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INSIDE

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Confused about condoms? It's the data, not condoms, that may be inadequate

Stay consistent in delivering STD prevention message

While controversy swirls in the wake of a government evaluation of male latex condom research, make sure that your facility is delivering one clear message: Consistent and correct use of latex condoms continues to be an effective tool in the prevention of sexually transmitted diseases (STDs).

The report, released July 20, followed a June 2000 workshop organized by the Bethesda, MD-based National Institutes of Health (NIH), the Atlanta-based Centers for Disease Control and Prevention, the Rockville, MD-based Food and Drug Administration, and the Washington, DC-based U.S. Agency for International Development. The workshop was held at the request of Tom Coburn, a physician and former Republican congressman from Oklahoma who had questioned the role of condoms in prevention of human papillomavirus during public health legislation. ***(Contraceptive Technology Update* offered an overview of the legislation in its "Washington Watch" column, May 2000, p. 61.)**

During the June 2000 workshop, 28 expert panel members analyzed 138 peer-reviewed, published studies on the properties and user patterns of the male latex condom during penile-vaginal intercourse.

EXECUTIVE SUMMARY

A government evaluation of male latex condom research confirms that condoms are highly effective in preventing transmission of HIV, as well as gonorrhea from women to men.

- After reviewing 138 scientific papers, the authors concluded that epidemiological evidence is insufficient to determine the effectiveness of condoms in preventing the spread of chlamydial infection, syphilis, chancroid, trichomoniasis, genital herpes, and genital human papillomavirus infection.
- The inadequacy of the reviewed data should not be interpreted as the inadequacy of condoms, say public health advocates. Used correctly and consistently, condoms are an important weapon in the fight against sexually transmitted diseases.

The NIH workshop summary report confirms that correct and consistent use of condoms can reduce the risk of HIV / AIDS transmission.[1] The epidemiological studies reviewed by the experts also show condoms aid in protecting men from acquiring gonorrhea from a female partner, the report states.

"Given that the consequences of HIV are so serious, including lifelong diesase and death, and that gonorrhea is one of the most common curable STDs on earth, these are strong reasons for persons who choose to be sexually active to use condoms correctly and consistently," says **Edward Hook III**, MD, professor of medicine at the University of Alabama at Birmingham and medical director of the Jefferson County STD Control Program. Hook served as a member of the workshop panel.

However, the NIH review panel concluded that due to limitations in study designs, epidemiological evidence is currently insufficient to provide an accurate assessment of condom effectiveness in preventing spread of chlamydial infection, syphilis, chancroid, trichomoniasis, genital herpes, and genital human papillomavirus infection. The panel recommended further well-designed research to help answer questions about those infections.

Make the distinction

The release of the report has sparked markedly different interpretations of its information. Some conservative groups have pointed to the report as proof that the term "safe sex" is a myth.[2]

National organizations including the New York City-based Planned Parenthood Federation of America, the Washington, DC-based American College of Obstetricians and Gynecologists, and the Research Triangle Park, NC-based American Social Health Association, have issued statements affirming condoms' role in STD prevention.

It is important that the public understand the difference between the inadequate data and inadequate condoms, says Hook.

"The data simply are not good enough for STDs; other than gonorrhea in men, HIV, and perhaps herpes infections, to really know whether and how well condoms work," states Hook. "This is very, very different from data that might show that condoms do not work; we just can't tell for most STDs with a high degree of scientific certainty."

Very few studies have been performed in which condom use for STD prevention was the major outcome of the study, states Hook. Thus, other than the instances mentioned above, the data simply are not sufficient to draw conclusions, he notes.

"Deliberate attempts by political groups to misrepresent the evidence as demonstrating 'ineffectiveness of condoms' constitute a misunderstanding of what the report states," states **Willard Cates Jr.**, MD, MPH, president of Family Health International, a Research Triangle Park, NC-based research organization that has conducted numerous studies of condoms and other contraceptive methods. "Moreover, by undermining the public's confidence in condoms, this misrepresentation may lead to public health harm," he says.

Review STD study design

The studies reviewed by the NIH panel were observational in nature and carry a variety of methodologic limitations well described in the text, states Cates, author of an upcoming overview of the workshop's findings.[3]

"Unfortunately, as the report states, the ideal study design of a prospective randomized controlled trial is not possible to evaluate condom effectiveness," Cates observes. "Ethical concerns do not allow randomization of individuals to a condom nonuse group in populations at high risk for STDs."

While many studies have gathered information on condom use while addressing other topics and specific aims, few studies actually have been designed to study how well condoms protect against STDs, says Hook.

"As a result, questions such as, 'How often did you use condoms,' are asked without too much precision," Hook comments. "In addition, to

COMING IN FUTURE MONTHS

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- Make male involvement meaningful to men
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- Contraceptive challenges in adolescents

really evaluate how condoms were used by a study participant, a rather large number of questions [must be asked] to delineate the proportion of acts of intercourse in which condoms were used, whether they were used correctly or not, whether slippage or breakage occurred, etc."

Unless a study is designed specifically to answer such questions, the information is not fully covered within the confines of the research paper, says Hook. As a result, the data are not adequate to definitively answer the efficacy question, he explains.

Look at evidence

Evidence that was either not considered by the NIH report or surfaced since the panel met has leaned toward strengthening the already-acknowledged protective effects of condoms against a range of STDs, says Cates.

A just-published study of a randomized, controlled trial which examined condom efficacy in prevention of herpes simplex virus type 2 (HSV-2) transmission in discordant couples, found that condoms offered significant protection against HSV-2 infection in susceptible women.[4]

"Not only has the adequacy of the data improved since the [NIH] report, but the deliberate attempts by some groups to misrepresent the absence of data with the ineffectiveness of condoms is doing exactly what the report cautioned them not to do," stresses Cates. "This deliberate misrepresentation undermines the reinforcing public health messages and may lead to wider transmission of STDs by encouraging nonuse of condoms, and it's the nonuse of condoms, not the ineffectiveness of condoms, that is the problem."

