The dangers of parental consent start before obstetric care

TO THE EDITORS: The "Call to Action" issued by Dr Bortoletto and colleagues focuses attention on a key population.[1] As with many transitions, that between adolescence and adulthood exposes adolescents to the risk of being subject to the rules of both and the privileges of neither. It is essential to ensure that adolescents are empowered to receive the quality prenatal and obstetric options and care that all women deserve. However, it is critical to note that our failure to ensure that adolescents receive comprehensive reproductive health care predates their first prenatal visit. Currently, 21 states have laws requiring parental consent, 11 have laws mandating prior parental notification, and 5 have both. Six states have laws that have been temporarily or permanently enjoined.[2] Given that 75% of pregnancies among adolescents are unintended, the right to choose how to manage a pregnancy must be part of a conversation about adolescent reproductive care.[3]

Dr Espey and colleagues elegantly outline the importance of full reproductive autonomy for all women, and particularly for adolescents, in their articles in this journal, with the support of our subspecialty societies and the Society for Adolescent Health and Medicine.[4] In this spirit, I echo Dr Bortoletto's call and urge us to consider not just obstetric care or gynecologic care, but women's care. ■

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Are early screening biomarkers for endometrial cancer needed to reduce health disparities?

TO THE EDITORS: We read with interest the study by Doll et al,[1] highlighting the health disparities that the reliance on patient recognition of the most common endometrial cancer early sign (postmenopausal bleeding) and appropriate clinical follow-up has created. As the authors show, while it is remarkable that more than 90% of women diagnosed with endometrial cancer report vaginal bleeding, this number conceals the third largest racial disparity in US cancers among women. Although endometrial cancer is diagnosed more often in white than black women (27 vs 25 per 100,000), it kills double the number of black women (8 vs 4 per 100,000).[2] The authors indicate a variety of contributing factors to this disparity and suggest that future work should focus on changing provider perceptions and patient expectations, which is undoubtedly needed.

Screening tests are not used or needed for the majority of patients with endometrial cancer. However, to address the disparities affecting subgroups of patients with delayed diagnosis, identification of early biomarkers may potentially help. This is because the current approach for the detection of endometrial cancer relies entirely on the premise that all patients are able to recognize early symptoms, able to report it, and that the clinicians will be adequately responsive.

This framework has worked very well for white patients, resulting in a 15% mortality rate (4 deaths per 27 individual diagnostic rate) but terribly for black patients, who have a mortality rate of 32% (8 deaths per 25 individual diagnostic rate). Relying solely on symptom-driven manifestation, reporting, and follow-up has created multiple levels of disparities. An early screening biomarker will not fix all problems, but it will standardize the approach into a more objective one. In breast cancer, whose diagnosis is primarily screen based, the white and black mortality rate is much more balanced (16% for white vs 23% for black patients).

In endometrial cancer we have the luxury of being able to detect it early in its progression in most women. Let us not let that luxury be the nail in the coffin for those who do not have it. There are developing screening and prevention options, which include epigenetic[3] and microbiome[4] biomarkers. These early detection biomarkers may one day allow the identification of patients in the path to carcinogenesis and lead to primary prevention interventions that may end the status of endometrial cancer as the most common gynecologic cancer among all women. ■

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REPLY

Check for updates

We thank Walther-Antioni and Mariani for their interest and response to our study on the role of bleeding recognition and evaluation in the black-white disparities in endometrial cancer. They correctly emphasize the impact of our primary findings, which is that differences in health care delivery before diagnosis may influence the stage at diagnosis and thus mortality rates for women with this disease.

Walther-Antioni and Mariani go on to suggest that early biomarkers may help mitigate the contribution of variation in health care delivery to these racial disparities by bypassing reliance on patient reporting of symptoms and provider response. We agree overall that standardization in the form of a potential biomarker result obtained from screening can reduce racial disparities.

In cervical cancer, the objective nature of the screening Papanicolaou test provided a context-independent method of identifying women at risk. However, disparities persisted for decades after the introduction of screening and only recently have begun to improve and then only for some.[1] The social impact of racialization and subsequent discrimination is not limited to any 1 arena of health care and does not disappear with medical innovation.[2]

The current approach to early detection in endometrial cancer is failing black women, the population most at risk. Scientific advances that can augment or replace this system to allow for earlier medical detection or prevention altogether are needed but are not sufficient. These advances will not succeed without concurrent research and intervention to remove the patient, provider, and system-level factors that impede the highest quality of care for black women's gynecological health. Early patient engagement,[3] development of technology that is resource independent, and real-world testing among high-risk communities will be important methods moving forward. ■

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