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Will HCFA proposal keep women from receiving certain breast procedures?

HCFA tables proposal until mid-2000

The prospective payment system proposed by the Baltimore-based Health Care Financing Administration (HCFA) for outpatient procedures performed in surgery centers and hospital outpatient surgery departments may prevent many Medicare women from being able to choose some of the most advanced surgical procedures.

Three breast diagnostic procedures will be reimbursed at a lower rate under the proposed surgery center ambulatory payment classifications (APCs). And some new minimally invasive procedures essentially will be unavailable to elderly women because their higher equipment costs are not recognized in the proposed APCs, according to directors at several surgery centers. Two of the three breast diagnostic procedures will see a lower reimbursement rate for hospital outpatients with the third procedure receiving a slightly higher reimbursement than previous reimbursements to hospitals.

"The APCs might prevent women from having biopsies done with new instruments, and these new instruments are an improvement," says **Beth A. Boyd**, RN, clinical director and educational coordinator for The Breast Center in Marietta, GA. The Breast Center is a private surgical

Key Points

The Baltimore-based Health Care Financing Administration (HCFA) has two fee schedule proposals that would directly impact the financial health of surgery centers and hospitals performing breast procedures and other women-specific surgeries.

- Industry experts criticize what they say is HCFA's outdated methodology, which relied upon old cost information.
- Critics also have pointed to the exclusion of new technology such as stereotactic breast biopsy.
- Implementation of the surgery center and hospital proposals has been delayed until mid-2000.

practice that specializes in breast procedures, including ultrasound, stereotactic biopsy, and mammography.

"Overall, to me it's unfortunate," says **Maxine Brinkman**, MHA, director of women's health services for Mercy Health Network in Mason City, IA. Brinkman also is the president of the National Association of Professionals in Women's Health in Chicago.

"It's a step backward and is subjecting women to less technically good procedures," she says.

HCFA tables proposal

In September 1998, following months of heated outcry from surgery centers, the HCFA tabled proposals for fee schedules for both outpatient surgery centers and hospital outpatient surgery departments.

A major reason for the delay in completing these schedules is the need for HCFA to concentrate on the potential year 2000 (Y2K) problems that could delay Medicare payments to patients and to providers. The delay also has been extended to the controversial reimbursement system for surgery centers that was proposed in June 1998.

Both the proposed system for hospital outpatient services, which was published Sept. 8, and surgery centers, which was published June 12, rely on APCs. APCs are groups of procedures that are reimbursed at the same rate because they are similar clinically and similar in terms of resource costs. The same classification system, with different rates, is proposed for surgery centers and hospital outpatient services.

Because HCFA tabled both projects so soon after the hospital-based outpatient rates were proposed, hospital-based financial managers are holding off on analyzing the reimbursement levels in detail.

"We are not conducting an in-depth analysis at this time because the rates will probably change when HCFA re-issues them after the beginning of the year 2000," says **Tracie Holyfield**, product line specialist for women's services at Moses Cones Health System in Greensboro, NC.

Although reimbursement for outpatient services will continue as business as usual for the next 13 months or longer, it is important to understand the reasons for the heated debate generated by the APCs specific to women's surgeries and the potential impact of the lower reimbursements.

Comments on the surgery center and hospital-based outpatient rates will be accepted by HCFA until Nov. 9. **(For information on how to submit comments or access the original document, see box, p. 139.)**

Will private payers cut payments?

A frightening possibility if HCFA proposes similar rates in 2000 is that commercial payers will follow suit, as they usually do, and base their payment structures on Medicare's APCs, says **Jerry Henderson**, executive director of SurgiCenter of Baltimore in Owings Mills, MD. The multispecialty center performs about 11,000 procedures a year, including breast procedures.

At the center of the controversy are the proposed reimbursement rates for breast biopsy diagnostic procedures. Currently these are reimbursed under these three CPT codes:

❒ **19100: Breast biopsy; core** — $314 for surgery centers; $224 for hospitals.

(Editor's note: Hospital outpatient rates are based upon national averages and do not take into account the wage index for each urban or rural area. A cost-to-charge ratio of 45% was assumed. The source for this information is the Healthcare Financial Management Association in Washington, DC.)

❒ **19101: Breast biopsy; incisional** — $422 for surgery centers; $699 for hospitals.

❒ **19125: Excision of breast lesion identified by preoperative placement of radiological marker** — $482 for surgery centers; $699 for hospitals.

