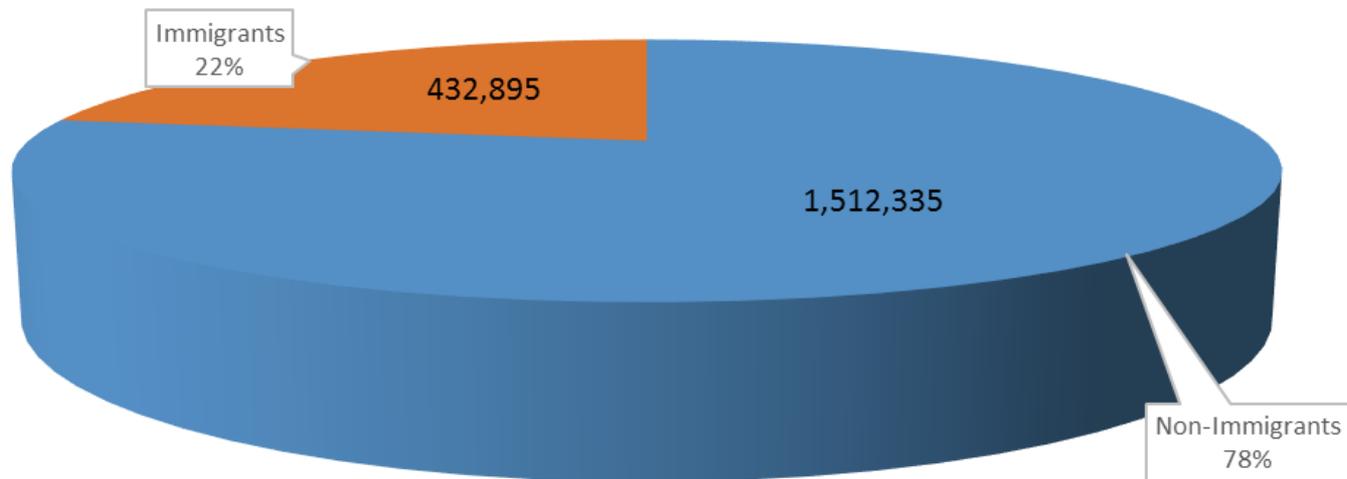


Mortality



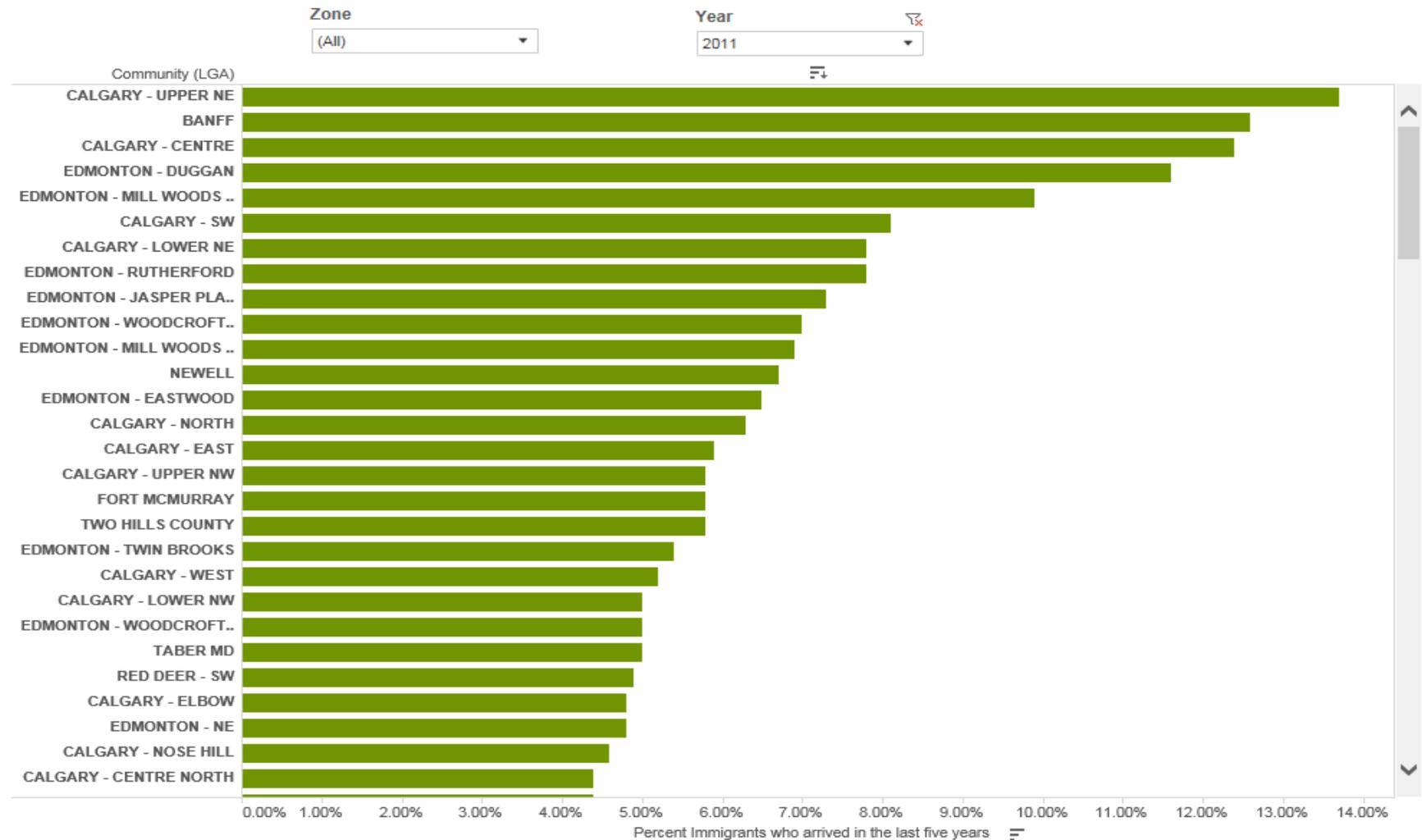


Alberta 2016 Immigrant Status (Female)



