EBP

e-Newsletter

WOMEN'S HEALTH

2023
Issue 5

Spring 2023

Issue 5th of e-Newsletter Theme Women's Health

CONTENTS

1 Breast Self-examination, Do or not to do?

2 Latest Update on Prevention & Screening of Cervical Cancer

3 EBP Activities
- EBP Subcommittee Logo Competition
- 2023 Journal Club
- Local EBP Training
- Farewell to Dr Chu Y M

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EBP Subcommittee Adviser's Message

Do you notice there is a brand new layout in this EBP e-newsletter? Heartfelt thanks for the dedication and creativity of the editorial board.

Such a change reminded me of the story of the EBP journey in TKOH. With the establishment of the Nursing Services Development & EBP Committee in TKOH on 24 Oct 2016, the journey of EBP kicked off in the hospital. Apart from the development of nurse clinics, we have initiated a regular journal club since Jan 2017, organized EBP Nursing Forum since Sept 2018 and launched our own EBP e-newsletter from Aug 2020 onwards. We have also created an EBP talent pool through structured training.

The information in the EBP e-newsletter enables us to integrate science into our daily practice so as to achieve the best clinical outcomes to our patients. This issue focuses on women's health. It is an interesting topic, not only for the benefit to the patient care but it also delivered an important evidence-based message for our own health / health of our significant other. Care for oneself before we can take care of others, do stay healthy.

WOMEN'S HEALTH

Women's Health is one of population health, that health is defined by World Health Organization (WHO) as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".

Despite lung cancer is the leading cause of cancer death in women, breast cancer remains the commonest cancer in women in the developed countries. Moreover, cervical cancer remains one of the commonest cancers in developing countries, associated with human papilloma virus (HPV). HPV vaccine together with screening offers the promise of controlling these diseases.

In this 5th issue of EBP e-newsletter, we would like to invite APN Jennifer Leung & APN Yvonne Lee sharing their nursing specialties practices. To update the information on breast self-examination (BSE) and HPV vaccine & screening of cervical cancer encourages our colleagues to make their health a priority.

EBP Editor's Note

Article Review

Breast Self-examination, Do or Not to Do?

Scan QR Code for full version article

APN Leung Yuen Ling, Jennifer
Breast Care Centre

Breast cancer has been the most common cancer among women in Hong Kong. In 2019, there were 4,761 newly registered female breast cancer cases, accounting for 27.4% of all new cancer cases in females. The median age at diagnosis was 58 years and the lifetime risk before age 75 was 1 in 14 (Hong Kong Cancer Registry, 2019).

There are different risk factors for women breast cancer, family history is one of them (Pharoah, 1997; Kharazmi, 2014). Generally, for women with a family history of breast cancer, the risk of developing breast cancer increases with increasing degree of relatedness to the affected relatives. Having one first-degree relative with breast cancer doubles a woman's risk while having an affected second-degree relative increases risk by 50% (PDQ® Cancer Genetics Editorial Board, 2020).

Breast cancer screening aims to detect breast cancer in asymptomatic population before symptoms develop so as to achieve better treatment outcome and improve survival.

However, there are two sides of the same coin. Screening tests have both benefits and harms. Benefits include improvement in the detection of early-stage cancer when it is still treatable with reduction in mortality (Myers, 2015; Marmot, 2013), whereas harms include psychological distress due to false positives, over diagnosis and over treatment to screened populations (Nelson, 2016; Siu 2016).

Breast Self Examination (BSE) is a regular, formally taught and ritual examination of a woman's breasts by oneself at a monthly interval. A large-scale randomized controlled trials was performed by Thomas et al. (2002) in Shanghai showed no different on the number of breast cancer deaths for women who had been taught to use systematic approach for BSE screening compared with those who had not.

