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CONTEMPORARY ISSUES IN WOMEN'S HEALTH

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The editors of Contemporary Issues in Women's Health solicit reporters and correspondents from throughout the world to make contributions to this section. Please feel free to email Doctor Richard Adanu at rmadanu@yahoo.com or Doctor Maya Hammoud at immaya@umich.edu if you have reports or items that you would like included. We would be happy to attribute the items to those reporters and correspondents who give permission in their transmittal. Otherwise, we will share those reports that we think are of the greatest interest to our readership without attribution.

New guidelines for breast cancer screening cause controversy

The US Preventive Services Task Force (USPSTF) has released revised recommendations on breast cancer screening amid much controversy in the United States. The new guidelines, published in the November 2009 issue of *Annals of Internal Medicine* [1], recommend against screening mammography for women in their 40s and recommend screening only once every two years for women aged between 50 and 74. This differs from the American Cancer Society (ACS) guidelines that recommend screening yearly beginning at 40 years and the American College of Obstetricians and Gynecologists (ACOG) who recommend screening mammography for women every 1–2 years between the ages of 40 and 50 years and yearly thereafter [2]. Furthermore, the USPSTF recommends against teaching women how to perform a breast self-exam (BSE). ACOG's position remains to counsel women that BSE has the potential to detect palpable breast cancer.

The new USPSTF recommendations are based on a systematic evidence review by Dr Heidi D. Nelson [3] and a modeling estimates study on potential benefits and harms of different screening schedules by Dr Jeanne S. Mandelblatt [4]. Based on these analyses, the 2009 USPSTF concluded that women should not be getting mammograms in their 40s because they experience greater harms from screening than women in their 50s including additional imaging, biopsies, and psychological stress. Furthermore, although the benefit of screening women in their 40s is the same as women in their 50s, 1904 women between the ages of 39 and 49 need to be screened to prevent one cancer death compared with 1339 women between the ages of 50 and 59. The Mandelblatt modeling study states: "If the goal of a national screening program is to reduce mortality in the most efficient manner, then programs that screen biennially from age 50 years to age 69, 74, or 79 years are among the most efficient on the basis of the ratio of benefits to the number of screening examinations. If the goal of a screening program is to efficiently maximize the number of life-years gained, then the preferred strategy would be to screen biennially starting at age 40 years. Decisions about the best starting and stopping ages also depend on tolerance for false-positive results and rates of overdiagnosis" [4].

The major concerns stem from the fact that those recommendations may be adopted as policy and Medicare and private insurers will no longer pay for these services to cut costs. Many have suggested that the USPSTF, a federally supported body, is indeed trying to cut costs as these recommendations come at the same time the US government is trying to cut costs. Interestingly, these new recommendations are similar to those adopted in other high-income countries. For example, in England, screening mammograms are offered to women aged between 47 and 70 every 3 years; in France, they are offered every 2 years from age 50 to 74; in Canada, mammograms are recommended every 2 years between the age of 50 and 69. Regardless of what the "best" screening schedule should be, these new recommendations have caused much confusion among the lay public; however, it is most important to remember that recommendations are intended as guidance. The decision whether to screen or not should be left up to the woman and a discussion with her physician.

References

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[4] Mandelblatt JS, Cronin KA, Bailey S, Berry DA, de Koning HJ, Draisma G, et al. Effects of mammography screening under different screening schedules: model estimates of potential benefits and harms. Ann Intern Med. 2009; 151(10):738-47.

Vaginal hysterectomy is the approach of choice when feasible

Hysterectomy is one of the most common surgical procedures performed for women in the United States, at a rate of 4.81 per 1000 woman-years. This is similar or higher than rates reported in other

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industrialized countries (e.g., 4.80 in Australia and 3.46 in Canada). With advances in technology and the ability to perform hysterectomies laparoscopically with or without robotic assistance, it is important to continually assess the safest approach to the procedure. The American College of Obstetricians and Gynecologists (ACOG) released an ACOG Committee Opinion (Number 444) in November 2009 [1] concluding that vaginal hysterectomy (VH) is associated with better outcomes and fewer complications than laparoscopic (LH) or abdominal hysterectomy (AH).