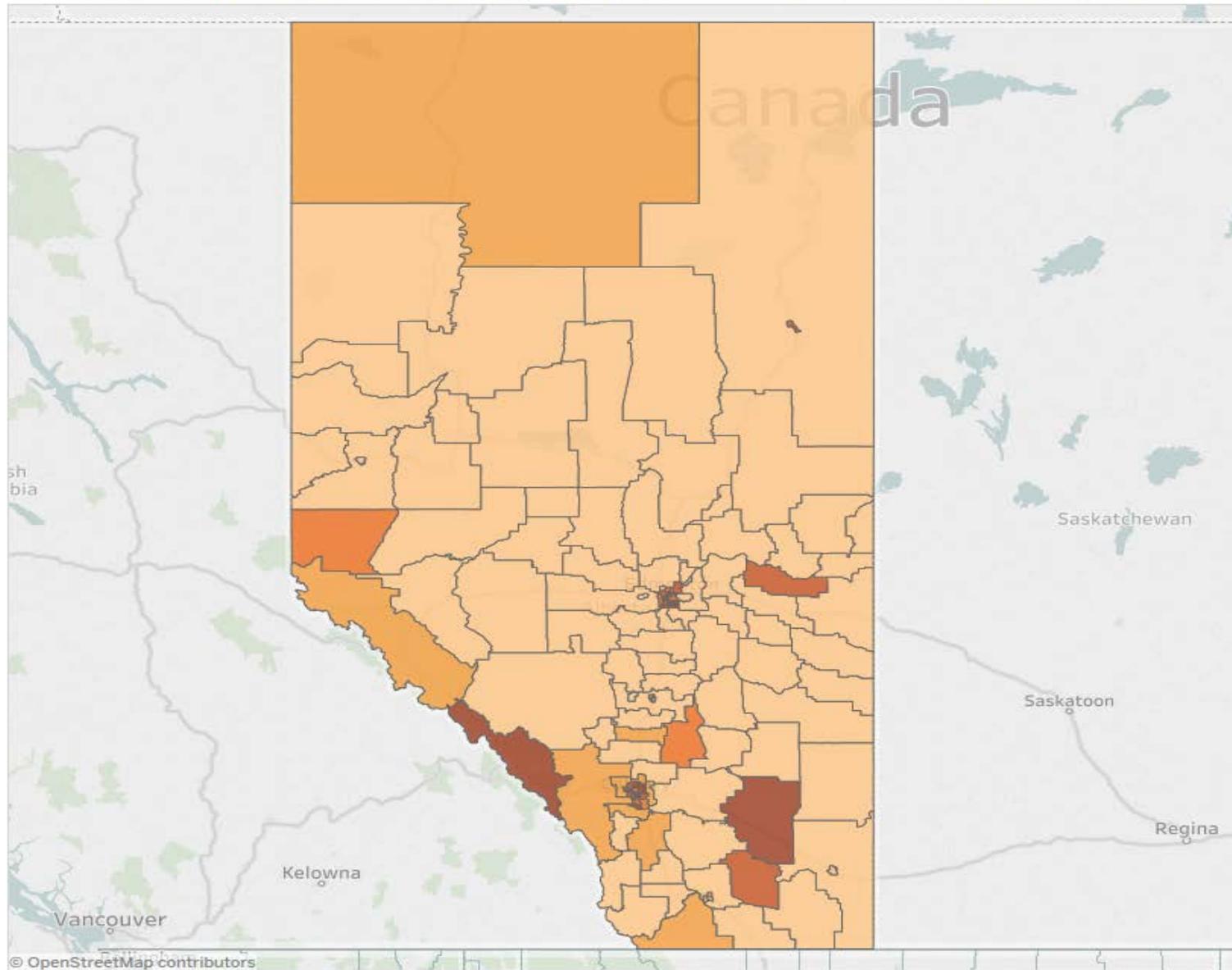
Immigration

This graphic shows the percentage of the population that immigrated in the last five years. The data has been automatically sorted from highest per cent to lowest, but can also be sorted from lowest per cent to highest or alphabetically by clicking on the little graph that appears when moving the mouse over the Community (LGA) title.

