Title: Awareness of Breast Cancer

Ghanwa Aman Paracha[1], Ahsan Ali Lakho[2], Shoaib Muhammad[3], Mariam Younis Paracha[4]

[1]MBBS, Sir Syed College of Medical Sciences, Karachi, Pakistan. ghanwa7@hotmail.com
[2]FCPS Part II Resident of Cardiology, National Institute of Cardiovascular Diseases, Karachi, Pakistan.
ahsanlakho39@yahoo.com
[3]FCPS Part II Resident of General Surgery, Jinnah Postgraduate Medical Centre, Karachi, Pakistan. drshoaib.bmc@gmail.com
[4] BDS, Lecturer Jinnah Medical & Dental College, Karachi, Pakistan. Dr.my.paracha12@gmail.com

ABSTRACT:

BACKGROUND:

OBJECTIVE: To determine "Awareness of Breast cancer among fourth and final year MBBS students**."**

METHODOLOGY:

We conducted cross-sectional study to know about the suspected cause most frequently occurring in those females who are aware of breast cancer or in those who are not aware of breast cancer. The sample technique was non-probability convenience and the sample size was one hundred and twenty (20). Attributes of subjects that are essential for their selection to participate are females whether pregnant, single or married. We excluded males because breast cancer of males is uncommon. We collected data via a structured questionnaire derived from literature. We ourselves informed each respondent. The questionnaire consisted of 28 questions. Data were entered in SPSS version 20.

RESULTS:

One hundred and twenty eligible patients (females) were identified. Majority of the females are unaware of mammography (screening). Mostly hesitate so that's why don't visit male doctor. Our result is significant because females were aware of breast cancer but does not have knowledge about Brest Self Examination.

CONCLUSION:

The findings indicated that the women awareness of breast cancer warning signs (painless lump, retraction of nipple, and blood discharge). Clinical examination and mammography were very inadequate. Therefore we should encourage them to report any unusual changes in their breast to their family or care physicians.

INTRODUCTION:

Breast cancer is one of the most common cancers among females worldwide. Global statistics show the annual incidence of breast cancer is increasing and this is occurring more rapidly in countries with a low incidence rate of breast cancer [1][2]. It has been reported that each year over 1.15 million women worldwide are diagnosed with breast cancer and 502,000 die from the disease [3]. In Iran the incidence of the disease is rising, patients present with advanced stage of disease and they are relatively younger (about 10 years) than their western compartments [4][5].

Early detection of breast cancer plays the leading role in reducing mortality rates and improving the patients' prognosis [7]. The recommended screening methods for early detection of this fatal disease are: mammography, clinical breast examination and breast self-examination (BSE).

Mammography is an expensive modality for screening and needs several requisites including logistic and professional manpower before its implementation. Randomized trials comparing mammography with no mammography screening found that at best women might benefit a 15% relative risk reduction in mortality from mammography [8]. In addition it has been shown that for women under the age of 50 years mammography screening is ineffective [9].

Clinical breast examination is relatively simple and inexpensive but the exact benefit of this screening modality in reducing mortality is yet to be established. It is argued that in diagnosis of breast cancer by screening the shift should be to the point that will cost least both in human and financial terms and be effective in reducing mortality, and that clinical breast examination would be able to fulfill this [10]. However, it has been shown that clinical breast examination could only detect about 60% of breast cancers detected by mammography as well as some breast cancers not detected by mammography [11]. Recent estimates suggest that clinical breast examination has a sensitivity of about 54% and specificity of about 94% [12].

- RISK FACTORS:

The risk factors are family history (13%), Race (Caucasians), BRCA 1 and 2 mutations, Alcohol consumption, Lack of exercise, Radiation exposures, Environmental toxins, Hormonal factors, Avoidance of breast feeding.

- CLASSIFICATION:

Breast Cancer is classified into two categories which are: In-Situ Carcinoma (15-30%) and Invasive Carcinoma (60-75%).

- CLINICAL FEATURES:

The Clinical features are: Painless mass in the breast, Mass is hard and has a gritty feeling, Bloody nipple discharge, circumferential nipple retraction. The most common site where breast cancer occurs is upper outer quadrant**.**

- METASTATIC FEATURE:

Bone pain, Pleural effusion, Jaundice and Hepatomegaly, and Weight loss.

- MAJOR PROGNOSTIC FACTORS:

Axillary lymph node metastasis, Distant metastasis, Tumor size, and Staging.

- MINOR PROGNOSTIC FACTORS:

Estrogen and progesterone receptors, Her2/neu expression, Lymphovascular invasion

- OTHER FACTORS:

Grading system, DNA ploidy, and Proliferative rate.

- BREAST CANCER AS A BRAND:

Breast cancer advocacy uses the pink ribbon and the color pink as a concept brand to raise money and increase screening. The breast cancer brand is strong: people who support the "pink brand" are members of the socially aware niche market, who are in favor of improved lives for women, believe in positive thinking, trust biomedical science to be able to solve any problem if given enough money, and prefer curative treatments to prevention. The brand ties together fear of cancer, hope for early identification and successful treatment, and the moral goodness of women with breast cancer and anyone who visibly identifies themselves with breast cancer patients. This brand permits and even encourages people to substitute conscientious consumption and individual symbolic actions, like buying or wearing a pink ribbon, for concrete, practical results, such as collective political action aimed at discovering non-genetic causes of breast cancer. The establishment of the brand and the entrenchment of the breast cancer movement has been uniquely successful, because no countermovement opposes the breast cancer movement or believes that breast cancer is desirable.

– THE SHE-RO:

The term "she-ro", derived from hero, is used in discussions of breast cancer to refer to women who have been diagnosed with breast cancer, and sometimes to those who have survived breast cancer. The term describes an "idealized" patient who combines assertiveness, optimism, femininity and sexuality, despite the effects of treatment, and as a "paragon [who] uses a diagnosis of breast cancer as a catalyst for a personal transformation".