(Editor's note: The entire workshop summary report is available in Adobe Portable Document Format form at www.niaid.nih.gov/dmid/stds/condomreport.pdf.)

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Advisory issued on HRT and heart disease

Patients may be asking questions about hormone replacement therapy (HRT) following the July 2001 release of a scientific advisory from the Dallas-based American Heart Association.

The advisory recommends that HRT should not be initiated for the prevention of future coronary events in postmenopausal women with cardiovascular disease (CVD).[1] For HRT use as a primary prevention tool in women without pre-existing CVD, the advisory notes that current data are inconclusive regarding possible coronary benefits or risks. In these women, the association says the decision to start or continue HRT should be based on noncoronary benefits and risks, and patient preference.

"The American Heart Association document basically defines that currently there is no good evidence from randomized, controlled trials, which are the strictest evidence, for benefit of hormone therapy for cardiac protection," states **Nanette Wenger**, MD, professor of medicine in the division of cardiology at the Emory University School of Medicine and chief of cardiology at Grady Memorial Hospital, both in Atlanta. Wenger served as a co-author of the advisory.

Rather than prescribing HRT solely for cardiac prevention, providers can look to lifestyle interventions, such as smoking cessation, weight control, healthy diet, and exercise, says Wenger. Pharmacotherapy for lipid lowering and blood pressure

EXECUTIVE SUMMARY

The American Heart Association has issued a scientific advisory that hormone replacement therapy (HRT) should not be initiated solely for the prevention of future coronary events in postmenopausal women with cardiovascular disease (CVD).

- For HRT use as a primary prevention tool in women without pre-existing CVD, current data are inconclusive regarding possible coronary benefits or risks. In these women, the decision to start or continue HRT should be based on noncoronary benefits.
- Women who have cardiovascular disease and have used HRT for many years may continue use of the drug for noncoronary benefits, the advisory says.

control may be used when such lifestyle interventions do not meet desired targets, she adds.

For patients who do not have cardiovascular disease and are taking HRT for noncoronary benefits, reassure them that they do not need to change their treatment, the advisory states.

For women who do not have CVD and are considering HRT for other reasons, review the drug therapy's noncoronary benefits, such as treatment of hot flashes and prevention of osteoporosis, the advisory notes. Explain that the current data are inconclusive regarding possible coronary benefits or risks for women without cardiovascular disease.

Women who have cardiovascular disease and have used HRT for many years may continue use of the drug for noncoronary benefits. However, for those women who do have cardiovascular disease and are not currently taking HRT, do not prescribe the drug regimen solely for the prevention of future coronary events, the advisory states.

Waiting on study results

Providers are looking to the Women's Health Initiative to offer definitive information on the issue of HRT and cardiovascular disease, but the results of this trial are at least five years away. The Bethesda, MD-based National Institutes of Health established the initiative, one of the largest U.S. prevention studies of its kind, to address the most common causes of death, disability, and impaired quality of life in postmenopausal women. The HRT component of the study is examining the effects of HRT on heart disease, osteoporosis-related bone fractures, and breast and endometrial cancer.

In 2000, the Initiative reported a small increase in the number of heart attacks, strokes, and blood clots in those taking active hormones during the first two years of the national study.[2] The Initiative update came on the heels of two clinical trials that challenged the belief that postmenopausal hormone therapy protects against coronary heart disease.[3,4] ***(Contraceptive Technology Update* reported on the update in its June 2000 issue, p. 68.)**

It is important for clinicians to understand that the advisory follows similar statements from other scientific organizations, says **Wulf Utian**, MD, PhD, executive director of the Cleveland-based North American Menopause Society.

Similar information has come from both the Brussels, Belgium-based International Menopause Society[5] as well as from the North American Menopause Society,[6] he states. All three organizations appear to have a concordant point of view, observes Utian.

According to information presented in the North American Menopause Society's 2000 publication, there is some evidence that there may be a primary preventive role for HRT in CVD, notes Utian. Until this evidence is confirmed through a randomized, prospective trial, such as the Women's Health Initiative, HRT should not be prescribed with the only indication being primary protection against CVD.

However, if a patient is considering HRT for menopausal symptom relief, and there may be an added benefit for cardiovascular protection, then providers should proceed, says Utian.

"If there's no reason to prescribe, the simple concept to be taking to prevent cardiovascular disease does not hold at this point in time because it's an unproven case," he states.

Emphasize safe indications

The important news to stress with patients is that HRT **is** safe for such indications as relief of hot flashes and reducing the risk of osteoporosis, says **Susan Wysocki**, RNC, NP, president and chief executive officer of the Washington, DC-based National Association of Nurse Practitioners in Women's Health.

"What concerns me is that the recent headlines have lead to a tremendous amount of confusion in which the approved benefits of HRT — the treatment of [menopausal] symptoms, prevention of osteoporosis, and the prevention of vaginal dryness and atrophy — are almost completely lost," Wysocki reflects. "If HRT is eventually shown to have a role in the prevention of cardiovascular disease, women who might have benefited may have stopped using the HRT they were taking for other reasons because of this confusion."

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Should access to birth control be streamlined?

When women come to your facility for hormonal contraception, is it mandatory for them to receive a breast and pelvic examination prior to getting a prescription for hormonal birth control? In most cases, waiting to schedule such exams causes an unnecessary and potentially dangerous delay, according to a review of existing recommendations performed by researchers at the University of California, San Francisco (UCSF) Center for Reproductive Health Research and Policy and colleagues.[1]

Delay can be dangerous for women when it comes to contraception; unintended pregnancy has important health risks and is very common when contraception is not used, states **Felicia Stewart**, MD, co-director of the UCSF Center for Reproductive Health Research and Policy and lead author of the review.