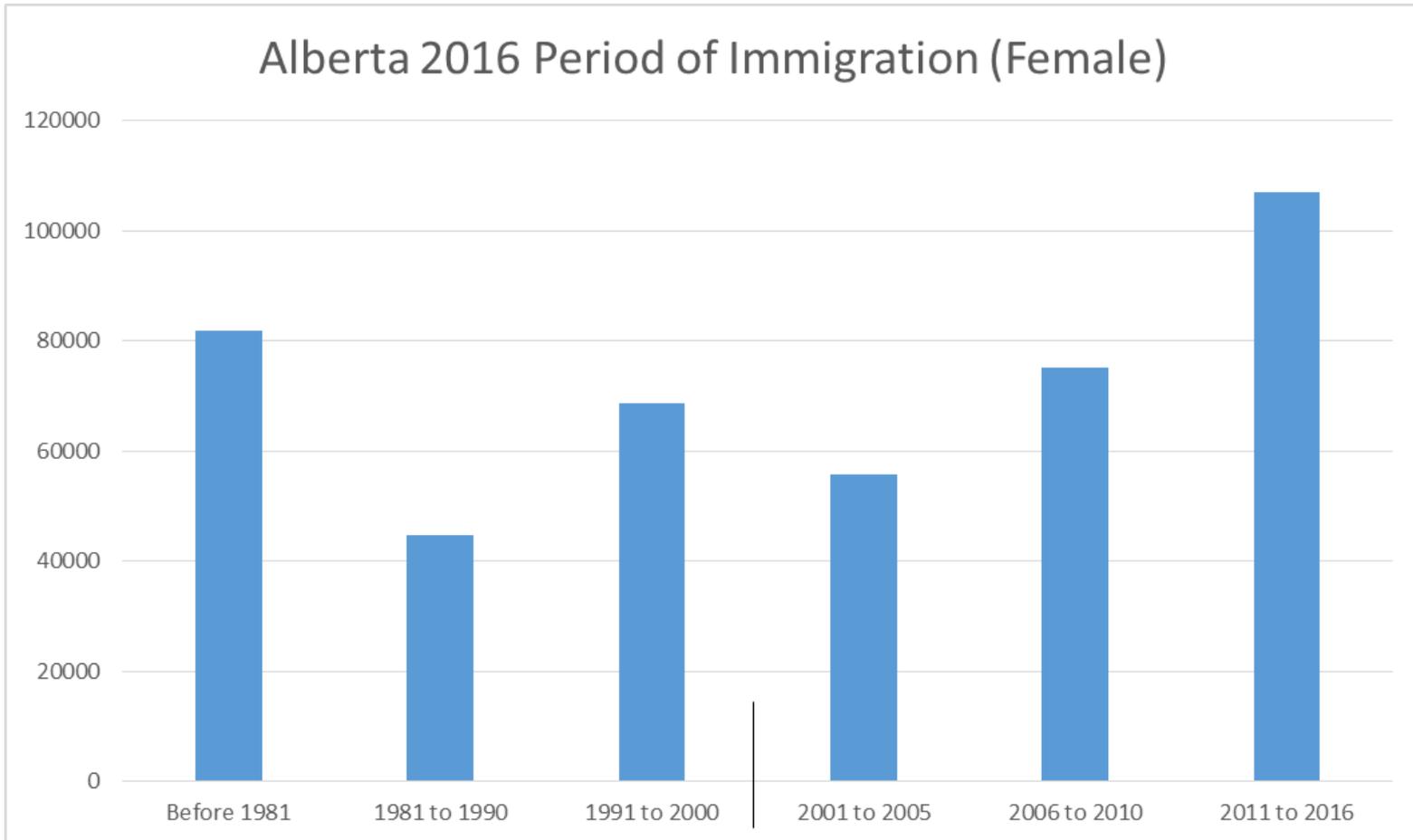


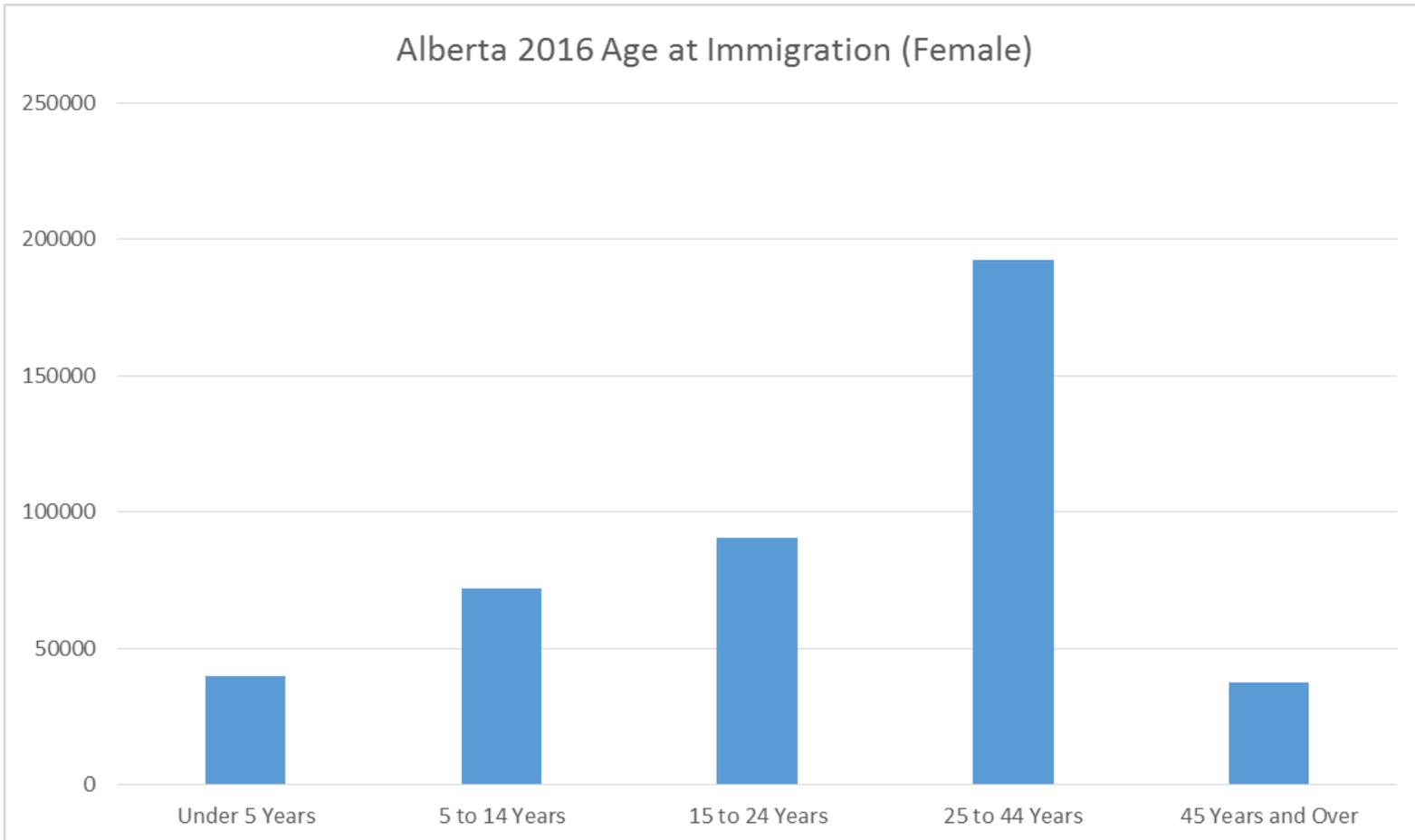


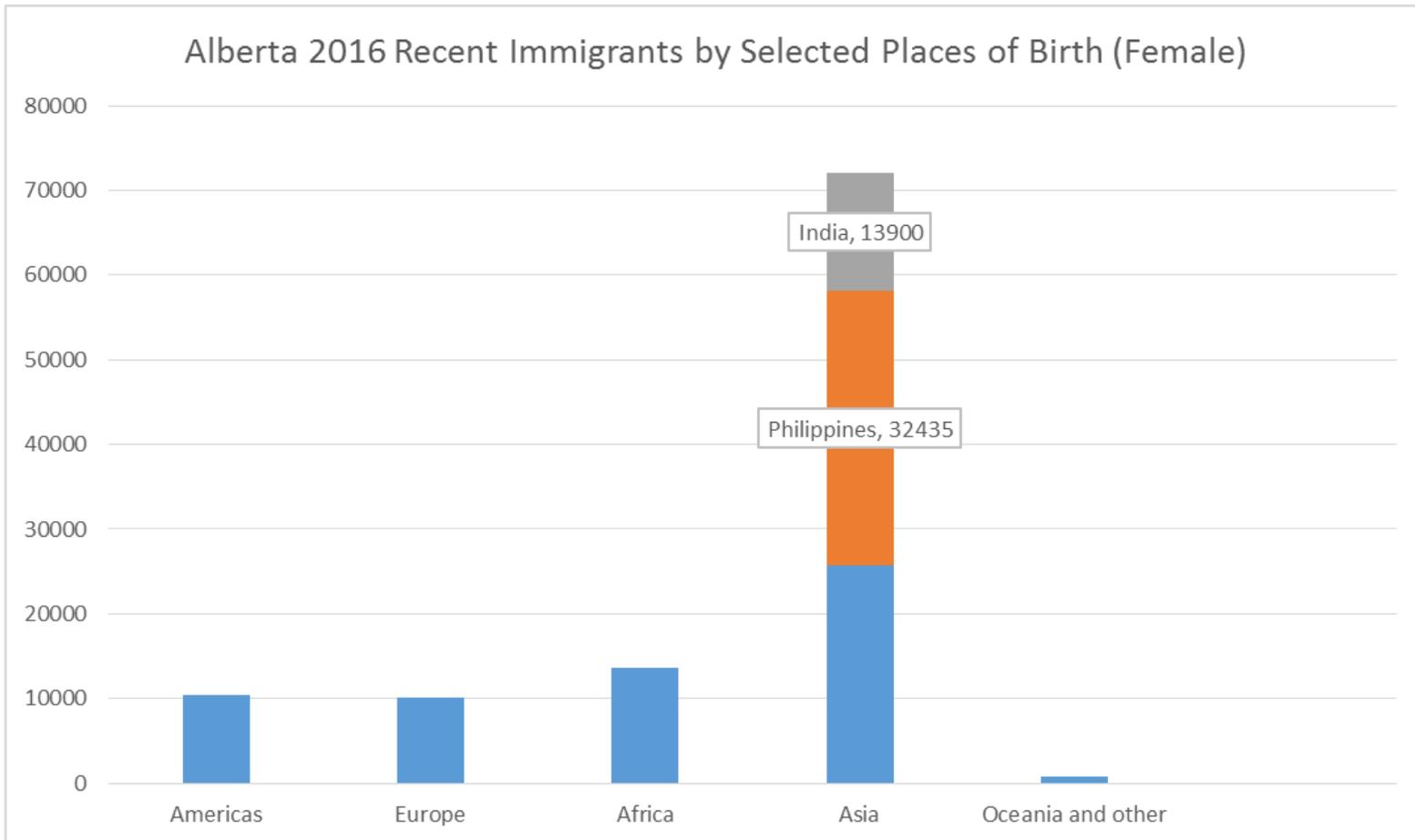
Population Proportion of Immigrants Who Arrived in the Last Five Years, 2011



- 1 Lowest
- 2 Low
- 3 Average
- 4 High
- 5 Highest







Strategies

What other tools can help

Screening Status for Breast, Cervical and Colorectal Cancer

(Report Date: 07-Jan-2018)

SMITH, Sally Mary

Age:	54
Date of Birth:	21-Mar-1963
Gender:	Female
Alberta Unique Lifetime Identifier:	123456789

Type	Last Screen Type	Date of Last Exam*	Result of Last Exam	Status	Qualifier
Breast	Screening mammogram	18-Mar-2017	Normal	Up-to-date	As per recommendation of last exam
Cervical	Pap Test	12-Feb-2017	Normal	Up-to-date	Cervical cancer screening should be considered based on Alberta TOP Clinical Practice Guidelines. Pap once every 3 years.
Colorectal	FIT	03-Jun-2017	Normal	Up-to-date	FIT every 1-2 years

Cervical Cancer Screening: Women with a history of hysterectomy may appear on this report.

