ACCESS TO THE EXAMINATION OF MAMMOGRAPHY IN PRIMARY CARE

ACESSO AO EXAME DE MAMOGRAFIA NA ATENÇÃO PRIMÁRIA

ACCESO AL EXAMEN DE MAMOGRAFÍA EN LA ATENCIÓN PRIMARIA

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ABSTRACT

Objective: to evaluate the access to mammography of referenced primary care patients. **Method:** a cross-sectional, quantitative study performed at the IMIP / AVON Breast Cancer Diagnostic and Treatment Center, involving a sample of 88 women. The data were analyzed from tables elaborated in Epilinfo version 3.5.2. **Results:** 93.2% (82) reported having performed this examination previously, which demonstrates a wide knowledge of its importance, 51.2% (42) complained of pain during the examination, followed by 17.1% (14) reported nervousness. **Conclusion:** there is a need to broaden the dissemination of the importance of mammography for its greater adherence. **Descriptors:** Health Services Accessibility; Mammography; Breast Neoplasms.

RESUMO

Objetivo: avaliar o acesso à mamografia de pacientes referenciadas da atenção primária. **Método:** estudo quantitativo, de corte transversal, realizado no Centro de Diagnóstico e Tratamento do Câncer de Mama IMIP/AVON, com uma amostra de 88 mulheres. Os dados foram analisados a partir de tabelas elaboradas no Epilinfo, versão 3.5.2. **Resultados:** 93,2% (82) relataram ter realizado este exame anteriormente, o que demonstra amplo conhecimento de sua importância; 51,2% (42) queixaram-se de dor durante o exame, seguidos por 17,1% (14), que referiram nervosismo. **Conclusão:** Observa-se a necessidade de ampliar a divulgação da importância da mamografia para sua maior adesão. **Descritores:** Acessibilidade aos Serviços de Saúde; Mamografia; Neoplasias da Mama.

RESUMEN

Objetivo: evaluar el acceso a la mamografía de pacientes referenciados de la atención primaria. **Método:** estudio cuantitativo, de corte transversal, realizado en el Centro de Diagnóstico y Tratamiento del Cáncer de Mama IMIP / AVON, e involucró con una muestra de 88 mujeres. Los datos se analizaron a partir de tablas elaboradas en Epilinfo, versión 3.5.2. **Resultados:** 93,2% (82) reportaron haber realizado este examen anteriormente, lo que demuestra amplio conocimiento de su importancia, el 51,2% (42) se quejaron de dolor durante el examen, seguidos por el 17,1% (14) que se refirieron nerviosismo. **Conclusión:** se observa la necesidad de ampliar la divulgación de la importancia de la mamografía para su mayor adhesión. **Descriptores:** Accesibilidad a los Servicios de Salud; Mamografía; Neoplasias de la Mama.

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INTRODUCTION

Cancer is defined as a group of diseases characterized by uncontrolled and abnormal cell growth, the causes of which can be attributed to external factors such as tobacco, chemicals and radiation, or internal factors, such as genetic, immune and hormonal changes. It is emphasized that the performance of these factors, in a joint or sequential manner, can initiate or promote carcinogenesis.¹

It is a global public health problem, not only because of its increased prevalence, but, also, because of the high investments in various levels of action such as health promotion, early detection, care, surveillance, human resources training, research and in the management of the Unified Health System (UHS).²

For the year 2017, in Brazil, the expectation on the number of new cases of cancer is that around 420 thousand new cases, excepting the cases of non-melanoma skin cancer. In specific cases of female breast cancer, more than 57,960 new cases are expected³. The INCA estimates are valid for the biennium 2016 / 2017.³

Breast cancer is composed of a set of diseases with diverse clinical manifestations, multiple genetic and morphological variations and, consequently, several therapeutic approaches. When diagnosed early and treated, there is a reduction in morbimortality rates.⁴