Approximately 1.5 million unintended pregnancies occur among women who are not using a method of contraception at the time;[2] however, most of them have used contraception in the past or plan to do so in the future, notes Stewart. For that reason, reducing obstacles to starting effective methods is a priority, she notes.

"Health policy should be honest and ethical," Stewart says. "It is not honest to imply that breast and pelvic exam are necessary for safe initiation of hormonal methods for most women, and [it is] not ethical to coerce women about routine health screening unrelated to hormone use."

EXECUTIVE SUMMARY

A review of the existing recommendations for hormonal contraceptives concludes that, in most cases, waiting to schedule a pelvic and breast exam prior to prescribing hormonal contraception causes an unnecessary and potentially dangerous delay.

- Although hormonal contraceptives are not recommended for women with some serious medical conditions, the problems that make their use unwise are effectively identified through medical history, the review states.
- Hormonal contraceptives can safely be started based on medical history review and a blood pressure check; for most women, no further evaluation is needed, concludes the analysis.

Look at the review

The researchers examined and summarized published literature and recommendations from relevant professional organizations regarding the role of clinical breast and pelvic examinations in the provision of hormonal contraceptives, including pills, implants and injectables available in the United States. Progestin-releasing intrauterine devices were not included because the pelvic exam is part of the insertion process.

Consensus developed during the last decade supports a change in practice that such hormonal contraception can safely be provided based on careful review of medical history and blood pressure measurement. For most women, no further evaluation is necessary, the researchers conclude.

"We agree that hormonal methods are not a wise choice for some women who have serious medical conditions and that routine preventive care services are important," states Stewart. "All women should be advised about recommended screening for STDs, cervical and breast cancer, and these services are an essential part of family planning and reproductive health care."

The researchers note the Geneva-based World Health Organization (WHO) guidelines for identifying conditions that preclude use of hormonal contraception: pregnancy, breast cancer, hypertension, certain heart and liver diseases, and diabetes mellitus. Women with a history of thromboembolic disease, stroke, or migraine headaches with focal neurological symptoms also are advised to avoid these methods, as are women who are fewer than six weeks postpartum and breast-feeding, and those older than age 35 who smoke more than 15 cigarettes per day.

The WHO guidelines suggest cautious use of hormonal contraception in women with hyperlipidemia, women fewer than 21 days postpartum, women breast-feeding from six weeks to six months postpartum, light smokers older than age 35, and women using medications affecting liver enzymes. Additional cautions apply to women

receiving estrogen-containing medications but not progestin-only medications; these include agents for biliary tract disease and use by women who are undergoing major surgery with prolonged immobilization.

When do you examine?

If a first-time patient presents with abnormal bleeding, discharge, or pain, a pelvic examination is appropriate, states **Andrew Kaunitz**, MD, professor and assistant chair in the obstetrics and gynecology department at the University of Florida Health Science Center/Jacksonville. In the absence of a specific indication for an examination, however, conducting a "stirrup-free" [no exam] visit can be conducive to building rapport with a new patient that much faster, he states. At a subsequent visit, a physical examination and cytology can be performed.

Programs that provide hormonal contraceptives without requiring a pelvic examination can expand low-income women's access to such methods and improve the chances that they will obtain other reproductive health services, according to an analysis of one such program.[3]

First Stop, an 18-month demonstration project that operated in 1996-1997, provided low-income adult women in California with hormonal contraceptives without requiring a pelvic examination. After the initial First Stop visit, 38% of women adopted a more effective method than they had used at last sex, 47% remained with the same method, 12% switched to a less effective method, and 3% accepted no method. Of clients who were referred for additional medical care, 73% followed through on their referrals.

The project showed that many women appreciate being able to obtain hormonal methods of contraception without a mandatory pelvic examination at the same visit, says **Cynthia Harper**, PhD, a demographer at the UCSF Center for Reproductive Health Policy and Research and lead author of an analysis of the project.

"The services allowed women to switch to more effective contraceptive methods than they had been using before their First Stop visit," says Harper.

Simplified requirements such as those used in the First Stop program mean that health care providers have more flexibility in meeting the needs of their established and new patients to offer services when the woman needs them, observes Stewart.

"We need to treat contraception as an 'urgent' health issue just like the many other health problems that warrant an immediate — if brief — health care service to deal specifically with an urgent condition," Stewart advocates.

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Rescreening can stem repeat chlamydia

You have just delivered some bad news to the adolescent female patient in the exam room: Her test for chlamydial infection proved positive. After you have provided the appropriate counseling about partner treatment and prescribed drug therapy, what is your next course of action?

If you are planning to rescreen the patient within three to six months, you are tapping into a prevention effort that may well stem repeat chlamydial infection in young women, termed "an urgent public health priority" by authors of a recently published analysis of a population-based sexually transmitted disease (STD) registry in Washington state.[1]

One of the major findings of the study was that

EXECUTIVE SUMMARY

Nearly one in five female teen-agers who have had a chlamydial infection are reinfected within two years, according to an analysis of Washington state data. Researchers conclude that rescreening women may help to control the spread of the disease.

- King County, WA, health department officials encourage women to return to their providers or clinics to be retested three months after treatment.
- The department has implemented a similar rescreening program for gonorrhea.

repeat chlamydial infection was common, especially for young women, says **Fujie Xu**, MD, PhD, a researcher in the Atlanta-based Centers for Disease Control and Prevention (CDC) National Center for HIV, STD, and TB Prevention, Division of STD Prevention.

According to the study's findings, among 32,698 women with an appropriately treated initial chlamydial infection during 1993-1998, 15% developed one or more repeat infections during a mean follow-up time of 3.4 years. Among women younger than age 20 at the time of initial infection, 6% were reinfected by six months, 11% by one year, and 17% by two years. Young age was the strongest predictor for one and two or more repeat infections after controlling for the length of follow-up and other variables, researchers reported.