– CONSEQUENCES:

The effort of maintaining the role of a she-ro can be stressful. The role encourages women to care for others rather than themselves, which the patient may find comforting, but this may lead to the reluctance or inability to ask for help they need or want which can lead to bitterness that their friends and family did not offer these services unbidden. The success of the patient's normalization efforts may paradoxically increase their dissatisfaction, as their apparent ability to handle it all discourages people from offering help. The breast cancer culture celebrates women who display the attitude deemed correct, which implies that their continued survival is due to this positive attitude and fighting spirit. While cheerfulness, hope, and good social support can be advantageous to health outcomes, it cannot determine survival rates. Women who reject the she-ro model may find themselves socially isolated by the breast cancer support groups that are nominally supposed to help them. Support from "the sisterhood" favors the "passionately pink", and tends to overlook those whose response is incompatible with the pink ribbon culture because it is angry, unhappy, or afraid.

– BREAST CANCER CULTURE:

The breast cancer culture is ill-equipped to deal with women who are dying or who have died and their experiences may not be memorialized, validated or represented as part of the movement, instead being ignored or shunned as failures and as hope-destroying examples of reality. Similarly, the culture is also ill-equipped to deal with the news that a previously hyped treatment or screening procedure has been determined to be ineffective, with women advocating for the acceptance and promotion of inexpedient activities and inefficient or even sometimes harmful drugs.

– INCREASED RESOURCES AND FOR TREATMENT AND RESEARCH:

Supporting breast cancer was seen as a distinctively pro-woman stance popular among public official. This has resulted in better access to care. For example, in much of the United States, low-income women with breast cancer may qualify for taxpayer-funded health care benefits, such as screening mammography, biopsies, or treatment, while women with the same income, but another form of cancer or a medical condition other than cancer, do not. Breast cancer advocates have successfully increased the amount of public money being spent on cancer research and shifted the research focus away from other diseases and towards breast cancer. Breast cancer advocates also raise millions of dollars for research into cures each year, although most of the funds they raise is spent on screening programs, education and treatment. Most breast cancer research is funded by government agencies. The high level of awareness and organized political lobbying has resulted in a disproportionate level of funding and resources given to breast cancer research and care. Favoring breast cancer with disproportionate research may have the unintended consequence of costing lives elsewhere. In 2001 UK MP Ian Gibson said, "The treatment has been skewed by the lobbying, there is no doubt about that. Breast cancer sufferers get better treatment in terms of bed spaces, facilities and doctors and nurses."

SIGNIFICANCE OF THE STUDY:

- To developed awareness about the breast tumor at the community level.

- Aims to highlight the significance of attending breast screenings in detecting

breast cancers as early as possible and increasing the chances of successfully managing and treating the disease.

METHODOLOGY:

- **STUDY DESIGN:**
  - The study conducted was Cross-Sectional.

- **SAMPLING TECHNIQUE:**
  - The study's sampling technique was non probability convenience.

- **SAMPLE SIZE:**
  - Total samples were 120.

- **INCLUSION DATA:**
  - Attributes of subjects that are essential for their selection to participate (Females whether pregnant, single, and married).

- Most common age group was between 20 and 28.
- Many of the females got there periods in the age of 12 or 13 years old.
- Health status was good.
- Many of the female used hormonal contraceptives in the form of control pills, implants and injections.
- Positive family history (1st degree relations).
- Not associated with co-morbidities.
- Not associated with tobacco.
- No prior exercise within first 24 hours.
- BMI range was 18.5 to 24.9.
- No risk of other infections.
- Written consent form was obtained.

- **EXCLUSION DATA:**

Responses of subjects that require their removal as subjects (Males, Children's, and Diseased patients).

- Diseased patients were excluded because we wanted to know awareness in healthy patients.
- Male having breast cancer is not common.
- Young children and adolescents have just a 0.1 percent chance of developing breast cancer.
- Many of the patients were unaware of mammography.
- Many of the people were unaware of BSE.
- Many of the patients were with BMI range (30).
- Health status (suffering from any disease, unstable, disability).
- Associated with other risk factors and infections.
- Unaware of exercise.
- Alcohol consumption.
- Unaware about the treatment of breast cancer.
- Mostly avoid visiting doctor.

- **DATA COLLECTION PROCEDURE:**

Data were collected via a structured questionnaire derived from the literature. We ourselves informed each respondent. An informed consent was obtained before conducting the interviews. The questionnaire consisted of 28 questions on marital status, history of personal breast problems, family history of breast cancer, knowledge about breast cancer covering its symptoms, the screening methods and practice of BSE, .age of menarche, pain on BSE, BMI, use of contraceptive pills, knowledge about awareness of breast cancer, and does mammography will help in anyway, ETC.

ETHICAL BOARD:

Study was approved by ethical review board of "SIR SYED COLLEGE OF MEDICAL SCIENCES FOR GIRLS."

- **STATISTICAL ANALYSIS:**

Data were entered in SPSS version 20.Continuous variables were presented as mean± STD. Categorical variables were presented as frequency (%). Chi-square tests were used to check the associations between the categorical variables. P-value less than 0.05 were considered statistically significant.

LITERATURE REVIEW:

Al Otaibi Sh[1], Al Harbi M, Al Kahmoas A, Al Qhatani F, Al Mutairi F, Al Mutairi T, Al Ajmi R, Al Mousawi F.

Breast cancer is the most common cancer among women globally. Early diagnosis can improve prognosis and breast self-examination (BSE) may be a cost effective way to achieve this. Only a few studies have been conducted to address breast cancer awareness. Most showed a suboptimal level of understanding. The cross-sectional survey study was conducted in accordance to assess the current knowledge and practices of women regarding breast self-examination and mammography screening. The sample comprised of 137 females aged 18 and older. Data were collected using face-to-face interviews with a questionnaire and analyzed using SPSS. Similar to previous studies', the results were suboptimal. Out of the 137, about 54% claimed they are aware of breast cancer and BSE, however, only 62% of them knew how to conduct self-examination. Far fewer were aware of mammography screening (38%). When asked about the source of breast cancer information, most of the women answered awareness campaigns (39%) while school/university and TV (22% each) were the sources for others.