Among the clinical manifestations, the most commonly mentioned sign is the nodule, which is usually painless, hardened and irregular, but there are tumors of differentiated consistency, soft, globose and well defined. However, there are other signs and symptoms of breast cancer, such as: cutaneous edema, which resembles the skin of an orange; cutaneous retraction; nipple changes such as pain, inversion, hyperemia, peeling or ulceration, and papillary secretion, especially when it is spontaneous and unilateral. This secretion is generally transparent, but, may present in the pink or reddish coloration, consequent the presence of red blood cells.⁵

In Brazil, the increase in morbidity and mortality is observed, since there are numerous barriers that persist from access to screening to difficulties in the use of diagnostic resources and treatments. As a result, there are important impacts both in the individual, as social and political scope, being considered a public health problem and

one of the targets of the National Policy of Oncological Care.⁵

The Ministry of Health, by the National Policy of Oncology, highlighted the control of breast cancer as a fundamental and obligatory component in the state and municipal health plans. Early diagnosis was listed as one of the national priorities in the set of proposals for the "Health Pact" in 2006, one goal being to expand mammography coverage to 60 %.⁶

Mammography is the screening test, with the ability to detect non-palpable lesions and, therefore, have an impact on breast cancer mortality. In this way, this is the image exam recommended for the screening of breast cancer in Brazil.⁷

It is an image examination obtained by an X-ray machine, known as a mammograph, in which there is compression of the breast to be examined. In this way, it overcomes the anatomical difference between the base and the mammary apex, for a better visualization of the structures. It looks for minimal lesions, not palpable, or changes denominated microcalcifications. In addition, it is classically used for the investigation of breast nodules perceived by palpation or even by other symptoms in the region, and recognizes tumors in sizes between 1- 3mm.⁸

Mammography screening has sensitivity between 46% and 88% and specificity between 82% and 99% and its use, for screening, reduces mortality by 25%. However, a good image will depend on the following aspects: lesion size and location; breast tissue density (young women have denser breasts); a correct radiological technique; knowledge; practice and dedication of the professionals involved.^{5,8}

Mammography and its results are classified according to the Breast Imaging Reporting and Data System (BI-RADS®), published by the American College of Radiology (ACR) and translated by the Brazilian College of Radiology.⁷ The main purpose of using BI-RADS is the standardization and standardization of the mammography sides, subject to discrepancy in the interpretation when descriptive criteria are used. In addition, the BI-RADS serves as quality control of the data from the radiography, since it allows the review and adequacy of the previous radiological diagnosis.⁷ Classification of BI-RADS is divided into a group of assessments (0 to 6), where zero consists of incomplete examination; one, on negative exam; two, on exam with a typically benign finding; three, on exam with a probable benign finding; four, on exam with a suspicious finding; five, in the highly suspect finding, and six in the

examination with findings whose malignancy is already proven, and each result proposes recommendations and follow-up accordance with its gravity.⁷

According to the Basic Attention Report, published in 2013 by the Ministry of Health, it is recommended that the clinical examination of the breasts be performed annually in women aged between 40 and 49 years. If an alteration is indicated the mammography examination and screening, by mammography, every two years in women aged 50-69 years; women who are 35 or older, at high risk, should undergo mammography and clinical examination of the breasts annually.⁹

However, tracking programs are not yet reality due to several factors, such as, low coverage of the target population, poor infrastructure for program routines and lack of population follow-up in the medium and long term. Thus, screening occurs opportunistically when women spontaneously seek health services and receive recommendations for testing.¹⁰

In 2009, the Information System for Breast Cancer Control (SISMAMA) was implemented to standardize data collection on the screening, diagnosis and treatment of breast cancer throughout the country and to allow the evaluation of control actions of the disease.¹¹

SISMAMA-based breast cancer screening assessments, have so far been limited to describing the main features of the system and estimating coverage and quality with a regional coverage.¹¹

SISMAMA is contained in another more comprehensive Information System, the SISCAN (Cancer Information System), which was established by Portaria n. 3.394, of December 30, 2014, and has, as its objective, the "monitoring of actions related to detection early diagnosis, and early treatment of malignant neoplasms."¹²