Vaginal hysterectomy, whenever feasible, has been cited as the safest and most cost-effective approach in most of the literature, including a Cochrane Review updated in 2009 [2]. The benefits of VH versus AH were speedier return to normal activities, fewer febrile episodes, and lower intraoperative blood loss. LH was also found to have benefits over AH including all the above and fewer abdominal infections, but the operative time was longer and there were more urinary tract infections. There was no evidence of benefits of LH over VH, and the operative time and substantial bleeding were higher in LH. Experience with robotic-assisted surgeries remains limited to draw any conclusions of benefits and risks. Despite these findings, in the United States, AH is still performed in 66% of cases, VH in 22%, and LH in 12% of cases. Obviously, there are many factors that influence the approach to a hysterectomy, including the size and shape of the uterus and vagina, the extent of extrauterine disease and prior procedures performed on the patient, surgeon training and experience, available equipment and support, as well as preference of the patient. However, vaginal hysterectomy is the approach of choice whenever feasible, based on its well-documented advantages and lower complication rates.

References

[1] American College of Obstetricians and Gynecologists. ACOG Committee Opinion No. 444: Choosing the route of hysterectomy for benign disease. Obstet Gynecol 2009; 114(5):1156-58. Available at: http://journals.lww.com/greenjournal/Citation/2009/11000/ACOG_Committee_Opinion_No__444__Choosing_the_Route.37.aspxhttp://www.acog.org. Accessed December 21, 2009.
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Women and health: Today's evidence tomorrow's agenda

A report with the above title was commissioned by Dr Margaret Chan, Director General of the World Health Organization. The report examines women's health needs and their contribution to the health of societies. This report uses a life-course approach to investigate issues that are peculiar to the health of women globally. It highlights the consequences and costs of not addressing health issues at the appropriate points of women's lives.

The key findings of the report are as follows:

- There are widespread and persistent inequities in health and healthcare between women and men.
- The central issue in the area of women's health is related to sexuality and reproduction.
- Chronic diseases, injuries, and mental issues have become major sources of morbidity and mortality for women.
- To improve the health of women it is critical for girls to have a fair start on the road to health.
- Societies and health systems worldwide continue to fail women.

The following were identified as key areas for reform:

- Building strong leadership and a coherent institutional response to women's health issues.
- Getting health systems to work for women.
- Leveraging changes in public policy to produce healthier societies.
- Building the knowledge base and monitoring progress in the health of women.

Reference

http://whqlibdoc.who.int/publications/2009/9789241563857_eng.pdf.

New HIV recommendations by the World Health Organization

The World Health Organization has produced new recommendations for the management of HIV infection. Implementation of these recommendations is expected to result in reduced infections and more lives saved. It is currently estimated that there are almost 34 million people living with HIV/AIDS, with close to 3 million new infections each year. It is an accepted fact that HIV/AIDS is the leading worldwide cause of mortality among women of reproductive age.

For HIV treatment, WHO currently recommends that antiretroviral therapy (ART) be started at a CD4 threshold of 350 cells/mL for all HIV patients regardless of symptoms. This also applies to pregnant women. Countries are being asked to phase out the use of stavudine (d4T) because of its adverse effects. Zidovudine (AZT) or tenofovir (TDF) are recommended as effective alternatives.

To improve prevention of mother-to-child transmission, ART should be initiated at 14 weeks of gestation and continued to the end of the breastfeeding period. HIV positive women who choose to breastfeed can do so until the infant is 12 months of age provided the mother or baby is on ART.

Reference

http://www.who.int/mediacentre/news/releases/2009/world_aids_20091130/en/index.html.

Women's health: useful sources of information

Macro International together with National Statistical Services conducts Demographic Health Surveys in many low-income countries. These surveys focus on maternal and child health and for most of these countries they provide the most reliable data on the population health parameters of women and children. Free access to survey reports can be obtained at: http://www.measuredhs.com. People interested in gaining access to the survey data can register for free access.

The WHO Library Database can be accessed at: http://dosei.who.int. Publications and documents from WHO, in multiple languages, can be downloaded from this site for free. The site also provides the means for users to search the database using search terms.