Tackling Racial Disparities in Breast Cancer Screening

BY LINDA GOLER BLOUNT, MPH

In a year marked by the #BlackLivesMatter movement and a national conversation on racial reckoning, issues of racial disparity and injustice have seen a renewed focus across all sectors. In health care, there is a long-standing and urgent need to better understand the implications of racial bias and disparities on the health outcomes of patients, and to align on strategies to address these inequities.

A recent study from the Journal of the American College of Radiology helps shed some light on the disparities that exist for Black women with regards to breast cancer screening, finding that Black women were less likely to be screened via digital breast tomosynthesis (DBT) and also less likely to be screened multiple times during the 5-year study period than White women (2021; https://doi.org/10.1016/j.jacr.2020.12.033).

The publication is part of a comprehensive, real-world, evidence-based study designed to analyze mammograms, screening intervals, and interpretation performance for Asian, Black, and Caucasian women across health systems throughout the U.S. The study reported breast cancer screening access, utilization, and outcomes by race for 385,504 Asian, Black, and Caucasian women who underwent a total of 804,304 screening exams at 63 breast imaging facilities in the United States from January 2015 through January 2019.

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The fact that Black women were found to be less likely to receive DBT screening is particularly concerning, given that DBT is widely considered the standard of care for annual breast cancer screening. Furthermore, the study also found DBT screening improved both recall rates and cancer detection for women of all races—adding to the existing body of extensive research that has already demonstrated the benefits of DBT compared to 2D mammography.

Simply put, the study revealed Black women are receiving inferior breast cancer screening compared to White women—an alarming racial disparity. The data suggests this disparity is an urgent issue—particularly because research has shown that Black women are almost 40 percent more likely to die from breast cancer than non-Hispanic White women, despite having a similar breast cancer incidence rate. Solving for this will require a concerted effort to reduce inequalities in DBT utilization, screening intervals, and outcomes.

So, what can be done to overcome this disparity? There is a lot of work to be done on many levels. One of the first steps that should be considered is commissioning a randomized controlled study with appropriate representation from women of all races. The current USPSTF screening guidelines are based on data that fundamentally lacks diversity. Black women are not meaningfully represented in the datasets upon which these guidelines were built.

Besides the obvious implications of omitting an entire population from studies that ultimately determine the health care policy and insurance coverage for a nation, this also means the guidelines do not take into account the fact that Black women tend to get breast cancer 5-7 years younger than White women and are diagnosed at a much later stage than women of other races. And they certainly do not factor in that 6-8 percent of breast cancers in Black women occur younger than age 40.

Not only will commissioning a racially diverse, randomized controlled study have implications for screening guidelines, but it could also help us better understand why Black women develop breast cancer younger and why they have higher rates of triple-negative breast cancer. However, given such a study would take 20 years to complete, we also have to think in terms of how to support Black women now, until we have the accurate data we are currently missing.

That is why step two is to maintain the recommended age to begin breast cancer screening at 40 years for women of average risk. While there are valid concerns regarding overdiagnosis among younger women, we cannot prove it outweighs the harm for Black women, who are known to develop breast cancer at younger ages. And we know for a fact that when breast cancer is detected earlier, the chance of survival is greater and there are more treatment options available.

The next consideration is ensuring Black women are increasingly educated and encouraged to get annual mammograms beginning at age 40. The JACR data supports the need for improved educational strategies to emphasize the importance of regular screening, ideally with DBT, OB/GYNs and primary care providers play an important role in this, particularly by initiating screening conversations and making referrals, thus they should be educated to recommend DBT to their Black patients. Radiologists need to be trained on how to have conversations about results, breast health, and treatment with Black patients. Technologists can also contribute to educational efforts, particularly given the large amount of face time they have with patients. Technologists should be empowered to act as navigators and trained to help facilitate productive screening conversations between Black women and radiologists.

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Dostarlimab helps the body’s immune system in its fight against cancer cells by blocking this pathway. The safety and efficacy of dostarlimab was studied in a single-arm, multi-cohort clinical trial. Of the 71 patients with dMMR recurrent or advanced endometrial cancer who received dostarlimab in the trial, 42.3 percent had a complete response or partial response to treatment. For 93 percent of responders, the response lasted for 6 months or more.

Common side effects of dostarlimab include fatigue, nausea, diarrhea, anemia, and constipation. Dostarlimab can cause serious conditions known as immune-mediated side effects, including pneumonitis, colitis, hepatitis, endocrinopathies, and nephritis.