The new APC group definition lists CPT 19100 as APC 122, defined as a Level II needle biopsy, aspiration, and the proposed reimbursement rate is $186, a decrease of $128 from the

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current payment rate. Hospital reimbursement for APC 122 is $258, an increase of $34.

The CPT codes 19101 and 19125 are grouped under the APC 197 as an incision / excision breast procedure, and the proposed reimbursement for this APC is $411. It's an $11 decrease from CPT 19101 and a $71 decrease from CPT 19125. Hospital reimbursement for APC 197 is $642, which represents a $58 decrease.

Newest technology left out of APCs

The reduction in reimbursement is only part of the problem. The bigger issue, directors say, is that the proposed codes do not address new breast biopsy procedures.

For example, until 1994, most stereotactic breast biopsies in outpatient settings involved using a core needle biopsy. And the gold standard was an open excisional biopsy performed in a hospital operating room. The latter procedure requires a general anesthesia, and the woman needs longer recovery time. Plus it leaves some internal and external scarring, Boyd says.

Then manufacturers introduced the stereotactic biopsy procedure with the vacuum-assisted biopsy device. The new stereotactic technology allows digital imaging on a computer during the biopsy.

The new technique is minimally invasive, so it doesn't cause as much scarring, and the woman does not need general anesthesia. The woman can drive herself to and from the outpatient facility, and the whole procedure and recovery may take two hours, she says.

(For more information about stereotactic breast procedures, see *Women's Health Center Management*, March 1996, p. 25.)

"It's a very big difference," Boyd explains. "You don't have operating room time, pre-operative laboratory time to pay for, so it benefits the insurance companies to work with this too."

Stereotactic biopsy is better diagnostic tool

Although the stereotactic biopsy, using a vacuum-assisted biopsy device, costs more than the traditional stereotactic core needle biopsy, it is a much better diagnostic tool because it allows the surgeon to remove larger tissue samples and an entire area of abnormality in the breast, instead of only a small tissue sample, she adds.

The Biopsys Mammotome Breast Biopsy System, manufactured in 1994, is now marketed by Ethicon Endo-Surgery Inc. in Cincinnati. It was the first vacuum-assisted biopsy device, Boyd says. Norwalk, CT-based United States Surgical Corp. has recently introduced the MIBB (minimally invasive breast biopsy), which also is a vacuum-assisted breast biopsy device used with stereotactic imaging.

Both devices use new technology that allows larger tissue samples and removal of the lesion

Resources

To obtain a copy of the Sept. 8, 1998, *Federal Register* that contains the Medicare Program; Prospective Payment System for Hospital Outpatient Services; Proposed Rules, and the June 12, 1998, *Federal Register* that contains the Medicare Program: Update of Ratesetting Methodology, Payment Rates, Payment Policies and the List of Covered Surgical Procedures for Ambulatory Surgical Center Effective Oct. 1, 1998, send your request to:

- **New Orders**, Superintendent of Documents, P.O. Box 371954, Pittsburgh, PA 15250-7954. Specify the date of the issue requested and enclose a check or money order for $8, payable to the Superintendent of Documents, or enclose your Visa or Master Card number and expiration date. Credit card orders also may be made by telephone to (202) 512-1800 or by faxing to (202) 512-2250.

- **The *Federal Register*** is also available for viewing at many libraries or through an on-line database through GPO Access, a service of the U.S. Government Printing Office. Internet users may access the data base by using the World Wide Web: http://www.access.gpo.gov/su_docs/.

The Health Care Financing Administration (HCFA) will accept comments on the proposed rules through 5 p.m., Nov. 9, 1998. HCFA requests that participants mail one original written comment and three copies to the Health Care Financing Administration, Department of Health and Human Services, Attention: HCFA-1885-P, P.O. Box 26688, Baltimore, MD 21207-5178.
Or comments may be delivered to the Hubert H. Humphrey Building, Room 309, 200 Independence Ave. SW, Washington, DC 20201, or Room C5-09-26, 7500 Security Blvd., Baltimore, MD 21244-1850. For more information, contact: Joan H. Sanow at (410) 786-5723.

through a 4 mm incision, Boyd says.

United States Surgical Corp. also manufactures the ABBI (Advanced Breast Biopsy Instrumentation), another new stereotactic breast biopsy technology that would be adversely affected by the APCs, says **Kathryn Barry**, senior director of health policy and reimbursement for United States Surgical Corp.

The MIBB was introduced this year, and the ABBI was introduced in 1996, which means they were not included in cost data HCFA collected in its 1994 ASC survey, Barry says.

