

THE CSTE WASHINGTON REPORT

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April 30, 2007

Volume 11, Number 9

INSIDE THIS ISSUE

... FY 2008 APPROPRIATIONS TIMELINE

... RECENTLY INTRODUCED BILLS OF INTEREST

... CDC LAUNCHES NEW HOME PAGE AND OTHER WEB SITE
IMPROVEMENTS

... USE OF MAMMOGRAMS AMONG WOMEN AGED ≥ 40 YEARS
--- UNITED STATES, 2000—2005

... REDUCING SODIUM DECREASES LONG-TERM RISK FOR
CARDIOVASCULAR DISEASE

... DECREASE IN BREAST CANCER RATES RELATED TO REDUCTION
IN USE OF HORMONE REPLACEMENT THERAPY

EDITOR'S NOTE: -- Breast cancer is the most commonly diagnosed cancer and the second leading cause of cancer-related death (after lung and bronchial cancer) among women in the United States (1). In 2002, at least 182,125 women in the United States had a diagnosis of invasive breast cancer, and 41,514 died from the disease* (1). Screening mammography can reduce mortality from breast cancer by approximately 20%--35% in women aged 50--69 years and approximately 20% in women aged 40--49 years (2,3). Organizations including the American Medical Association, American College of Obstetricians and Gynecologists, and American Cancer Society support mammography screening beginning at age 40 years, although these groups vary in their recommendations regarding intervals for rescreening. The U.S. Preventive Services Task Force, an independent panel of private-sector experts in prevention and primary care convened by the Department of Health and Human Services, recommends that women aged ≥ 40 years be screened for breast cancer with a mammogram every 1--2 years (4). Although mammogram use increased substantially during the 1990s (5), results from a

recent cohort study of health maintenance organization members revealed declining screening rates during 1999--2002. This report describes Behavioral Risk Factor Surveillance System (BRFSS) findings that indicate a similar decreasing trend in self-reported use of mammograms among women aged ≥ 40 years during 2000--2005. Continued declines in mammography use might result in increased breast cancer mortality-- additional details are provided in this Washington Report.

The *CSTE Washington Report* is provided as an information resource for members of the Council of State and Territorial Epidemiologists on federal legislation and regulation affecting public health and epidemiology in the U.S. Legislation cited in the report can be accessed via <http://www.thomas.loc.gov> Regulations cited can be accessed via <http://www.gpo.gov>

FY 2008 APPROPRIATIONS TIMELINE – In a recent meeting with the new Clerk of the House Labor-HHS-Education Appropriations Subcommittee, health groups learned that Appropriations Committee Chairman David Obey (D-WI) plans to finish all appropriations bills, including the Labor-HHS-Education bill, by the July 4th recess. The first series of bills to be marked up in the Subcommittee as early as May 17th could include the Labor-HHS-Education Appropriations bill. Groups were also assured that health programs, particularly those providing access to health care services, are a top priority for Chairman Obey who also chairs the Labor-HHS-Education Subcommittee. Groups were told to expect a reasonably good allocation for the Subcommittee this year and good attention to health programs in the final bill.

Health groups are also pressuring House and Senate conferees negotiating the Budget Resolution to adopt the House provision on the overall domestic discretionary cap. At \$451 billion, the House provision (H.Con. Res. 99) is \$6 billion higher than the Senate's Budget Resolution (H.Con. Res. 21). Health groups are also working with education and human service groups to push for the highest possible 302b allocation for the House and Senate Labor-HHS-Education Subcommittees on Appropriations once the final Budget Resolution is adopted. Last year this effort produced a letter with 800 groups signed on.

