

## BREAST CONDITIONS IN FAMILY PLANNING

This *Clinical Practice Alert* (CPA) implements changes in national guidelines and addresses the impact of common breast conditions on contraceptive management. Unless otherwise stated, Family PACT has adopted the guidelines of the United States (U.S.) Preventive Services Task Force (USPSTF)<sup>1</sup> and the U.S. Medical Eligibility Criteria (US-MEC).<sup>2</sup>

### KEY POINTS

- In women with a benign breast condition or a family history of breast cancer, all methods of contraception are US-MEC Category 1.\*
- All hormonal methods of contraception can be continued while a woman with a breast mass is being evaluated.
- While the routine teaching of breast self-examination (BSE) is no longer recommended, all female clients should be advised to report changes in their breasts to their clinician.
- The recommended interval for screening mammography is every two years. The benefit of biennial mammograms is similar to annual mammography but the longer interval results in a substantial reduction in false positives.

### QUESTIONS AND ANSWERS: CONTRACEPTION AND BREAST CONDITIONS

#### **Do any benign breast conditions impact contraceptive choice?**

No. All methods are US-MEC Category 1\* in women with benign breast conditions, including fibrocystic change and fibroadenoma. Fibroadenomas are solid benign breast tumors that occur mainly in young women that must be confirmed either with fine needle aspiration biopsy or diagnostic imaging (not Family PACT benefits).

#### **Are oral contraceptives a good treatment for pre-menstrual breast pain (cyclic mastodynia)?**

Oral contraceptives (OC) usually reduce cyclical breast pain symptoms in women with fibrocystic breasts and reduce the likelihood of requiring a biopsy for a benign breast cyst. Premenstrual breast tenderness is avoided entirely with an extended OC regimen.

#### **Does a family history of breast cancer or susceptibility genes (BRCA1 or -2) affect contraceptive decisions?**

No. All hormonal methods in women with a family history of breast cancer are US-MEC Category 1.\* While a woman with a family history of breast or ovarian cancer has an increased risk of developing cancer, hormonal contraceptives do not increase her risk.

#### **What should I do if I find an area of breast “fullness” on breast exam that is not a discrete mass?**

It is not uncommon to discover a focal area of breast “fullness” due to fibrocystic change (as opposed to a dominant nodule). This can be managed conservatively with watchful waiting if the client is premenopausal, the area does not have “measurable” dimensions, and there are no physical signs of breast cancer. Have the client return after her next menses. If the suspicious area is the same size or larger, refer for expert evaluation.

- Useful algorithms describing the management of women with breast complaints or abnormal mammograms have been developed by the California Department of Public Health and can be found at <http://qap.sdsu.edu/screening/breastcancer/bda>.

#### **Should hormonal contraceptives be discontinued immediately if a woman is found to have a breast mass?**

Not necessarily. While women with a dominant breast nodule should be referred for expert evaluation, diagnostic testing can take weeks or longer until diagnosis. Evaluation and treatment of breast cancer is more difficult if the withholding of contraceptives results in unintended pregnancy. In addition, even if a breast cancer is present, short term hormone exposure is unlikely to affect outcome. In a woman with an undiagnosed breast mass, the US-MEC make the following recommendations:

- OCs, patch, ring, injections, implants, and the levonorgestrel intrauterine system (LNG-IUS): US-MEC Category 2\*
- Copper IUC: US-MEC Category 1\*

#### **Can a woman with previously treated breast cancer use a hormonal method of contraception?**

There are no studies that evaluate breast cancer recurrence rates in women using contraceptive hormones, but since breast cancer is a hormonally sensitive tumor, there is concern that contraceptive hormones may increase recurrence risk.

- For women treated for breast cancer within five years, all hormonal methods are US-MEC Category 4.\*
- If there is no evidence of recurrence for at least five years after diagnosis, OCs, patch, ring, injections, implants, and the LNG-IUS are US-MEC Category 3.\*
- For women who are being treated for, or who have a history of, breast cancer, the copper IUC is US-MEC Category 1.\*

#### **How should a woman with a nipple discharge be evaluated?**

- Because of the risk of intraductal papilloma or carcinoma, a woman with a bloody or brownish nipple discharge should be referred for expert evaluation.
- If the client's nipple discharge appears milky, an evaluation for galactorrhea should be initiated by ordering a prolactin level (not a Family PACT benefit). Women using OCs may have mild elevation of prolactin sufficient to cause galactorrhea, especially during hormone-free days. The prolactin level is usually under 50 ng/mL, and never more than 100 ng/mL. Hormone-induced elevation in prolactin levels should resolve within six months of hormone discontinuation.

\* Refer to CDC. **U.S Medical Eligibility Criteria for Contraceptive Use, 2010** MMWR 2010;59 RR-4.

## BREAST CONDITIONS IN FAMILY PLANNING (CONTINUED): JULY 2011

### Should women be routinely instructed in the performance of breast self-examination (BSE)?

The USPSTF recommends against clinicians teaching women to perform BSE (Grade D). This is based on two large randomized clinical trials that did not show improved breast cancer outcomes in women who regularly performed BSE compared to those who did not. If asked, clinicians should explain the benefits and hazards of BSE and offer instruction if requested.

