

Cancer Screening and Early Detection Guidelines

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Director**

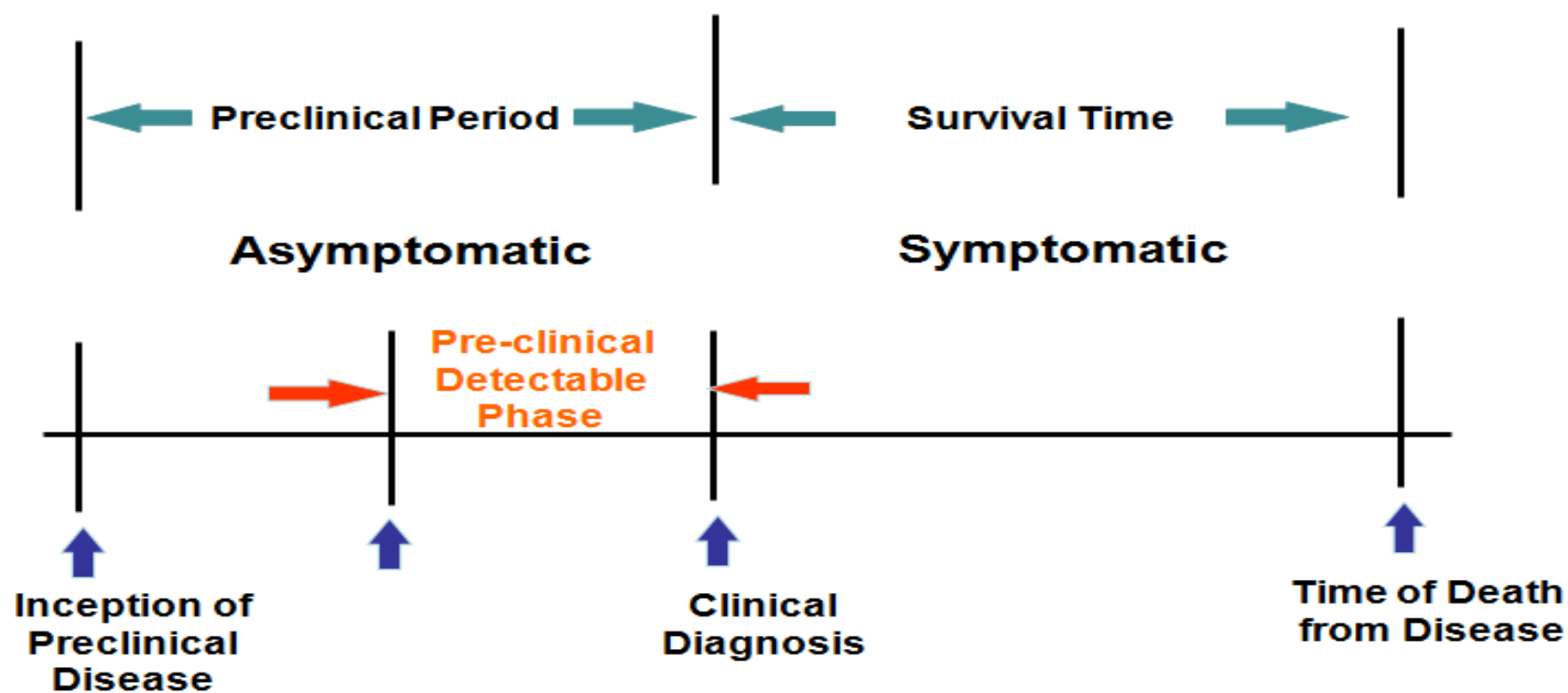
**Cancer Control and Population Sciences Program
University of Puerto Rico
Comprehensive Cancer Center**

ASPPR Clinical Summit

Objectives

- Define Screening
- Review the Implication of Cancer Screening
- Identify the Rational for Cancer Screening
- Review Current Cancer Screening Guidelines
 - Average Risk Populations
 - High Risk Populations
- Discuss the Role of Primary Providers in Cancer Screening

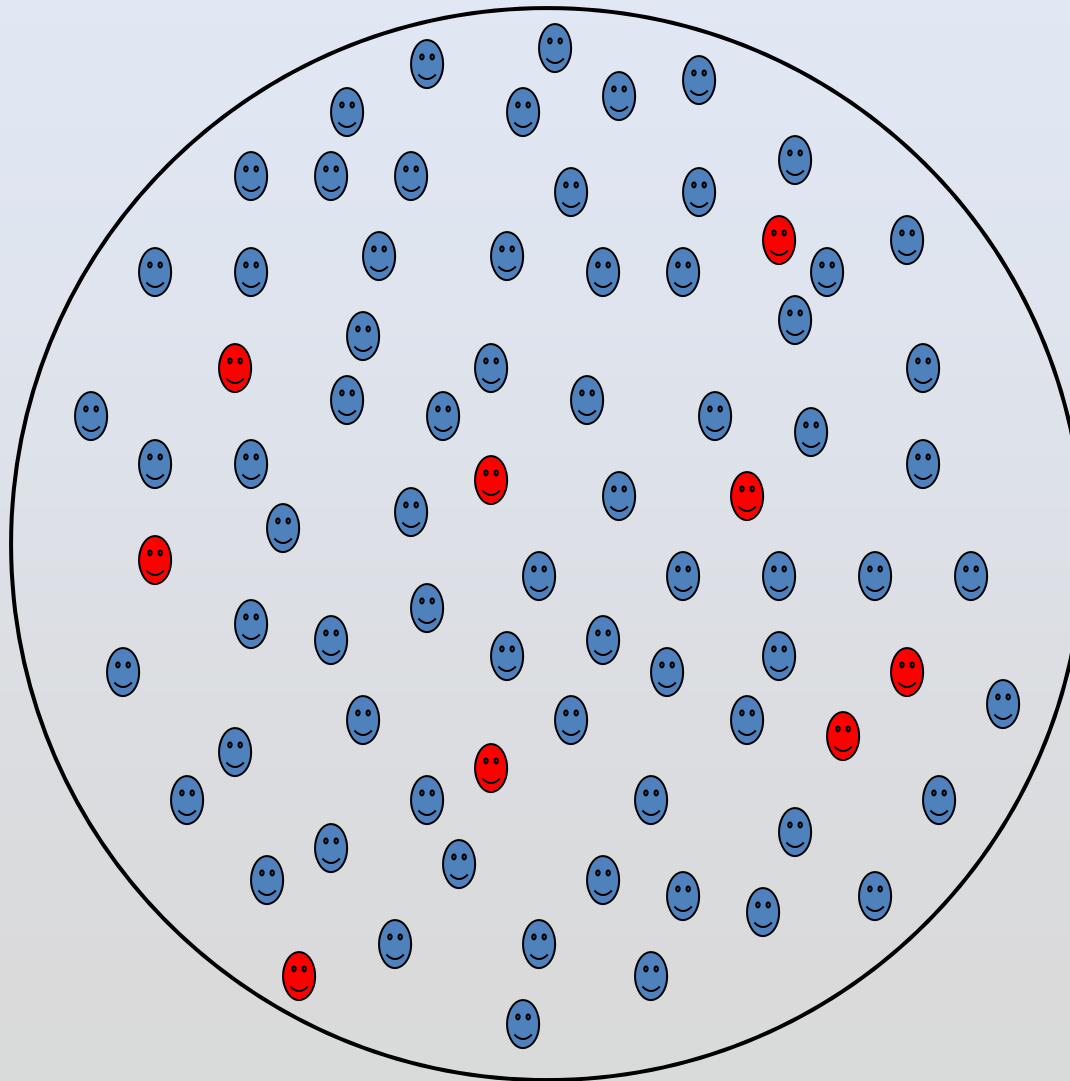
NATURAL HISTORY OF DISEASE WITHOUT SCREENING



WHAT IS SCREENING?

Systematic examination of ***asymptomatic***
Individuals to detect and treat subclinical
disease

Screening Population



Healthy Individual



Disease
Asymptomatic
Individual

Implication of Screening in the Population

- **Small risks of serious complications associated with procedures**
 - Immediate (e.g., perforation with colonoscopy)
 - Delayed (e.g., potential carcinogenesis from radiation)
- **False-positive test resulting in:**
 - Anxiety
 - Unnecessary invasive diagnostic procedures
 - Higher risks of serious complications associated with procedures

Implication of Screening in the Population

- **False-negative screening test:**
 - Falsely reassure an individual
 - Delay diagnosis
 - Delay effective treatment
- **Over-diagnosis-** the diagnosis of a condition that would not have become clinically significant had it not been detected by screening
 - Becoming more common as screening tests become more sensitive at detecting tiny tumors

Criteria for Mass Screening Program

1. Disease of interest should represent a **public health problem** and have a **prevalent, asymptomatic non-metastatic phase**
 - Breast Cancer
 - Colon Cancer
 - Cervical Cancer
 - Prostate Cancer
 - Lung Cancer

Criteria for Mass Screening Program

2. Disease should have a **recognizable**
asymptomatic, nonmetastatic phase
3. Screening test:
 - **Reasonable** sensitivity, specificity, and predictive value
 - **Low** risk and cost
 - **Acceptable** to both screener and person screened

Criteria for Mass Screening Program

4. **Available therapeutic measurements** with higher curative potential in early than advanced stages of disease
5. **Treatment** of screened-detected patients should **improve outcome** (*cause-specific mortality*)

***RATIONAL FOR CANCER
SCREENING***

World Cancer Burden: GLOBOCAN 2012

- **14.1** million new cancer cases
- **8.2** million cancer deaths
- **32.6** million people living with cancer (within 5 years of diagnosis)
- Estimated to double by **2030**
 - **21** million new cancer cases
 - **13** million Deaths
- Developing world: **56%** of the cases and **64%** of the deaths

Burden of Cancer, U.S. 2014

- Cancer **2nd** leading cause of death
- Accounts for approximately **25%** of all deaths
- Estimated **1,665,540** new cases
- Estimated **585,720** deaths
- Estimated **13,683,850** cancer survivors
- By 2022, **18 million** cancer survivors

Burden of Cancer Puerto Rico, 2008-2012

- Cancer **2st** leading cause of death in Puerto Rico
- Accounts for approximately **25%** of all deaths
- **70,751** new cancer cases were diagnosed
- **20,725** died from cancer
- **61,928** Cancer Survivor (1987-2010)

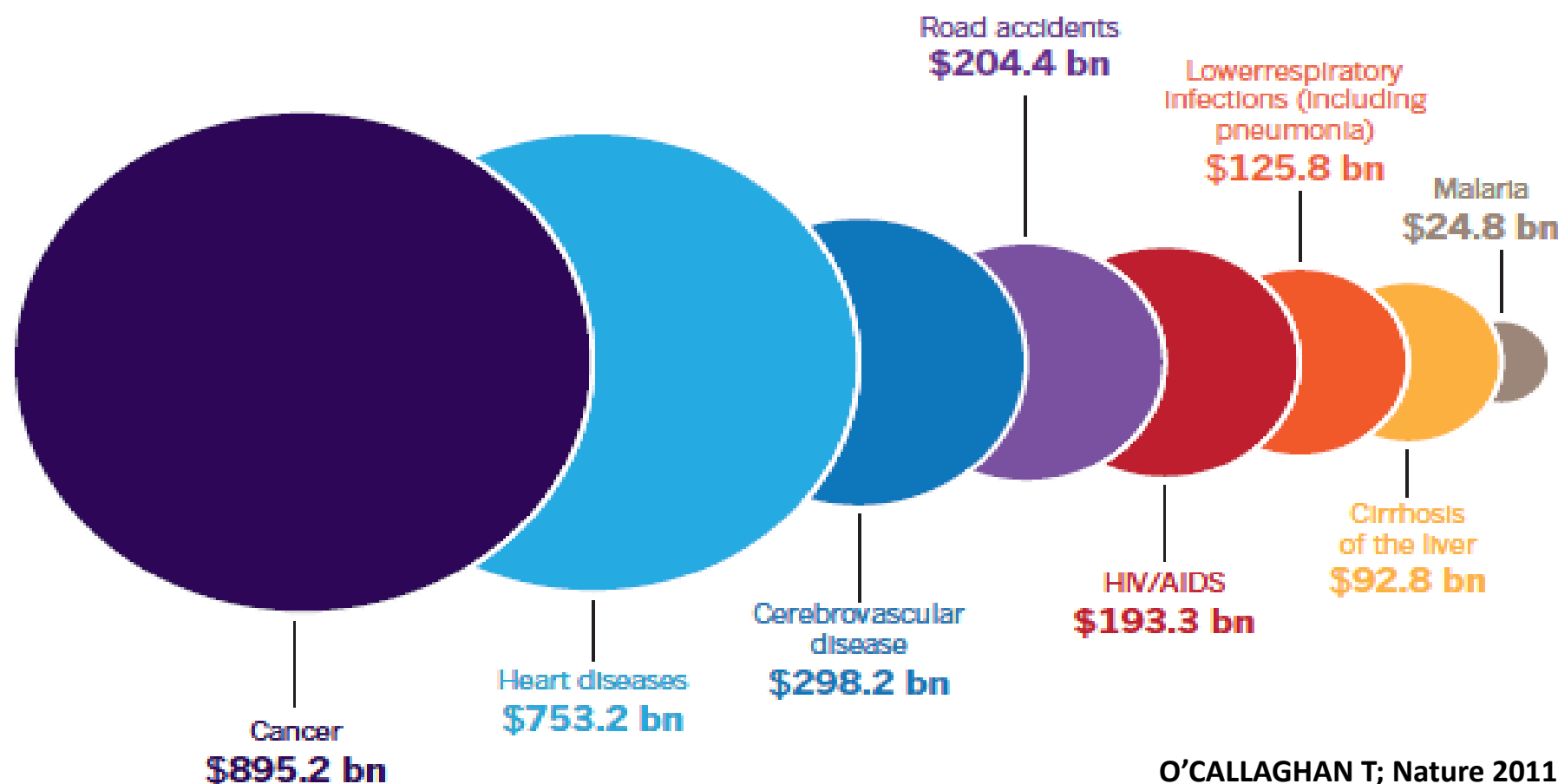
Data Source: Incidence Case File of Puerto Rico from the Puerto Rico Central Cancer Registry (January 9, 2015).