RECENTLY INTRODUCED BILLS OF INTEREST-- H.R. 1968, "Community Health Workers Act," introduced 4/18/07 by Rep. Hilda Solis (D-CA) authorizes \$15 million in annual grants through CDC to states, local health departments, tribes and community-based organizations to engage community health workers to target at-risk women and children in minority communities. The bill has been referred to the Energy and Commerce Committee. S. 1120, a bill introduced 4/17/07 by Senator Harkin (D-IA) creates a grant program within the CDC for training of graduate medical residents in preventive medicine and public health. The bill is not yet available on the internet. H.R. 2045, the "Promoting Lifelong Active Communities Every Day Act" or the "PLAY Every Day Act", was introduced 4/25/07 by Rep. Udall (D-CO). The bill is designed to help promote the national recommendation of physical activity to kids, families, and communities across the United States. It proposes using any additional funding under the Steps to a Healthier US program for the effort, including development of a community national play index so communities can measure the obstacles to physical activities in workplace, schools, and community settings. A small \$750,000 grant program to three states to

develop model communities of play implementation is also authorized. The bill has been referred to the Energy and Commerce Committee.

CDC LAUNCHES NEW HOME PAGE AND OTHER WEB SITE

IMPROVEMENTS -- The Centers for Disease Control and Prevention (CDC) April 9 unveiled a new look for the home page and major topic pages of its Web site. The changes are designed to make it easier for people to find health information and resources quickly. The CDC Web site address is www.cdc.gov.

The redesigned site has an improved layout, a more powerful search engine, and other features to help people locate needed health and science information more efficiently. The CDC Web site averages nine million visits a month, with an average of 37 million pages viewed monthly.

“The new CDC.gov home page is our first big step toward a truly interactive web gateway for people seeking personalized information about health issues,” said Dr. Julie Gerberding, director of the CDC. “We want all our customers – not just health professionals and scientists, but also parents, students, businesses, and other stakeholders - to get the information they need from CDC where they want it, when they want it, and how they want it.”

Among new features on the home page:

- Health and safety information is now grouped in broad, easy-to-browse topic areas. For example, clicking on “Life Stages and Populations” takes visitors to a page with sections including pregnancy, women’s health, men’s health, minority health, and more (<http://www.cdc.gov/LifeStages/>).
- Additional new features provide better access to data and statistics, recent news, tools and resources, and new publications.
- A new Google-based search engine provides more relevant search results.
- An interactive features area at the top of the new home page highlights a number of current issues, events and health topics with relevant photographs or videos. This feature enables CDC to better display health recommendations, guidelines and upcoming events.
- A “Top 20 at CDC.gov” section allows visitors to quickly view a list of the most popular health topics, and access each directly from the home page.

CDC’s new Web site improvements were guided by Internet industry studies, analyses of CDC Web site visits, information about how visitors use the CDC Web site and research conducted with a wide range of CDC.gov users. In the user studies, CDC employees, members of the public and individuals from groups that frequently use the CDC Web site (e.g., health professionals) were brought in to test the previous CDC.gov site to identify

problem areas and to test different home page designs and potential features.

"The CDC's new home page and Web site improvements were guided by extensive research with people who use it," said Jay Bernhardt, PhD, MPH, director of the National Center for Health Marketing (NCHM), the Center leading CDC's e-health and new media innovations. "We want it to be easy for people to find the health information they are seeking. We believe the millions of people who come to CDC's Web site will be pleased with these changes, and the many innovations we have planned for the months ahead."

Bernhardt pointed out that not every page on the CDC Web site has been changed yet. And he said that additional upgrades will be made in coming months.

For more information and a tutorial about the changes to the CDC Web site, visitors can take a virtual tour at <http://www.cdc.gov/vrtour.html>. Additional information and images can also be found at http://www.cdc.gov/Other/about_cdcgov.html.

