

Guest Editorial for: “Addressing Disparities Related to Access of Multimodality Breast Imaging Services Before and During the COVID-19 Pandemic”

Carolynn M. DeBenedectis, MD

The COVID-19 pandemic brought into the spotlight significant preexisting disparities in care throughout medicine, including Radiology; they most adversely affect racial minorities, patients of lower socioeconomic status, and those with no or inadequate health insurance (1,2). The article by Nguyen et al., entitled “Addressing Disparities Related to Access of Multimodality Breast Imaging Services Before and During the COVID-19 Pandemic” explores the disparities specific to access of breast imaging services due to the pandemic (3). Sixty percent of breast imaging services were delayed for all populations during the first 6 months of the pandemic, and it is projected that this will have a small negative impact on breast cancer mortality by 2030 (3). This data is for overall populations but given some racial and ethnic minority populations (Blacks, Hispanics, and Native Americans) already have increased mortality from breast cancer it can be assumed that this will only compound the difference. In addition, breast cancer is the leading cause of cancer death in Hispanic women, but they had one of the lowest rebound screening mammography rates after the pandemic which is very concerning (4). This article is extremely important and should be used as a call to action for breast imaging departments to focus on addressing these now exacerbated disparities in these select populations.

While we know that prior to the pandemic racial and ethnic minority groups utilized screening mammography at lower rates than whites. The reasons cited for this are cultural barriers, knowledge gaps, access, and transportation. We also know that rebound rates for screening in some racial and ethnic minorities were lower than for white women. Thus, we need to encourage these women back to regular

mammography screening through aggressive interventions that address these barriers. As this article suggests we need to address cultural and knowledge barriers, which can be done with outreach activities to target knowledge gaps and cultural barriers in certain populations (3). Breast imagers need to mobilize and bring educational programming to churches and community centers where at risk populations are more common. Since access and transportation are issues for many minority and low socioeconomic status communities, breast imaging providers should consider using mobile mammography units to reach both urban and rural communities with limited access or difficulty with transportation. Mobile mammography units have previously been shown to increase adherence to screening in American Indian women in rural settings, a group that has not seen as decline in breast cancer mortality like other groups did with the advent of screening (5). In addition to screening mammography, Nguyen and colleagues also advocate for equal access to advanced imaging technologies, such as screening MRI and ultrasound, which suffer from the same barriers to access in these populations (6). Given that some of these populations are at increased risk for breast cancer, access to supplemental screening can help with early detection and the resulting decreased mortality.

Prompt follow up from screening mammography is essential, and this paper points out two ways for improvement in these populations; (1) ensure readability of patient letters from screening mammography facilities, (2) use patient navigators, and (3) offer same day work ups. Breast imaging departments need to make sure screening mammography result letters are readable for all literacy levels and available in all languages so that patients can understand the results of their screening mammogram and why they need to return for more imaging. Patient navigators play an important part in calling patients who need to come back for diagnostic imaging to both remind patients they need an appointment and to answer questions. This has been shown to increase the likelihood of follow up by a factor of three (7). Lastly, if possible,

Acad Radiol 2022; ■:1-2

From the Department of Radiology, UMass Chan Medical School, Worcester, MA. Received August 30, 2022. accepted August 30, 2022. **Address correspondence to:** C.M.D., 55 Lake Avenue North Worcester MA, 01655. e-mail: carolynn.debenedectis2@umassmemorial.org

© 2022 The Association of University Radiologists. Published by Elsevier Inc. All rights reserved.
<https://doi.org/10.1016/j.acra.2022.08.036>

performing same day interpretations of screening studies, and, if needed, same day diagnostic breast imaging and biopsy has been shown to mitigate disparities in racial/ethnic minority populations (8,9). All these interventions can help decrease the time from diagnosis to treatment of breast cancer in these vulnerable groups, which in turn can help decrease mortality from breast cancer in these populations (3).

This review paper by Nguyen et al. is of great importance as it spotlights on not only the preexisting disparities in breast imaging that we must address, but it also demonstrates how the COVI-19 pandemic has exacerbated those differences, making it vital for breast imaging providers to start addressing these disparities now. All breast imaging departments should do a deep dive into their data to see where disparities exist at their institutions and use interventions like patient navigators, same day work ups, and other innovative ways to address disparities to ensure equitable breast imaging for all patients.

REFERENCES

1. Abraham P, Williams E, Bishay AE, et al. the roots of structural racism in the United States and their manifestations during the COVID-19 pandemic. *Acad Radiol* 2021; 28(7):893–902.
2. Abraham P, Bishay AE, Farah I, et al. Reducing health disparities in radiology through social determinants of health: lessons from the COVID-19 pandemic. *Acad Radiol* 2021; 28(7):903–910.
3. Nguyen DL, Ambinder EB, Myers KS, et al. Addressing disparities related to access of multimodality breast imaging services before and during the COVID-19 pandemic. *Acad Radiol* 2022. doi:10.1016/j.acra.2022.03.017. S1076-6332(22)00194-5.
4. Sprague BL, Lowry KP, Miglioretti DL, et al. Changes in mammography use by women's characteristics during the first 5 months of the COVID-19 pandemic. *J Natl Cancer Inst* 2021; 113(9):1161–1167.
5. Roubidoux MA, Richards B, Honey NE, et al. Adherence to screening among American Indian women accessing a mobile mammography unit. *Acad Radiol* 2021; 28(7):944–949. doi:10.1016/j.acra.2021.03.014. Epub 2021 Apr 22. PMID: 33896716.
6. Miles RC, Onega T, Lee CI, et al. Addressing potential health disparities in the adoption of advanced breast imaging technologies. *Acad Radiol* 2018; 25(5):547–551.
7. Nguyen DL, Oluyemi E, Myers KS, et al. Impact of telephone communication on patient adherence with follow-up recommendations after an abnormal screening mammogram. *J Am Coll Radiol* 2020; 17(9):1139–1148.
8. Dontchos BN, Achibiri J, Mercaldo SF, et al. Disparities in same-day diagnostic imaging in breast cancer screening: impact of an immediate-read screening mammography program implemented during the COVID-19 pandemic. *AJR Am J Roentgenol* 2022; 218(2):270–278.
9. Dontchos BN, Narayan AK, Seidler M, et al. Impact of a same-day breast biopsy program on disparities in time to biopsy. *J Am Coll Radiol* 2019; 16(11):1554–1560. doi:10.1016/j.jacr.2019.05.011. Epub 2019 May 29. PMID: 31152690.