Population Source: Vintage 2012 estimates series from the Population Division of the United States Census Bureau.

Global Cost of Cancer

COUNTING THE COST OF CANCER

The burden of cancer, calculated as the cost of years lost from ill-health, disability or early death, outweighs all other health concerns.



U.S. Cost of Cancer

- Cancer is **costly** disease
 - reduction of quality and years of life
 - monetary costs
- 2008 estimated **overall costs of cancer** in at **\$228.1 B**
 - **Direct costs \$93.2 B** (medical cost)
 - **Indirect cost**
 - Lost productivity due to illness **\$18.8 B**
 - Lost productivity due to premature death **\$116.1 B**

Table 1. Preliminary estimate of economic costs of cancer for Puerto Rico for the period 2002-2006. Indirect cost is approximately twice the direct medical costs. Puerto Rico Central Cancer Registry, 2008.

Estimate of Economic Costs of Cancer in Puerto Rico, 2002-2006*					
Expenditures (In millions of dollars)	Fiscal Years				
	2002	2003	2004	2005	2006
Total Medical Care Expenditures	\$6,768.8	\$6,960.4	\$7,162.5	\$7,527.7	\$7,935.3
Direct Medical Costs of Cancer	\$338.4	\$348.0	\$358.1	\$376.4	\$396.8
Indirect Costs	\$687.1	\$706.5	\$727.0	\$764.1	\$805.5
Morbidity	\$102.5	\$105.5	\$108.5	\$114.0	\$120.2
Mortality	\$584.5	\$601.1	\$618.5	\$650.1	\$685.3
Total Estimated Costs of Cancer	\$1,025.5	\$1,054.5	\$1,085.1	\$1,140.4	\$1,202.2
					15%

* Notes: 1) Data source of Total Medical Care Expenditures: Puerto Rico Planning Board, Program of Economic and Social Planning, Subprogram of Economic Analysis. 2) To calculate the direct cost of services for cancer patients it is assumed that 5.0% of the total spent on health services in Puerto Rico are consumed by this condition. 3) It is assumed that the total cost of cancer for the whole society is divided into 33% for direct costs, 10% in costs related to the morbidity, and 57% related to costs of mortality.

Rational for Cancer Screening

- Early detection  ***5-year survival rate***
- Early detection  ***quality of life***
- Screening  ***mortality***

Rational for Cancer Screening

- Research has established that early detection of cancer through screening reduces mortality from:
 - Uterine Cervix
 - Breast
 - Cancers of the Colon and Rectum
 - Lung

Rational for Cancer Screening

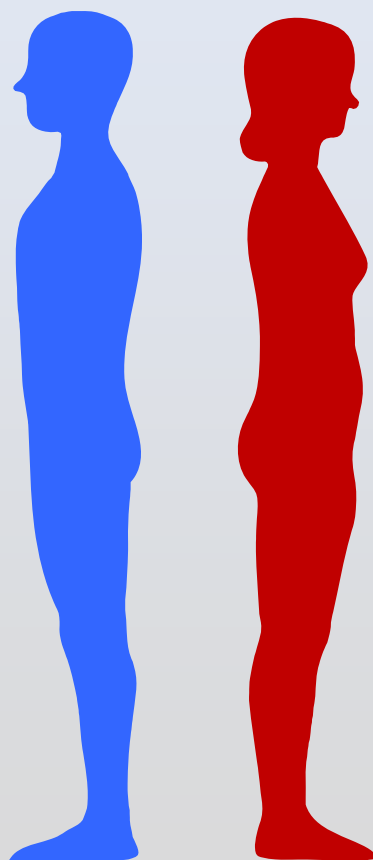
- In addition to detecting cancer early, screening for colorectal or cervical cancers can prevent cancer by identifying and removing abnormalities that may become precancerous and prevent potential progression to cancer

Top Ten Incidence Cancer Sites In Puerto Rico, 2008-2012

Males (N=38,054) %

Females (N=32,725) %

Prostate	39.6
Colon and Rectum	12.9
Lung and Bronchus	6.1
Urinary Bladder	4.2
Oral Cavity and Pharynx	4.0
Non-Hodgkin Lymphoma	3.6
Liver and Intrahepatic Bile	3.1
Stomach	2.6
Kidney and Renal Pelvis	2.5
Leukemia	2.3
Other Locations	19.1



Breast	29.9
Colon and Rectum	12.3
Thyroid	10.0
Corpus and Uterus, NOS	7.6
Lung and Bronchus	4.1
Non-Hodgkin Lymphoma	4.0
Cervix Uteri	3.7
Ovary	2.5
Stomach	2.2
Leukemia	2.2
Other Locations	21.6

Data Source: Incidence Case File of Puerto Rico from the Puerto Rico Central Cancer Registry (January 9, 2015).

***Screening
Guidelines for Breast,
Cervical, and
Colorectal Cancer in
the U.S.***

Cancer Screening Guidelines

- U.S. Preventive Services Task Force (USPSTF)
- American Cancer Society
- American College of Obstetricians and Gynecologists
- American Society for Colposcopy and Cervical Pathology
- American College of Gastroenterology
- American Society for Gastrointestinal Endoscopy
- U.S. Multi-Society Task Force on Colorectal Cancer
- American College of Radiology

Cancer Screening Guidelines

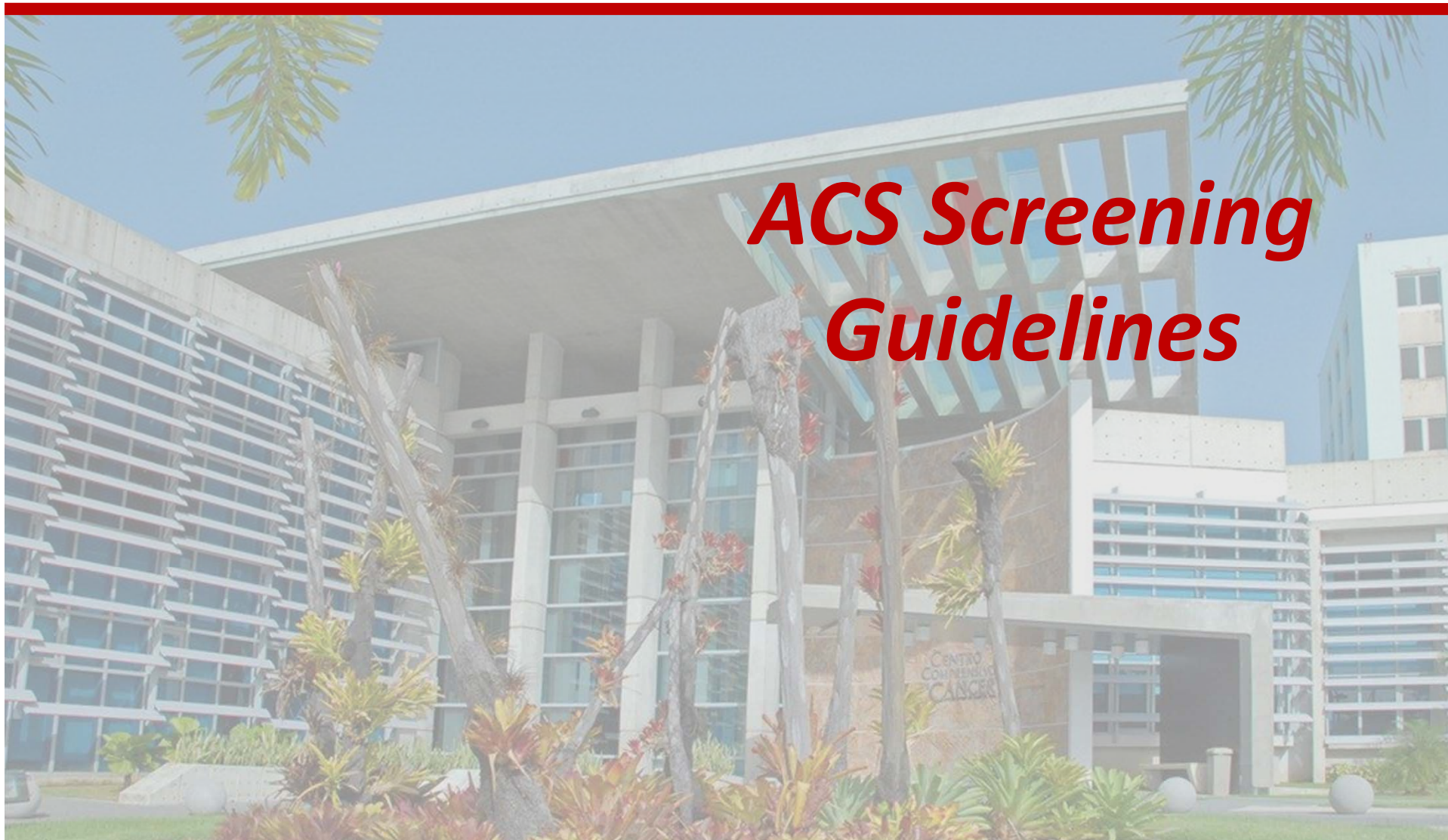
- U.S. Multi-Society Task Force on Colorectal Cancer
- (USMSTF, which represents the American College
- of Gastroenterology, American Gastroenterological
- Association, and American Society for
- Gastrointestinal
- Endoscopy), and the American College of Radiology