USE OF MAMMOGRAMS AMONG WOMEN AGED ≥ 40 YEARS --- UNITED STATES, 2000--2005 -- Breast cancer is the most commonly diagnosed cancer and the second leading cause of cancer-related death (after lung and bronchial cancer) among women in the United States (1). In 2002, at least 182,125 women in the United States had a diagnosis of invasive breast cancer, and 41,514 died from the disease* (1). Screening mammography can reduce mortality from breast cancer by approximately 20%--35% in women aged 50--69 years and approximately 20% in women aged 40--49 years (2,3). Organizations including the American Medical Association, American College of Obstetricians and Gynecologists, and American Cancer Society support mammography screening beginning at age 40 years, although these groups vary in their recommendations regarding intervals for rescreening. The U.S. Preventive Services Task Force, an independent panel of private-sector experts in prevention and primary care convened by the Department of Health and Human Services, recommends that women aged ≥ 40 years be screened for breast cancer with a mammogram every 1--2 years (4). Although mammogram use increased substantially during the 1990s (5), results from a recent cohort study of health maintenance organization members revealed declining screening rates during 1999--2002. This report describes Behavioral Risk Factor Surveillance System (BRFSS) findings that indicate a similar decreasing trend in self-reported use of mammograms among women aged ≥ 40 years during 2000--2005. Continued declines in mammography use might result in increased breast cancer mortality.

BRFSS is a state-based, random-digit--dialed telephone survey of the civilian, noninstitutionalized adult population. BRFSS data are weighted for probability of selection and to match the age-, race-, and sex-specific populations from annually adjusted intercensal estimates. During 2000--2005, adult female respondents were asked whether they had ever had a mammogram.[†] Respondents who answered "yes" were then asked how long it had been since their last mammogram. The response rate ranged from a mean of 49.0% to 57.9% among states that posed the mammography questions. The percentage of all women aged ≥ 40 years who reported having had a mammogram within

the 2 years preceding the survey was calculated, with 95% confidence intervals (CIs), and estimates were age adjusted to the 2000 U.S. Census standard population of women. Logistic regression was used to assess the linear time trend, which was considered statistically significant if the beta coefficient for year was nonzero at $p \leq 0.01$.

The total age-adjusted proportion of all women aged ≥ 40 years who were asked the BRFSS mammography questions each year and reported having had a mammogram within the 2 years preceding the survey decreased significantly from 76.4% (CI = 75.8--76.9) in 2000 to 74.6% (CI = 73.8--75.4) in 2005 (test for trend, $p < 0.001$)

REDUCING SODIUM DECREASES LONG-TERM RISK FOR CARDIOVASCULAR DISEASE

-- Reducing sodium intake not only prevents high blood pressure, but also prevents heart disease, according to new clinical trial data from the National Heart, Lung, and Blood Institute of the National Institutes of Health. Men and women with pre-hypertension who reduced their sodium intake by 25 to 35 percent had a 25 percent lower risk of total cardiovascular disease over the 10 to 15 years after they reduced their sodium intake.

“The Long-term Effects of Dietary Sodium Reduction on Cardiovascular Disease Outcomes: Observational Follow-up of the Trials of Hypertension Prevention,” is published online on April 20, 2007 by the *British Medical Journal*.

Two Trials of Hypertension Prevention were conducted in 10 clinical sites in 1987-1990 and 1990-1995, with follow up for 10 to 15 years after that. Through dietary and behavioral intervention, participants in the trials achieved average dietary sodium reductions of 25 to 35 percent lower than their average intake before the trial. Both trials found that the reductions in sodium intake prevented high blood pressure. This new follow-up data shows that the groups who reduced their sodium intake also had lower mortality from cardiovascular disease. Mail questionnaires during the follow-up period suggested that some of the dietary changes are long-lasting, despite the difficulty in avoiding high-sodium foods in the United States.

DECREASE IN BREAST CANCER RATES RELATED TO REDUCTION IN USE OF HORMONE REPLACEMENT THERAPY

-- The sharp decline in the rate of new breast cancer cases in 2003 may be related to a national decline in the use of hormone replacement therapy (HRT), according to a new report in the April 19, 2007, issue of the *New England Journal of Medicine*. The report used data from the Surveillance, Epidemiology and End Results (SEER) program of the National Cancer Institute (NCI), part of the National Institutes of Health.