HCFA's outdated methodology

"We are concerned they are using an outdated methodology that doesn't keep pace with advancements of technology that are piloting a shift to ambulatory care," Barry says.

The ABBI, which uses a disposable product, costs more than the proposed APC surgery center reimbursement of $411, Barry says. Add in the cost of the surgeon, facility, and staff time, and the cost of the new stereotactic breast biopsy will exceed Medicare's reimbursement rate.

"So this creates two perverse incentives: There are ASCs with this technology, but they won't schedule Medicare patients for the procedure, so Medicare women will be denied access to the technology," she says.

"Or physicians will be motivated to send their patients to a hospital because the procedure is reimbursed more there." While the hospital reimbursement of $642 is more generous, hospital outpatient departments are still facing higher overhead costs than surgery centers that will not be covered by the reimbursement level, Barry says

Ironically, while Medicare's low reimbursement level might deny older women stereotactic technology, other government agencies are paying for it, Brinkman notes. The Atlanta-based Centers for Disease Control and Prevention (CDC) has included stereotactic procedures for low-income women in its Breast and Cervical Cancer Early Detection Program, which is funded by the National Institutes of Health in Washington, DC.

Henderson points out that women also are being shortchanged with HCFA's proposed reimbursement for surgical hysteroscopy, which is under APC code 550 and corresponds to CPT code 56356, which is for hysteroscopy, surgical, with endometrial ablation. The procedure allows a surgeon to destroy the endometrial lining of a woman's uterus, and this can be done in place of a hysterectomy.

Payment would drop for ablation

The procedure traditionally has been done in a hospital setting, where the reimbursement rate is more than $1,000 in many states, Henderson says. The proposed hospital reimbursement for APC 550 is $893.

The proposed APC code 550 would reimburse the procedure in an outpatient surgery center setting at $610. Surgeons now have the option of using new technology that uses a heated balloon to destroy the endometrial lining, which is safer and quicker, but uses a disposable instrument that costs about $650, Henderson says.

"So before you have the first minute of surgery, the first staff person, and the first suture, you're already behind," he says. ■

Want to Know More?

For more information on how the proposed APCs will affect Medicare patients, contact:

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Emergency contraceptive product hits U.S. shelves

Preven Emergency Contraceptive Kit is here

After almost 25 years of waiting, American women finally have a product approved by the federal Food and Drug Administration (FDA) for emergency contraception: the Preven Emergency Contraceptive Kit. With the doors now open for the contraceptive method, women may see two more progestin only products enter the U.S. market in 1999.

Gynétics of Somerville, NJ, the company responsible for introducing Preven, has announced it is in advanced stages of developing a levonorgestrel-only emergency contraceptive. "We are hopeful that this [product] will be on the market before the end of 1999," states **Roderick Mackenzie**, company chairman and founder.

At press time, another company, Women's Capital Corp., based in Seattle and Washington, DC, planned to submit its New Drug Application to the FDA for a similar progestin only product, confirms **Sharon Camp**, PhD, company president. Company officials hope it, too, will receive FDA approval in 1999.

Competition in the emergency contraception marketplace can only bode well for women, explains Camp, who served as head of the Welcome, MD-based International Consortium for Emergency Contraception, a global initiative promoting the method.

Key Points

Women now have a dedicated prescription only emergency contraceptive product they can ask for by name: the Preven Emergency Contraceptive Kit, marketed by Gynétics of Somerville, NJ. Shelves have been stocked with the new kit following Food and Drug Administration's approval of the product.

- The Preven kit consists of an easy-to-use pregnancy test, patient information guide, and four blue pills. Each pill contains 0.05 mg ethinyl estradiol and 0.25 mg levonorgestrel. After a woman determines she is not pregnant by using the kit's test, she takes two pills as soon as possible within 72 hours after unprotected sex. The next two pills are taken 12 hours later.

"We have 100 brands of oral contraceptives [OCs] on the world market, so why should there only be one emergency contraceptive?" Camp asks. "The more companies that are out there advertising emergency contraception directly to the consumer and educating health care providers, the more likely it is that emergency contraception will become a standard part of reproductive health care."

New women's health care market

The debut of the Preven Emergency Contraceptive Kit signals a new market in women's health care, notes **Anita Nelson**, MD, associate professor of OB/GYN at the University of California at Los Angeles and medical director of the Women's Health Care Programs at Harbor-University of California at Los Angeles Medical Center in Torrance.