Surprisingly, BSE was found to result in greater harm due to increased number of benign lesions and biopsies performed. Due to lack of evidence on the benefits of BSE screening but potential harms associated with false-positives, International guidelines no longer recommend women to perform regular BSE screening, but rather support all women being aware of Changes in their breasts and discussing these changes with clinicians. **Methods:** From October 1989 through October 1991, 266,064 women associated with 519 factories in Shanghai were randomly assigned to a BSE instruction group or a control group. Initial instruction in BSE was followed by reinforcement sessions 1 and 3 years later, by BSE practice under medical supervision at least every 6 months for 5 years, and by ongoing reminders to practice BSE monthly. The women were followed through December 2000 for mortality from breast cancer.

Results: There were 135 (0.10%) breast cancer deaths in the instruction group and 131 (0.10%) in the control group.

Comment: It is an article of a health screening evaluation. It applies direct trials approach that women were randomized to screening versus no screening. Only women in the screening group confirmed to have signs or symptoms compatible with breast cancer, then they would be referred to a surgeon for further evaluation. Although this article shows that the mortality rate from breast cancer by BSE alone would be unlikely to reduce; RR in this study is 1., breast awareness is much important for all aged women: being familiar with the normal look and feel of the breasts and should visit doctors promptly if suspicious symptoms developed.

Due to lack of comprehensive local data to identify women at moderated and high risk of breast cancer, the Cancer Expert Working Group on Cancer Prevention and Screening based on its review on international studies and oversea practices. The workgroup revised breast cancer screening in 2021 recommendations for local female population: **Breast self-examination is not recommended as a screening tool for breast cancer for asymptomatic women. Women are recommended to be breast aware and seek medical attention promptly if suspicious symptoms arise. Women with certain combinations of risk factors are recommended to consider mammography screening every 2 years.**

Summary of Recommendation

Latest Update on Prevention & Screening of Cervical Cancer

Human Papillomavirus Vaccination for Adults: Updated Recommendations of the Advisory Committee on Immunization Practices

APN Lee Ying Lan, Yvonne
SOPD (O&G)

The use of HPV vaccination is a potential way to prevent high risk HPV (HPV 6, 11, 16 and 18) infection, genital warts, and subsequent cervical carcinogenesis.

Most new HPV infections occur in adolescents and young adults. Routine HPV vaccination is recommended to all girls at 11 to 12 of age, with catch-up vaccinations at 13 to 26 years of age.

HPV vaccination is **NOT** recommended for everyone older than 26 years of age. Because most people in this age range have already been exposed to HPV, population benefit would be minimal.

Be alert that HPV vaccination only prevent NEW HPV infections but does not treat existing HPV infections.

HPV vaccination should be delayed for persons who are pregnant, but pregnancy testing is not needed before vaccination.

Persons who are breastfeeding or lactating can receive HPV vaccine.

Table 1: Recommendations for Human Papillomavirus Vaccination by the Advisory Committee on Immunization Practices, 2019

Population	Recommendation for HPV vaccination
Females or males 11-12 years of age	Routine vaccination with 3 doses at 0, 1-2, and 6 months. Can be initiated as early as age 9 and be given up to age 26
Females or males 13-26 years of age	Recommended catch up immunization with 3 doses at 0, 1-2, and 6 months
Females or males 27-45 years of age	Not recommended catch-up immunization for all adults. But recognized that some persons who are not adequately vaccinated might be at risk for new HPV infection and might benefit from vaccination in this age range. Recommended shared clinical decision-making regarding potential HPV vaccination for these persons
Female or males with inadequate dose of HPV vaccine	Minimum time between 1st and 2nd vaccine doses is 1 month. Minimum time between the 2nd and 3rd vaccine doses is 3 months. Insufficient receipt of HPV vaccine due to shorter than the recommended dosing interval should be re-administered
Females or males with interrupted vaccine schedule	HPV vaccination does not need to be restarted. The 2nd dose should be administered as quick as possible if delayed after the 1st dose. The 2nd and 3rd dose should be separated by 3 months. If just the 3rd dose is late, it should be given as soon as possible

Cervical cancer screening for individuals at average risk: 2020 guideline update from the American Cancer Society

