

Lower Minority Screening Rates Tied to Mistrust

BY PATRICE WENDLING

Mistrust of the health care system was linked to lower use of breast cancer screening among black, Hispanic, and Arab American women, in a prospective study of 341 patients from these ethnic groups.

Using the previously validated seven-item Medical Mistrust Index, community health workers found that more than 40%

of the women in these three racial-ethnic groups agreed or strongly agreed with all of the mistrust statements in the index.

For example, 49% of surveyed women agreed with the statement that “Patients have sometimes been deceived or misled by health care organizations.”

Black, Hispanic, and Arab American women with higher levels of mistrust were less likely to adhere to appropriately timed breast cancer screening, Dr. Karen Patricia Williams and her associates reported at the American Association for Cancer Research conference on the science of cancer health disparities.

Overall, 44% of these women who had never had a clinical breast exam agreed with the statement that “Health care organizations have sometimes done harmful experiments on patients without their knowledge,” compared with 38% of women who had ever received a clinical breast exam. The difference between groups was significant.

Significantly more women who had not received a clinical breast exam in the previous 12 months (49%) also agreed with this same statement, compared with women who had had a breast exam in the previous 12 months (33%), the investigators reported.

In addition, 64% of women who had no history of an exam in the previous 12 months agreed with the statement “Sometimes I wonder if health care organizations really know what they are doing,” compared with 47% of those who had received an exam in the past year—a significant difference.

“Typically, what we have done is intellectualize the problem; that the problem is that blacks have a memory of the Tuskegee Experiment,” Dr. Williams said in an interview. “But this shows that

medical mistrust goes beyond Tuskegee to where we are today in 2009,” and that it’s not just blacks, but also Arabs and Hispanics.

“That says something about the system and that we need to work on the system itself,” she said.

Black women were found to have the highest level of medical mistrust.

More than one-third (39%) of black women strongly agreed with the statement that “Health care organizations don’t always keep your information totally private,” compared with 15% of Hispanic women and 9% of Arab American.

Hispanic and Arab American women may have demonstrated less distrust because many were newly immigrated and may have had limited experience with the health care system, according to Dr. Williams of the departments of obstetrics, gynecology, and reproductive biology at Michigan State University, East Lansing.

The Medical Mistrust Index was orally administered by community health workers in English, Spanish, or Arabic to 116 black women, 113 Hispanic women, and 112 Arab American women.

Their median age was 44 years (range 21-87 years). Annual income was \$40,000 or more for 14% of black women and 8% of Hispanic and Arab women.

Insurance was in place for 94% of blacks, 45% of Hispanics, and 43% of Arabs.

During a press conference at the meeting, Dr. Williams acknowledged

that insurance coverage plays a large role in the use of cancer screenings but said that the role of medical mistrust cannot be ignored.

She urged health care organizations to tailor prevention interventions to individual ethnic groups, rather than adopting a “one size fits all” approach.

All of the women in the study were marginalized, she said, citing racial discrimination for blacks, immigration concerns for Hispanics, and anger toward Arabs over Sept. 11.

When asked specifically how this played

out in the patient-physician interaction, Dr. Williams said they had only anecdotal information and it was directed at the health care system as a whole.

She also noted that women in the study used various health care systems in southeast Michigan, suggesting that mistrust is not with one problematic clinic, but rather is systemwide.

“Our medical systems in general have some work to do to build trust with racial [minorities] and ethnic women,” she said.

It is unclear how the level of medical mistrust observed in these three ethnic groups compares with mistrust among whites, Dr. Williams said.

The next step is to study the issue in a larger, national population as it relates to the use of breast and cervical screening and other medical services.

The study was funded by Susan G. Komen for the Cure.

The investigators reported no conflicts of interest. ■

Nearly 50% of surveyed minorities agreed that ‘Patients have sometimes been deceived or misled by health care organizations.’

Prenate DHA[®]

Rx prenatal vitamin & DHA

DESCRIPTION: PRENATE DHA[®] is a prescription prenatal/postnatal multi-vitamin/mineral/essential fatty acid softgel. Each softgel is blue-green in color, opaque, and imprinted with “Prenate DHA” on one side.

Each softgel contains

Vitamin C (ascorbic acid)	85 mg
Vitamin D ₃ (cholecalciferol)	200 IU
Vitamin E (d-alpha tocopherol)	10 IU
Vitamin B ₆ (pyridoxine HCl)	25 mg
Folate	1 mg
(L-methylfolate as Metafolin [®] 600 mcg)	
(folic acid USP 400 mcg)	
Vitamin B ₁₂ (cyanocobalamin)	12 mcg
Calcium (calcium carbonate)	150 mg
Iron (ferrous fumarate)	27 mg
Magnesium (magnesium oxide)	50 mg
Docosahexaenoic Acid (DHA)	300 mg
(from 365 mg omega-3 fatty acids)	
Calcium Docosate	not more than 50 mg

Other Ingredients: Soy lecithin, beeswax, corn oil, fish oil, hydrogenated vegetable oil, gelatin, sorbitol, glycerin, propylene glycol, titanium dioxide, vanillin, FD&C blue No. 1, hypromellose.