"We know with all these unintended pregnancies that women are having unprotected intercourse, and that their methods are failing them," Nelson observes. "If we have a product that women can ask for and that physicians can prescribe, we will be creating something that hasn't been there before — we won't be subtracting from something that exists now."

All systems were go as of *Women's Health Center Management* press time to have Preven in all Planned Parenthood Federation of America clinics and on the shelves of retail pharmacies. The kits also are being made available to family planning clinics and college student health centers, with information broadcast through the mail, Mackenzie says.

(To find out more about Preven, check the World Wide Web site or dial the toll-free information number; both are listed in the resource box, p. 142.)

Preven is now available by prescription only, but that may change as Gynétics continues to track its usage, says Mackenzie. The company will cooperate with the FDA in evaluating whether over-the-counter (OTC) status is warranted, he says.

Most HMOs to cover

In looking at the OTC issue, Gynétics' market research indicates that women want the opportunity to have emergency contraception reimbursed by their health care plans or by Medicaid, he adds.

Preven carries Health Care Financing

Administration approval for Medicaid reimbursement, and most health maintenance organizations have agreed to cover its costs, he says.

Preven should qualify under new legislation that will require federal employees' medical insurance to cover contraceptives approved by the FDA, says **James Trussell**, PhD, associate dean of the Woodrow Wilson School of Public and International Affairs and professor of economics and public affairs at Princeton (NJ) University. Private companies that now cover contraceptives also will include Preven, says Mackenzie.

The approval of the new emergency contraceptive may indeed represent the turning point in gaining insurance coverage for all contraceptives, predicts **Arthur Caplan**, PhD, director for the Center for Bioethics at the University of Pennsylvania in Pittsburgh. Women are going to demand emergency contraception, with providers joining in the chorus, Caplan observes. The result is a constituency that will bring pressure to obtain coverage for emergency contraception, he says.

A big advantage of Preven is its cost. Women will be able to fill prescriptions at a pharmacy for about $20, says Mackenzie. That's less than any OCs currently used as emergency contraceptives, says **Robert Hatcher**, MD, MPH, professor of OB/GYN at Emory University in Atlanta.

Meeting women's needs

Women previously have had to buy an entire month's supply of OCs if they filled their emergency contraceptive prescriptions at a retail facility. By buying the kit, women will be purchasing exactly what they need for pregnancy prevention.

The Preven kit consists of an easy-to-use pregnancy test, a patient information guide, and four blue pills. Each pill contains 0.05 mg ethinyl estradiol and 0.25 mg levonorgestrel. After a woman determines she is not pregnant by using the test, she takes the first two pills as soon as possible within 72 hours after unprotected sex and the last two pills 12 hours later.

"Having the kit makes this whole process much simpler," notes Mackenzie. "It is simpler for the doctors to prescribe, it is simpler for the pharmacists to dispense, the instructions make it simple for a woman to use, the pregnancy test adds confidence, and just the right number of the right pills are there — there's no guessing."

The pregnancy test offers peace of mind because woman know the pills will work for them if they are not already pregnant, says Nelson. Women are encouraged to seek provider care if the test proves positive.

It is estimated that emergency contraceptive pills could prevent half of all abortions and unintended pregnancies that occur each year in the United States, notes **Judith DeSarno**, president and chief executive officer of the Washington, DC-based National Family Planning and Reproductive Health Association. With more than 11 million women now using contraceptive methods associated with high failure rates, Preven and similar products have a large market opportunity.

Prior to its Sept. 2 announcement, the FDA had declared 10 brands of regular OCs safe and effective for use for emergency contraception, notes Trussell. However, the labeling on these products fails to include any specific instructions for postcoital use.

Preventing more unplanned pregnancies

"Not having a dedicated product specifically packaged and labeled for emergency contraception has been the largest single barrier to more widespread use," Trussell says. With Preven in hand, a specific product can be marketed and promoted actively, with clear package instructions available for guidance, he notes.

"For a long while, we have been saying that half of the 3 million unintended pregnancies each year in the United States could be prevented if emergency contraceptives were widely available and consistently used," Hatcher agrees. "The exciting thing about Preven is that it is going to help us in a major way toward achieving that goal." ■

Want to Know More?

For more information on Preven, contact:

- **Gynétics**, P.O. Box 8509, Somerville, NJ 08876. Telephone: (908) 359-2429. Fax: (908) 359-6660.
  A special provider and consumer toll-free number is available for Preven: (888) Preven2. World Wide Web: http://www.Preven.com.