Why is it so important to stem chlamydia? Although it is often asymptomatic, chlamydial infection can result in pelvic inflammatory disease, infertility, and ectopic pregnancy. It also may result in adverse pregnancy outcomes, such as neonatal conjunctivitis and pneumonia. In addition, recent research has shown that women infected with chlamydia have a three- to fivefold increased risk of acquiring HIV.[2]

County uses three-month tests

To stem the spread of chlamydia in King County, WA, local health department officials encourage women to return to their providers or clinics to be retested three months after treatment. The department has implemented a similar rescreening program for gonorrhea.

County public health officials began the prevention effort two years ago by simply advising infected women to return for retesting after three months. But as of spring 2001, tracking procedures and other measures were initiated in an attempt to make sure rescreening occurs, says **H. Hunter Handsfield**, MD, director of the STD Control Program at Public Health — Seattle and King County in Seattle, and professor of medicine at the University of Washington, also in Seattle.

The department contacts patients from the public health STD clinic if they have not returned for rescreening by four months, says Handsfield. For those women with chlamydial infection diagnosed elsewhere in King County, the health care provider gets a letter reminding him / her to contact his / her patient and ask her to return for rescreening or refer her to the STD clinic for this purpose, Handsfield explains.

By tracking reported cases, as well as the number of testing requests at local labs, public health officials soon will have ongoing data on the frequency with which infected women return for rescreening, as well as their test results, says Handsfield.

What is the cost of such a program? Not that much, says Handsfield, who offers this thumbnail calculation:

If an STD program performs 5,000 chlamydia tests in women per year and has a 10% positivity rate, then only 500 women are subject to rescreening. If 60% of these patients are retested, this results in 300 "extra" tests per year — a 6% increase in the cost of the testing program, he concludes.

"Remember, too, that most rescreening can be done without a full clinic visit; the patient can just deliver a urine or vaginal swab specimen, so the clinical encounter costs are nil," explains Handsfield. "The remaining costs are just those of the telephone and mailed reminders, [so] in that same program [5,000 tests with 500 positives], the cost is that of a few hundred phone calls and a couple of hundred letters."

Testing, education key

As vital as rescreening efforts are in driving down rates of chlamydia infection, they are just one facet of a multipronged approach in controlling the STD's infection rates, says Handsfield. Prompt partner treatment and patient education also play key roles.

More frequent screening may be useful, but interventions also are needed to help women reduce their risk of re-exposure to chlamydia, agrees Xu. He and the analysis authors point to evidence that a two-session, 40-minute total interactive, client-centered HIV / STD counseling resulted in an overall reduction in STD incidence of about 30% after six months and 20% after 12 months of follow-up.[3] Stratified analysis of that data showed that the relative effectiveness of counseling was greatest for adolescent patients with prior STDs.

Look to the update of the CDC's *Guidelines for Treatment of Sexually Transmitted Diseases* to include information on rescreening of women with chlamydial infection, says Handsfield. The publication is due for release this fall, he says.

"I predict that within a couple of years, rescreening will be recognized as a sine qua non of effective chlamydia prevention," states Handsfield. "All reproductive health clinics and providers should

rush to initiate routine rescreening of women with chlamydial infection as promptly as possible."

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Boost knowledge of emergency contraception

Do gaps remain at your facility when it comes to providers' knowledge about emergency contraception (EC)? If so, now is the time to take advantage of a newly updated teaching curriculum and supporting materials from the Washington, DC-based Association of Reproductive Health Professionals (ARHP).

ARHP's continuing medical education-accredited "Train the Trainer" emergency contraception program for health care providers started its new phase in August 2001, says **Wayne Shields**, ARHP president. The program was launched in 1999 with a grant from the David and Lucile Packard Foundation in Los Altos, CA, with updates supported through the Reproductive Health and Rights Program of the Open Society Institute, a New York City-based private operating and grant-making foundation, and Women's Capital Corp. of Bellevue, WA, manufacturers of Plan B, the levonorgestrel-only emergency contraceptive pill (ECP). Both the teaching curriculum and the supporting materials have been revised to include new advances and recent data. They are available free of charge on ARHP's web site, www.arhp.org.

The original "Train the Trainer" program featured a formal training session for a clinical faculty representing 44 states. Faculty members presented educational sessions in their home regions, says Shields. To date, more than 10,000 health care providers in the United States and overseas have participated in some form of training based on the ARHP-sponsored curriculum, he states.

EXECUTIVE SUMMARY

The Association of Reproductive Health Professionals (ARHP) has kicked off its updated "Train the Trainer" emergency contraception (EC) program. The teaching curriculum and supporting materials are available free on ARHP's web site, www.arhp.org.

- A survey of providers who participated in an EC education project showed gaps in their knowledge regarding medications, side effects, and mode of action.
- An upcoming ARHP report will feature innovative approaches in reaching health care providers about EC.

ACOG revises EC recommendations

The Washington, DC-based American College of Obstetricians and Gynecologists also has revised its recommendations to physicians regarding the safety and efficacy of prescription EC. It issued a practice bulletin in February 2001, which includes charts on how to combine common prescription oral contraceptives in dosages that provide EC, and information on the two available designated ECPs, Preven (Gynétics, Belle Mead, NJ) and Plan B.

Look for a final report from an EC summit convened in December 2000 by ARHP, which will feature innovative approaches to reach health care providers with messages about emergency contraception. At press time, the report was scheduled for release in September 2001, according to Shields.

Also, check with ARHP about the limited number of "Train the Trainer" sessions scheduled for this fall and again in 2002. For more information about the program, providers may contact ARHP at (202) 466-3825.

Gaps in learning

Why is it so important to offer provider education when it comes to EC?

Analysis of a survey of health care providers from 13 San Diego County Kaiser Permanente medical offices shows that while providers who participated in an EC education project showed changes in perceptions, knowledge, and behavior about the method, gaps remained in their

knowledge regarding medications, side effects, and mode of action.[1]

The Kaiser Permanente program was designed to introduce EC as a new service option in the health maintenance organization. ***(Contraceptive Technology Update* reviewed the pilot project in its May 1997 issue, p. 56.)** Health care providers completed self-administered questionnaires before and one year after full implementation of the project. More than 60% of the providers who completed both questionnaires were physicians and midlevel professionals who worked in departments such as obstetrics and gynecology, primary care, and emergency medicine.