INDICATIONS: PRENATE DHA is a multivitamin/mineral/essential fatty acid nutritional supplement indicated for use in improving the nutritional status of women throughout pregnancy and in the postnatal period for both lactating and non-lactating mothers. PRENATE DHA can also be beneficial in improving the nutritional status of women prior to conception.

CONTRAINDICATIONS: PRENATE DHA is contraindicated in patients with a known hypersensitivity to any of the ingredients.

WARNING: Ingestion of more than 3 grams of omega-3 fatty acids (such as DHA) per day has been shown to have potential antithrombotic effects, including an increased bleeding time and International Normalized Ratio (INR). Administration of omega-3 fatty acids should be avoided in patients taking anticoagulants and in those known to have an inherited or acquired predisposition to bleeding.

WARNING: Accidental overdose of iron-containing products is a leading cause of fatal poisoning in children under 6. Keep this product out of reach of children. In case of accidental overdose, call a doctor or poison control center immediately.

PRECAUTIONS: Folic acid alone is improper therapy in the treatment of pernicious anemia and other megaloblastic anemias where vitamin B₁₂ is deficient. Folic acid in doses above 1 mg daily may obscure pernicious anemia in that hematologic remission can occur while neurological manifestations progress.

ADVERSE REACTIONS: Allergic sensitization has been reported following both oral and parenteral administration of folic acid.

DOSE AND ADMINISTRATION: Before, during, and/or after pregnancy, one softgel daily or as directed by a physician.

HOW SUPPLIED: Unit-dose packs of 30 softgels
NDC #59630-414-35

KEEP THIS AND ALL DRUGS OUT OF THE REACH OF CHILDREN.

Store at 20°-25°C (68°-77°F). Excursions permitted to 15°-30°C (59°-86°F).

[See USP Controlled Room Temperature]

Scieele
Pharma, Inc.

Manufactured by:

Scieele Pharma, Inc.
Atlanta, Georgia 30328

Manufactured by:

Catalent Pharma Solutions
Swindon, UK

Made in the United Kingdom

U.S. Patents #5,997,915; #6,254,904; #6,011,040; #6,451,360;
#6,673,381; #6,808,725; #6,441,168

Metafolin[®] is a registered trademark of Merck KGaA, Germany
For inquiries call 1-800-849-9707 extension 1454.

PND-Pl-3 Rev 08/07

Higher Stroke Risk Tied to Early Menopause

BY ROBERT FINN

SAN DIEGO — Women who reach menopause before the age of 42 years are twice as likely to suffer a stroke in later life as women who reach menopause after age 42, according to a new analysis of data from the Framingham Heart Study presented at the International Stroke Conference.

The study involved prospectively collected data from 1,430 women who were followed for an average of 22 years, said Lynda Lisabeth, Ph.D., of the University of Michigan, Ann Arbor. All participants were stroke-free at 60 years of age, experienced natural menopause, and had never taken estrogen before menopause. The use of self-reported data on the age of menopause was a limitation of the study, Dr. Lisabeth acknowledged.

In all, the women had 234 ischemic strokes at an average age of 80 years. The unadjusted rate of strokes was 23% among women who reached menopause before the age of 42 years, 16% among women who reached menopause be-

tween the ages of 42 and 54 years, and 11% among women who reached menopause at age 55 years or older.

After adjustment for age, systolic blood pressure, atrial fibrillation, diabetes, current smoking, cardiovascular disease, and estrogen use after menopause, the investigators determined that the age of menopause was an independent predictor of ischemic stroke.

Compared with women who reached menopause before age 42 years, women who reached menopause between ages 42 and 54 years were half as likely to experience a stroke, and those who reached menopause at age 55 or older were 69% less likely to experience a stroke.

In other words, women who reached menopause before age 42 years were 2.03-fold more likely to have a stroke than the other women. This difference was statistically significant.

The study showed that 4%-5% of strokes in women can be attributed to menopause before age 42, Dr. Lisabeth said.

About 1%-2% of women reach meno-

pause at or before age 40 years, which is referred to as “premature ovarian failure.” The etiology of this condition remains unknown, but investigators are certain that it’s different than natural menopause. About 3%-10% of women experience “early” menopause, defined as natural menopause before age 45 years.

Several possible mechanisms could account for the increased rate of stroke, Dr. Lisabeth said. Estrogen may play a role, since estrogen deficiency is thought to promote cardiovascular disease through functional or structural changes in arteries. Androgens and sex hormone-binding globulin are also risk factors for cardiovascular disease.

Additional studies with measures of endogenous hormones would be needed to unravel the relationship between the hormonal changes of menopause and ischemic stroke, she said.

The study was supported by the National Heart, Lung, and Blood Institute and the National Institute of Neurological Disorders and Stroke. Dr. Lisabeth said that she had no conflicts of interest. ■