The SISCAN must be implanted by the following public or private healthcare institutions, that act in a complementary way to the UHS: cytopathology laboratories and pathological anatomy; fixed and mobile radiology units with mammography service; in services that perform cancer treatment in the modalities of surgery, chemotherapy and radiotherapy; and in the State, Federal District and Municipal coordinations that accompany cancer control actions.¹²

In 2012, the National Quality Program in Mammography was instituted with the objective of "evaluating the performance of diagnostic imaging services that perform mammography, based on criteria and

parameters related to the quality of the structure, process, results, the clinical picture and the report". This program is nationally applicable and applies to all public and private establishments that perform mammography and that are linked or not to the UHS.¹³

The term access was cited several times, but it is important to define this word, according to the Houaiss Dictionary of the Portuguese Language consists of "the act of entering, entering, entering; possibility of reaching the approach, arrival; possibility of achieving something."¹⁴

The establishments previously mentioned must, obligatorily, feed the following fields of SISCAN: requisition of cytopathological examination of cervix; requisition of cytological examination of the breast; mammography requisition; result of mammography; requisition of histopathological examination of cervix; and histopathological examination of the breast. Thus, it is assumed that all women referred, from primary care, have direct access to the SISCAN mammography requisition. After all, only financial rapass occurs if it is correctly filled.¹³

In the context of health services, it is based on the paths that the user uses in the system in the search for the solution of their need, a "gateway". In addition, universal access is a principle of the Unified Health System and a constitutional guarantee.¹⁵

When discussing the issue of access from the possibilities of approaching health services, it is important to have a comprehensive view, where it is possible to include an economic dimension, related to the relationship between supply and demand; a technical overview on the planning and organization of the service network; a political vision regarding the development of sanitary awareness and popular organization; and a symbolic dimension, related to social representations about attention and the health system.¹⁵

Barriers to access to screening procedures present a selective pattern, evidencing social inequalities. The literature suggests that the factors associated with the accomplishment of screening tests in Brazil verified an increasing gradient, according to income levels and schooling, in the prevalence of mammography. This, when related to the existence of a health plan, is much higher than that found for those who report that they do not have a plan (60% and 27%, respectively).¹¹

In the United States, in the period from 1992 to 2000, despite the substantial reduction in the proportion of women between 50-69 years of age who had never performed mammography, inequalities in the use of mammography remained unfavorable for the poorest social class lower, and lower educational level. Among women over 60 years old, in the State of Minas Gerais, the prevalence of non-mammography remained associated with socioeconomic status and self-assessment of health status.¹¹

From the exposure of the access to the mammography examination of the patients from the primary care, came the intention to list factors that permeate this access in the primary care to this part of the population.

OBJECTIVE

- To evaluate the access to mammography of referenced primary care patients.

METHOD

A quantitative, cross-sectional study with 88 women referred from primary care who performed screening mammograms at a referral center in Recife, PE, Brazil, and who were required to fill out the completed SISCAN form.

For the calculation of the sample, the total number of mammograms performed at the Breast Cancer Diagnostic and Treatment Center IMIP / AVON was considered: one thousand screening mammograms per month. A statistical formula was applied, which resulted in a sample of 88 women interviewed.

Data collection comprised the period between September and October 2015. The study was carried out at the mastology outpatient clinic of the Instituto de Medicina Integral Professor Fernando Figueira (IMIP). From the previous analysis of the referrals at the reception, the women who attended the screening mammography screening service that were referred by a primary care service were identified. Afterwards, the patients were invited to participate in the interview that will be performed through a semi-structured questionnaire.

The ethical aspects are in accordance with Resolution 466/2012 of the National Health Council, which respected bioethical principles, as well as, the confidentiality and anonymity of research volunteers including freedom of participation and freedom of movement. The volunteers were guided about the research, and the signing of the Free and

Informed Consent Term (FICT) was requested in two ways.¹⁶

In compliance with the ethical principles of the research, this study was submitted for approval by the Research Ethics Committee (REC) of the IMIP. Approval was given with CAAE number: 47559515.8.0000.5201 and the interviews only occurred after its approval and the consent of the place demarcated for their occurrence.

