cancers to a similar degree but had no significant effect on mucinous ovarian cancers.

The degree of protection offered by the pill appeared to lessen the longer it had been since a woman last took it. Nevertheless, the protective effect of oral contraception was significant even 30 or more years after use stopped (RR 0.86).

The study also examined the role of estrogen levels in oral contraceptives. Even though the amount of estrogen used in birth control pills lessened between 1960 and 1980, the researchers did not see a different level of risk reduction.

Based on these data, the researchers estimated that 200,000 ovarian cancer cases and 100,000 deaths worldwide have been prevented by oral contraceptive use during the past 50 years and that if use remains at the current level, as many as 30,000 ovarian cancers a year could be prevented.

However, while oral contraceptive use could reduce a woman’s risk of ovarian cancer by almost 50%, it is not recommended for all women.

“Ovarian cancer prevention is only one consideration to take into account when balancing the risks and benefits of oral contraceptives,” says Carmen Rodriguez, MD, MPH, Strategic Director, Biospecimen Repository, ACS, and one of the study coinvestigators. “There are cardiovascular disease contraindications that should be discussed between women and their doctors. Pill use would certainly be contradicted among smokers or women with hypertension.”

Oral contraceptives also have been shown to slightly and temporarily increase the risk for both breast and cervical cancers.

“However, oral contraceptive use is the strongest modifiable risk factor that can reduce the likelihood of being diagnosed with ovarian cancer, and it should be at least mentioned to women if they are considering their use for birth control,” Rodriguez says.

A second study by Harvard University researchers suggests caffeine intake might affect ovarian cancer risk, particularly in women who have never used oral contraceptives. Although the finding is preliminary, it merits further study, they say.

The researchers analyzed data from the Nurses’ Health Study to look for associations among cigarette smoking, alcohol use, and caffeine intake (measured by the cups of coffee, tea, or cola consumed in a week) and the likelihood a woman might develop ovarian cancer. They assessed the relationship between smoking status and ovarian cancer among 110,454 women and examined the records of 80,253 women for links between alcohol and caffeine use.

The results, published in Cancer (2008;112:1–9) showed that cigarette smoking had no significant effect on ovarian cancer incidence overall, although there was a higher risk for mucinous ovarian cancers. Researchers did not detect any association with alcohol use.

On the other hand, caffeine intake was significantly associated with lower incidence, but only in women who had never used oral contraceptives or postmenopausal hormone therapy. RR for the top quintile of caffeine intake versus the bottom quintile was 0.65 among women who never used oral contraceptives and 0.57 among postmenopausal women who never used hormone therapy.

Although tantalizing, the researchers say their finding of a lower risk associated with caffeine should be interpreted with caution, and other experts agree.

“The findings regarding caffeine are interesting as a biological hypothesis, but women should not increase caffeine intake until we know more about its role. So far, the strongest modifiable factor for preventing ovarian cancer is oral contraceptive use,” says Rodriguez.

DOI: 10.3322/CA.2008.0004

Cost sharing, now a mainstay of most health care plans, may be discouraging patients from getting the preventive care they need. According to a recent study by Brown University and Harvard University researchers, a copayment of as little as $12.50 was enough to deter women from getting screening mammograms.

The study, published in The New England Journal of Medicine (2008;358:375–383), was based
on data from the National Committee for Quality Assurance’s Medicare Health Plan Employer Data and Information Set available through the Centers for Medicare and Medicaid Services. Researchers reviewed the biennial mammography rates of 366,475 women aged 65 to 69 years in 174 Medicare managed care plans during 2001 to 2004. They compared rates among women in plans with cost sharing for mammography (which required copayments of more than $10 or a coinsurance of more than 10%) with rates for women in plans offering full coverage of mammography. In addition to this cross-sectional analysis, they also performed a longitudinal analysis comparing plans offering full coverage from 2001 to 2004 with plans that instituted cost sharing during that period.

According to the study, the number of Medicare managed-care plans with mammography cost sharing increased from 3 to 21 during 2001 to 2004, with the proportion of women enrolled in these plans growing from 0.5% to 11.4%. Costs ranged from $12.50 to $35, with a median of $20.

During the study period, screening rates were 8.3 percentage points lower among women in cost-sharing plans compared with those who were fully covered (69.2% versus 77.5%, \( P < .001 \)). Screening rates decreased by 5.5 percentage points among women whose plans implemented cost-sharing schemes during the study period (from 74.8% to 69.3%), while rates rose 3.4 percentage points among women in full-coverage plans (from 71.9% to 75.3%). Compared with women in plans with full coverage, women in cost-sharing plans were more likely to be African American and living in low-income areas with low education levels; however, researchers observed that copayments adversely affected screening rates for women across all groups.

“Recent surveys have shown a troubling drop in the use of mammography, but the reasons behind the drop have not been well understood. This study lends credibility to the idea that access to affordable health care is a very real factor. We already know many women are somewhat unwilling to receive regular mammography screening. Unfortunately, the added burden of a copayment may make some women even less likely to make screening a priority,” said Otis Webb Brawley, MD, Chief Medical Officer, ACS, when the report was released.

While $12.50 may not seem like much, it could be a significant barrier for the elderly, a population already beset with hefty health care costs, the researchers note. Adults over age 65 years are typically faced with mounting health care bills because of other illnesses, many of them chronic. Furthermore, several studies suggest that when faced with copays for preventive care, people are less likely to use those services because they seem less essential than care associated with symptomatic health conditions.

The authors of this study question the economic sense of requiring cost sharing for older Americans to receive underutilized, evidence-based preventive services. Cost-sharing plans, while designed to curb inappropriate health care spending, could inadvertently lead to higher costs associated with treatment of advanced breast cancer.

“We’ve isolated the effects of copayments on an important preventive health measure,” says Amal Trivedi, MD, lead author of the study and Assistant Professor in the Department of Community Health at Brown University’s Alpert Medical School. “Mammograms are an essential service for older women, yet many women avoid that service when they are required to pay out of pocket. By eliminating copayments for mammograms, we could get more women tested. More testing would mean earlier breast cancer treatment and improved chances for breast cancer survival.”

DOI: 10.3322/CA.2008.0005

© American Cancer Society, Inc., 2008.