Ask Dr. Miller

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The following questions were posed by NBCCEDP grantees:

Question #1: Current guidelines do not address 'hyperkeratosis' so we aren't sure if they should have a repeat Pap in 3 years or a shorter time frame, or if other studies should be done.

Answer: Hyperkeratosis does not mean a patient is at increased risk for cancer, but is an abnormality that should be followed up. Often it is the result of an infection or irritation from use of vaginal devices like a diaphragm. Hyperkeratosis often obscures the cells and requires short term follow up. Previously most physicians would repeat a Pap test in six months to one year. This was not specifically addressed in the updated 2012 ASCCP guidelines. Follow up determination is a medical decision that also depends on the other cytology findings and HPV results. These women should probably still have a repeat Pap within one year. Most literature, although a few years old, recommends colposcopy if the repeat Pap still finds hyperkeratosis.

Question #2: One of our health-care providers has chosen not to do a clinical breast exam (CBE) if a mammogram is done first and is normal. The provider says that a CBE is not needed. What guidance should I provide to health-care providers who are not doing CBEs, but relying on mammography exclusively for breast cancer screening?

Answer: This is a difficult dilemma because the USPSTF found that the evidence is insufficient to determine if CBE provides any additional benefits and harms beyond screening mammography in women 40 years or older. That does not mean that the CBE is not needed. It simply means we don't have enough information to say if it helps or not. Some often interpret not sufficient evidence to mean don't do and that is not correct. We have always encouraged providers to perform CBEs as a part of the complete assessment. There are times when a CBE may identify an abnormality even though the mammogram is negative. A CBE is an important complement to mammography in the early detection of breast cancer. CBE can identify some cancers missed by mammography, and it provides an important screening tool for use with women for whom mammography is not recommended or with women who refuse mammography. While mammography will pick up most cancers, it is not perfect and does miss some cancers. Studies have reported that CBE detects an estimated 16% of breast cancers and up to 45% of the breast cancers that were missed by mammography. You should discuss the importance of doing a complete evaluation for women undergoing breast cancer screening and make sure that providers are interpreting the recommendations appropriately.

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Question #3: We have women who are eligible for our program but go to the health department and receive their screening services through the Family Planning program. The program pays for a pelvic examinations, Pap testing, and CBE. However, if any abnormality is identified, there is no service for the woman. They would be referred into our BCCEDP program for diagnostic care. Can we enroll these women?

Answer: Yes, as long as she has no other source to pay for her diagnostic work-up and meets all other program eligibility criteria, she may be enrolled into the program for diagnostic services.

Question #4: Some of our staff have reservations about the guidance stating that a negative diagnostic mammogram is not adequate follow-up for an abnormal CBE. Can you provide any additional guidance on expectations following an abnormal CBE?

Answer: A negative mammogram result as a follow-up to an abnormal CBE does not rule out cancer. This scenario requires some additional work-up such as short-term exam, biopsy, or additional imaging studies depending upon the CBE findings. A classic example is a case I recently reviewed of a 45 year old female who had a breast lump on CBE and a normal mammogram result. No others studies were done. One year later she was diagnosed with stage 3 breast cancer. If she had undergone a needle biopsy of the lump or an ultrasound during the initial work-up, they would have found the breast cancer at an earlier stage. Some additional diagnostic testing MUST be done to get a definitive diagnosis.

Question #5: We are concerned that doctors will refer women that have normal/benign mammography results to have a breast MRI because of the new breast density laws. What directive should give our providers?

Answer: The breast density laws do not state that providers must do an MRI. They do provide some discrimination by including statements like “as determined by the patient's health care provider”. These laws are to ensure that women are informed about their potential breast cancer risk related to breast density and in some cases make sure that insurers will cover an MRI if requested by their provider. Providers should still assess the woman's risk, have an informed discussion with the woman, and make a determination if she needs an MRI. Breast density alone is not an indication for breast MRI under current guidelines. You should consider having your MAB review any requests for approval to make sure it is appropriate.