Kirubakaran R[1], Chee Jia T, Mahamad Aris N.

Background: Breast cancer is the commonest cancer among women worldwide. A cross-sectional survey using a validated self administered questionnaire was conducted among 119 consecutive surgical female patients admitted from 1st of September to 8th of October 2015 in Hospital Sultan Abdul Halim, Kedah. Data were analyzed using General linear regression and Spearman's correlation with Statistical Package for Social Science (SPSS) version 20. Results: Mean (SD) age was 40.6 (15.1) years and majority of the patients were Malay (106, 89.1%). Mean scores for general knowledge, risk factors and symptoms of breast cancer were 50.2 (24.0%), 43.0 (22.9%) and 64.4 (28.4%) respectively. Mean total knowledge score was 52.1(19.7%). 80 (67.2%) and 55 (46.2%) patients were aware of breast self-examination and clinical breast examination recommendations, respectively. Knowledge was significantly better among

married women with spouses (p=0.046), those with personal history of breast cancer (p=0.022) and with monthly personal income (p=0.001) with the coefficient of determination, R2=0.16. .

Conclusion: Awareness on breast cancer among our patients was average. Thus, there is a need for more awareness programs to educate women about breast cancer and promote its early detection.

O'Mahony M[1], Comber H[2], Fitzgerald T[3], Corrigan MA[4], Fitzgerald E[5], Grunfeld EA[6], Flynn MG[7], Hegarty J

We included two RCTs involving 997 women: one RCT (867 women) randomized women to receive either a written booklet and usual care (intervention group 1), a written booklet and usual care plus a verbal interaction with a radiographer or research psychologist (intervention group 2) or usual care (control group); and the second RCT (130 women) randomized women to either an educational programmed (three sessions of 60 to 90 minutes) or no intervention (control group).

Knowledge of breast cancer symptoms In the first study, knowledge of non-lump symptoms increased in intervention group 1 compared to the control group at two years postintervention, but not significantly (OR 1.1, 95% CI 0.7 to 1.6; P = 0.66; 449 women; moderate-quality evidence). Similarly, at two years' post intervention, knowledge of symptoms increased in the intervention group 2 compared to the control group but not significantly (OR 1.4, 95% CI 0.9 to 2.1; P = 0.11; 434 women; moderate-quality evidence).

In the second study, women's awareness of breast cancer symptoms had increased one month post intervention in the educational group (MD 3.45, SD 5.11; 65 women; low-quality evidence) compared to the control group (MD -0.68, SD 5.93; 65 women; P < 0.001), where there was a decrease in awareness. Knowledge of age-related risk. In the first study, women's knowledge of age-related risk of breast cancer increased, but not significantly, in intervention group 1 compared to control at two years' post intervention (OR 1.8; 95% CI 0.9 to 3.5; P < 0.08; 447 women; moderate-quality evidence). Women's knowledge of risk increased significantly in intervention group 2 compared to control at two years' post intervention (OR 4.8, 95% CI 2.6 to 9.0; P < 0.001; 431 women; moderate-quality evidence). In the second study, women's perceived susceptibility (how at risk they considered themselves) to breast cancer had increased significantly one month post intervention in the educational group (MD 1.31, SD 3.57; 65 women; low-quality evidence) compared to the control group (MD -0.55, SD 3.31; 65 women; P = 0.005), where a decrease in perceived susceptibility was noted. Frequency of Breast Checking In the first study, no significant change was noted for intervention group 1 compared to control at two years postintervention (OR 1.1, 95% CI 0.8 to 1.6; P = 0.54; 457 women; moderate-quality evidence). Monthly breast checking increased, but not significantly, in intervention group 2 compared to control at two years' post intervention (OR 1.3, 95% CI 0.9 to 1.9; P = 0.14; 445 women; moderate-quality evidence). In the second study, women's breast cancer preventive behaviors' increased significantly one month post intervention in the educational group (MD 1.21, SD 2.54; 65 women; low-quality evidence) compared to the control group (MD 0.15, SD 2.94; 65 women; P < 0.045). Breast Cancer Awareness women overall breast cancer awareness did not change in intervention group 1 compared to control at two years post intervention (OR 1.8, 95% CI 0.6 to 5.30; P = 0.32; 435 women; moderate-quality evidence) while overall awareness increased in the intervention group 2 compared to control at two years' post intervention (OR 8.1, 95% CI 2.7 to 25.0; P < 0.001; 420 women; moderate-quality evidence). In the second study, there was a significant increase in scores on the Health Belief Model (that included the constructs of awareness and perceived susceptibility) at one month post intervention in the educational group (mean 1.21, SD 2.54; 65 women) compared to the control group (mean 0.15, SD 2.94; 65 women; P = 0.045).Neither study reported outcomes relating to motivation to check their breasts, confidence to seek help, time from breast symptom discovery to presentation to a healthcare professional, intentions to seek help, quality of life, adverse effects of the interventions, stages of breast cancer, survival estimates or breast cancer mortality rates.

Lukong KE[1.]

BACKGROUND:

Despite a remarkable increase in the depth of our understanding and management of breast cancer in the past 50 years, the disease is still a major public health problem worldwide and poses significant challenges. The palpability of breast tumors has facilitated diagnosis and documentation since ancient times. The earliest descriptions of breast cancer date back to around 3500 BCE. For centuries to follow, theories by Hippocrates (460 BCE) and Galen (200 CE), attributing the cause of breast cancer to an "excess of black bile" and treatment options including the use of opium and castor oil, prevailed. Surgical resection was introduced in the 18th century. The advent of modern medicine led to the development of novel treatment options that include hormonal, targeted and chemo-therapies. There are still several therapeutic challenges including the treatment of triple negative breast cancer (TNBC), and overcoming drug resistance.

Santiago-Rivas M[1], Benjamin S[2], Jandorf L[2].

Author information

Abstract

We reviewed the literature on breast density knowledge and breast density awareness to explore what challenges are faced by this area of research.