For more on emergency contraception, contact:

- **Emergency Contraceptive Hotline**, 21 Prospect Ave., Princeton, NJ 08544-2091. Telephone: (888) NOT-2-LATE. E-mail: ec@opr.princeton.edu. World Wide Web: http://opr.princeton.edu/ec/.

State-specific data give extra ammunition

You know you need data to plan new programs, justify existing services, apply for grants, and raise awareness of women's health needs. You even have lots of books, lists, World Wide Web page addresses, and stacks of paper with data.

With all of this data available, you have only two questions: What does it mean, and how do I use it?

As with any information, you have to know how it was obtained and when it is appropriate to apply to your situation, say the experts.

Collection methods vary in different regions

The difficulty with data specific to women is that it isn't readily available in many databases and it isn't always collected in the same manner from state to state or from region to region, says **Martha Romans**, executive director of the Jacobs Institute of Women's Health in Washington DC.

"National databases give you an overview of women's health on a national level, but they don't tell you how the health of women in your state compares to the health of women in other states," Romans explains. "Many national statistics also don't break morbidity or mortality in gender-specific results."

A new publication, *State Profiles on Women's Health*, by the Jacobs Institute does compare women's health status from state to state. **(See resource box, p. 144, for ordering information.)** The institute used national statistics from organizations such as the Centers for Disease Control and Prevention in Atlanta, the American Cancer Society in Atlanta, and the U.S. Census Bureau. The institute broke the information into state specific sections, explains Romans.

"We show which states rank highest and lowest in categories such as STDs and other illnesses as well as risk factors such as smoking or obesity," she adds.

This information will give people a starting point for discussing women's health for a variety of reasons, adds Romans.

Use data to lobby for funding

The best use of statewide data is for lobbying efforts as women's health providers strive to affect legislature and government funding of programs that impact the health of women in their state, says **Judith B. Collins** RN, MS WHNP, director of MCV Women's HealthCare in Richmond, VA.

Being able to show that programs are needed because the women in your state have a higher incidence of breast cancer than in states with similar demographics, or that a higher percentage of the women in your state have a higher percentage of smokers, gives you some leverage when trying to influence legislative actions that fund health programs, she explains.

The same statistics can be used to help women's centers identify a need for outreach programs or new services, adds Collins.

"We used similar data when setting up our program," she explains. "This type of information was used as a guideline to help us start identifying needs. We wanted information on demographics as well as women's psychosocial and health status."

Bonnie Flood Chez, RNC, MSN, director of the women's center at University Community Hospital in Tampa, FL, says, "I usually start with local or regional information when setting up a new program or service, then use statewide data to see how our region's needs might differ from the entire state."

City or county planning departments or even local universities are a good source for local information. Chambers of commerce and realtor organizations can provide data on new homes, numbers of people moving to the area, as well

Key Points

Finding the information needed to plan a program, identify a community need, or justify your existence is frustrating for women's health managers because it is hard to find women's health-specific data. The information can be found at a state level, but how can these statistics be used within a women's center? Experts point to four areas in which the information can be helpful:

- lobbying state governments for women's health program funding;
- applying for grant funds;
- identifying a need for outreach programs;
- justifying the need for women-specific services.

Want to Know More?

For more information about the use of state-specific data, contact:

- **Martha C. Romans**, Executive Director, Jacobs Institute of Women's Health, 409 12th St. SW, Washington DC 20024-2188. Telephone: (202) 863-4989. Fax: (202) 488-4229. E-mail: mromans@acog.org.
- **Judith B. Collins**, Director, MCV Women's HealthCare, 9000 Stony Point Parkway, Richmond, VA 23235. Telephone: (804) 560-8954. Fax: (804) 560-7343. NO EMAIL.
- **Bonnie Flood Chez**, Director of Women's Center, University Community Hospital, 3100 E. Fletcher Ave., Tampa, FL 33613. Telephone: (813) 979-7909. Fax: (813) 979-7416. E-mail: bonniec@ uch.org.

To order a copy of *State Profiles on Women's Health*, send $33.50 (includes shipping and handling) to Jacobs Institute, 409 12th St. SW, Washington DC 20024-2188. Telephone: (202) 863-4990. Fax: (202) 488-4229. Include your name, organization, address, telephone, and fax numbers with your order. Checks, VISA, or MasterCard are accepted. If paying by credit card, include card number and expiration date.

as demographics of newcomers. A look at statewide information gives her organization a chance to benchmark the program and evaluate the impact on women in her community, adds Flood Chez.