TABLE 1. History of Recent Updates to ACS Cancer Early Detection Guidelines

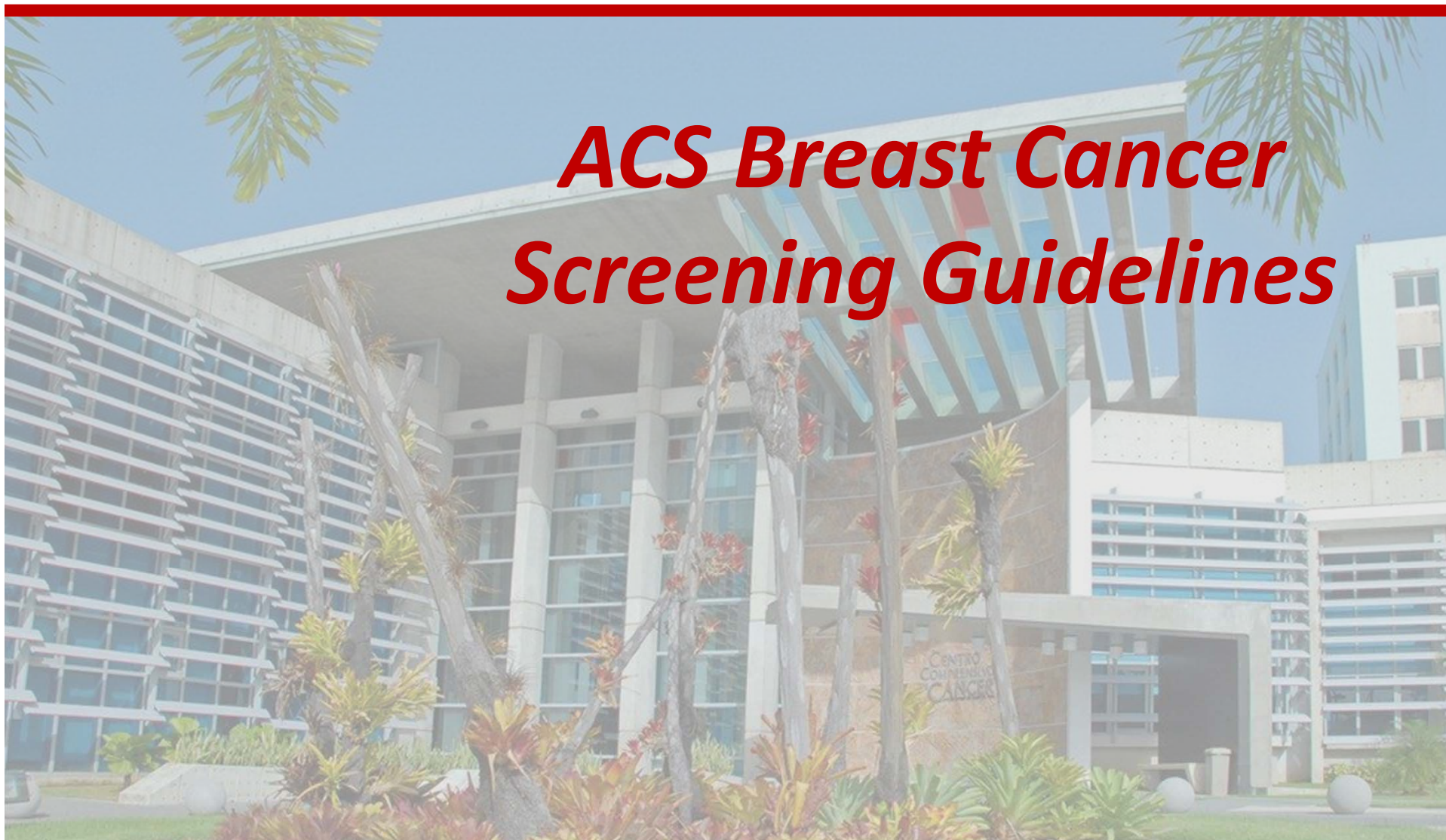
CANCER SITE	YEAR
Breast cancer	2003, Complete update ³
	2007, Guidelines for MRI use in high-risk women ⁴
	2013, Update anticipated
Cervical cancer	2002, Complete update ⁵
	2007, Guidelines for HPV vaccine use ⁶
	2012, Complete update ⁷
Colorectal cancer	2001, Complete update ⁸
	2003, Technology update ⁹
	2006, Update for postpolypectomy and postcolorectal cancer resection surveillance ^{10,11}
	2008, Complete update ¹²
Endometrial cancer	2001, Guidance for counseling, shared decision-making, and high-risk women ⁸
Prostate cancer	2001, Guidance for shared decision-making related to testing for early detection and screening recommendations for higher-risk men ⁸
	2010, Complete update ¹³
Lung cancer	2001, Guidance for shared decision-making ⁸
	2011, Interim guidance on lung cancer screening ¹⁴
	2013, Complete update ¹⁵

ACS indicates American Cancer Society; MRI, magnetic resonance imaging; HPV, human papillomavirus.

ACS Screening Guidelines



ACS Breast Cancer Screening Guidelines



Breast Cancer Screening Guidelines

- Annual mammograms beginning at age 40

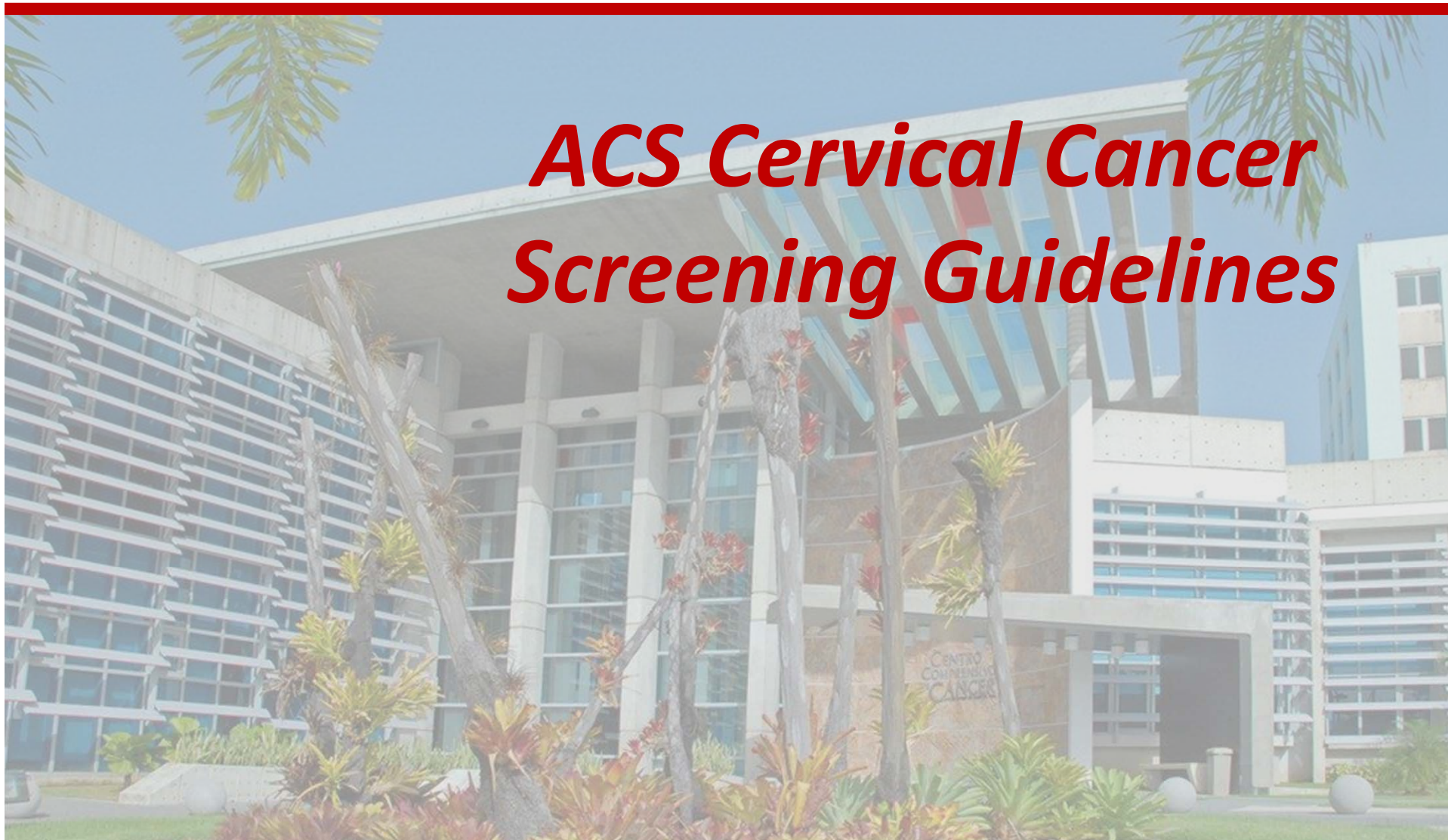
- Clinical breast exam:
 - Ages 20-39, as part of a periodic health exam at least every 3 years
 - Ages 40+, prior to mammogram as part of a periodic health exam annually.

- Breast self-exam:
 - Optional; beginning in their early 20s, women should be told about the benefits and limitations of breast-self examination. Women should know how their breasts normally feel and report any breast changes promptly to their health care providers.

BREAST CANCER SCREENING IN HIGH-RISK WOMEN

- **High Risk women:**
 - Known or likely carriers of a BRCA mutation
 - Other rarer high-risk genetic syndromes
 - Treated with radiation to the chest for Hodgkin disease
- Mammography and MRI ***annually starting at age 30 years***

ACS Cervical Cancer Screening Guidelines



Cervical Cancer Screening Guidelines

- Cervical cancer screening should begin at age 21.
- Preferred screening test/s and frequency vary by age:

<u>Age</u>	<u>Frequency</u>	<u>Test</u>
21-29	Every 3 yrs	Pap test*
30-65†	Every 5 yrs	HPV & Pap tests

*Conventional or liquid-based test.

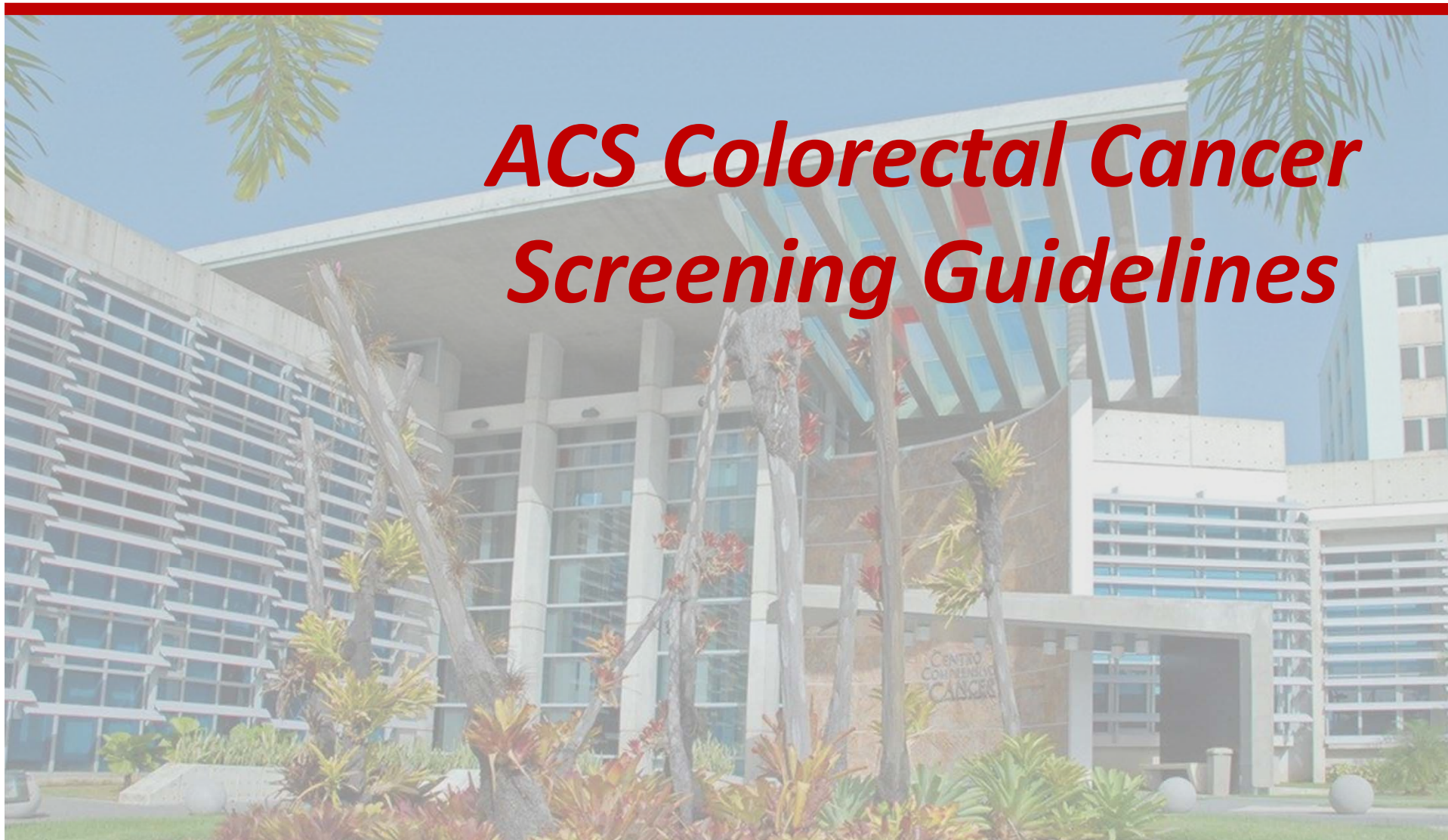
†Every 3 years with the Pap test alone is acceptable.