A review of PubMED, PsycINFO, and CINAHL databases was performed. Studies were published in peer-reviewed journals (in all years available) and written in English. The broad search terms used were ["breast density"] AND ["knowledge" OR "awareness"]. Eligible articles were included in the final analysis after meeting the following inclusion criteria: (1) the records had to quantitatively examine and report breast density knowledge and awareness, (2) the number of participants in the sample had to be clearly specified, and (3) studies reporting differences in breast density knowledge and awareness between racial and ethnic groups were included in the review.

The 277 articles identified, only 5 met inclusion criteria and addressed breast density knowledge and awareness. Characteristics of studies and results were examined. There is insufficient evidence to determine a pattern of breast density knowledge and awareness in women. More quality studies are needed that focus on how well women understand the relationship between breast density, breast cancer risk, and breast cancer screening, especially in diverse populations.

RESULTS:

One hundred and twenty eligible patients (females) were identified. Baseline pain during BSE P-value>0.05 (non-significant) and clinically examination of breast P-value<0.05 (significant). Majority of females are unaware of mammography (screening), mostly hesitate so that's why they don't visit male doctor. According to our research

result females have knowledge about the awareness of breast cancer but most of the females don't have knowledge about BSE (Breast Self Examination). Majority of females don't smoke which is a significant result but females are not prior to exercise within 24 hours instead they should do exercise on regular basis. Family history according to this research is uncommon. Very less females have felt lump or nodule in their breast and most of them are with good health status.

TABLE NO. 1: What is your marital status? * What is your current age?

Crosstab

What is your marital status?	Married	Count			
		% within What is your marital status?			
	Single	Count		50	40	90
		% within What is your marital status?	55.6%	44.4%	100.0%
Total		Count			
		% within What is your marital status?			

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	4.444a	1			
Continuity Correctionb	3.600	1			
Likelihood Ratio	4.511	1			
Fisher's Exact Test					
N of Valid Cases	120				

a. 0 cells (.0%) have expected count less than 5. The minimum expe

b. Computed only for a 2x2 table
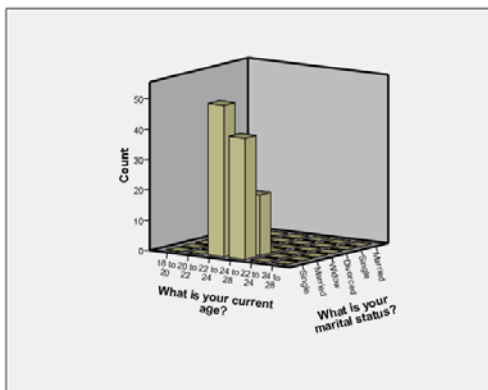
We cross tabulated between Age and Marital Status. This table indicated what is your age in married females are more likely to (22 to 24) (33.3%) and (24 to 28) (66.7%). Similarly, what is your age in single females are more likely to (22 to 24) (55.6%) and (24 to 28) (44.4%). P-value<0.05 this mean statistically significant association between them.

TABLE NO.2: What is your body mass index? * What is your current age?

Crosstab

What is your body mass index?	18.5 to 24.9	Count	
		% within What is your body mass index?	
	25 to 29.9	Count	
		% within What is your body mass index?	
	30	Count	
		% within What is your body mass index?	
Total		Count	
		% within What is your body mass index?	

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	10.470a	2	.005
Likelihood Ratio	10.652	2	.005
N of Valid Cases	120		

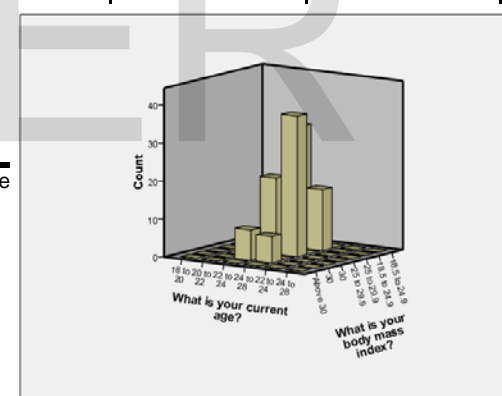a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 7.50.

We cross tabulated between Age and BMI. This table indicated what is your age and BMI in females with normal BMI are more likely to (22 to 24) (66.7%) and (24 to 28) (33.3%), what is your age and BMI in over weight females are more likely to (22 to 24) (35.1%) and (24 to 28) (64.9%) and what is your age and BMI in obese females are more likely to have (22 to 24) (53.3%) and (24 to 28) (46.7%). P-value<0.05 this mean statistically significant association between them.

**TABLE NO.3: Do you have pain in your breast during BSE? * What is your current age?**

Crosstab

Do you have pain in your breast during BSE?	No	Count	
		% within Do you have pain in your breast during BSE?	
	Yes	Count	

		% within Do you have p... your breast during BSE...	
Total	Count		
		% within Do you have p... your breast during BSE...	

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	2.160ᵃ	1	
Continuity Correctionᵇ	1.500	1	
Likelihood Ratio	2.188	1	
Fisher's Exact Test			
N of Valid Cases	120		

a. 0 cells (.0%) have expected count less than 5. The minimum expe...