Patients who experience severe or life-threatening infusion-related reactions should stop taking dostarlimab. Women who are pregnant or breastfeeding should not take dostarlimab because it may cause harm to a developing fetus or newborn baby. The safety and effectiveness of dostarlimab in pediatric patients are not known.

Dostarlimab received Priority Review designation and Breakthrough Therapy designation for this indication. Priority Review designation directs overall attention and resources to the evaluation of applications for drugs that, if approved, would be significant improvements in the safety or effectiveness of the treatment, diagnosis or prevention of serious conditions when compared to standard applications. Breakthrough Therapy designation is a process designed to expedite the development and review of drugs that are intended to treat a serious condition and preliminary clinical evidence indicates that the drug may demonstrate substantial improvement over available therapy on a clinically significant endpoint(s).

Dostarlimab was approved for this new indication using the Accelerated Approval pathway, under which the FDA may approve drugs for serious conditions where there is unmet medical need and a drug is shown to have certain effects that are reasonably likely to predict a clinical benefit to patients. Further clinical trials may be required to verify and describe anticipated clinical benefits of dostarlimab and the sponsor is currently conducting these trials in additional patients with dMMR endometrial tumors.

**Immunotherapy for Endometrial Cancer With Specific Biomarker**

The FDA granted accelerated approval to dostarlimab for treating patients with recurrent or advanced endometrial cancer that has progressed on or following prior treatment with a platinum-containing chemotherapy and whose cancers have a specific genetic feature known as dMMR (which contain abnormalities that affect the proper repair of DNA inside the cell), as determined by an FDA-approved test.

“Today’s approval of [dostarlimab] is evidence of the FDA’s progress in applying precision medicine to expand treatment options for patients with cancer,” said Richard Pazdur, MD, Director of the FDA’s Oncology Center of Excellence and acting director of the Office of Oncologic Diseases in the FDA’s Center for Drug Evaluation and Research. “This immunotherapy was specifically studied to target dMMR endometrial cancer and leverages scientific knowledge surrounding the mechanism of immunotherapy response in this unmet medical need population.”

Dostarlimab works by targeting the cellular pathway known as PD-1/PD-L1. Dostarlimab helps the body’s immune system in its fight against cancer by blocking this pathway. The safety and efficacy of dostarlimab was studied in a single-arm, multi-cohort clinical trial. Of the 71 patients with dMMR recurrent or advanced endometrial cancer who received dostarlimab in the trial, 42.3 percent had a complete response or partial response to treatment. For 93 percent of responders, the response lasted for 6 months or more.

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**References**

7. JAMA Intern Med 2019; 179: 1292-1295

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Because the JACR study also found Black women were less likely to have two or more screening exams during the 4-year study period, there should be an increased emphasis on maintaining screening frequency. Screening reminders can help combat this by helping to reduce the interval between screenings, so that cancers can be diagnosed and treated earlier. Additionally, when women are sent screening invitations and reminders, health systems should pull from their entire database of women ages 40 years and older—not just those patients who have come in for their last screening exam.

Another essential step is to guarantee every woman is screened with DBT. The JACR study concluded that DBT screening improved both recall rates and cancer detection for women of all races, but also found Black women were less likely to be screened with DBT. The primary reason Black women are not being screened with DBT is because providers are not offering the technology as an option to their Black patients. That needs to change.

Even in facilities where both 2D mammography and DBT are available, providers are not recommending the better technology to their Black patients. We need to address the fact that screening mammography is not recommended as often by providers for Black women and then we need to understand why providers do not recommend DBT to Black women as often when available. Ideally, every single woman being screened for breast cancer would receive a DBT exam as the standard of care.

In addition, focus needs to be placed on improving health care access. It has been previously shown that Black women are more likely to be screened at lower resourced facilities, while also experiencing delays or interruptions to diagnosis and treatment. In the JACR study, insurance coverage of DBT was incomplete. In addition, people who are uninsured or underinsured are generally at greater risk of experiencing delays or interruptions to diagnosis and treatment. In the JACR study, insurance coverage of DBT was incomplete. In addition, in many cases, DBT screening required additional out-of-pocket payments. While Medicare and Medicaid cover DBT, not all commercial insurers will cover it. In some instances, doctors will not recommend DBT based on the patient’s insurer or if it is perceived that the patient is unable to pay for the exam.

Racial disparities are an unnecessary reality of our health care system, impacting care and outcomes for countless Black women. Overcoming this will require additional research to ensure the best evidence informs screening guidelines and treatment. We understand the origins of these disparities and must make a concerted effort to tackle them from every level and angle.