Age-adjusted breast cancer incidence rates in women in the United States fell 6.7 percent in 2003. During this same period, prescriptions for HRT declined rapidly, following highly-publicized reports from the Women’s Health Initiative (WHI) study that showed an increased risk of breast cancer, heart disease, stroke, blood clots, and urinary incontinence among postmenopausal women who were using hormone replacement therapy that included both estrogen and progestin. The two most commonly prescribed forms of HRT in the United States, Premarin® and Prempro™, had their steepest

declines starting in 2002-2003 — from 61 million prescriptions written in 2001 to 21 million in 2004.

Led by senior investigator, Donald Berry, Ph.D., of the University of Texas M.D. Anderson Cancer Center, Houston, Texas, the research team showed that the decrease in breast cancer incidence began in mid-2002 and leveled off after 2003. Comparing rates from 2001 and 2004 showed a decrease in annual age-adjusted incidence of 8.6 percent. The decrease occurred only in women over the age of 50 and was more evident in women with cancers that were estrogen receptor (ER) positive — tumors that need estrogen in order to grow and multiply. The speed at which breast cancer rates declined after the WHI announcements may indicate that extremely small ER-positive breast cancers may have stopped progressing, or even regressed, after HRT was stopped.

“Breast cancer is the most frequently diagnosed cancer among women in the United States, and we have made great strides in its treatment,” said NCI Director John E. Niederhuber, M.D. “Still, we don’t know all the causes of breast cancer, and breast cancer rates had been increasing for two decades up to 2002. Finding the simple ways, such as limiting HRT use to decrease breast cancer risk, is a step forward.” Preliminary findings of this report were presented at the 29th annual San Antonio Breast Cancer Symposium in 2006. Data from 2004, which was of great interest to those present for the meeting, were not available at that time. This report now includes the data from 2004, which show a leveling-off of breast cancer incidence from 2003 to 2004. This observation, combined with a stabilization of HRT use in 2004, further strengthens the association between breast cancer incidence and use of HRT.

Understanding the effect of cessation of HRT may be complex. Effects may vary depending on the type of HRT used and other factors specific to how the hormones affect the body. From the data in this report, it seems that the decline in breast cancer incidence that is related to a nationwide decline in use of HRT may have run its course, and breast cancer incidence rates may stabilize or even begin to rise again. Researchers do not yet know if this reduction in HRT use will have a long-term effect on rates, or whether reduction in hormone levels simply slowed the growth of clinically detectable tumors, in which case as HRT use stabilizes, breast cancer incidence will begin to rise again.

Several other possibilities were considered to explain the sudden decrease in new breast cancer cases, including changes in reproductive factors, rates of mammography screening, environmental exposures, and changes in diet. HRT was the only risk factor that changed substantially from 2002 to 2003 and provides a possible explanation for this trend. “Recent reports have suggested a small decline in mammography use after 2000,” said Kathy Cronin, Ph.D., of the Surveillance Research Program at NCI. “Screening may play a role as well, and the contribution of mammography to the observed decline in incidence is currently being investigated.”

Because this analysis is based on population statistics, the study does not prove a link between HRT and breast cancer incidence. Only a randomized clinical trial could prove causation. When the link between breast cancer and HRT was first confirmed in the

WHI, which was a randomized clinical trial, women in the study were asked to discontinue their study medications (either placebo or hormones), and were encouraged to continue undergoing annual mammography. These women are still being followed, and the WHI researchers are expected to release a follow-up report later this year about the group who received HRT (estrogen and progestin) later this year. This report will provide a much higher level of evidence about the influence of HRT (and cessation of HRT) on the incidence of breast cancer.

“The decision about use of HRT is complex,” says study researcher Christine Berg, M.D., from the National Cancer Institute. “While HRT provides relief from the symptoms of menopause, it may also increase one’s risk of breast cancer. It is important that women meet with their doctor to discuss what decision is right for them, particularly if they are at high risk for breast cancer.”