b. Computed only for a 2x2 table
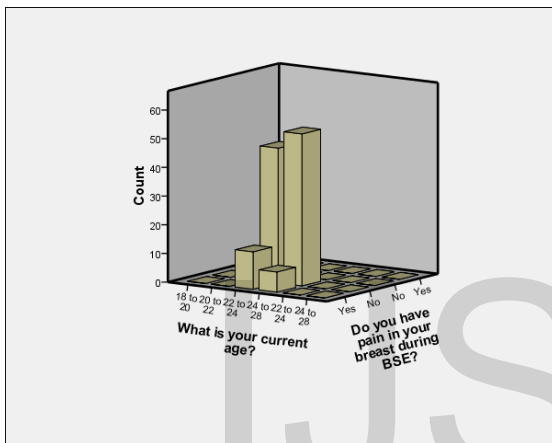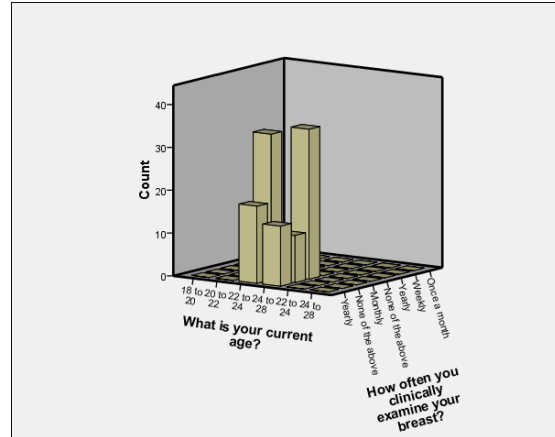
We cross tabulated between Age and Pain during BSE. This table indicated what is your age and do you have pain during BSE in females with no pain are more likely to (22 to 24) (47.0%) and (24 to 28) (53.0%). Similarly, what is your age and do you have pain during BSE in females with pain are more likely to (22 to 24) (65.0%) and (24 to 28) (35.0%). P-value>0.05 this mean statistically non-significant association between them.

TABLE NO.4: How often you clinically examine your breast? * What is your current age?

Cr...

How often you clinically examine your breast?	Monthly	Count		
		% within examine... your...		
	None of the above	Count		
		% within examine...		
	Yearly	Count		
		% within examine...		
Total		Count		
		% within examine...		

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	29.209ᵃ	2	.000
Likelihood Ratio	31.124	2	.000
N of Valid Cases	120		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 16.00.

| Exact Sig. (2-sided)	Exact Sig. (1-sided)

We cross tabulated between Age and Clinically examination of breast. This table indicated what is your age and how often you CEB in females who don't clinically exam their breast is more likely to (22 to 24) (75.6%) and (24 to 28) (24.4%). Similarly, what is your age and how often you CEB in females who yearly examine their breast are more likely to (22 to 24) (56.3%) and (24 to 28) (43.8%). P-value<0.05 this mean statistically significant association between them.

TABLE NO.5: Are you suffering from stress or depression? * What is your current age?

Crosstab

Are you suffering from stress or depression?	No	Count	
		% within Are you suffering from stress or depression?	
	Yes	Count	
		% within Are you suffering from stress or depression?	
Total		Count	
		% within Are you suffering from stress or depression?	

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	3.429ᵃ	1	.064
Continuity Correctionᵇ	2.777	1	.096
Likelihood Ratio	3.447	1	.063
Fisher's Exact Test			
N of Valid Cases	120		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count...

b. Computed only for a 2x2 table
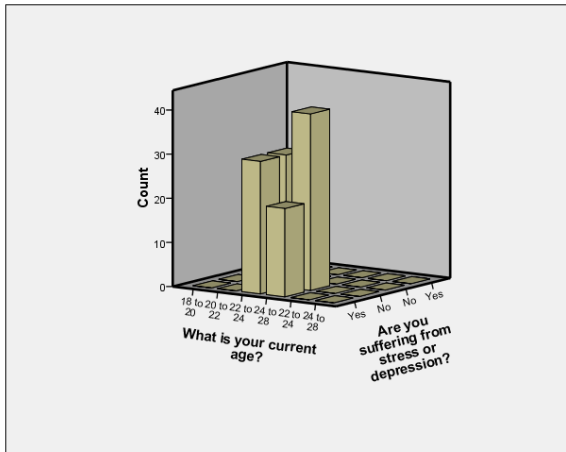
We cross tabulated between Age and Suffering from Stress or Depression. This table indicated what is your age and are you suffering from stress or depression in females who are not stressed or are more likely to (22 to 24) (42.9%) and (24 to 28) (57.1%). Similarly, what is your age and are you suffering from stress or depression in females who are stressed or depressed are more likely to (22 to 24) (60.0%) and (24 to 28) (40.0%). P-value<0.05 this mean statistically significant association between them.

TABLE NO.6: Have you ever smoked? * What is your current age?

We cross tabulated between Age and Smoking. This table indicated what is your age and have you ever smoked in females who don't smoke are more likely to (22 to 24) (49.5%) and (24 to 28) (50.5%). Similarly, what is your age and have you ever smoked in females who smoke are more likely to (22 to 24) (53.8%) and (24 to 28) (46.2%). P-value>0.05 this mean statistically non-significant association between them.

Have you ever smoked?

		Frequency	Percent	Valid Percent	Cumula
Valid	No	107	89.2	89.2	
	Yes	13	10.8	10.8	
	Total	120	100.0	100.0	

Crosstab

			What is your current age?			
			22 to 24	24 to 28	Total	
Have you ever smoked?	No	Count			107	
		% within Have you ever sr			00.0%	
	Yes	Count			13	
		% within Have you ever sr			00.0%	
Total		Count			120	
		% within Have you ever sr			00.0%	
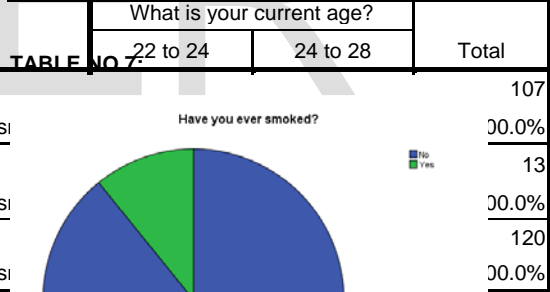
TABLE NO.7:

This Pie Chart shows that majority of females don't smoke while some do smoking.