- Women should stop screening:
 1. At age 66 with adequate negative prior screening
 - ≥ 3 consecutive negative Pap tests within 10 yrs, most recent within 5 yrs **OR**
 - ≥ 2 consecutive negative HPV and Pap tests within 10 yrs, most recent within 5 yrs
 2. After hysterectomy

Guidelines for Cervical Cancer Screening among High Risk Women

- History of CIN2+
 - Continue routine screening recommendations for at least 20 years, even beyond age 65 years
- Immune compromised
 - Tested twice during the first year after diagnosis/treatment
 - Annually thereafter
- No age limit

ACS Colorectal Cancer Screening Guidelines



Colorectal Cancer Screening Guidelines*

Beginning at age 50, men and women should follow one of the following examination schedules:

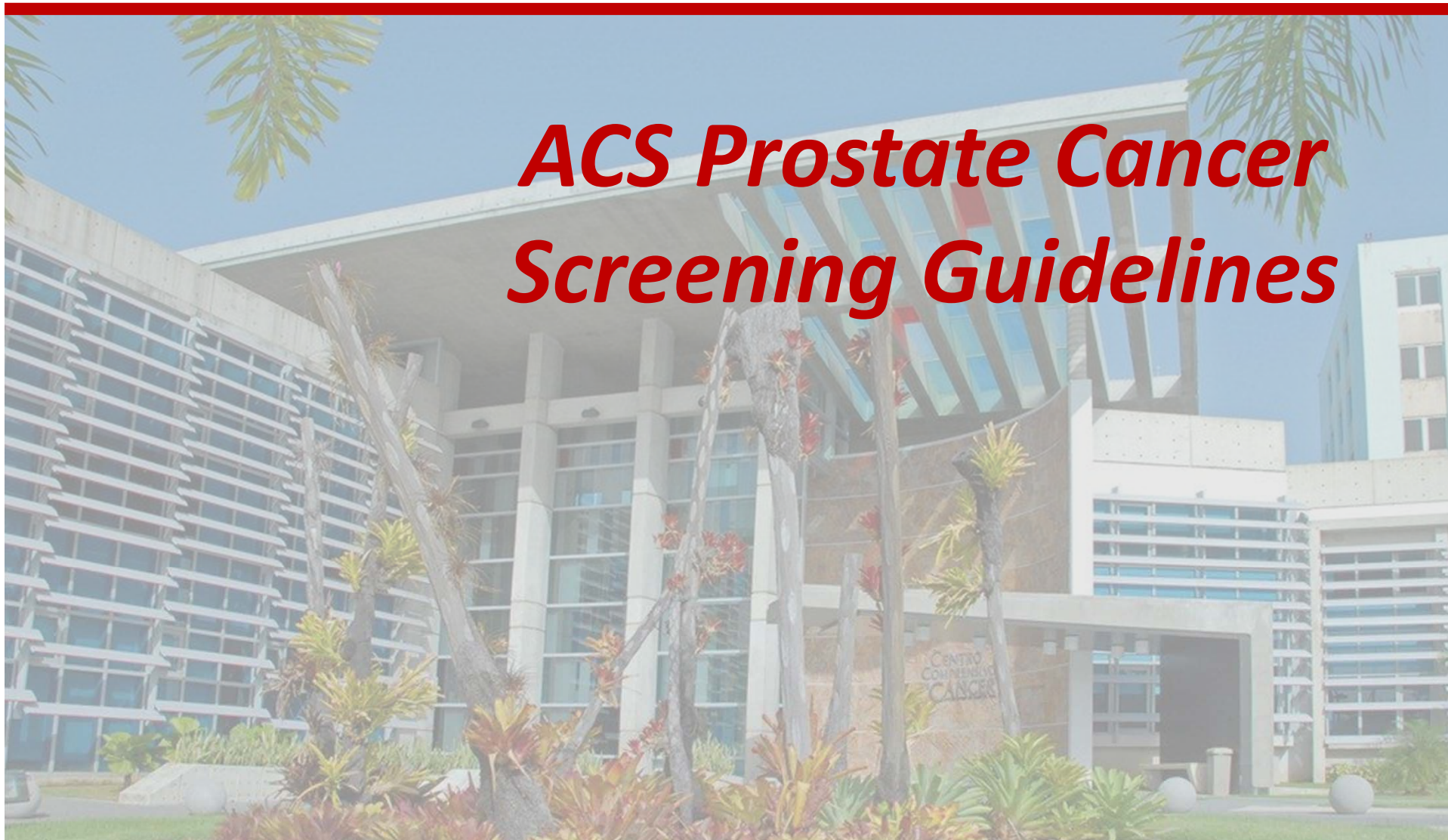
Test	Time interval
Fecal occult blood test: FOBT/FIT	Annual
Flexible sigmoidoscopy	5 yrs
Double contrast barium enema	5 yrs
Colonoscopy	10 yrs
CT Colonography	5 yrs

*For people at average risk; individuals at higher risk should talk with a doctor about a different testing schedule.

CRC Cancer Screening Guidelines for High Risk Populations

- **Beginning at early age and more frequent**
 - HX. of adenomatous polyps
 - HX. of curative-intent resection of CRC
 - Family HX. of CRC or colorectal adenomas diagnosed in a first-degree relative
 - HX. of inflammatory bowel disease of significant duration
 - Known or suspected presence of hereditary nonpolyposis colon cancer (HNPCC) or familial adenomatous polyposis

ACS Prostate Cancer Screening Guidelines



Prostate Cancer Screening Guidelines

- Men with at least a 10-year life expectancy should have an opportunity to make an informed decision with their health care provider about:
 - Screening with DRE and PSA after receiving information about the benefits, risks, and uncertainties of screening

TABLE 3. Core Elements of the Information to be Provided to Men to Assist With Their Decision Regarding Prostate Cancer Screening⁴

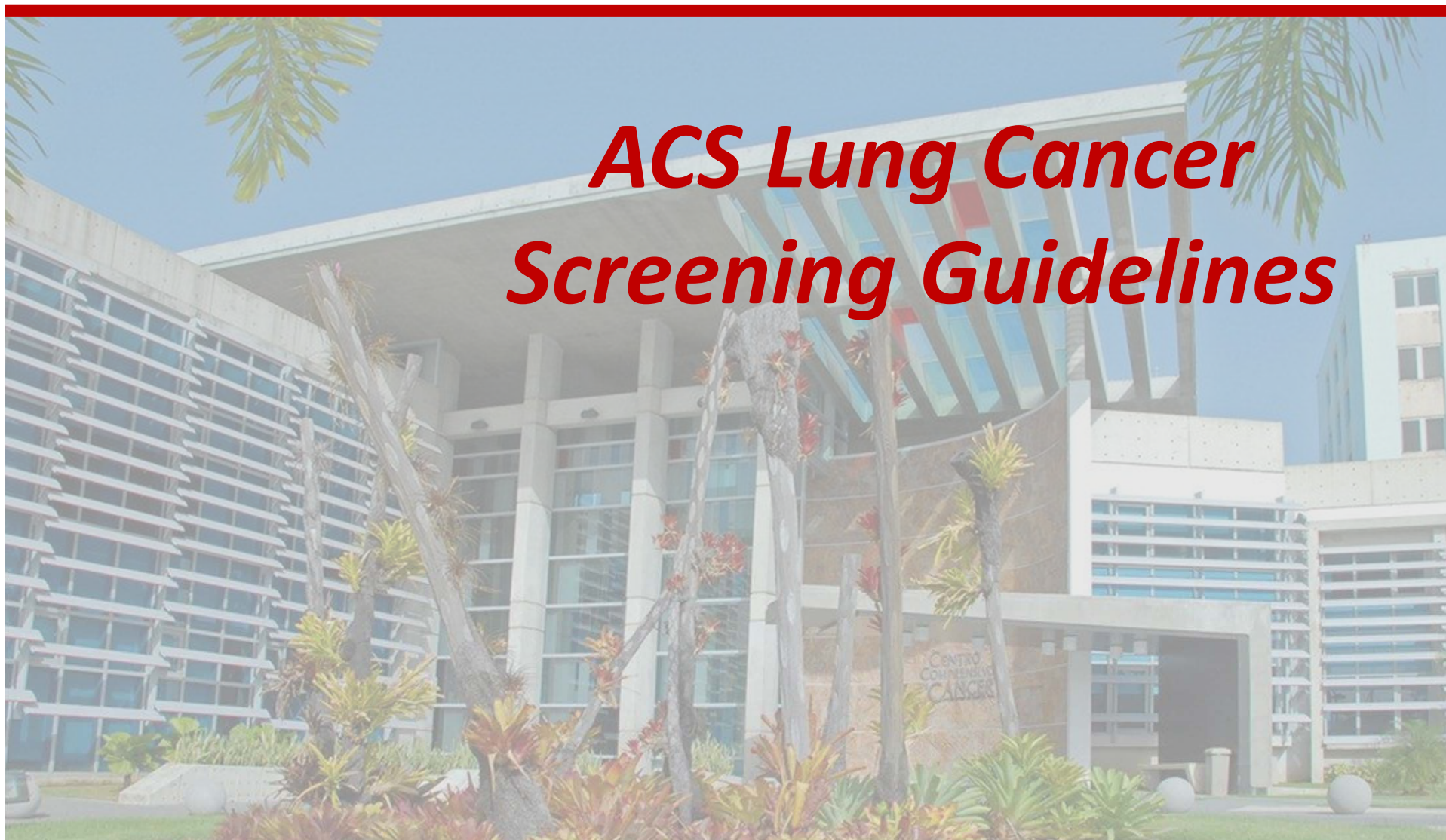
Prostate cancer is an important health concern for men:
• Screening with the PSA blood test alone or with both the PSA and DRE detects cancer at an earlier stage than if no screening is performed.
• Prostate cancer screening may be associated with a reduction in the risk of dying from prostate cancer. However, evidence is conflicting and experts disagree about the value of screening.
• For men whose prostate cancer is detected by screening, it is currently not possible to predict which men are likely to benefit from treatment. Some men who are treated may avoid death and disability from prostate cancer. Others who are treated would have died of unrelated causes before their cancer became serious enough to affect their health or shorten their lives.
• Depending on the treatment selected, treatment of prostate cancer can lead to urinary, bowel, sexual, and other health problems. These problems may be significant or minimal, permanent or temporary.
• The PSA and DRE may have false-positive or false-negative results, meaning men without cancer may have abnormal results and undergo unnecessary additional testing, and clinically significant cancers may be missed. False-positive results can lead to sustained anxiety about prostate cancer risk.
• Abnormal results from screening with the PSA or DRE require prostate biopsies to determine whether the abnormal findings are cancer. Biopsies can be painful, may lead to complications such as infection or bleeding, and can miss clinically significant cancer.
• Not all men whose prostate cancer is detected through screening require immediate treatment, but they may require periodic blood tests and prostate biopsies to determine the need for future treatment.
• In helping men to reach a screening decision based on their personal values, once they understand the uncertainties, risks, and potential benefits, it can be helpful to provide reasons why some men decide for or against undergoing screening. For example: ■ A man who chooses to be screened might place a higher value on finding cancer early, might be willing to be treated without definite expectation of benefit, and might be willing to risk injury to urinary, sexual, and/or bowel function. ■ A man who chooses not to be screened might place a higher value on avoiding the potential harms of screening and treatment, such as anxiety or risk of injury to urinary, sexual, and/or bowel function.

PSA indicates prostate-specific antigen; DRE, digital rectal examination.