Colorectal Cancer Screening: At the current time, the Alberta Colorectal Cancer Screening Program does not capture information about screening colonoscopy or diagnostic follow up. The status in this report is based solely on the availability of FIT or FOBT test results, and a 2-year screening interval with FIT.

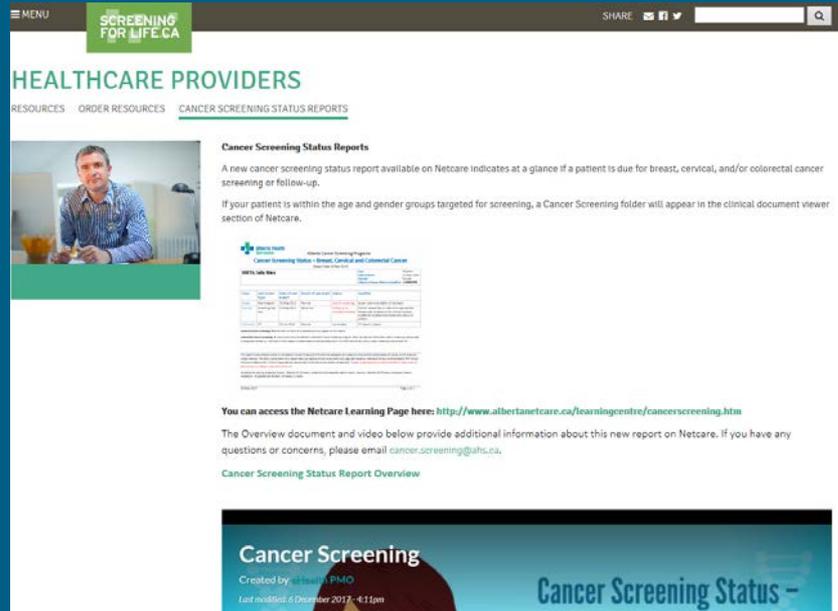
This report tracks patients active in the Alberta Cancer Screening Program (CSP) with the exception of a diagnosis of one of the above types of cancer, out of province and/or exempt. The status contained in this report does not replace clinical assessment and judgement based on individual history and the Alberta TOP Clinical Practice Guidelines. (For a link to the guidelines, please refer to the Resources section of Netcare).

**Newer screening exams may be available in other areas of Netcare due to a delay in data sent to the CSP.*

Guideline for routine screening: Breast – Women 50-74 years, screening mammography every 2 years; Cervical – Women 25-69 years, Pap every 3 years; Colorectal – all genders 50-74 years, FIT every 1-2 years.

More information

<http://screeningforlife.ca/cancer-screening-status-reports/>



The screenshot shows a webpage from 'SCREENING FOR LIFE CANADA'. The page is titled 'HEALTHCARE PROVIDERS' and has a sub-header 'CANCER SCREENING STATUS REPORTS'. It features a video thumbnail of a man speaking, a text block explaining the 'Cancer Screening Status Reports' (a new report available on Netcare indicating due dates for breast, cervical, and colorectal cancer screening), and a link to a Netcare Learning Page. Below the text is a thumbnail for a video titled 'Cancer Screening Status - Overview'.

HEALTHCARE PROVIDERS

RESOURCES | ORDER RESOURCES | CANCER SCREENING STATUS REPORTS

Cancer Screening Status Reports

A new cancer screening status report available on Netcare indicates at a glance if a patient is due for breast, cervical, and/or colorectal cancer screening or follow-up.

If your patient is within the age and gender groups targeted for screening, a Cancer Screening folder will appear in the clinical document viewer section of Netcare.

Alberta Health Services
Alberta Cancer Screening Program
Cancer Screening Status - Breast, Cervical and Colorectal Cancer

NETCARE LINK

You can access the Netcare Learning Page here: <http://www.albertanetcare.ca/learningcentre/cancerscreening.htm>

The Overview document and video below provide additional information about this new report on Netcare. If you have any questions or concerns, please email cancer_screening@ahs.ca.

Cancer Screening Status Report Overview

Cancer Screening
Created by: [Name] PMO
Last modified: 6 December 2017 - 4:11 pm

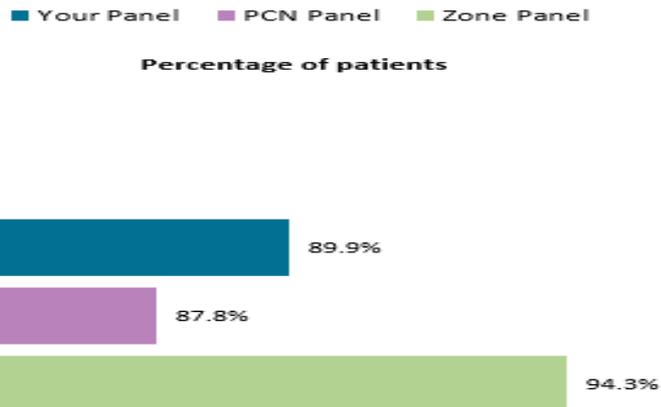
Cancer Screening Status - Overview

HQCA reports

Breast cancer screening ▼

Percentage of female patients age 50 to 74 with at least one mammogram between April 1, 2014 and March 31, 2017.