The frequency of prescription for emergency contraceptive pills (ECPs) increased significantly from baseline to follow-up, according to the survey results. Findings reflected an almost 20% increase in the percentage who prescribed EC at least once a year. While many providers increased their knowledge about the safety and effectiveness of the method, just 13% were aware of all the oral contraceptives recommended for EC, and only 27% could correctly identify the common side effects of ECPs, according to the survey results.

Provider education is critical

Provider education is an important part in the continued success of EC, says **Marie Harvey**, DrPH, professor and director of research of the Center for the Study of Women in Society at the University of Oregon in Eugene. Harvey served as co-author for the recently published analysis.

"I do feel very strongly that educating providers and having providers knowledgeable of this method, prescribing it for women when they need it and when they don't need it to have as a backup, is essential until it can go over the counter or [be offered through pharmacist collaborative practice]," Harvey notes. "But as long as the method has to be prescribed by a provider, if providers aren't aware of this method and/or aren't willing to prescribe it to their patients, then it certainly isn't going to make the impact we all hope that it will on preventing unintended pregnancies."

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Observe October events with web site info

Breast cancer and domestic violence targeted

Put women's health front and center at your facility this month, as October serves as Breast Cancer Control Month and Domestic Violence Awareness Month.

Check out the following web sites for information both you and your patients can use:

1. National Breast Cancer Awareness Month. Web: www.nbcam.org.

Seventeen national public service organizations, professional medical associations, and government agencies comprise the Board of Sponsors for this nonprofit group, working in partnership to raise awareness of the importance of early detection of breast cancer.

Special emphasis is placed on the third Friday in October, National Mammography Day. On this day, or throughout the month, participating radiologists provide discounted or free screening mammograms. In 2001, National Mammography Day will be celebrated on Oct. 19. Call the following national organizations to find out which facilities in your area are taking part in the event: American Cancer Society, (800) 227-2345; Susan G. Komen Breast Cancer Foundation, (800) 462-9273; National Alliance of Breast Cancer Organizations, (888) 806-2226; Y-me National Breast Cancer Organization, (800) 221-2141.

Providers can download the 2001 Promotion Guide, which offers several ideas for promoting breast cancer awareness, as an Adobe Portable Document Format from the web site.

The web site also allows providers to freely download reproducible early detection brochures in English and Spanish, as well as print out 8.5 by 11-inch black and white posters featuring prevention messages with images of Asian-American, Hispanic, and African-American women. **(See Early Detection Brochure in English and Spanish and fact sheet enclosed in this issue.)**

2. American Cancer Society. Web: www.cancer.org.

The web site for this national organization, based in Atlanta, offers a great deal of information on breast cancer. Patient information includes a brochure, *Breast Cancer Questions and Answers,* a "Breast Cancer Early Detection" shower card, and a "Breast Cancer Early Detection" bookmark, with all available in English and Spanish. One free sample of each item may be ordered from the web site. To order multiple copies of any of these items, contact the organization at (800) 227-2345.

3. American College of Obstetricians and Gynecologists. Web: www.acog.org.

Click on "Violence Against Women" at the introductory page of the Washington, DC-based professional society's web site to review a wide variety of information on the subject.

The American College of Obstetricians and Gynecologists (ACOG) now recommends that physicians screen ALL patients for intimate partner violence.

For women who are not pregnant, screening should occur at routine OB/GYN visits, family planning visits, and preconception visits.

For women who are pregnant, screening should take place at various times over the course of the pregnancy, since some women do not disclose abuse the first time they are asked and abuse may begin later in pregnancy, according to ACOG.

How can you conduct a domestic violence screening? ACOG suggests making the following statement, "Because violence is so common in many women's lives and because there is help available for women being abused, I now ask every patient about domestic violence."

Follow this statement with these three simple questions:

- Within the past year — or since you have been pregnant — have you been hit, slapped, kicked, or otherwise physically hurt by someone?
- Are you in a relationship with a person who threatens or physically hurts you?
- Has anyone forced you to have sexual activities that made you feel uncomfortable?

Providers who would like to conduct an in-service session on domestic violence may want to download a slide set, Intimate Partner Violence During Pregnancy: A Guide for Clinicians, which was developed by ACOG and the Atlanta-based Centers for Disease Control and Prevention (CDC). The slide set is designed as a training tool to help clinicians understand their role in identifying, preventing, and reducing intimate partner violence. The slide set may be downloaded in PowerPoint Screen Show format from the CDC web site, www.cdc.gov/nccdphp/drh/violence/ipvdp_download.htm.

4. Family Violence Prevention Fund. Web: http://fvpf.org.

The Family Violence Prevention Fund, a San Francisco-based nonprofit organization, sponsors "Health Cares About Domestic Violence Day" to raise awareness within the health care community about the importance of screening to prevent abuse. Oct. 10, 2001, is the third observance of this event.

A free "Screening to Prevent Abuse" packet of materials is available on the web site and via hard copy to assist providers in event planning. Also available free for download is *Preventing Domestic Violence,* a comprehensive routine screening document on domestic violence. ■

Get *Pocket Guide to Managing Contraception*

Pocket Guide to Managing Contraception, The 2001-2002 Millennium Edition, now in its fourth printing, is available in printed and on-line formats.

The new edition contains the 2001 medical eligibility criteria for starting contraceptive methods issued by the Geneva-based World Health Organization. It also includes updated information on the vaginal ring; Lunelle, the combined injectable contraceptive; and Plan B, the progestin-only emergency contraceptive pill. Eight pages of color photographs of oral contraceptive pill packs also are listed.