Guidelines for Prostate Cancer Screening among High Risk Men

- **Higher Risk:** Information beginning at age 45 years
 - African American men
 - HX. Family member (father or brother) with prostate cancer
- **Appreciably Higher Risk:** before Information age 40 years
 - Multiple family members diagnosed with prostate cancer before age 65 years

ACS Lung Cancer Screening Guidelines



Lung Cancer Screening Guidelines

- Clinicians with access to high-volume, high-quality lung cancer screening and treatment centers should:
 - Ascertain smoking status and smoking history of patients aged 55 years to 74 years
 - Initiate discussion about lung cancer screening with those who have:
 - At least a 30 pack-year smoking history
 - Currently smoke
 - Have quit within the past 15 years
 - Are in relatively good health

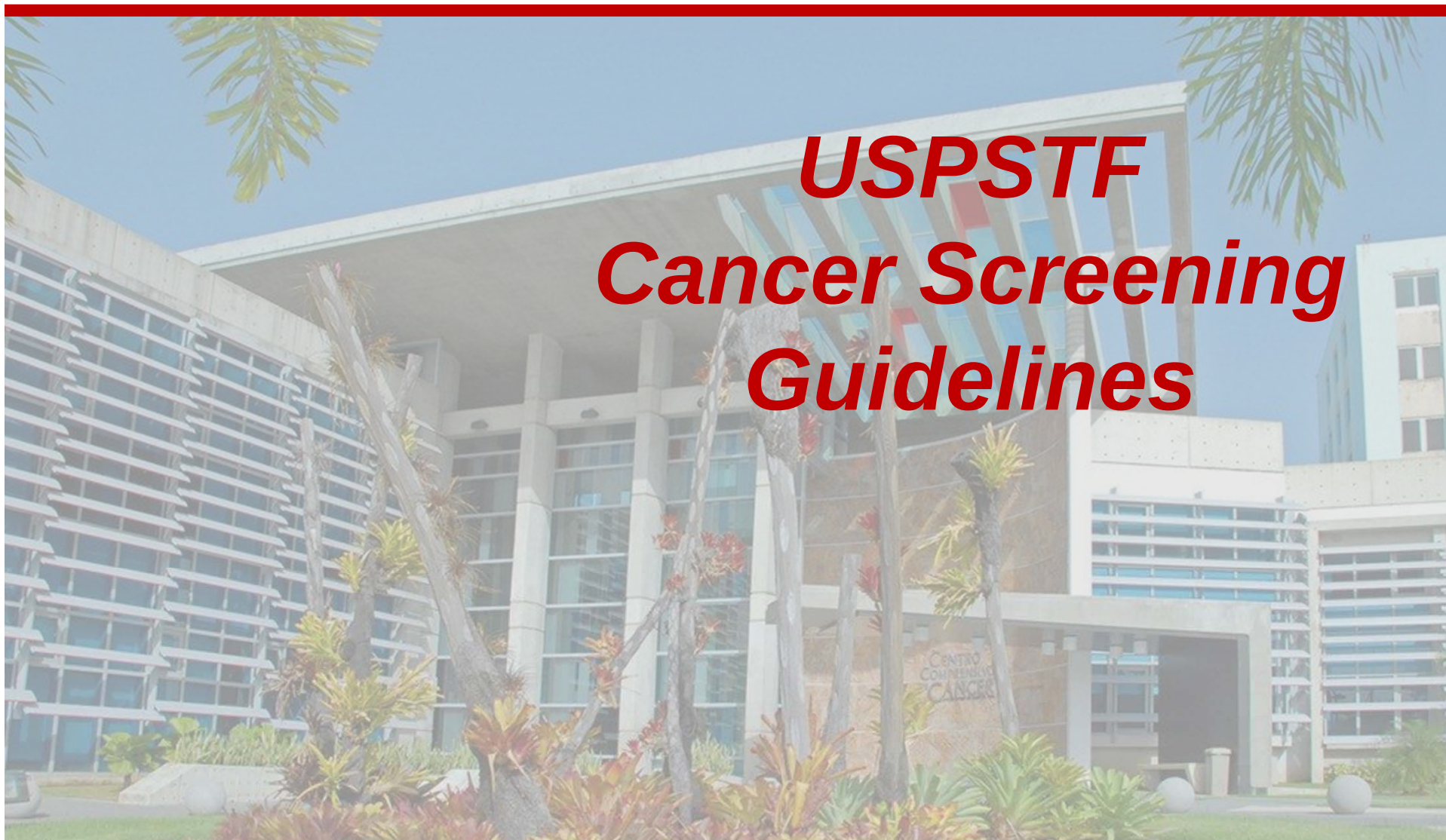
Lung Cancer Screening Guidelines

- Core elements of this discussion should include:
 - Benefits
 - Uncertainties
 - Harms of screening with **Low-Dose Helical Computed Tomography (LDCT)**

Lung Cancer Screening Guidelines

- ***Annual Low-Dose Helical Computed Tomography (LDCT)*** screening
- Stop screening at age 74 years
- Chest-X Ray should **NOT** be used for cancer screening
- They should enter organized screening programs at institutions with:
 - Expertise in LDCT screening
 - Access to a multidisciplinary team skilled in the evaluation, diagnosis, and treatment of lesions

USPSTF Cancer Screening Guidelines



USPSTF



CERVICALCANCER SCREENING RECOMMENDATIONS



- **CERVICAL Cancer**

- every three years for women ages 21-65
- Routine cervical cancer screening for women under 21 and over 65 is no longer recommended
- Five-year screening interval for women ages 30-65 when screened with a combination of Pap testing and human papillomavirus (HPV) testing

Cervical Cancer Screening Guidelines

	ACS 2012	USPSTF 2012	ACOG 2012
Age to start	Age 21	Age 21	Age 21
Women ages 21-29	Cytology every 3 years	Cytology every 3 years	Cytology every 3 years
Women ages 30-65	Cotesting every 5 years (preferred) or Every 3 years with Pap alone	Cotesting every 5 years or Every 3 years with Pap alone	Cotesting every 5 years (preferred) or Every 3 years with Pap alone
Women ages >65	Discontinue after age 65 years (adequate screen)	Discontinue after age 65 years -	Discontinue at age 65 years (adequate screen)
Total Hysterectomy	Discontinue (if no history of CIN2+)	Discontinue (if no history of CIN2+)	Discontinue (if no history of CIN2+)
Screening among fully vaccinated	Same as for non-vaccinated	Not reviewed	Same as for non-vaccinated

Table 1. Cancer Screening Recommendations from the U.S. Preventive Services Task Force (USPSTF), 2009

Cancer	Population	Screening Method	When
Breast Cancer⁵	Women 50 years of age and over*	Mammography with or without a clinical breast exam	Biennially, beginning at age 50
Colon Cancer⁷	Average risk men and women 50 years of age or older	Colonoscopy	Every 10 years, beginning at age 50
		Flexible sigmoidoscopy or double-contrast barium enema	Every 5 years, beginning at age 50
		Fecal occult blood test	Every year, beginning at age 50

* The updated breast cancer screening guidelines limit *routine* screening to women 50 years and older, but suggest that clinicians consider biennial screening mammography before the age of 50 years on an individual basis, taking into consideration patient context, including the patient's values regarding the specific benefits and harms. The National Cancer Institute and the American Cancer Society continue to suggest routine mammography beginning at the age of 40.

USPSTF

LUNG CANCER SCREENING RECOMMENDATIONS

- **LUNG Cancer**
 - Annual screening with low-dose computed tomography (LDCT)
 - Adults aged 55 to 80 years
 - 30 pack-year smoking history
 - Currently smoke
 - quit within the past 15 years
 - Discontinued after 15 years of non-smoking, limited life expectancy or ability or willingness to have curative lung surgery
- **PROSTATE Cancer**
 - Recommends against PSA-based screening

USPSTF

LUNG CANCER SCREENING RECOMMENDATIONS

- **LUNG Cancer**
 - Annual screening with low-dose computed tomography (LDCT)
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 - Recommends against PSA-based screening



CANCER SCREENING IN PUERTO RICO: ***How Are We Doing?***

Cancer Screening in U.S. and Puerto Rico, BRFSS 2012

Screening Test	U.S. (Md%)	Puerto Rico
Pap Smear (21-64 yr./≤3 yr.) (18+/≤3 yr.)	85% (78%)	74% (71%)
Mammography (≤2 yr.)		
40+ years	74%	78%
50+ years	77%	79%
Colonoscopy/FlexSig	67%	47%
FOBT (50+ yr./Last 2 yr.)	14%	26%
PSA (40+ yr. /Last 2 yr.)	45%	77%

Centers for Disease Control and Prevention (CDC). *Behavioral Risk Factor Surveillance System Survey Data*. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2010.

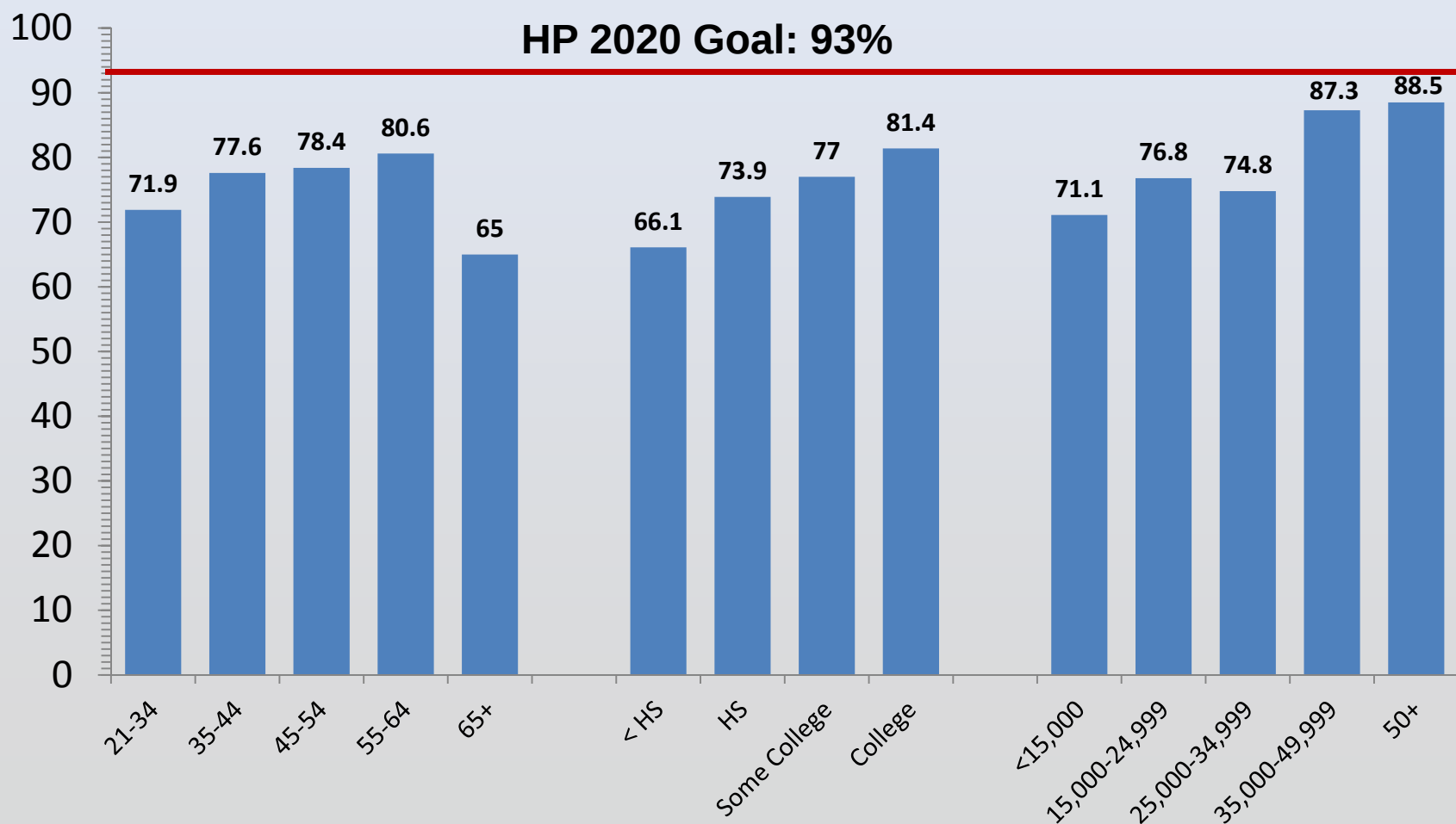
Cancer Screening in Puerto Rico, BRFSS 1996, 2010, & 2012

Screening Test	1996	2010	2012
Pap Smear (18+ yr./≤3 yr.)	70%	75%	71%
Mammography (≤2 yr.)			
40+ years	60%	77%	78%
50+ years	61%	80%	79%
Colonoscopy/FlexSig	28% ¹	43%	47%
FOBT (50+ yr./Last 2 yr.)	12% ¹	10%	26%
PSA (40+ yr. /Last 2 yr.)	65% ²	63%	77%

