Ask Dr. Miller

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The following questions were posed at the 2011 QSST Meeting:

Question #1: A 30-year-old client with a history of two ASC-US Paps and colposcopy showing CIN1 was referred for repeat coloposcopy per the ASCCP algorithm. The MD/Colposcopist refused to repeat the colposcopy because only 6 months had passed since the initial colposcopy. Since this is a rural area with limited gynecological resources, how should we proceed?

Answer: The ASCCP recommends that women with repeat Pap test results of ASC-US after CIN1 be referred for repeat coloposcopy. There is no specific language in the recommendation about the timing between colposcopies. A clinical judgment by the provider has to be made. In addition, a clear plan of follow-up care should be documented and discussed with the patient regarding when and what follow-up care will be done. Furthermore, the grantee should discuss the plan of care with the provider and ensure the patient receives follow-up care as planned.

Question #2: What's the difference between case management and patient navigation/care coordination?

Answer: There are no standard national definitions for case management or patient navigation. In fact, these job titles and responsibilities are often used interchangeably in many settings. Many individual institutions have developed their own definitions with specific training criteria and licensing qualifications. Both case management and patient navigation/care coordination share the overall goal of ensuring that women receive adequate and timely clinical services.

Question #3: Please describe a standing order for screening. How is it implemented? How is the effectiveness of the standing order for screening measured?

Answer: Standing orders are physician-approved/institutional-approved protocols that authorize nurses or other staff members to perform procedures or orders without direct physician involvement. These are pre-printed orders with specific protocol instructions that include, but are not limited to, criteria for implementation of the order, a patient assessment, the desired outcome, and when to notify the physician. The effectiveness of the order is often measured by are the desired outcomes achieved without adverse consequences.

Question 4: I have a question about surgical vs. core needle biopsy. A recent publication in The *American Journal of Surgery found a high rate of surgical biopsy at approximately 30% and*

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stated that a rate of approximately 10% can be justified. Is the 10% figure well-known/accepted by breast surgeons? It seems like this issue should be looked at by CDC in terms of potential cost savings and improved care outcomes for women.

Answer: This specific study is about biopsy rates in Florida and not the entire U.S. There was another study published showing similar results at an academic center in New York. The New York study's authors found that academic surgeons had lower surgical biopsy rates than surgeons in private practice. It has been hypothesized that the difference may be because academic surgeons were more likely to have more updated training and adapt newer technology, and that surgeons may not want to release control to radiologists who often perform the needle biopsies requiring guidance by imaging. The American College of Surgeons International Consensus panel of physicians (panel) released a statement noting that "minimally invasive biopsy is the recommended procedure for breast lesions detected by image only." This recommendation statement was specifically for image-detected lesions only but has been used to support biopsies of other clinically-detected lesions. The panel also concluded that surgical biopsy rates should be between 5%-10%. While this is an important recommendation for best practices, it is not one that can be mandated across the program from CDC's perspective. Appropriate training, credentialing and availability of equipment must be accessible for these biopsies to be done. Provider education is the key to ensure that women undergo the most appropriate biopsy procedures and do not undergo unnecessary surgery.

Questions 5: Many physicians and radiologists want to do an ultrasound of the breast without doing a mammogram, especially in the younger population with abnormal breast exams. (Our program screens women 25-64 years of age.) Can an ultrasound be reimbursed with National Breast and Cervical Cancer Early Detection Program (NBCCEDP) funds without a mammogram being done first? What about a 6-month follow-up? If yes, how does this affect MDEs? Currently, when a breast ultrasound is entered in CaST without a mammogram this is an error in CaST data.

Answer: Technically, the program can reimburse for an ultrasound without a mammogram. But *clinically* the client should have a mammogram if she has an abnormal clinical breast exam (CBE). An ultrasound is a diagnostic test to assess specific abnormalities and should never used as a screening test., only a diagnostic test for specific abnormalities. There are occasional situations among very young women (usually under 30 years of age) when an ultrasound may be the appropriate diagnostic tool alone following an abnormal CBE. However, that should be a clinical judgment that is clearly documented with a follow-up plan. An ultrasound without a mammogram will create an error in the MDE because an ultrasound is generally a diagnostic test that follows a mammogram. If the completed clinical evaluation shows a benign lesion that warrants a six-month follow-up, then that is appropriate and can be paid for with NBCCEDP funds.