Data demonstrate needs

In addition to enhancing lobbying efforts and identifying a need for outreach programs, statewide data can be used to support grant proposals, says Romans. Any grant proposal is more effective when quantitative data pulled from reputable sources are used to demonstrate the need for a new service.

Perhaps the best use of women's health data if your woman's center is a part of a hospital or larger health care system is to share the information with administrators and financial managers who may not understand the need for a women's service, says Collins.

"We often need to reassure administrators that a women-specific service is justified and that there is an opportunity to affect women's health," she says. ■

Oral contraceptives cut inherited cancer risk

Good news: the protective effects of oral contraceptives (OCs) against ovarian cancer extend not only to healthy women, but to those who carry an inherited risk as well.

While only 10% of all ovarian cancers can be attributed to a genetic mutation in the BRCA1 or BRCA2 genes, women who carry mutations of either gene have a high lifetime risk for the disease, says **Steven Narod**, MD, PRCPC, chair of breast cancer research at the Women's College Hospital, University of Toronto (Ontario). Narod is a molecular epidemiologist who, along with others, mapped the gene for hereditary breast-ovarian cancer syndrome.

He served as lead investigator for the multinational study that shows the pill's effect in reducing ovarian cancer risk in women with the mutated genes.[1] The study shows that birth control pills appear to cut the risk of ovarian cancer in half among women with the genetic mutations.

Researchers in Canada, Sweden, Norway, Italy, England, and the United States compared OC use in 207 women with the inherited form of the disease with 161 of their sisters, some of whom also had the genetic mutations.

Women who had used OCs any time in the past had an overall 50% lower risk of ovarian cancer, the researchers discovered. If the use had extended for more than six years, the risk was decreased by 60%.

While many family planners may not regularly see women who have identified BRCA1 or BRCA2 mutations, it is important to recognize the noncontraceptive benefits offered by OCs, say reproductive health experts.

"I think the clinical message here is another confirmation that the powerful protection of oral contraceptives not only applies to women in general, but to women who have elevated risk and, therefore, particular concerns about this often fatal gynecologic malignancy," says **Andrew Kaunitz**, MD, professor and assistant chair of the department of OB/GYN at the University of Florida Health Sciences Center in Jacksonville.

For **Stephen Rubin**, MD, professor and chief of the division of gynecologic oncology at the University of Pennsylvania Medical Center, the

Key Points

Providers have a new choice in 20 mcg oral contraceptives: Levlite from Berlex Laboratories of Wayne, NJ. Levlite, which contains 20 mcg of ethinyl estradiol and 100 mcg of levonorgestrel, joins Alesse, a similar formulation manufactured by Wyeth-Ayerst of Philadelphia.

- Two other 20 mcg pills also are available: Loestrin 1/20 from Parke-Davis of Morris Plains, NJ, and Mircette from Organon of West Orange, NJ. Loestrin uses a different progestin, and Mircette differs in dosing regimen and progestin.
- Clinical trials show that Levlite provides contraceptive efficacy with good cycle control. Headache, the most noted side effect, was reported by 17% of users.

study is consistent with what is now known about OCs and the risk of ovarian cancer in the general population. While Rubin, who wrote a commentary on the new study,[2] finds it "interesting and provocative," he does not believe it offers a complete answer to the effects of OCs in women with the inherited risk. "I think we will have to wait for further results before we can say definitely what the effects of OCs are in this patient population," he says.

OCs and breast cancer risk

The same genetic defects that lead to ovarian cancer also cause breast cancer. Use of combined oral contraceptives must be weighed in treatment of such women, says Narod. Breast cancer tumors appear to be sensitive to estrogen, he notes. For women with documented BRCA1 mutations, exposure to estrogen may increase their already-heightened risk for the disease, a premise his research team is studying.

"We are hoping to look at 500 women with breast cancer with BRCA1 mutations, 500 women with the same mutations who didn't get breast cancer, and compare their OC use," the researcher explains. "I think that should be finished within a year."

Clinicians need to remember that a large re-analysis[3,4] of 54 studies representing 90% of the world's data on breast cancer showed that women are not at increased risk for the disease after more than 10 years after stopping the Pill, Kaunitz notes.

"When collaborative investigators did their re-analysis and looked at OC use in women with a positive family history of breast cancer again, there was no different association than women in general," he says. "Long-term OC use had no impact on the risk of breast cancer being diagnosed later in life."

Clinicians should understand that women with a family history of breast cancer are at high risk compared with other women, Kaunitz says. It is just that the pill does not alter that risk, he explains.