All 35 chapters of the pocket-sized guide are available for free download in Adobe Acrobat Portable Document Form at the following web site: www.managingcontraception.com. Copies of the book also may be ordered from the web site or by contacting Bridging the Gap Foundation, P.O. Box 33218, Decatur, GA. Telephone: (404) 373-0530. Fax: (404) 373-0480. E-mail: savenow@projectplanetcorp.com. Costs are: one to 99 copies, $10 each; 100-199, $9 each; 200-299, $8 each. Check for shipping and handling charges, as well as for prices for larger quantity orders. ■

CE objectives

After reading *Contraceptive Technology Update*, the participant will be able to:

• State the main findings of Workshop Summary: Scientific Evidence on Condom Effectiveness for Sexually Transmitted Disease (STD) Prevention.

• Discuss the finding from the scientific advisory from the American Heart Association regarding provision of hormone replacement therapy (HRT) for prevention of future coronary events in postmenopausal women with cardiovascular disease (CVD).

• Name a key finding of a recently published analysis of a population-based sexually transmitted disease registry in Washington state.

• State the American College of Obstetricians and Gynecologists' (AGOG) recommendation on when providers should screen nonpregnant women for intimate partner violence. ■

Nurse practitioners push for contraceptive coverage

The National Association of Nurse Practitioners in Women's Health (NPWH) in Washington, DC, is getting behind the push for universal contraceptive insurance coverage. It has issued the following tips for women who are concerned about contraceptive coverage and who seek low-cost options:

• For women who have health care coverage options through their employer, open enrollment may be approaching this fall, when employees can change plans. Women should check whether their prescription plan covers oral contraceptives and, if so, which brands are on the formulary.

• Women can obtain brand name birth control pills at a discount through SmartWoman Rx, a mail-order program that offers free home delivery and up to a three-month supply. For more information or to enroll in the program, women can visit www.smartwomanrx.com or call (866) 376-6527.

• Women should notify their employer if they are not satisfied with the coverage provided under the plan by writing a letter or contacting the company's human resources department.

• Women are urged to send a letter to Congress showing support of contraceptive coverage. Visit the National Association of Nurse Practitioners web site at www.npwh.org for a sample letter. ■

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CE/CME Questions

13. What was one of the primary findings of Workshop Summary: Scientific Evidence on Condom Effectiveness for STD Prevention?
    A. The evidence is clear that condoms are effective against HIV and all forms of STDs.
    B. The evidence is clear that condoms are ineffective in preventing transmission of HIV but are effective in protection against other STDs.
    C. The evidence is clear that condoms are ineffective in preventing transmission of HIV and other STDs.
    D. The evidence is clear that correct and consistent use of condoms can reduce the risk of HIV/AIDS transmission, as well as reduce a man's risk of acquiring gonorrhea from a female partner.

14. What did the 2001 scientific advisory from the American Heart Association state regarding the provision of HRT for prevention of future coronary events in postmenopausal women with CVD?
    A. HRT should not be initiated for the prevention of future coronary events in postmenopausal women with CVD.
    B. HRT should be used for the prevention of future coronary events in postmenopausal women with CVD.
    C. Providers should use only estrogen replacement therapy for the prevention of future coronary events in postmenopausal women with CVD.

15. What was a key finding of a recently published analysis (Xu F, 2000) of a population-based STD registry in Washington state?
    A. Race/ethnicity was the strongest predictor for one and two or more repeat infections after controlling for the length of follow-up and other variables.
    B. Young age was the strongest predictor for one and two or more repeat infections after controlling for the length of follow-up and other variables.
    C. Coinfection with gonorrhea was the strongest predictor for one and two or more repeat infections after controlling for the length of follow-up and other variables.
    D. County of residence was the strongest predictor for one and two or more repeat infections after controlling for the length of follow-up and other variables.

16. According to ACOG, when should providers screen nonpregnant women for intimate partner violence?
    A. Women should be screened only when they present with physical signs of abuse.
    B. Women should be screened only when family members are present with them in the examination room.
    C. Screening should occur at routine OB/GYN visits, family planning visits, and preconception visits.

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NATIONAL ASSOCIATION NPWH
National Association of Nurse Practitioners in Women's Health

A • R • H • P
Association of Reproductive Health Professionals

For more information about breast cancer or to learn when and where you can obtain a low-cost mammogram or other cancer services, please call any of the following toll-free numbers.

American Cancer Society
(800) ACS-2345

Cancer Care, Inc.
(800) 813-HOPE

Cancer Research Foundation of America
(800) 227-2732

Centers for Disease Control and Prevention's National Breast and Cervical Cancer Early Detection Program
(888) 842-6355

The Susan G. Komen Breast Cancer Foundation
(800) I'M AWARE

National Alliance of Breast Cancer Organizations (NABCO)
(888) 80-NABCO

National Cancer Institute's Cancer Information Service
(800) 4-CANCER

National Cancer Institute's Cancer Information Service-TTY
(800) 332-8615

Y-me National Breast Cancer Organization
(800) 221-2141

Y-me Spanish Language Hotline
(800) 986-9505

To learn more about National Breast Cancer Awareness Month or to order materials, log on to our website at www.nbcam.org, or call us toll-free at (877) 88-NBCAM.

AstraZeneca
HealthCare Foundation

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BREAST CANCER

EARLY DETECTION IS A WOMAN'S BEST PROTECTION

NBCAM
NATIONAL BREAST CANCER AWARENESS MONTH

Breast Cancer

Breast cancer is the leading cancer diagnosed in women in America. Each year, more than 182,800 new cases of breast cancer will be diagnosed. More than 40,800 women will die from the disease. The good news is, as more breast cancer is detected early, far fewer women will lose their lives.

Early Detection

Early detection, followed by up-to-date treatment, provides women with a better chance for long-term freedom from the disease and may prevent the necessity of removing lymph nodes, undergoing radiation or chemotherapy, or removing a breast.