### Is a clinical breast exam (CBE) required before the prescription of hormonal contraceptives?

The USPSTF concludes that the current evidence is insufficient to assess the additional benefits and harms of a CBE beyond screening mammography and makes no recommendation. However, the American Cancer Society recommends a CBE at least every three years between 20-39 years of age, and then annually beginning at age 40<sup>3</sup> and the American College of Obstetricians and Gynecologists recommends an annual CBE starting at 19 years of age.<sup>4</sup> Since 5-15 percent of women with a palpable breast cancer will have a falsely negative mammogram often owing to a higher degree of breast density, a CBE should be seen as an adjunct to mammography. Given the differences in these guidelines in the interval between 20-39 years of age, each provider site should develop a policy regarding the age to begin routine CBEs and designate screening intervals in your practice. A CBE should not be required for the prescription of hormonal contraceptives at any age.

### When should women initiate screening mammograms and how often should they be done?

The USPSTF recommends:

- Biennial (every other year) screening mammography for women between the ages of 50 and 74 years
- Against *routine* mammography in women aged 40-49 years. If ordered, screening mammograms should be done biennially

This statement should not be interpreted to mean that mammograms should not be performed in this age group. Instead, the decision must be an individual one that “takes into account patient context, including the patient’s values regarding specific benefits and harms.” Clinicians should routinely *counsel* women regarding the pros and cons of mammography and leave the decision to the client.

- Benefit: 15-30 percent reduction in breast cancer mortality in women 40-59 years of age who obtain biennial mammograms.<sup>5</sup>
- Harms: risk of over-diagnosis (unnecessary imaging tests, biopsies in women without cancer, inconvenience due to false positive test results) and over-treatment of breast cancer that would not have become apparent during her lifetime or would have become apparent, but would not have shortened her life. Radiation exposure from mammograms is a minor concern.

### What is the best way to evaluate a women’s risk of developing breast cancer?

Two web-based tools for evaluating an individual’s breast cancer risks are:

- *The Breast Cancer Risk Assessment Tool*, sponsored by the National Cancer Institute, which projects a woman’s individualized risk for invasive breast cancer over a five-year period and her lifetime. It can be found at [www.cancer.gov/bcrisktool](http://www.cancer.gov/bcrisktool).
- *The Detailed Breast Cancer Risk Calculator* which produces estimates using the Gail Model 1 and National Surgical Adjuvant Breast and Bowel Project (NSABP) Model-2. It is located at [www.halls.md/breast/risk.htm](http://www.halls.md/breast/risk.htm).

## APPLICATION OF FAMILY PACT POLICY

### Does Family PACT cover digital mammograms?

Yes. A number of clinical trials have shown improved accuracy of digital mammograms in pre- and perimenopausal women, those under 50 years of age, and women with dense breasts. In addition, many breast imaging centers no longer offer film mammography and digital mammography is the only locally available option. Family PACT benefits include screening mammograms, but not diagnostic mammography.

### Can women be enrolled in Family PACT solely because a payer is needed for a screening mammogram or breast diagnostic services?

No. Family PACT is a limited-benefit family planning and reproductive health program. Eligibility for Family PACT is based upon a client’s need for family planning services.

### If a woman has an abnormal mammogram and needs additional studies, such as a diagnostic mammogram or biopsy, or if she requires treatment for breast cancer, where can financial support be found?

When a woman requires a medically necessary service and does not have other coverage, the Cancer Detection Programs: Every Woman Counts (CDP: EWC) may cover diagnostic testing. The state program affiliated with the CDC *Breast and Cervical Cancer Treatment Program* (BCCTP) may provide support for treatment of breast cancer. Family PACT providers can enroll clients in the CDP: EWC and BCCTP via an internet application.<sup>6</sup>

### Since this CPA recommends biennial screening mammograms, will Family PACT cover annual mammograms?

Providers are expected to educate clients with information that is consistent with the content of this CPA. However, if a client chooses to have annual screening mammograms, the Program continues to offer this coverage; however, the client should be counseled about the benefits and risks.

*Providers should refer to the Family PACT Policies, Procedures, and Billing Instructions for the complete text of the Family PACT standards, official administrative practices, and billing information.*

## References

1. USPSTF. Screening for breast cancer: U.S. Preventive Services Task Force recommendation statement. *Ann Intern Med.* 2009 151(10):716-26.
2. CDC, U.S. Medical Eligibility Criteria for Contraceptive Use, 2010: adapted from the World Health Organization Medical Eligibility Criteria for Contraceptive Use, 4th edition. *MMWR Recomm Rep.* 2010 Jun 18;59(RR-4):1-86.
3. Smith RA, Cokkinides V, Brooks D, Saslow D, Brawley OW. Cancer screening in the United States, 2010: a review of current American Cancer Society guidelines and issues in cancer screening. *CA Cancer J Clin.* 2010;60(2):99-119.
4. [ACOG Committee Opinion No. 483: Primary and preventive care: periodic assessments](#). ACOG Committee on Gynecologic Practice. *Obstet Gynecol.* 2011 Apr;117(4):1008-15.
5. Tabár L, et al. Swedish Two-County Trial: Impact of Mammographic Screening on Breast Cancer Mortality during 3 Decades. *Radiology.* 2011 Jun 28. (Epub ahead of print)
6. CDP: EWC: <http://www.cdph.ca.gov/programs/CancerDetection/Pages/CancerDetectionProgramsEveryWomanCounts.aspx>.