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INTERNATIONAL JOURNAL OF NURSING STUDIES

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Commentary

Why are we still promoting breast self-examination?

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Received 2 December 2005; accepted 9 December 2005

Keywords: Breast self-examination; Breast cancer screening

Nurses have long been advocates of breast self-examination (BSE), believing that not only were they promoting a practice that could be life-saving but that they were also empowering women to take greater control over their health. There is an abundance of research in the nursing literature reporting the measurement of women's BSE practices, the psychometric correlates of BSE practice and strategies attempting to increase BSE practice among women (Champion and Menon, 1997; Chouliara et al., 2004; Petro-Nustus and Mikhail, 2002; Reis et al., 2004; Secginli and Nahcivan, 2004). In their study to be published in forthcoming issue of IJNS, Secginli and Nahcivan (in press) sought to identify variables correlated with the breast cancer screening behaviours of BSE and mammography in Turkish women, presumably so that rates of both these practices could be increased. While I do not take issue with the methodology or results presented in this paper, it is still, nonetheless, fundamentally flawed. The authors clearly delineate the rates of participation in both screening activities and the psychometric correlates of both BSE and mammography separately. There is a tendency, however, when discussing the benefits of screening to combine both BSE and mammography as if they were interconnected. BSE and mammography are two discrete procedures and should be discussed as such. Furthermore, all studies examining breast screening practices are designed on the premise that through early detection of breast lumps, breast cancer mortality can be reduced and lives can be saved. In the introduction and literature review sections of their paper, Secginli and Nahcivan present no evidence on the effectiveness of either BSE or mammography in detecting breast cancer and decreasing mortality. Perhaps, this is because although the benefits of mammography are still currently being debated (Goodman, 2002; Olsen and Gotzsche, 2005; U.S. Preventive Services Task Force, 2002), a preponderance of evidence has now clearly shown that BSE does not save lives and offers no benefit to women.

Results from two large randomized controlled trials (RCTS) involving almost 400,000 women in Russia and China have shown that BSE is not effective in reducing mortality from breast cancer, and does not improve the probability of survival after breast cancer diagnosis (Semiglazov et al., 1999; Thomas et al., 2002). Moreover, both studies also demonstrated that regularly practicing BSE was significantly more likely to cause harm by way of increased biopsies for benign breast lumps. In a systematic review of the benefits of BSE, the Cochrane group has concluded that "screening by breast self-examination cannot be recommended" (Kosters and Gotzsche, 2005) and most experts no longer recommend BSE (Baxter and Canadian Task Force on Preventive Health, 2001; Elmore et al., 2005; Harris and Kinsinger, 2002). Furthermore, even in countries such as Turkey, where mammography screening may not be widely available, because of its lack of demonstrable benefits, promoting BSE is not a prudent use of the limited funds available for preventive services (Thomas et al., 2002).

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0020-7489/$ - see front matter © 2006 Published by Elsevier Ltd.
doi:10.1016/j.ijnurstu.2005.12.001

Contrary to the recommendation of Secginli and Nahcivan that more longitudinal studies on the factors influencing the use of BSE are required, the evidence against BSE is sufficiently compelling that the Cochrane group has also concluded that "it is unlikely that additional trials investigating breast-self examination as a single general screening method would be worthwhile" (Kosters and Gotzsche, 2005).

What does all of this mean for nursing? Firstly, it means that promoting BSE at a population level and investigating factors which can increase performance of BSE are not worthy of valuable time and money. Resources should be focused on promoting and investigating screening practices with proven benefits, or on more accurate measurement of the benefits of other screening practices currently in use, such as mammography. What these findings do not mean, however, is that we should teach women to ignore their breasts. Education on BSE should be replaced by breast awareness education, where women are taught the cardinal sign of breast cancer, a painless lump, and the necessity of seeking prompt medical evaluation of that lump (Harris and Kinsinger, 2002). Additionally, if women choose to continue to regularly perform BSE, they should be informed that the benefits are unproven and that it may result in unnecessary biopsies for benign breast lumps (Thomas et al., 2002). Finally, women should continue to participate in mammography screening programs and receive annual clinical breast exams as indicated by the national or regional guidelines for where they reside.

The time has come, therefore, to say good-bye to BSE. There is no evidence to support the practice, and the best available evidence tells us that it does more harm than good. It is natural that nurses would not willingly give up promoting a practice that they have strongly believed in and have invested in considerably. However, if we are fully embracing an evidence-based practice we have to go with the evidence, even if we do not like what it is telling us.

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