Mammography Screening
Clinical Breast Examination
Breast Self-Examination

Women should ask their health care providers about mammography screening.

Mammography (an "x-ray" picture of the breast) is the single most effective method to detect breast changes that may be cancer, long before physical symptoms can be seen or felt. But, it must be done routinely.

As women age, their risk of breast cancer increases. For most women, **high-quality mammography screening should begin at the age of 40**. The exact frequency should be determined by each woman and her doctor.

In addition to the use of mammography, health care providers should also physically examine a woman's breasts (clinical breast examination) at least once a year.

The practice of monthly breast self-examination will alert a woman to any breast changes that may signal the need for a visit to her doctor.

Medicare covers mammography screening for women age 65 and older every year. For more information, please contact the Medicare toll-free hotline at (800) MEDICARE. During October, National Breast Cancer Awareness Month, many facilities offer special programs, including extended hours. Some facilities are also willing to offer services at no charge, at a lower fee, or establish a payment schedule.

Is Mammography Reliable?

The federal government requires that mammography screening performed at more than 10,000 facilities throughout the country is of high quality and reliable. A certificate issued by the U.S. Food and Drug Administration must be displayed prominently at each facility. The U.S. Agency for Health Care Policy and Research has developed the booklet *Things to Know About Quality Mammograms.* This booklet can be obtained at no charge, in English or Spanish, by calling (800) 358-9295. Information for health care professionals is also available.

Para mayor información sobre el cáncer del seno, o para informarse sobre cuando o cómo se puede obtener una mamografía a bajo costo, u otros servicios relacionados con el cáncer, llame gratis a cualesquiera de los siguientes números:

American Cancer Society
(800) ACS-2345

Cancer Care, Inc.
(800) 813-HOPE

Cancer Research Foundation of America
(800) 227-2732

The Susan G. Komen
Breast Cancer Foundation
(800) I'M AWARE

National Alliance of Breast Cancer
Organizations (NABCO)
(888) 80-NABCO

National Cancer Institute's
Cancer Information Service
(800) 4-CANCER

National Cancer Institute's
Cancer Information Service-TTY
(800) 332-8615

Y-me National Breast Cancer Organization
(800) 221-2141

Y-me Línea de emergencia en español
(800) 986-9505

Para mayor informatión acerca del Mes nacional de la información sobre el cáncer, por favor, llame grátis al teléfono (877) 886-2226, o vea nuestra página en la internet: www.nbcam.org.

AstraZeneca
HealthCare Foundation

La Campaña del Mes Nacional del Cáncer del Seno está patrocinada por la Fundación AstraZeneca HealthCare Foundation.

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CÁNCER
DEL SENO

Un Diagnóstico Temprano es la Mejor Protección Para la Mujer

NBCAM
NATIONAL BREAST CANCER
AWARENESS MONTH

El cáncer del seno

El cáncer del seno es el cáncer más común en las mujeres en los Estados Unidos. Más de 182.800 casos serán diagnosticados cada año y más de 40.800 mujeres morirán de esta enfermedad. La buena noticia es que mientras más temprano se detecte el cáncer, muchas menos mujeres perderán su vida.

El diagnóstico temprano

Un diagnóstico temprano seguido de un tratamiento actualizado le da a las mujeres una mejor oportunidad para liberarse por un largo plazo de esta enfermedad y además, puede llegar a prevenir la necesidad de radiación o quimoterapia, o de remover los nódulos linfáticos o el seno. Las mujeres deben hacer averiguaciones sobre las mamografias con sus medicos.

Mamografía
Examen clínico del seno
Autoexamen del seno

Las mujeres deben hacer averiguaciones sobre las mamografías con sus médicos.

La mamografía (una radiografía del seno) es el método mas efectivo para detectar, mucho antes de que los síntomas físicos se puedan ver o sentir, cualquier cambio en el seno que pudiera llegar a ser cáncer. Pero para lograr esto, las mamografías se deben hacen rutinariamente.

A medida que la mujer envejece aumenta el riesgo del cáncer. La mayoría de las mujeres **deben comenzar las mamografías, a partir de la edad de cuarenta años**. La frecuencia de las mamografías debe ser determinada por cada mujer de mutuo acuerdo con su médico.

Además del uso de la mamografía, los médicos deben hacer un examen físico del seno de la mujer (examen clínico del seno), por lo menos una vez al año.

La práctica del autoexamen manual del seno puede dar a las mujeres una voz de alerta sobre cualquier cambio en el seno, que podría ser la señal sobre la necesidad de visitar a su médico.

Medicare cubre el gasto de las mamografías para las mujeres mayores de sesenta y cinco años, una vez cada año. Para mayor información, contacte la linea telefónica gratis para emergencias de Medicare (800) MEDICARE. Durante el mes de octubre, el Mes Nacional del Cáncer, muchas instituciones ofrecen programas especiales, incluidos horarios extensos. Además, algunas instituciones están dispuestas a ofrecer sus servicios de forma gratuita, o a bajo costo, o a establecer un programa de pago por cuotas.

¿Son las mamografías de confiar?

El gobierno federal requiere que las mamografías que se efectuan en más de 10.000 instituciones en todo el país, sean confiables y de muy alta calidad. Un certificado que otorga la "U.S. Food and Drug Administration" (el Departamento de Administración de Drogas y Alimentos de los Estados Unidos) debe de ser colocado a la vista del público, en cada institución. La agencia norteamericana llamada "U.S. Agency for Health Care Policy and Research" tiene un folleto titulado Las Cosas que se Deben Saber Sobre los Mamogramas de Calidad. Este folleto se puede obtener gratis, tanto en español como en inglés, llamando al telefono (800) 358-9295. También aquí se puede obtener información sobre médicos y otros profesionales de la salud.

FACT SHEET

BREAST CANCER:
KNOW THE FACTS ABOUT YOUR RISK

What is cancer?