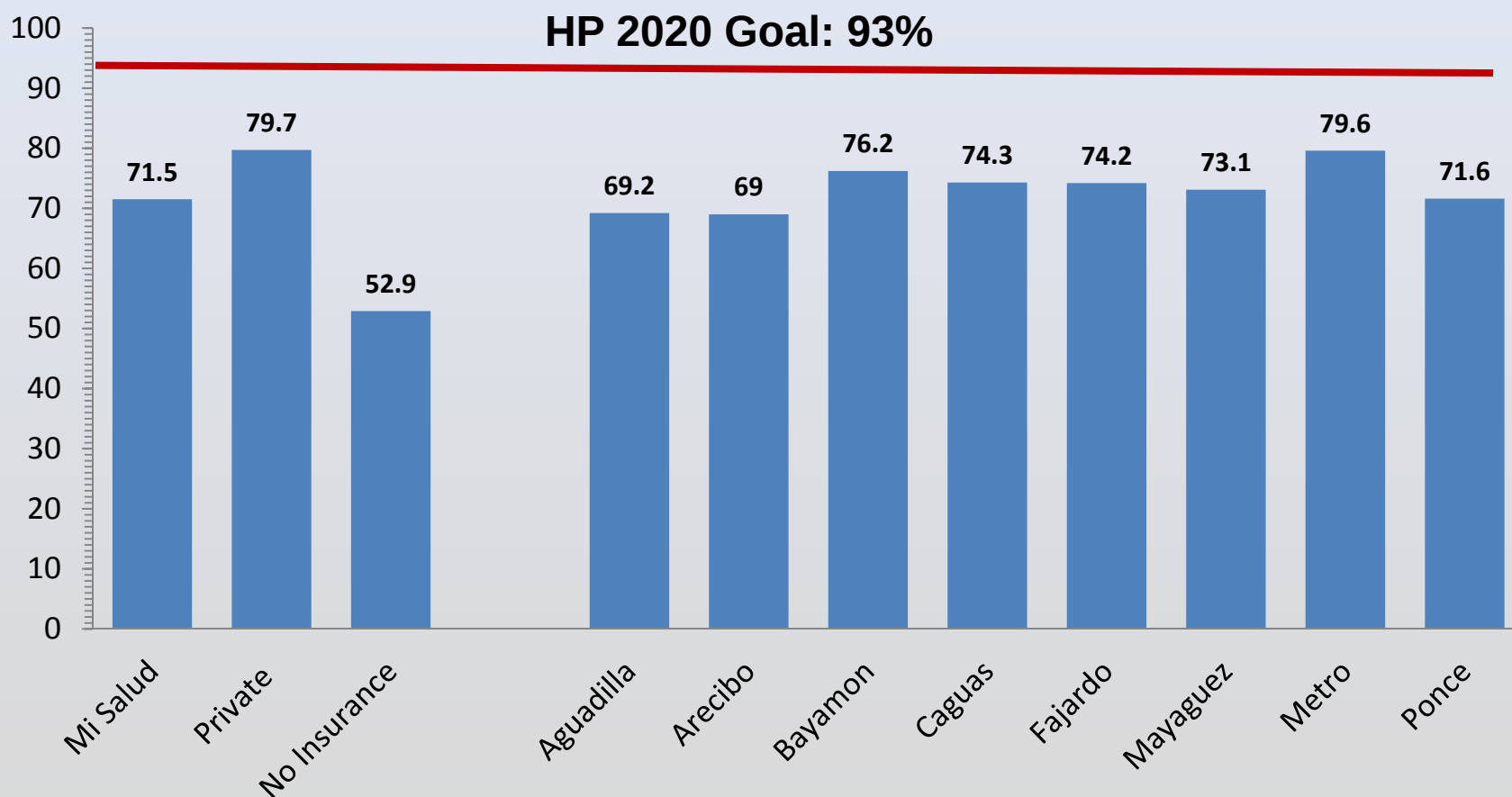
¹ 1999; ² 2002

Centers for Disease Control and Prevention (CDC). *Behavioral Risk Factor Surveillance System Survey Data*. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.

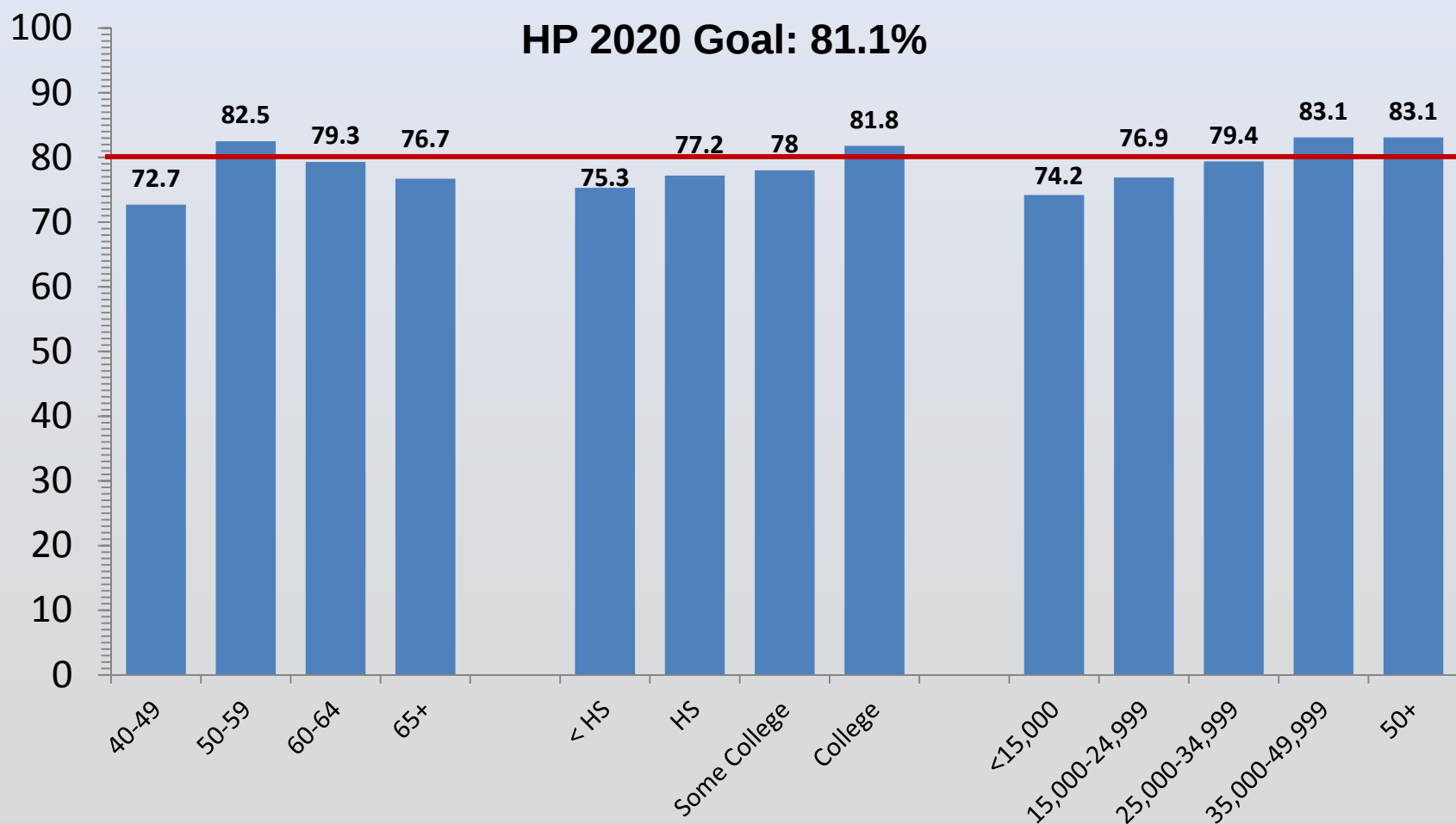
Prevalence of Cervical Cancer Screening among PR Women Aged 21+ by SES Characteristics: PRBRFSS 2012



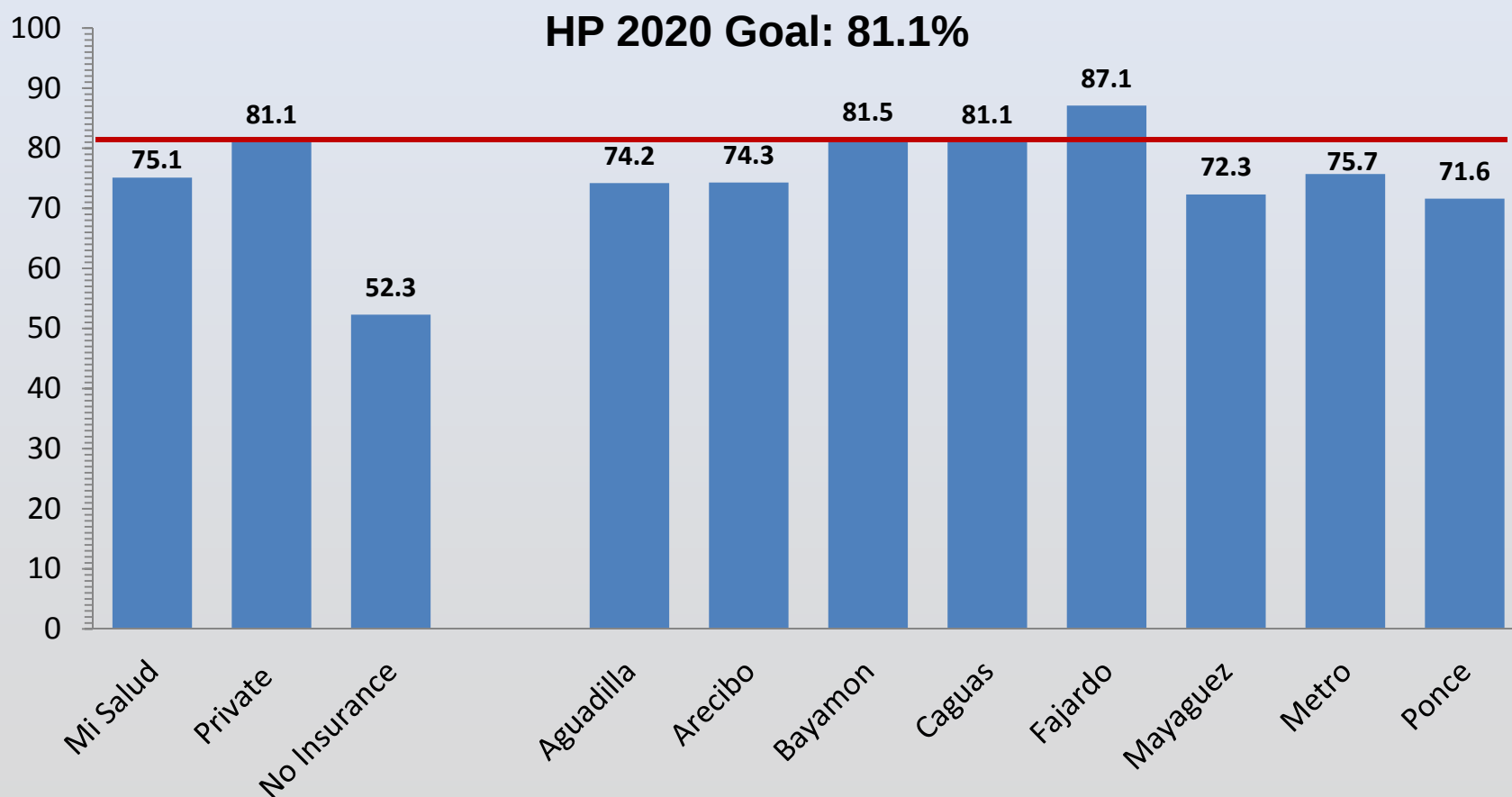
Prevalence of Cervical Cancer Screening among PR Women Aged 21+ by SES Characteristics: PRBRFSS 2012



Prevalence of Breast Cancer Screening among PR Women Aged 40+ by SES Characteristics: PRBRFSS 2012



Prevalence of Breast Cancer Screening among PR Women Aged 40+ by SES Characteristics: PRBRFSS 2012







Contáctenos



INICIO SOBRE NOSOTROS CANCER DE SENO CANCER DE CERVIX PARTICIPANTES RECURSOS PROVEEDORES EVENTOS Y NOTICIAS



Bienvenidos a nuestro nuevo Portal

Bienvenido a nuestro nuevo portal - El Programa de Prevención y Detección Temprana de Cáncer de Mama y Cuello Uterino de PR es auspiciado por los Centros de Control y Prevención de Enfermedades (CDC) y el sistema de salud de Puerto Rico. El Programa





**Puedes hacer la diferencia...
hazte las pruebas hoy.**

MAMOGRAFÍA Y PAPANICOLAOU

GRATIS
para mujeres elegibles
al programa

REQUISITOS:

- Estar entre las edades de 21 a 64 años
- No cualificar para la Reforma de Salud
- No tener plan médico privado
- Cumplir con los requisitos de ingreso económico
- Mujeres de 65 años o más que no cuentan con Medicare, o no tienen Medicare Parte B

Si desea saber si es elegible para el programa o recibir más información, puede comunicarse al

(787) 522-3265

**CENTRO
COMPRENSIVO
DE
CÁNCER**
universidad de puerto rico



**ESTADO LIBRE ASOCIADO DE
PUERTO RICO**
Departamento de Salud

GUÍAS PARA LA DETECCIÓN TEMPRANA DE CÁNCER DE MAMA*

Infórmate

Ninguna mujer está libre de padecerlo.