OCs and oophorectomies

Women with identified BRCA mutations traditionally have had oophorectomies (removal of the ovaries) to minimize their risk of developing ovarian cancer. With data now in hand, providers may want to begin OC use in this population during the reproductive years and follow it closely with oophorectomies, Narod suggests.

"I think the combination of OCs and preventive surgery should be very close to complete prevention," he observes. "Unfortunately, I don't see the third arm of that, which is ovarian cancer screening, so I think the mainstay should be OCs and prophylactic oophorectomy." (The 1994 National Institutes of Health Consensus Development Conference on Ovarian Cancer concluded that there was no evidence to support routine ovarian cancer screening for all women.)

Rubin agrees with Narod's position and says, "From a clinician's point of view, I think it would be perfectly reasonable for these women who go on OCs to have their breasts followed carefully, and when they are through childbearing, have their ovaries removed."

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Learn from our elders: Prevent osteoporosis

By **Penelope Morrison Bosarge**
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Examine this case history: Susan is a 76-year-old Caucasian woman who presents at the emergency department via ambulance after falling in her yard. Tests reveal a severe fracture of the left wrist, which requires placement of a metal plate. Since Susan already has limited use of her right hand, she is placed in a short-term, skilled nursing facility for three weeks, where she receives physical and occupational therapy.

A review of Susan's medical history reveals a relatively sedentary lifestyle for the past 25 years. A longtime heavy smoker, she began hormone therapy after a total hysterectomy at age 45, only to abandon the course when she noted a weight gain. She has taken calcium replacements for the past 10 years, but the type and dose have varied.

This story is played out across the United States every day, with medical costs mounting as the number of bone fractures due to osteoporosis grows. What can providers do? Lifestyle changes are the answer — and they are among the most difficult to initiate in patients.

An age-old condition

Osteoporosis is not a new disease. It has been described throughout the ages as a problem of the elderly that resulted in fractures and, in many cases, disability. Hippocrates may have seen its association with nutrition when he said, "Let thy food be thy medicine and thy medicine be food."

It is said that osteoporosis is a disease that begins in adolescence. Providers can begin early prevention with education and support to young women to instill healthy eating habits that last a lifetime.

But what can be done for mid-life and mature women? Providers who are now treating members of the baby boom generation need to pay attention to Susan's case history because every patient who has poor eating habits, smokes, drinks alcohol, and reports a sedentary lifestyle, while steering away from long-term hormone therapy, is in for a challenging time.

The gold standard for prevention and stopping the progression of bone loss includes:

- balanced diet;
- calcium and vitamin D supplementation;
- exercise;
- hormone therapy for postmenopausal women.

Menopausal women who are at high risk of fractures still can benefit from calcium supplementation, as well as hormone therapy. While this benefit is not great and does not occur right away, most women can see a 50% reduction in the incidence of fractures associated with osteoporosis if exposed to estrogen for seven to 10 years.

The effects of estrogen are seen only while therapy is given, and bone is lost after estrogen is discontinued.[1]

In one study, women older than 70 who had taken estrogen for less than five years, then discontinued treatment, were evaluated for skeletal mass. Researchers found no remaining evidence of the effects of the hormones.[2] Conclusion: Estrogens should be administered long-term, probably for a lifetime.

Create a lasting plan

Providers should help patients design a lifetime program to optimize bone mass and preserve skeletal integrity:[3]

- Promote good nutrition and a diet with adequate calcium. Milk and other low-fat dairy products, leafy green vegetables, soybeans, and tofu are good calcium sources.
- Advocate regular weight-bearing exercise. Brisk walking, running, aerobics, weight training, cross-country skiing, dancing, and tennis can help the bones and improve the heart function, muscle tone, and balance.
- Strongly discourage use of tobacco and

intake of large amounts of alcohol. Both can interfere with bone health.

• Consider other preventive measures such as pharmacological therapy with bisphosphonates, calcitonin, or selective estrogen receptor modulators.[4,5,6]

An adequate calcium intake must be consumed to prevent further demineralization of bone, which may compromise the usefulness of any therapeutic or preventive plan. New national dietary guidelines specify 1,000 mg daily for all women younger than 65 who are premenopausal or taking estrogen. Women who are menopausal and not on estrogen or older than 65 should take 1,500 mg.[7]

Give careful instructions for choosing a calcium supplement and its proper administration. Make sure the supplement not only provides adequate elemental calcium but also is bioavailable.

A recent Gallup survey of U.S. women ages 45 to 75 reveals that three out of four have never spoken with their health care providers about osteoporosis.