- No clinical antibody test can determine whether a person is already immune or still susceptible to any given HPV type
- The goal of cervical cancer screening is to detect treatable abnormalities and pre-cancers that are likely to progress to invasive cancer
- The second goal is the detection of earlier stage invasive cervical cancer, which also contributes to reduced mortality and decreased treatment-related morbidity
- In 2020, the American Cancer Society updated the guideline towards the cervical cancer screening
- Screening more frequently than recommended will increase unnecessary burden and exposure to the risk of harms

Table 2: Comparison of American Cancer Society (ACS) Guidelines for Cervical Cancer Screening, 2020 & 2021

Population	Recommendations for Cervical Cancer Screening	
	ACS 2020	ACS 2012
Aged <25 years of age	No screening	Cytology alone every 3 years starting at age 21 years of age
Aged 25-65 years of age	Starting at age 25 years of age, primary HPV test alone every 5 years (preferred) Cotesting every 5 years or cytology alone every 3 years are acceptable options	Cytology alone every 3 years until age 29 years of age Aged 30-65 years of age, switch to cotesting (preferred), cytology alone every 3 years (acceptable)
Women >65 years of age	Stop screening if adequate prior negative screening result and women not at high risk	Stop screening if adequate prior negative screening result and women not at high risk

DISCUSSION AND FUTURE PERSPECTIVE ON CERVICAL CANCER PREVENTION AND SCREENING

HPV vaccines are prophylactic. They do not prevent progression of HPV infection to disease, decrease time to clearance of HPV infection, or treat HPV-related disease. It is hopeful that in the near future we will have a therapeutic HPV vaccine which can stimulate immunity and kill infected cells.

The greatest risk of mortality rates from cervical cancer is on women that are unscreened or under screened. If this population is able to benefit from low-cost screening and vaccinations subsidized by the government, it is possible that women in future generations will reduce the risk of cervical cancer.

e-Resources

Breast Cancer Risk Assessment
https://www.cancer.gov.hk/en/bctool/index.html

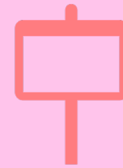
Breast Health Screening
https://www.hkbcf.org/en/breast_cancer/main/16/

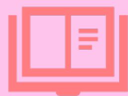
Cervical Screening Program
https://www.cervicalscreening.gov.hk/en/csp.html

Cervical Screening Service 24-hour Hotline:
3166 6631
https://www.fhs.gov.hk/english/main_ser/woman_health/phone_booking.html

EBP Activities

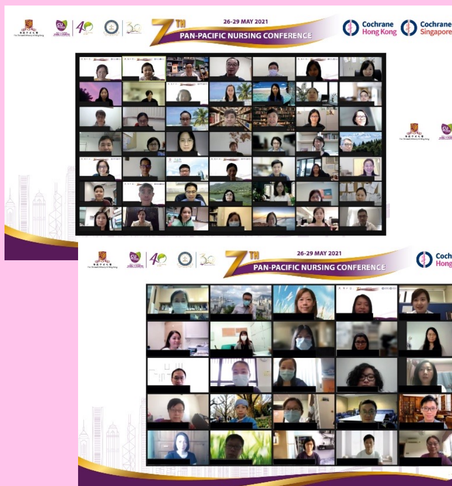
EBP Subcommittee
Logo Competition



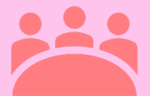


Journal Club Schedule

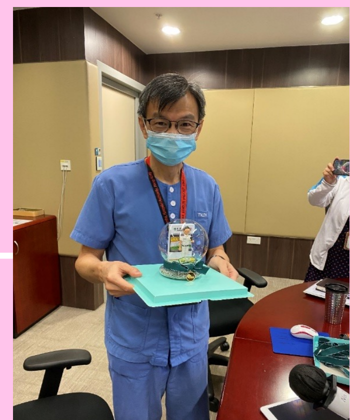
- 16 Jan 2023
- Mar 2023
- May 2023



7th Pan-Pacific
Nursing Conference
26-29 May 2021



Farewell to
Dr Chu Yin Man



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