Ask Dr. Miller

August 2016

The following questions were posed by NBCCEDP grantees:

Question #1: A 39 year old female who presented to our program for her yearly screening mammograms. She had a right breast biopsy in 2015 that was a fibroadenoma and has a history of chest wall radiation for lymphoma at age 29. The provider is requesting annual MRI as an adjunct to annual mammograms, due to her history of prior thoracic irradiation. Can CDC funds can be used to pay for her annual MRI?

Answer: This patient would be considered high risk for breast cancer because of her chest radiation at a young age. Guidelines recommend that this patient have an annual MRI along with her annual mammogram. NBCCEDP funds can be used to provide annual breast MRI along with mammograms to program-eligible women who are considered high risk for breast cancer.
As per ACS guidelines, high-risk includes women who:

- Have a lifetime risk of breast cancer of about 20% or greater, according to risk assessment tools that are based mainly on family history;
- Have a known BRCA1 or BRCA2 gene mutation;
- Have a first-degree relative (parent, brother, sister, or child) with a BRCA1 or BRCA2 gene mutation, and have not had genetic testing themselves;
- Had radiation therapy to the chest when they were between the ages of 10 and 30 years; and
- Have Li-Fraumeni syndrome, Cowden syndrome, or Bannayan-Riley-Ruvalcaba syndrome, or have first-degree relatives with one of these syndromes.

Question #2: At what point in time will a client's previous abnormal Pap/HPV/Colposcopy results be considered not current for follow-up and management? Although ASCCP 2012 guidelines outline management of women with abnormal cervical cancer screening or colposcopy results, they do not address gaps in care such as 2 or more years.

Answer: There are no set guidelines regarding how long an abnormal Pap result should still be considered for diagnostic management versus repeating the screening test. That decision is based on the medical judgement of the provider given the patient's abnormal results. There are several issues the provider must consider. For example, a provider may be concerned about a patient who has documentation of 2 Pap negative/HPV positive test results which were more than 2 years apart. This may indicate persistent HPV infection. She now returns over a year after the last result. Because a patient has been non-compliant with her follow-up, the provider may wish to proceed to colposcopy at the third visit versus repeating the screening test.

CAPT Jacqueline W. Miller, MD, USPHS ● Medical Director, National Breast and Cervical Cancer Early Detection Program
Centers for Disease Control and Prevention ● Division of Cancer Prevention and Control ● JMiller5@cdc.gov

Question #3: Is it appropriate to repeat a colposcopy and Pap test every 6 and 12 months after colposcopy with biopsy finding of HPV infection with CIN 1 and focal CIN 2 for "young women"? The ASCCP guidelines for young women states "consider risk to future pregnancies from treating cervical abnormalities to outweigh risk for cervical cancer during observation of those abnormalities." No specific age threshold was provided. One of our network physicians considers the term "young women" to apply to anyone of childbearing age. Is this correct?

Answer: In this situation of CIN 1 with focal CIN 2, it is most appropriate to treat the worst diagnosis. Therefore, she should be treated as CIN 2. ASCCP guidelines do say to repeat colposcopy and cytology at 6 month intervals for 12 months for young women with biopsy confirmed CIN 2,3. So that plan is correct. I have asked ASCCP guidelines group about the definition of "young women". They said they are referring to anyone who is still considering childbearing.

Question #4: Is it required that all pregnant clients with ASC-H have a colposcopy with biopsy post-partum even when colposcopy with biopsy finding CIN 1 was performed during pregnancy? ASCCP 2012 management guidelines indicate ECC in pregnant women is unacceptable, but that it is acceptable to defer colposcopy to 6 weeks post-partum. Neither clearly address whether to repeat colposcopy with biopsy at 6 weeks post-partum or to follow the algorithm for the antenatal biopsy results.

Answer: The management of high grade lesions in pregnant women is a little tricky. The guidelines don't recommend ECC because of the risk for pre-term labor, but colposcopy is okay. The example you presented with a high-grade cytology does require close follow-up. These results are discordant in that a high-risk cytology was diagnosed with a low-grade histology. Because of the pregnancy, the management may be slightly different than the algorithm. During pregnancy, a provider may consider using some flexibility for early evaluation of a high grade cytology because of the increased risk of cervical cancer. With the histology being low grade, the provider then performed a postpartum follow-up to ensure the high grade cytology did not persist. These are situations are not always black and white, but require some medical judgement in deciding the best course. When difficult cases are presented to your program, you should have your MAB review the individual case.

Questions #5: Does the NBCCEDP cover genetic testing for breast cancer? We have a 16 year old who's grandmother, mother (passed at 34 of breast cancer), and aunt all had breast cancer.

Answer: The NBCCEDP does not cover genetic testing. Because this patient is very young and high risk, she should be seen by a genetic counselor prior to any genetic testing. Most experts do not recommend testing girls under the age of 18. Also, there are lots of medical implications to be considered. This is really a case where she needs to get medical insurance coverage. The best assistance may be to navigate the patient to getting coverage and referral to a genomics program.