TABLE NO.8:

Chi-Square Tests

	Value	df	Asymp. sid		
Pearson Chi-Square	.086ᵃ	1			
Continuity Correctionᵇ	.000	1	1.000		
Likelihood Ratio	.086	1	.769		
Fisher's Exact Test				1.000	.500
N of Valid Cases	120				

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 6.50.

b. Computed only for a 2x2 table
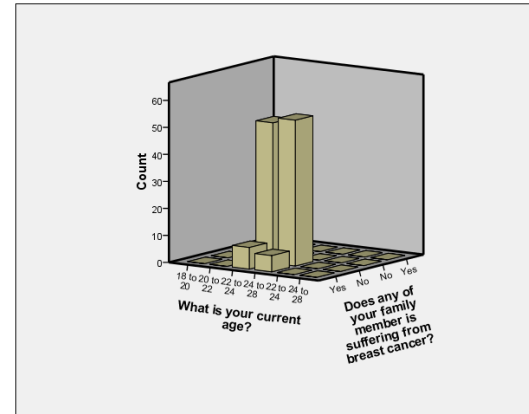
How often do you do any exercise?

This Bar Chart shows that about (35%) of females do exercise on regular basis, (35.5%) of female never do exercise and about (28.7%) of females do exercise once a week.

TABLE NO.9: Does any of your family member is suffering from breast cancer? * What is your current age?

We cross tabulated between Age and Family member suffering from breast cancer. This table indicated what is your age and does any of your family member is suffering from breast cancer in females whose family members are suffering from breast cancer are more likely to (22 to 24) (57.1%) and (24 to 28) (42.9%). Similarly, what is your age and does any of your family member is suffering from breast cancer in females whose family members are not suffering from breast cancer are more likely to (22 to 24) (49.1%) and (24 to 28) (50.9%). P-value>0.05 this mean statistically non-significant association between them.

Crosstab

			What is your current age?		
Does any of your family member is suffering from breast cancer?	No	Count			
		% within Does any of your family member is suffering from breast cancer?			
	Yes	Count			
		% within Does any of your family member is suffering from breast cancer?			
Total		Count	60	60	120
		% within Does any of your family member is suffering from breast cancer?			

TABLE NO.10: Do you have knowledge about BSE (Breast Self Examination) knowledge about awareness of breast cancer? Crosstabulation

Count

		Do you have knowledge about awareness of breast cancer	
		No	Yes
Do you have knowledge about BSE(Breast Self Examination)	No	8	
	Yes	13	
Total		21	

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	.001[a]	1	.980
Continuity Correction[b]	.000	1	1.000
Likelihood Ratio	.001	1	.980
Fisher's Exact Test			
N of Valid Cases	120		

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count
b. Computed only for a 2x2 table

Chi-Square Tests

	Value	df	Asymp. sided
Pearson Chi-Square	.323[a]	1	
Continuity Correction[b]	.081	1	
Likelihood Ratio	.324	1	
Fisher's Exact Test			.777 .389
N of Valid Cases	120		

a. 0 cells (.0%) have expected count less than 5. The minimum expe
b. Computed only for a 2x2 table
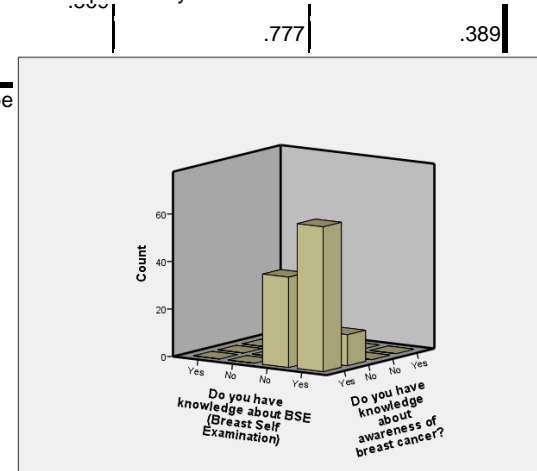
We cross tabulated between BSE and Awareness of breast cancer. This table indicated do you have knowledge about BSE and do you have knowledge about awareness of breast cancer in females who don't have knowledge about BSE are more likely to (8%) and (38%). Similarly, do you have knowledge about BSE and do you have knowledge about awareness of breast cancer in females who have knowledge about BSE and awareness of breast cancer (13%) and (61%). P-value>0.05 this mean statistically non-significant association between them.

DISCUSSION:

- One goal of this study was to assess breast cancer risk discussion and awareness among a group of medical students. Although overall awareness of therapies was quite high among all participants, discussion and use of any therapy was quite low, even for high-risk participants. Reasons for lack of discussion or use are unclear.
- A second goal was to examine racial/ethnic differences in breast cancer risk reduction practices and reported risk discussion.
- A third goal was to assess factors associated with recognition of therapies and discussion of risk.
- Perceived risk of breast cancer and perceived physical indicators of risk such as prior abnormal mammography were associated with increased discussion. Having an abnormal mammogram, even though not considered an independent risk for breast cancer, increases a woman's anxiety and may promote discussion with her provider
- Our study highlights that many women are aware of one or more of the individual preventive breast cancer therapies available to them, although discussion with their clinicians and use of therapies are limited.
- However, the data suggest that interventions to increase discussion of preventive therapies among women at high risk are warranted.

Lofters AK[1], Vahabi M[2], Prakash V[3], Banerjee L[4], Bansal P[5], Goel S[6], Dunn S[7].

DISCUSSION:

Using South Asian lay health educators embedded within primary care practices to telephone patients in their own languages showed promise in this study to increase awareness about willingness to screen and cancer screening uptake, but it was also time intensive and resource intensive with numerous challenges. Future quality improvement efforts should further develop the phone call invitation process, as well as explore how to provide infrastructure for lay health educator training and time.

Al-Khasawneh EM[1], Leocadio M[1], Seshan V[1], Siddiqui ST[1], Khan AN[1], Al-Manaseer MM[1].

DISCUSSION:

Through the incorporation of contextual characteristics and prevalent beliefs among Arab populations, the adapted Best Cancer Awareness Measure is a robust Arabic instrument for the measurement of breast cancer awareness and early detection practices among Arab women.

Khoshnazar TA[1], Rassouli M[1], Akbari ME[2], Lotfi-Kashani F[3], Momenzadeh S[4], Haghighat S[5], Sajjadi M[6].