▼ **Your result is in the bottom 16 per cent of all physicians in your zone.**



Number of patients on your panel

Eligible	Screened	Not screened
245	83	162

About the measure

This metric is based on data from the Alberta Breast Cancer Screening program where patients had at least one mammogram completed within a 30-month period. Each patient is counted only once.

This metric excludes female patients < age 50 years and > age 74 years and women with a history of invasive breast cancer who had a screening mammogram.

Interpretation

How many patients in the recommended age range in your setting have not been screened? Screening mammography is recommended every 2 years in women age 50 to 74.

How do your recommended screening rates compare to those of your main comparator? If they are substantially lower, what practice factors may account for this?

Possible actions

If your screening rates are lower than expected then an EMR search may help identify patients who should be called in for screening. Consider a quality improvement initiative to improve screening. Breast cancer screening recommendations are available at [Toward Optimized Practice](#)

Cultural Differences in Breast Health

Dr. Margaret Churcher
Dr. Gloria Roldan Urgoiti

Saturday, April 14, 2018



Faculty/Presenter Disclosure

- **Speaker:** Gloria Roldan Urgoiti MD, MSc, FRCPC
Cultural Differences in Breast Health
- **Relationships with commercial interests:**
 - **Grants/Research Support:** CIHR, Hotchkiss Brain Institute
 - **Speakers Bureau/Honoraria:** None
 - **Consulting Fees:** AMGEN (Advisory Meeting)
 - **Other:** Canadian Brain Tumor Consortium (Clinical Trial reviewer)



Disclosure of Commercial Support

- This Program is funded through AHS Operational Funding.
- This Program has not received financial support.
- This Program has not received in-kind support.
- Dr. Gloria Roldan Urgoiti is presenting at this Program on a voluntary basis.
- **Potential for conflict(s) of interest: None**

Case

- 50 yrs old female
- Recent immigrant from Pakistan
- Islamic faith
- Husband is a physician
- First time seeing you
- Hardly ever had a Pap or breast exams

What...?

Case

- 47 yrs old
- Immigrated from Pakistan > 10 yrs ago
- Undergoing treatment for another kind of tumor
- Previously had a male physician but changed to a female physician recently due to menopausal symptoms
- Diagnosed with an advanced breast cancer that evolved over 2 years

Case

- 40 F
- Moved from the Congo to Canada 2012
- Described nipple pruritus for 4 months
- On exam: 4x4 cm nodule in the breast and 1.5 cm LN in the axilla
- She mentioned knowing about the nodule for some time but she first consulted friends that urged her to go to her GP

Case

- 45 F
- From Syria
- Relates having enlargement of the left breast for 1.5 months, denies inflammatory changes in the skin.
- On exam: inflammatory breast cancer with multiple axillary lymph nodes.



THINK
About It.



BE
AWARE

- In Canada we are trained and follow guidelines based on the assumption that patients will TELL US their concerns.

Immigrant & Refugee Women's Cultural Health Practices

A guide for health care professionals

**A tool to enhance
cultural sensitivity,
awareness, and practice
within health care**



<http://fcrc.albertahealthservices.ca/publications/cultural/Womens-cultural-health-practices-November-2007.pdf>

Did you know?

- ... that in China mainly professionals go for regular check-ups as it is a requirement for their jobs?
- ... that in South Asia (India, Nepal, Pakistan) beliefs that may prevent women from breast self-exam include privacy, modesty and concerns about family appearances?
- ... that middle Eastern women (Saudi Arabia, Lebanon, Syria, Egypt, Jordan) see gowns as not being modest?

Physical exams such as breast exams are very different in Canada than they are in Pakistan. When doctors do breast exams in Pakistan, women leave their upper wear on, however, in Canada you are expected to take it off; I find this very uncomfortable.

J Immigrant Minority Health (2007) 9:269–279
DOI 10.1007/s10903-007-9044-z

ORIGINAL PAPER

Punjabi Immigrant Women's Breast Cancer Stories

A. Fuchsia Howard · Joan L. Bottorff ·
Lynda G. Balneaves · Sukhdev K. Grewal

J Immigrant Minority Health (2015) 17:746–755
DOI 10.1007/s10903-013-9890-9

ORIGINAL PAPER

Cultural Beliefs and Clinical Breast Examination in Hmong American Women: The Crucial Role of Modesty

Hee Yun Lee · Suzanne Vang

J Immigrant Minority Health (2008) 10:429–436
DOI 10.1007/s10903-007-9106-2

ORIGINAL PAPER

Arab American Immigrants in New York: Health Care and Cancer Knowledge, Attitudes, and Beliefs

Susan M. Shah · Claudia Ayash · Nora Alarifi Pharaon ·
Francesca M. Gany

The value of time...

5.10.15.

ACCULTURATION

1: cultural modification of an individual, group, or people by adapting to or borrowing traits from another culture the *acculturation* of immigrants to American life
; *also* : a merging of cultures as a result of prolonged contact



Time Spent in the United States and Breast Cancer Screening Behaviors among Ethnically Diverse Immigrant Women: Evidence for Acculturation?