The questionnaires were applied by the researcher after the acceptance and prior consent of the signing of the TCLE. The participants of the research were clarified regarding the aspects related to the Term of Free and Informed Consent, especially, regarding the guarantee of secrecy, the right to refuse to continue in the research, at any stage, without any damages, and the dissemination of results in periodicals and scientific events.

The sociodemographic variables of the patients were presented using tables elaborated in EpiInfo version 3.5.2. (2010).

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The inclusion criteria for the research were: being in the range above 40 years of age, since this is the target age range for screening mammograms; origin of primary care; and take possession of the referral form for such examination (SISCAN).

RESULTS

To characterize the sample, the following variables were evaluated: age; marital status; provenance; religion and schooling.

As to the age of the interviewees, the most common age group among women was 41 to 45 years and 46 to 50 years, both with 21.6%, according to table 1, which corroborates with the Ministry of Health that women over the age of 40 should be screened annually, and women aged 50-69, with no sign of pathology, should do so every year.⁹

In relation to work and occupation, 62.5% (55) of the interviewees do not work, and what was found in the statements of these women is that most are housewives and take care of their families, and 37.5% (33) have some kind of external work.

Regarding the origin of the interviewees, it was observed that 77.3% (68) women were

from the city of Recife; 21.6% (19) were from a city in the interior of Pernambuco, and only 1.1% (1) was from another state, Ceará, and explained that they liked a doctor close to relatives' house, and that she came to Recife precisely to perform this routine follow-up and exams.

Table 1. Socio-demographic aspects. Recife (PE), 2015, Brazil.

Variables	n=88	100%
Age group		
35 to 40 years	6	6.8%
41 to 45 years	19	21.6%
46 to 50 years	19	21.6%
51 to 55 years	12	13.6%
56 to 60 years	13	14.8%
61 to 65 years	7	8.0%
66 to 70 years	6	6.8%
71 to 75 years	4	4.5%
76 to 80 years	2	2.3%
Education		
From 1 st to 4 th grade of elementary school	18	20.5%
From 5 th to 8 th grade	25	28.4%
Full High School	15	17.0%
Incomplete high school	8	9.1%
Complete Higher Education	10	11.4%
Incomplete higher education	6	6.8%
Did not study	5	5.7%
Postgraduate studies	1	1.1%

Regarding the marital status, as can be seen in table 2, 43.7% (31) of the respondents reported being married or in stable union; 32.4% (23) explained that they were divorced; 16.9% (12), widows and 4.2% (3), single.

Regarding the presence of children, 85.2% (75) reported having them. It is important to note that the average number of descendants of the interviewees was 2.43, only one had (1%) women reported having 14 children,

something not so common nowadays. Of the total number of women who reported offspring, 13.3% (10) never breastfed, which is known to present a risk for breast cancer.¹⁷; 23 The importance of knowledge about offspring is confirmed, because it has already been proven that nulliparity is an important risk factor for the occurrence of breast cancer.²³

Table 2. Family Aspects. Recife (PE), 2015, Brazil

Data	n=88	100%
Marital status		
Married or stable union	31	43.7
Divorced	23	32.4
Single	3	4.2
Widow	12	16.9
Has children		
Yes	75	85.2%
No	13	14.8%

Of the 88 women interviewed, 93.2% (82) stated that they had previously performed the mammography exam, while 6.8% (6) denied having previously done the referred examination.

Of the 82 women who reported mammography previously, 61% (50) reported having done one to five times, 19.5% (16) performed between five and ten times, and 19.5% (16) reported more than ten times. What is perceived is that the older the woman presents, the greater is the report of repetition of the exam. This is due to the guidelines of the Ministry of Health.

The follow-up of what is recommended by the Ministry is confirmed when asked about the last examination performed: 79.2% (66)

said to have been between months and two years incomplete; 9.8% (8), have been incomplete two to three years and 11% (9) for over three years.