DISCUSSION:

The findings of the study identify views and perceptions of patients as well as the health professionals around the challenges of providing palliative care. To establish a structured PCS, we need to meet the challenges and remove perceived barriers to, including but not limited to, building up knowledge and awareness of health professionals, educating professional, and developing updated, well-defined, and standard treatment protocols, tailored to local conditions.

CONCLUSION:

Although this descriptive study has its own limitations, for the first time it provides useful information that could be utilized by both researchers and those involved in public health programmers. The findings indicated that the women awareness of breast cancer warning signs (painless lump, retraction of nipple, and bloody discharge) and effective screening methods i.e. clinical examination, and mammography were very inadequate. Thus, health education programmers to rectify the lack of women awareness is urgently needed. Indeed the focus of primary health care providers should be to raise awareness about breast care among women and to encourage them to report any unusual changes in their breasts to their family or care physicians.

RECOMMENDATIONS:

- Recommendation that ALL women have mammograms annually starting at age 40. We also believe that monthly breast self-exam and annual physical exams by a doctor are essential parts of an overall breast cancer screening strategy. If you're at high risk for breast cancer, you should talk to your doctor about starting annual mammograms at a younger age and consider other screening tools (such as MRI or ultrasound) to maximize the opportunity for early detection.
- All women should become familiar with the potential benefits, limitations, and harms associated with breast cancer screening. Women with an average risk of breast cancer should undergo regular screening mammography starting at age 45 (strong recommendation).
  - Women who are 45 to 54 years should be screened annually (qualified recommendation).
  - Women who are 55 and older should transition to biennial screening [screening every 2 years] or have the opportunity to continue screening annually (qualified recommendation).
  •Women should have the opportunity to begin annual screening between the ages of 40 and 44 (qualified recommendation).
  •Women should continue screening as long as their overall health is good and they have a life expectancy of 10 years or more

(qualified   recommendation).
•The ACS does not recommend clinical breast examination for breast cancer screening among average-risk women at any age (qualified recommendation).

- Breast Cancer is one of the leading causes of death worldwide. According to W.H.O estimates it represents 10% of all cancers diagnosed worldwide and constituted 22% of all new cancers in 2000 in women making it the most common cancer in females.

- Pakistan alone has the highest rate of Breast Cancer than any other Asian country as approximately 90000 new cases are diagnosed every year out of which 40000 die. According to a research conducted approximately 1 out of every 9 women are likely to suffer from this disease at any point in their lives and about 77% of invasive breast cancer occurred in women above 50 years, but if diagnosed early the survival rates approach 90%.

- Mortality in Breast cancer can be prevented in 1/3rd of women if routine mammography is done in women over 50 years, hence the longer a woman lives the lower is her risk of breast cancer therefore a 50 year old woman who has not had breast cancer has 11% chance of having it, whereas a 70 year old woman who has not had breast cancer has 7% chance of having it.

- BRCA1 and BRCA2 are the two most major breast cancer-susceptibility genes identified and testing for mutations in BRCA1 and BRCA2 is an important tool for predicting breast cancer. Besides that lack of breast feeding, diet, less parity and smoking are most significantly associated with breast cancer in patients. Therefore a short breast examination can prevent this cancer and protect women from this most horrifying and horrendous nightmare. The above mentioned facts highlight it beyond any doubt that breast cancer causes significant mortality in Pakistan. Hence the government should create widespread awareness in Pakistan. The focus of the awareness should be about:

- 1. The dangerously high incidence of breast cancer in Pakistan.
- 2. The disease is not fatal and is curable.
- 3. It can be detected early if routine breast examination is done.
- 4. The life after this cancer is same as before the diagnosis and is worth living. This can significantly control the burden of disease in a developing country like Pakistan with a paucity of financial resources.

REFERENCES:

1. Parkin DM, Bray F, Ferlay J, Pisani P: Global cancer statistics, 2002. CA Cancer J Clin 2005, 55(2):74–108.

2. Wilson CM, Tobin S, Young RC: The exploding worldwide cancer burden: the impact of cancer on women. Int J Gynecol Cancer 2004, 14: 1–11. 10.1111/j.1048-891x.2004.14178.x

3.   World   Health   Organization: Cancer.
[http://www.who.int/mediacentre/factsheets/fs297/en]

4. Harirchi I, Ebrahimi M, Zamani N, Jarvandi S, Montazeri A: Breast cancer in Iran: a review of 903 case records. Public Health 2000, 114: 143–145. 10.1016/S0033-3506(00)00324-3

5. Mousavi SM, Montazeri A, Mohagheghi MA, Mousavi Jarrahi A, Harirchi I, Najafi M, Ebrahimi M: Breast cancer in Iran: an epidemiological review. Breast J 2007, 13: 383–391. 10.1111/j.1524-4741.2007.00446.x

6. Ministry of Health and Medical Education: Iranian Annual National Cancer Registration Report 2005–2006. Ministry of Health and Medical Education, Office of Deputy Minister for Health, Center for Disease Control and Prevention, Cancer Office: Tehran, Iran 2007.

7. Elmore JG, Armstrong K, Lehman CD, Fletcher SW: Screening for breast cancer. JAMA 2005, 293: 1245–1256. 10.1001/jama.293.10.1245

8. Gotzsche PC, Nielsen M: Screening for breast cancer with mammography. Cochrane Database Syst Rev 2006. (4): Art No.: CD001877

9. Miller AB, To T, Baines CJ, Wall C: The Canadian National Breast Screening Study-1: breast cancer mortality after 11 to 16 years of follow-up. A randomized screening trial of mammography in women age 40 to 49 years. Ann Intern Med 2002, 137(5 Part 1):305–312.