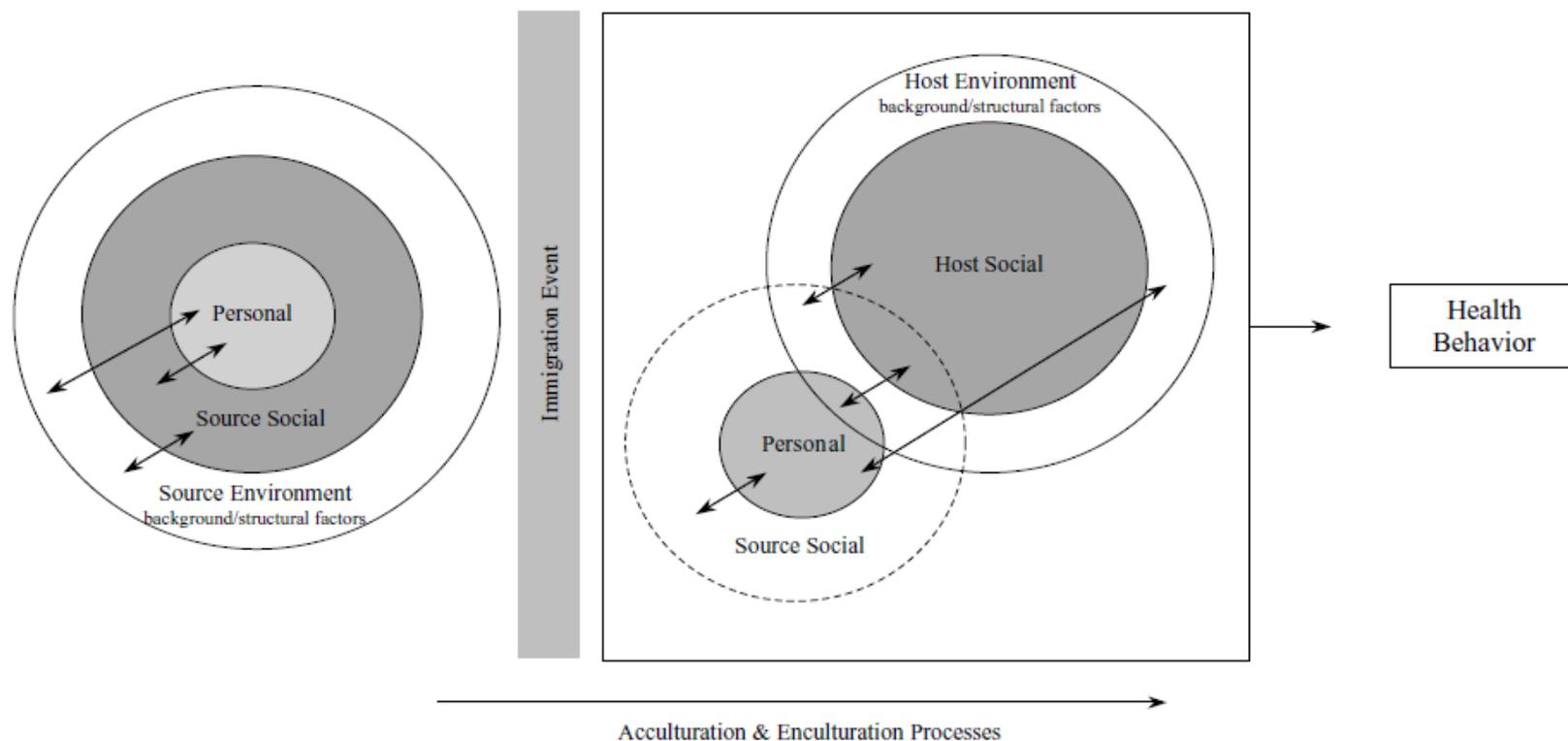


Fig. 1 A conceptual model of acculturation and enculturation processes as related to health behavior

	Total sample (<i>N</i> = 915)	English Caribbean (<i>N</i> = 299)	Haitian (<i>N</i> = 305)	Dominican (<i>N</i> = 160)	Eastern European (<i>N</i> = 151)
Acculturation	19.76 (12.33)	26.31 (12.16)	17.44 (10.59)	21.91 (11.14)	9.21 (7.80)

“Acculturation measure” age – age at immigration = years in the country

More mammograms associated with being married, having health insurance, physician’s recommendation to have one, greater number of PEx and being Dominican. Acculturation accounted for 20% of the variance in number of mammograms in the last 10 years.