Cancer is a group of diseases that occur when cells become abnormal and divide without control or order. Each organ in the body is made up of various kinds of cells. Cells normally divide in an orderly way to produce more cells only when they are needed. This process helps keep the body healthy. If cells divide when new cells are not needed, they form too much *tissue*. This extra tissue, called a tumor, can be *benign* or *malignant*. Eighty percent of all breast tumors are benign.

Benign tumors are not cancer.
They can usually be removed, and in most cases, they don't come back. Most important, the cells in benign tumors do not invade other tissues and do not spread to other parts of the body. Benign breast tumors are not a threat to life.

Malignant tumors are cancer.
The cancer cells grow and divide out of control, invading and damaging nearby tissues and organs. Cancer cells can also break away from the original tumor and enter the bloodstream or *lymphatic system*. This is how breast cancer spreads and forms secondary tumors in other parts of the body. This spread of cancer is called *metastasis*.

How common is breast cancer in the United States?

Breast cancer is the most common cancer in women, aside from skin cancer. During 2000, an estimated 182,800 new cases of breast cancer are expected to occur among women in the United States. It is the second leading cause of cancer death, after lung cancer. An estimated 40,800 women are expected to die from breast cancer this year.

What are breast cancer "risk factors"?

To predict when and in whom breast cancer will strike, scientists must often think like detectives, looking for clues to signal which women may be more likely than others to develop the disease. These clues are called "risk factors."

Scientific Detectives

To identify risk factors, scientists continually examine various trends and patterns among women worldwide who are diagnosed with the disease. Age, individual and family medical history, reproductive history, genetic alterations, race, economic status, neighborhood and workplace exposures to pollutants, and lifestyle habits are all examples of the factors that can be evaluated. This information tells a scientific story that helps experts predict with some certainty a woman's odds for developing breast cancer. It's important to note, however, that this is not an exact science and that such predictions are not definite.

Having one or two of these risk factors doesn't mean a woman will develop breast cancer (seven out of ten breast cancers occur in women with none of the important risk factors, other than simply being a woman). But *knowing her personal risk factor profile* and *understanding what it means* will help her and her doctor plan a course of action that may reduce her chances of ever getting the disease or, at least, to detect it in its earliest, most treatable stages.

The most common risk factors.

Age.
The risk of breast cancer increases, as a woman grows older. About 82 percent of breast cancers occur in women age 50 and older. The risk is especially high for women age 60 and older. Breast cancer is uncommon in women younger than age 35.

Personal History.
Women who have had breast cancer and women with a history of breast disease (not cancer, but a condition that may predispose them to cancer) may develop it again.

Family History.
The risk of getting breast cancer increases for a woman whose mother, sister, daughter, or two or more close relatives have had the disease. It is important to know how old they were at the time they were diagnosed.

The Breast Cancer Genes.
Some individuals, both women and men, may be born with an "alteration" (or change) in one of two genes that are important for regulating breast cell growth. Individuals who inherit an alteration in the BRCA1 or BRCA2 gene are at an "inherited" higher risk for breast cancer. They also may pass this alteration on to their children. It is very rare – scientists estimate that only about 5-10 percent of all breast cancers are due to genetic changes. One out of two women with these changes are likely to develop breast cancer. Women with a family history of breast cancer are encouraged to speak to a genetics counselor to determine the pros and cons of genetic testing.

FACT SHEET

The next three risk factors all involve estrogen, a hormone that naturally occurs in every woman. At the time menstruation begins, women start to produce larger amounts of estrogen and will continue to do so until they reach menopause. Estrogen appears to play a key role in breast cancer. Although estrogen doesn't actually cause breast cancer, it may stimulate the growth of cancer cells. Estrogen-related risk factors are:

Having an early first period.
Women who begin menstruating before age 12 are at increased risk of developing breast cancer. The more menstrual cycles a woman has over her lifetime, the more likely she is to get the disease.

Having a first pregnancy after age 25 or 30.
Although early pregnancies may help lower the chances of getting breast cancer, particularly before the age of 25, these same hormonal changes after age 35 may contribute to the incidence of breast cancer.

Having no children.
Women who experience continuous menstrual cycles until menopause are at a higher than average risk.

Other risk factors – and lifestyle choices to avoid them.

Common to all women are daily lifestyle decisions that may affect breast cancer risk. These day-to-day choices involve factors such as poor diet, insufficient physical activity, alcohol use, and smoking. Besides possibly reducing breast cancer risk, lifestyle improvements represent smart steps for a healthier life, since they can help prevent heart disease, diabetes, and many other chronic, life-threatening conditions.

Decrease your daily fat intake
– especially saturated or hydrogenated fats. Eat leaner meats and limit red meat. Reducing your fat intake helps prevent other health problems, such as heart disease and stroke, and may reduce your chance of developing breast and colon cancers.

Increase fiber in your diet.
Fiber is found in whole grains, vegetables, and fruits. This type of diet is beneficial for your heart, too, and can help prevent other cancers, such as colon cancer.

Eat fresh fruits and vegetables.
In addition to their fiber content, fruits and vegetables have antioxidant properties and micronutrients that may help prevent some cancers.

Limit alcohol.
Evidence suggests that a small increase in risk exists for women who average two or more drinks per day (beer, wine, and distilled liquor).

Stay active.
The U.S. Surgeon General recently reported that you can help prevent many health problems by engaging in a moderate amount of physical activity (such as taking a brisk, 30-minute walk) on most days of the week. Strive to maintain the body weight recommended by a health professional, since excess fat may stimulate estrogen production.

Don't smoke.
Although smoking doesn't cause breast cancer, it can increase the chance of blood clots, heart disease, and other cancers that may spread to the breast.

NBCAM
National Breast Cancer Awareness Month

For more information about breast cancer and breast cancer risk, please call any of the following toll-free numbers, or log on to our website at www.nbcam.org.

American Cancer Society
(800) ACS-2345

Cancer Care, Inc.
(800) 813-HOPE

Cancer Research Foundation of America
(800) 227-2732

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