CAPSULE COMMENTARIES

Capsule Commentary on Tosteson et al., Variation in Screening Abnormality Rates and Follow-Up of Breast, Cervical and Colorectal Cancer Screening within the PROSPR Consortium

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Reporting of cancer screening rates in the United States has been fraught with much variability, but maintains great importance with respect to cancer morbidity and mortality as well as related health disparities.[1] The situation is complicated by changes in national guidelines.[2]

Tosteson et al.[3] sought to extend our knowledge about cancer screening by providing data on follow-up of abnormal tests commonly performed in primary care. They documented rates of timely follow-up of abnormal mammograms (breast cancer screening, BCS), Pap (cervical cancer screening, CCS), and fecal occult or immunotherapy tests (FIT). Data is from the PROSPR consortium, an amalgam of center-level and statewide registry data. BCS follow-up was timely nearly 100% of the time, while action on abnormal CCS and colorectal cancer screening (CRCS) was untimely in up to 40% of cases.

CRCS centers exhibited significant variation in time to follow-up of abnormal fecal screening with colonoscopy. At the time of this study, colorectal cancer differed from breast and cervical cancer in that it was not undergirded by a federally funded screening program like the National Breast and Cervical Cancer Early Detection Program.[4] The extent to which such variation will be remedied by the preventive care provisions of the Affordable Care Act which include zero co-pays for cancer screening and other evidence-based preventive care services is not yet known.[5]

How were abnormal screening results delivered to the clinical team? Breast cancer screening (mammography) is radiology-based, while CCS and CRCS are lab-based. Radiology policies in several centers in the United States likely included a call or direct facsimile to the ordering provider or nurse—a transaction that is included on the final report. On the other hand, Pap and FIT interpretation services may be outsourced, and abnormal results may not be heralded by a telephone call.

An important limitation is the non-exclusion of patients with positive family history of the cancer being screened for; perhaps this contributed to the finding that women aged 40–49 had more abnormal mammograms than older women.

What should come next? More studies detailing 'quasi-outcomes' such as these are direly needed to advance the quality of ambulatory patient care.

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