Edad	Mamografía	Examen Clínico	Autoexamen
20 a 39 años	No	Cada 2 ó 3 años	Mensual
40 años o más	Anual	Anual	Mensual

*Recomendadas por la Sociedad Americana del Cáncer

SERVICIOS EN LA COMUNIDAD

El Programa de Prevención y Detección Temprana de Cáncer de Mama y Cuello Uterino en Puerto Rico, está afiliado al Centro Comprensivo de Cáncer de la Universidad de Puerto Rico. Este programa provee servicios de cernimiento y diagnóstico gratuitos para aquellas mujeres que cualifiquen.



Si usted quiere saber si es elegible para estos servicios comuníquese a:

PROGRAMA DE PREVENCIÓN Y DETECCIÓN TEMPRANA DE CÁNCER DE MAMA Y CUELLO UTERINO EN PUERTO RICO
787 772-8300
Ext. 1122 ó 1119

SOCIEDAD AMERICANA DEL CÁNCER

Unidad Metro
566 Calle Cabo Alverio
Hato Rey
787 764-2295

Unidad del Norte
2 Calle 4, Urb. Radioville
Arecibo
787 879-0656

Unidad Central - Este
Carr. 183 Km. 2.2
V-7, Urb. José Mercado
Caguas
787 743-4040

Unidad del Oeste
38 Calle José Campeche
Urb. Ramírez de Arrellano
Mayagüez
787 833-3320

Unidad del Sur
716 Calle Ferrocarril
Ponce
787 844-1037

SERVICIO DE INFORMACIÓN SOBRE CÁNCER
1 800 422-6237
(1-800-4-CANCER)

o para más información acceda:
www.cdc.gov/espanol
www.cancer.gov/espanol

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Madre Hermana Hija Amiga **TÚ**

Piensa en ti... hazte hoy la mamografía.

Guías para la Detección Temprana de CÁNCER DE MAMA

Mamografía
el único método para la detección temprana

QUIENES PUEDEN ESTAR A RIESGO

Investigaciones han demostrado que existen ciertos factores que podrían aumentar las posibilidades de desarrollar cáncer de mama. Algunos factores que aumentan el riesgo son:

- Ser mujer
- Envejecimiento
- Historial familiar de cáncer de mama (madre, hermana, hija)
- Primera menstruación antes de los 12 años
- Menopausia después de los 55 años
- Tener hijos tarde en la vida o nunca haber tenido hijos
- Historial clínico de cáncer de mama o de otras enfermedades no cancerosas en las mamas (biopsias previas benignas)
- Raza o grupo étnico
- Uso de terapia hormonal
- Obesidad
- Inactividad física
- Uso de bebidas alcohólicas

Ninguna mujer está exenta de padecer cáncer de mama, o sea...

- Usted puede presentar uno o dos factores de riesgo y llegar a padecer la enfermedad
- Usted puede presentar cuatro o cinco factores de riesgo y nunca padecer la enfermedad
- Lo importante es consultar con su médico

SIGNOS Y SÍNTOMAS

- Masa que pueda ver o palpar
- Cambio en tamaño y forma de la mama (seno)
- El pezón hundido
- Piel escamosa, roja o hinchada, dolor
- Hundimiento en el área de la mama
- Cualquier cambio inusual en el área de la mama(seno)

QUE HERRAMIENTAS TENGO PARA DETECTAR EL CÁNCER DE MAMA (SENO) A TIEMPO

MAMOGRAFÍA - Es una radiografía de la mama. Es el mejor método de detección temprana del cáncer de mama, ya que puede encontrar nódulos (masas) que no son palpables, cuando aun no se presentan síntomas y la probabilidad de curación es mayor.

EXAMEN CLÍNICO DE MAMA -

El médico o enfermera/o, observan y palpan las

En Puerto Rico el cáncer de mama es el más común en mujeres

mamas (senos) para detectar la posible presencia de una masa u otros cambios. Este examen es un complemento de la mamografía.

OTROS MÉTODOS DE DETECCIÓN

AUTOEXAMEN DE MAMA - Es cuando usted misma se observa y palpa las mamas (senos) para detectar posibles masas, cambios en el tamaño o la forma de la mama. Este examen se recomienda hacerlo mensualmente a partir de los 20 años de edad.

Es una prueba para auto cuidado y obtener responsabilidad por su salud. Las nuevas estadísticas han demostrado que no representa una prueba que detecte el cáncer a tiempo.

PUNTOS IMPORTANTES

- Es la primera causa de muerte por cáncer en mujeres en Puerto Rico.
- El Sistema de Vigilancia de los Factores de Riesgo en la Conducta conocido por sus siglas en inglés (BRFSS) y administrado por el Departamento de Salud, para el año 2008 indicó que aproximadamente el 22% (1 de cada 5) de las mujeres de 40 años o más NO se habían hecho una mamografía en los últimos 2 años.
- Se ha demostrado que la utilización de la mamografía reduce el número de muertes por cáncer de mama.
- En las mujeres de 40 a 69 años, la mamografía puede reducir las muertes por cáncer de mama.
- En las mujeres de 50 a 69 años, el ser diagnosticadas y tratadas a tiempo puede reducir el riesgo de morir por cáncer de mama.

No lo dejes para luego hazte una mamografía HOY

¡Infórmate!

GUÍAS PARA LA PREVENCIÓN DE CÁNCER DE CUELLO UTERINO*

Cuándo comenzar hacerse el Papanicolaou (prueba Pap)	21 a 29 años	Cuando terminar de hacerse la prueba Pap	Mujeres con Histerectomía (removieron el útero)
Aproximadamente 3 años después de comenzar a tener relaciones sexuales, pero no más tarde de los 21 años	Anualmente. Mujeres de 30 años o más, con tres Pap consecutivos negativos, realizarse la prueba cada dos o tres años	Mujeres de 70 años o más, que han tenido resultados normales en su prueba Pap los últimos 10 años, pueden optar por suspender la prueba, luego de consultar con su médico.	Se discontinúa la prueba Pap, si la razón de la histerectomía fue por lesiones benignas y sin antecedentes de alto riesgo

SERVICIOS EN LA COMUNIDAD

El Programa de Prevención y Detección Temprana de Cáncer de Mama y Cuello Uterino de Puerto Rico, está afiliado al Centro Comprensivo de Cáncer de la Universidad de Puerto Rico. Este programa provee servicios de cernimiento y diagnóstico gratuitos para aquellas mujeres que cualifiquen.



Si usted quiere saber si es elegible para estos servicios comuníquese a:

PROGRAMA DE PREVENCIÓN Y DETECCIÓN TEMPRANA DE CÁNCER DE MAMA Y CUELLO UTERINO DE PUERTO RICO
787 772-8300
Ext. 1122 ó 1119

SOCIEDAD AMERICANA DEL CÁNCER

Unidad Metro
566 Calle Cabo Alverio
Hato Rey
787 764-2295

Unidad del Norte
2 Calle 4, Urb. Radioville
Arecibo
787 879-0656

Unidad Central – Este
Carr. 183 Km. 2.2
V-7, Urb. José Mercado
Caguas
787 743-4040

Unidad del Oeste
38 Calle José Campeche
Urb. Ramírez de Arrellano
Mayagüez
787 833-3320

Unidad del Sur
716 Calle Ferrocarril
Ponce
787 844-1037

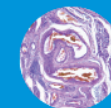
SERVICIO DE INFORMACIÓN SOBRE CÁNCER

1 800 422-6237
(1-800-4-CANCER)

o para más información acceda:
www.cdc.gov/espanol
www.cancer.gov/espanol

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Madre Hermana Hija Amiga TÚ



Piensa en ti... examínate y hazte el Pap hoy.



Guías para la Prevención de CÁNCER DE CUELLO UTERINO

La prueba Papanicolaou ayuda a detectar cambios en el cuello uterino

QUIÉNES PUEDEN ESTAR A RIESGO

Investigaciones han demostrado que la causa principal del cáncer de cuello uterino es la infección con ciertos tipos del virus del papiloma humano (VPH). Este virus es transmitido principalmente a través de contacto sexual. Además del VPH existen otros factores que incrementan el riesgo de desarrollar cáncer de cuello uterino. Estos factores incluyen:

- Inicio de actividad sexual a temprana edad
- Haber tenido una gran cantidad de compañero/as sexuales
- No hacerse la prueba de Papanicolaou regularmente
- Fumar cigarrillos
- Tener muchos partos
- Una dieta con bajo consumo de frutas y vegetales
- Sistema inmunológico débil
- Uso de anticonceptivos orales (píldora)

SIGNOS Y SÍNTOMAS

Normalmente esta enfermedad no produce síntomas hasta que la enfermedad ya está avanzada. Estos síntomas incluyen:

- Sangrado vaginal después de una relación sexual
- Sangrado vaginal que no está relacionado a la menstruación
- Sangrado vaginal después de la menopausia
- Sangrado vaginal después del examen pélvico
- Dolor pélvico
- Dolor durante las relaciones sexuales

QUE HERRAMIENTAS TENGO PARA PREVENIR O DETECTAR UNA LESIÓN PRECANCEROSA O CANCEROSA DEL CUELLO UTERINO PRUEBA DE PAPANICOLAOU

- Hacerse esta prueba regularmente puede ayudar a identificar cambios en el cuello uterino que pudieran convertirse en cáncer.

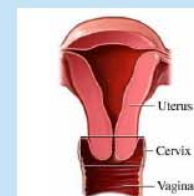
El cáncer de cuello uterino es prevenible

VACUNA CONTRA VPH

- Se recomienda el uso de la vacuna contra el Virus de Papiloma Humano (VPH) para adolescentes, mujeres y hombres jóvenes entre los 9 a 26 años de edad.
- La vacuna debe aplicarse preferiblemente antes del inicio de la actividad sexual, por lo que las guías actuales recomiendan que la vacuna se aplique entre los 11 y los 12 años de edad.
- Actualmente existen dos vacunas en el mercado.
- Consulte con su médico sobre estas vacunas.

PUNTOS IMPORTANTES

- Las vacunas contra el Virus de Papiloma Humano han demostrado ser muy efectivas y seguras.
- Todas las mujeres que reciben la vacuna contra el VPH deben continuar haciéndose la prueba de Papanicolaou regularmente.
- El 40 al 60 por ciento de las muertes por cáncer de cuello uterino pueden ser prevenibles aumentando la utilización de la prueba Papanicolaou.



No lo dejes para luego examínate HOY



GUÍAS PARA LA DETECCIÓN TEMPRANA DE CÁNCER DE MAMA Y CUELLO UTERINO PARA MUJERES ASINTOMÁTICAS DE RIESGO PROMEDIO

CÁNCER DE MAMA

POBLACIÓN	EXAMEN/PROCEDIMIENTO	FRECUENCIA
Mujeres de 20-39 años	- Autoexamen (BSE) - Examen Clínico (CBE)	- Opcional, si la mujer decide realizarse esta prueba, el médico debe informarle de los beneficios y limitaciones. - Se recomienda una vez al mes - En su prueba rutinaria de salud o cada 3 años.
Mujeres de 40+ años	Mamografía y CBE	Anual

www.cancerdesenoycuellouterino.org
www.coalicioncontroldecancer.org

CÁNCER DE CUELLO UTERINO

POBLACIÓN	EXAMEN/PROCEDIMIENTO	FRECUENCIA
Mujeres de 21 a 29 años	Prueba Pap	- Iniciar a los 21 años - Cada 3 años
Mujeres de 30 a 65 años	Prueba Pap Prueba Pap en combinación con la prueba de VPH	- Cada 3 años - Cada 5 años - No prueba de VPH antes de los 30 años de edad
Mujeres mayores de 65 años	Resultados de Pruebas Pap y VPH normales en los últimos 10 años	No es necesario realizarse la prueba Pap
Mujeres con ANTECEDENTES de CIN2/HSIL		Continuar realizando la prueba Pap por 20 años más, después del tratamiento o regresión espontánea de la lesión.
Mujeres con histerectomía	Se discontinúa la prueba Pap	- Histerectomía no relacionada a lesión pre-cancerosa o cáncer de cuello uterino - Mujeres en quien no se puede documentar la razón de su histerectomía deben continuar cernimiento.