The interviewees questioned about the sensation presented during the examination (Table 3), 51.2% (42) reported feeling pain. Several complaints were made. One of them defined mammography as a "photocopy" of the breast, since it is pressed; 17.1% (14) reported only nervousness; 13.4% (11) presented physical discomfort, something defined by them as light and bearable; 3.7% (3) claimed fear; 1.2% (1) reported shame; 13.4% (11) denied any feeling, explaining that they felt absolutely nothing when performing such an examination.

Table 3. Number and frequency of sensation during mammography. Pernambuco, 2015.

Sensation during mammography	N (82)	% (100)
Ache	42	51.2%
Nervousness	14	17.1%
Physical discomfort	11	13.4%
Anything	11	13.4%
Fear	3	3.7%
Shame	1	1.2%
Total	82	100.0%

As for the six women who never performed the exam, it was possible to observe, in **table 4**, that 33.3% (2) stated that they had never taken the exam, because they were not old enough to fit the requirements of the Ministry of Health; 33.3% (2) reported being healthy and, therefore, not necessary; one (16.7%) explained that he did not know the mammogram and / or was unaware of its purpose or importance; and another (16.7%) stated that they presented problems with distance to access the exam site.

From these data, it is possible to understand that, despite the intense disclosure for the adhesion to mammography as a routine examination, primordial for the maintenance of women's health, there are women who are unaware of the examination and the indications of it. In this way, these figures reinforce the importance of disclosure for the whole population, especially, the less financially favored women.

Table 4. Reasons for never having a mammogram. Recife (PE), 2015, Brazil.

Reason for never having done Mammography	N (6)	% (100)
Did not know the exam / did not know its purpose or importance	1	16.7%
I was not needed / I am healthy	2	33.3%
I was not old enough to perform	2	33.3%
Problems with distance	1	16.7%

Regarding the process of referral of the woman to the Breast Center, some questions were asked about the path taken to the final point, the mammography. When asked who was referred for the test, 88.6% (78) reported referrals by the physician; 7.9% (7) reported having been referred by friends and / or acquaintances; 2.3% (2) explained that they were referred by relatives; and one woman explained that she had been referred by the Residents' Association.

of those 19.3% (17) who arrived without referral, all were able to perform mammography.

The Breast Center acts as a spontaneous demand service, and, even if the women do not present the referral, the reception can enter an appointment with the Nurse, and, if the user is within the age range recommended for screening mammography, referral and examination are requested.

Regarding the delay in performing mammography, 84.1% (74) denied any delay; and 15.9% (14) stated that it took time to perform such an examination. Of these 15.9% (14) which confirmed the delay, 21.4% (3) reported having delayed between 15 days to one month and 78.6% (11) explained that they took more than one month to perform the test.

When asked if they arrived at the Breast / IMIP Center with the referral form / SISCAN, 80.7% (71) stated that they were in possession of such referral; 19.3% (17) of the interviewees explained that they were not in possession of this document, a very significant number, even more when it was observed that

Still, about 15.9% (14) of the women who reported delay in the mammography examination, when asked about the reason for such delay, as can be seen in **table 5**, 50% (7) time to do it; 28.6% (4) explained that they were due to distance factors; 14.3% (2) were for convenience, not wanting to; and one (7.1%) explained that it took time to do so, because the breast was sore and she hoped it would relieve.

Tabela 5. Motivo da demora para realização da Mamografia. Recife (PE), 2015, Brasil.

Reason for delay	n	%
Breast pain	1	7.1%
Convenience	2	14.3%
Distance	4	28.6%
Time	7	50.0%
Total	14	100.0%

As the last point to be approached, it was asked about the accomplishment of palpation of the breasts in search of some differential finding and how often they perform this procedure. Twenty women (22.7%) explained that they do not touch; 42% (37) stated that they do, but, with no defined frequency; 33% (29) reported monthly or more frequently; and 2.3% (2) explained that they do, however, on average, twice yearly, sporadically.