10. Mittra I, Baum M, Thornton H, Houghton J: Is clinical breast examination an acceptable alternative to mammographic screening? BMJ 2000, 321: 1071–1073. 10.1136/bmj.321.7268.1071

11. Weiss NS: Breast cancer mortality in relation to clinical breast examination and breast self-examination. Breast J 2003, 2(Suppl):S86-S89. 10.1046/j.1524-4741.9.s2.9.x

12. Jatoi I: Screening clinical breast examination. Surg Clin North Am 2003, 83: 789–801. 10.1016/S0039-6109(03)00028-8

13. Ellman R, Moss SM, Coleman D, Chamberlin J: Breast self-examination programmes in the trial of early detection of breast cancer: ten years findings. Br J Cancer 1993, 68(1):208–212.

14. Lam WW, Chan CP, Chan CF, Mak CC, Chan CF, Chong KW, Leung MH, Tang MH: Factors affecting the palpability of breast lesion by self-examination. Singapore Med J 2008, 49(3):228–232.

15. Semiglazov VF, Sagaidak VN, Moiseyenko VM, Mikhailov EA: The role of breast self-examination in early breast cancer detection (results of the 5-years USSR/WHO randomised study in Leningrad). Eur J Epidemiol 1992, 8: 498–502. 10.1007/BF00146366

16. Semiglazov VF, Sagaidak VN, Moiseyenko VM, Mikhailov EA: Study of the role of breast self-examination in the reduction of mortality from breast cancer. The Russian Federation/World Health Organization Study. Eur J Cancer 1993, 29: 2039–2046. 10.1016/0959-8049(93)90468-U

17. Thomas DB, Gao DL, Ray RM, Wang WW, Allison CJ, Chen FL, Porter P, Hu YW, Zhao GL, Pan LD, Li W, Wu C, Coriaty Z, Evans I, Lin MG, Stalsberg H, Self SG: Randomized trial of breast self-examination in Shanghai: methodology and preliminary results. J Natl Cancer Inst 1997, 89: 355–365. 10.1093/jnci/89.5.355

18. Thomas DB, Gao DL, Ray RM, Wang WW, Allison CJ, Chen FL, Porter P, Hu YW, Zhao GL, Pan LD, Li W, Wu

C, Coriaty Z, Evans I, Lin MG, Stalsberg H, Self SG: Randomized trial of breast self-examination in Shanghai: final results. J Natl Cancer Inst 2002,94(19):1445–1457.

AWARENESS OF BREAST CANCER
Among Fourth Year And Final Year MBBS Students
QUESTIONNAIRE

NAME:
CLASS:
COLLEGE / UNIVERSITY:

1. *What is your current age?*
   - *18 to 20*
   - *20 to 22*
   - *22 to 24*
   - *24 to 28*
2. *What is your gender?*
   - *Male*
   - *Female*
3. *Do you have knowledge about awareness of breast cancer?*
   - *Yes*
   - *No*
4. *What is your relationship status?*
   - *Single*
   - *Married*
   - *Divorced*
   - *Widow*
5. *What is your education status?*
   - *High school*
   - *College / University*
   - *Graduated*
   - *Vocational and technical training*
6. *What is your BMI (Body Mass Index)?*
   - *18.5 to 24.9*
   - *25 to 29.9*
   - *30*
   - *Above 30*
7. *What is the current status of your health?*
   - *Healthy*
   - *Suffering from any disease*
   - *Unstable*
   - *Disability*
8. *What age do you get your periods (Age of Menarche)?*
   - *8 or 9*
   - *12 or 13*
   - *15*
   - *16*
9. *How often you clinically examine your breast?*
   - *Once a month*
   - *Weekly*
   - *Yearly*
   - *None of the above*
   - *Yearly*
   - *None of the above*
10. *Do you have knowledge about BSE?*
    - *Yes*
    - *No*
11. *Do you have pain in your breast during BSE (Breast self-examination)?*
    - *Yes*
    - *No*
12. *Have you ever had mammography?*
    - *Yes*
    - *No*
13. *Do you think mammography will help in anyway?*
    - *Yes*
    - *No*
14. *Have you noticed nodule or lump in your breast?*
    - *Unilateral*
    - *Bilateral*

   - *Initially unilateral, but later on bilateral*
   - *Bilateral at a time*
   - *Nil*
15. *Does any of your family member is suffering from breast cancer?*
    - *Yes*
    - *No*
16. *If you have positive family history?*
    - *1ˢᵗ degree relations (Mother, Sisters, Daughters)*
    - *2ⁿᵈ degree relations (Aunts, Nieces, Half-sisters)*
    - *3ʳᵈ degree relations (First cousins, Grandparents, Great grandparents)*
    - *None of the above*
17. *Have you ever consumed volatile beverages like beer, liquor etc.?*
    - *Yes*
    - *No*
18. *Have you ever smoked?*
    - *Yes*
    - *No*
19. *Are you suffering from stress or depression?*
    - *Yes*
    - *No*
20. *Have you ever taken a drug for infertility?*
    - *Yes*
    - *No*
    - *Often*
21. *Have you ever used hormonal contraceptives?*
    - *In the form of birth*
    - *Control pills*
    - *Implants*
    - *Injections*
    - *No*
22. *Exposure to radiations or chemicals in cosmetics?*
    - *Mostly*
    - *Occasionally*
    - *Never*
23. *How often do you do any exercise?*
    - *Rarely / Never*
    - *Everyday*
    - *Once a week*
    - *Three times a week*
24. *Is there any asymmetry in your breast?*
    - *Yes*
    - *No*
    - *Maybe but not confirm*
25. *If yes did you visit the doctor?*
    - *Immediately*
    - *Within a week*
    - *Within a month*
    - *No*
26. *Have you ever noticed any of the following changes?*
    - *Painless lump in the breast*
    - *Swelling in the armpit*
    - *Changes in the size and shape of the breast*
    - *Nipple changes or discharge*
    - *No*
27. *If noticed any change in size of your breast, did visit the doctor?*
    - *Yes*
    - *No*
28. *If you have breast cancer, how you are preventing it?*
    - *Through medications (SERMs, Antiestrogen, Aromatase inhibitors)*
    - *Radiation therapy*
    - *Chemotherapy*
    - *Hormonal therapy*
    - *No*

IJSER