MUJERES VACUNADAS CONTRA EL VPH DEBEN CONTINUAR CERNIMIENTO DE ACUERDO A SU GRUPO DE EDAD

GUÍAS PARA LA DETECCIÓN TEMPRANA DE CÁNCER DE COLORECTAL Y PRÓSTATA PARA INDIVIDUOS ASINTOMÁTICOS DE RIESGO PROMEDIO

CÁNCER DE PRÓSTATA

POBLACIÓN	EXAMEN/PROCEDIMIENTO	FRECUENCIA
Hombres de 50 años o más	Examen Digital Rectal (DRE) y Antígeno Prostático Específico (PSA)	Discutir con el paciente los beneficios y riesgos de realizarse estas pruebas

CÁNCER COLORECTAL

POBLACIÓN	EXAMEN/PROCEDIMIENTO	FRECUENCIA
Mujeres y Hombres de 50+ años	Examen de Sangre Oculta en Heces (FOBT) con al menos 50% de sensibilidad para cáncer o Examen de Sangre Oculta en Heces Inmunoquímica (FIT) con al menos un 50% de sensibilidad para cáncer	- Anualmente - Es más cómodo para el paciente y es probable que tenga igual o mejor sensibilidad y especificidad que otras pruebas de cernimiento para este tipo de cáncer
	- Prueba de ADN en Heces	Intervalo incierto
	-Sigmoidoscopia Flexible (FSIG)	Cada 5 años y se puede considerar combinarse con la prueba de gFOBT o FIT que es anualmente
	-Enema de Bario de Doble Contraste (DCBE)	Cada 5 años
	-Colonoscopia	Cada 10 años
	-Colonografía por tomografía computarizada	Cada 5 años


Coalición para el Control de Cáncer de Puerto Rico
 PROGRAMA DE CONTROL COMPRENSIVO DE CÁNCER


PUERTO RICO BREAST & CERVICAL CANCER
 PREVENTION AND EARLY DETECTION PROGRAM


CENTRO COMPRENSIVO DE CÁNCER
 universidad de puerto rico

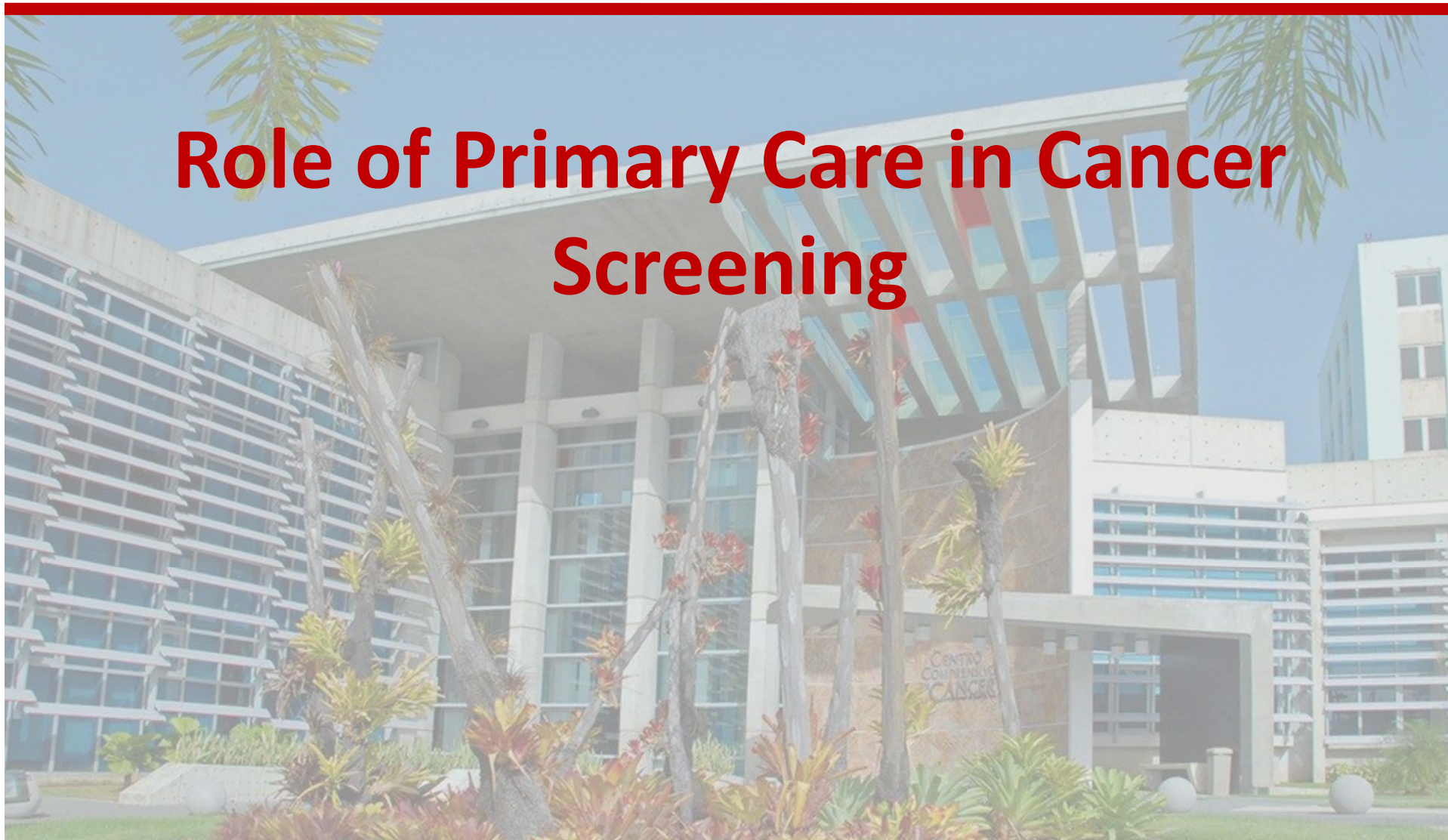

ESTADO LIBRE ASOCIADO DE PUERTO RICO
 Departamento de Salud

Smith R et al. Ca Cancer J Clin 2013; 63:87-105

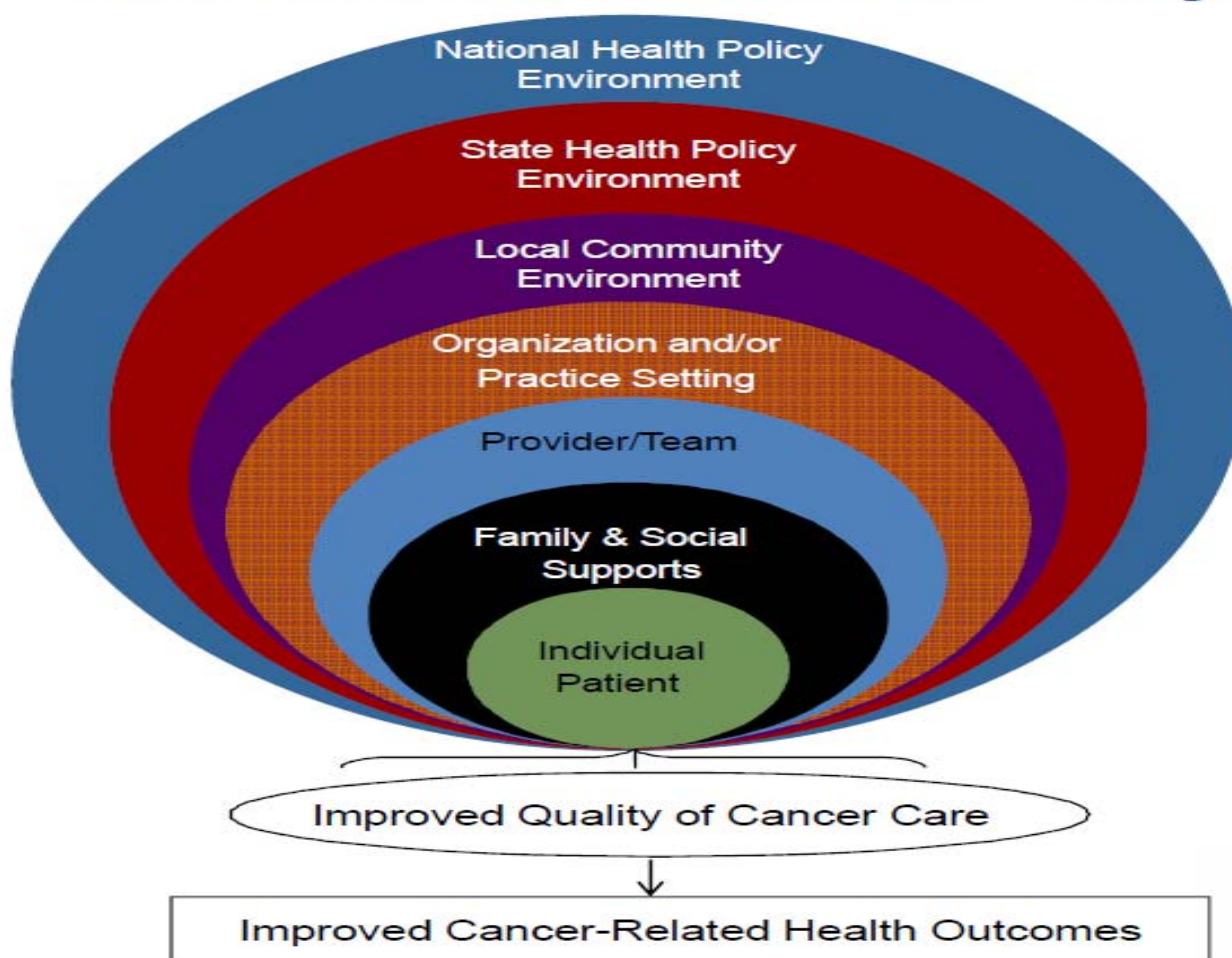
Thank you



Role of Primary Care in Cancer Screening



Care Process Within Layers



Role of Primary Care in Cancer Prevention

- Primary care providers play critical role in closing gaps to cancer prevention and early detection
- Primary care reduces
 - obstacles to prevention and early detection
 - prevents mortality
 - promotes health
- IOM emphasizes the critical role of primary care in disease prevention and early detection

Role of Primary Care in Cancer Prevention

- Opportunity for Risk Assessment and Intervention
- Receiving primary care has been positively associated with:
 - patients having up-to-date screenings
 - health habit-counseling
- >85% of all mammograms are ordered by primary care providers
- Physician's advice increases mammograms and CRC screenings

Role of Primary Care in Cancer Prevention

- Adequate cancer screening:
 - Access to primary care providers
 - Large supplies of family physicians in the area
 - Having at least one personal health care provider

Barriers to Cancer Prevention in Primary Care

- **Patient-level factors**
 - Sociodemographic Characteristics
 - Ability to pay for tests
 - Acceptance of prevention intervention
 - Trust in health care provider
 - Usual source of care
 - Transportation
 - Comfort with gender of health care provider

Barriers to Cancer Prevention in Primary Care

- **Provider-level factors**
 - Provider characteristics (age, gender, specialty, licensing status)
 - Provider awareness of prevention guidelines
 - Time constraints
 - Lack of training
 - Inadequate knowledge of how to counsel patients
 - Distraction by patient co-morbidities
 - Inadequate reimbursement
 - Provider attitudes about prevention

Barriers to Cancer Prevention in Primary Care

- **System-level factors**
 - Health insurance coverage for recommended preventive interventions
 - Having one personal health care provider
 - Inadequate space or staffing
 - Time constraints that system-level factors place on provider
 - Clinic schedules

Patient Protection and Affordable Care Act on Cancer Screening

TABLE 5. Cancer Screening Coverage Requirements for New Private Health Plans

CANCER SCREENING	DESCRIPTION	USPSTF GRADE	DATE IN EFFECT
Breast cancer screening	The USPSTF recommends screening mammography for women, with or without CBE, every 1-2 y for women aged ≥ 40 y. ¹⁰⁹	B	September 2002
Cervical cancer screening	The USPSTF strongly recommends screening for cervical cancer in women who have been sexually active and have a cervix. ⁹⁶	A	January 2003
Colorectal cancer screening	The USPSTF recommends screening for colorectal cancer using FOBT, FSIG, or colonoscopy in adults, beginning at age 50 y and continuing until age 75 y. The risks and benefits of these screening methods vary. ¹¹²	A	October 2008

USPSTF, US Preventive Services Task Force; CBE, clinical breast examination; FOBT, fecal occult blood test.

New private plans and insurance policies: September 23, 2010.
Medicare: January 1, 2011

Thank you