Acculturation Canada (entrez-pubmed) 474

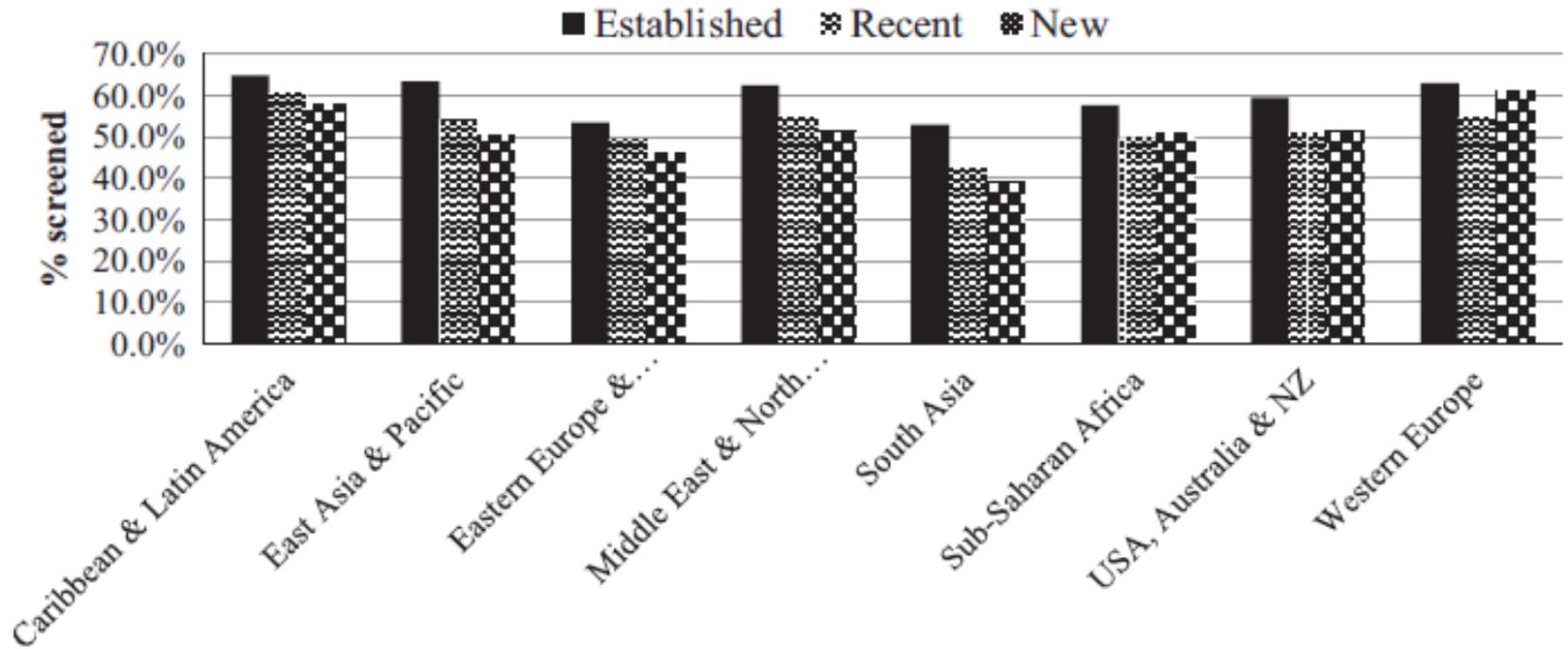
- Nutritional health, dietary patterns
- Mental health
- Leisure-time physical activity
- Implications on parenting
- Smoking
- Health-compromising behaviours
-
- 3 in cancer
 - Cervical cancer screening participation
 - Cervical cancer screening beliefs

Breast cancer screening disparities among immigrant women by world region of origin: a population-based study in Ontario, Canada

Mandana Vahabi^{1,2,3}, Aisha Lofters^{4,5,6,7}, Matthew Kumar⁷ & Richard H. Glazier^{4,5,6,7,8}

Cancer Medicine 2016; 5(7):1670–1686

- 183,332 screening-eligible immigrant women
- Ontario 2010-2012
- Screening varied by region of origin:
 - South Asian 48.5%
 - Caribbean and Latin American 63.7%



Mammography screening rates of immigrant women by region of origin and length of stay in Canada.



Breast cancer screening utilization among women from Muslim majority countries in Ontario, Canada

Mandana Vahabi^{a,b,c,*}, Aisha Lofters^{d,e,f,g,h}, Eliane Kim^g, Josephine Pui-Hing Wong^a, Lisa Ellison^g, Erin Graves^g, Richard H. Glazier^{d,e,f,g,h}

- Women who:
 - 1) eligible for health care coverage
 - 2) were in the 50–74 year age range
 - 3) April 1, 2013 to March 31, 2015
 - 4) resided in an Ontario Census Metropolitan Area



	East Asia & Pacific		Eastern Europe & Central Asia		Middle East & North Africa	
	Muslim majority	Non-Muslim majority	Muslim majority	Non-Muslim majority	Muslim majority	Non-Muslim majority
Numbers	688	38,570	1796	28,437	9924	283
Percent overdue	44.02	45.41	54.05	51.78	47.89	44.08
	1563	84,931	3323	54,920	20,721	642

	South Asia		Sub-Saharan Africa		Overall
	Muslim majority	Non-Muslim majority	Muslim majority	Non-Muslim majority	
	8171	23,691	1748	4395	117,703
	56.93	52.43	64.74	44.48	49.41
overdue	14,352	45,186	2700	9880	238,218

Overall Screening 51%

The value of trust...

J Immigrant Minority Health
DOI 10.1007/s10903-017-0580-x



ORIGINAL PAPER

Trust and Perceptions of Physicians' Nonverbal Behavior Among Women with Immigrant Backgrounds

Marij A. Hillen¹  · Hanneke C. J. M. de Haes¹ · Mathilde G. E. Verdam^{1,2} · Ellen M. A. Smets¹

What do
you think?

Leaning forward, eye contact, smiling.

(Morocco, Surinam, Turkey mainly)



- 34 Breast cancer patients and 34 healthy women; Paired immigrant-non immigrant
- 3 validated qualitative scales (trust, likelihood of recommending, perceived competence, friendliness, hurry and honesty)

RESULTS

- Immigrants reported stronger trust in the observed oncologist and perceived the oncologist as more honest.
- Consistent eye contact and forward leaning posture improve perceptions in both groups.
- Smiling did not influence perceptions of immigrants while was considered “ more friendly” by non-immigrants.



The value of trust...

- “a priori” high levels of trust may stem from patients’ vulnerability.
- Different MD model → “tell me what I need to do”
- If you ask... there is uncertainty. If you say, I trust.

Objectives

1. Describe which populations (especially in their panel or area) could be at risk for decreased breast cancer screening.
2. Discuss the barriers that might prevent screening in these individuals.
3. Start to develop strategies for your office/clinic to address barriers and improve breast cancer screening rates in this population.

“Seeking diversity automatically leads us to excellence, just as focusing on excellence inevitably leads us to diversity”.

William C. Steele

Cultural Differences in Breast Health

Dr. Margaret Churcher
Dr. Gloria Roldan Urgoiti

Saturday, April 14, 2018