Start the dialogue now with your patients. Remind them that although every woman's body goes through bone loss, especially in the years after menopause, not every woman will develop osteoporosis. Osteoporosis is generally preventable.

As the adage says, "Aging happens, but good health is planned."

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The Last Word

Events • Resources • News

Technology, attitudes improve birth experience

New types of pain relief, more education, and extra help when mom and baby get home are all innovations that combine to give women an **improved birthing experience**, according to an article in the October 1998 ***Redbook***.

A key development includes more comfortable labor. New types of anesthetics along with tension-reducing techniques have taken some of the pain out of labor. These comfort-producing tech-

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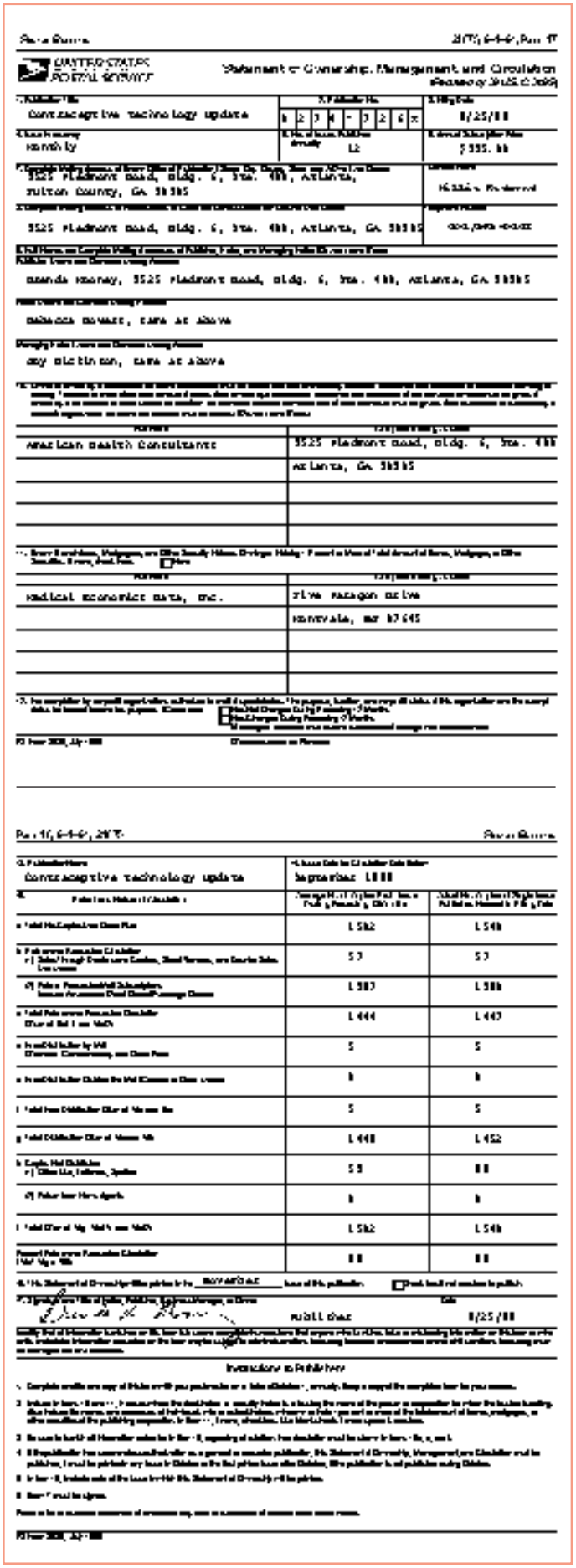

niques include lighter epidurals, massage, hypnosis, underwater births, acupuncture, and birthing balls. Perinatal care coordinators who handle patients' requests and help with the hospital paperwork and doulas who provide postpartum support as well as labor support are also key to a more pleasant birthing experience.

✧ ✧ ✧

Ten **lies about breast cancer** that some doctors still say to their patients are outlined in the October issue of ***Ladies Home Journal***. Any woman who hears these comments from her doctor should press for more information. Two of the lies presented are:

Lie: "You're too young for breast cancer."

Fact: It is estimated that 8,200 American women ages 39 and younger will be diagnosed with breast cancer in 1998. Breast exams should begin at age 20, and mammograms should be performed annually from age 40.

Lie: "You don't have a family history of breast cancer so you're not at risk."

Fact: Hereditary breast cancer accounts for only 5% to 10% of cases. In the other 90 to 95%, cells become cancerous spontaneously,, with no known cause. ■