DISCUSSION

It is known that factors such as family income, schooling and place of residence (rural or urban area), are associated with the accomplishment or not of mammography. There is a better adherence of this exam among individuals with high family income, good schooling and residing in the urban zone,¹⁷ a characteristic that was found very diversified among the women interviewed, finding different degrees of schooling.

As for the most incident age group among the women questioned, it was verified that the most representative age group was 41 to 50 years, which can be explained by the Ministry of Health's recommendation for mammography. Brazil, 2013, suggests that "when mammography is offered to women between 50 and 69 years of age, every two years, with coverage equal to or greater than 70% of the target population, it is possible to reduce breast cancer mortality by 15% to 23%."⁹

Most of the women resided in Recife, which corroborates the existing studies, which indicate the place of residence as an important factor for the adhesion of mammography. Far-distant rural sites make access more difficult, and the sample of the survey in question presented a number of women residing in the capital in the urban area, superior to cities in the interior.^{10,17-8}

Prevention related to primary care of breast cancer is related to the control of recognized risk factors. Although hereditary factors and many of those related to women's reproductive cycle are not amenable to change, evidence demonstrates a relative risk reduction for breast cancer of about 4.3% every 12 months of breastfeeding, in addition to risk reduction related to greater parity.⁹

Some women reported that they did not breastfeed their children, and this can be transformed through guidance and encouragement in prenatal care.

The Ministry of Health further explains that lifestyle factors, such as postmenopausal obesity, sedentary lifestyle, excessive alcohol consumption and hormone replacement therapy can be controlled and contribute to decrease the incidence of breast cancer, which historically has been little appreciated. Based on a broad summary of scientific evidence on the relationship between diet, physical activity, and cancer prevention, it is estimated that 28% of breast cancers can be prevented through diet, nutrition, physical activity, and adequate body fat.⁹

In 2003, 42.5% of the female population aged 25 years and over had undergone mammography at least once. In 2008, this number had an increase, of 54.8% (31.6 million) women aged 25 years and over underwent the examination. In absolute numbers, the growth was about 48% .²⁰ Regarding the mammography examination, data from the National Survey by Household Sample conducted by the Brazilian Institute of Geography and Statistics (IBGE), reveal the increase in the number of examinations in the recent years, representing an increase, albeit unequal, in the access to mammography.²⁰

Mammography has received robust investments from the federal government over the last four years. Between 2010 and 2014, R \$ 3.3 billion were transferred to hospitals of the Unified Health System (SUS), which deal with several cancers, including, breast cancer. According to the Ministry of Health, the resources of the last four years were 45% higher than that of the previous period.²¹

The result was reflected in the significant increase in mammograms performed in women aged 50 to 69 years, the age group with the highest number of cases of breast cancer. In 2010, SUS performed around 1.55 million mammograms. In 2013, that number jumped to just over 2.5 million, an increase of 61.9%. The UHS also, increased the volume of exams from just over three million in 2010 to 4.3 million in 2014.²¹

Nevertheless, it was observed that, of the 88 women interviewed, 93.2% (82) stated that they had previously performed the mammography exam, while 6.8% (6) denied having previously done the referred examination.

A study carried out in Dourados, Mato Grosso do Sul, showed an interesting fact. This research sought to identify if the women knew the risk factors for breast cancer, which found that a portion of the women identified not performing consultations and examinations as risk factors for breast cancer.²² This situation serves as a basis for understanding the good percentage of women who had already had the mammogram.

Law 11.664 / 2008, which deals with comprehensive health care for women, reinforces what is already established by the UHS principles: the universal right to health. It establishes that mammographic examinations should be ensured for all women aged 40 years or from 35 years, if they are at high risk.²³

The UHS assures all Brazilian women free access to mammography, as long as they are within the recommended age range.²⁸ This examination, like any other study carried out by the public or complementary health network, depends on a medical indication - which has not been modified by the new legislation. It is the health professional who tells the patient whether or not to take the test, according to their family history, their age or the suspicion of any change. It should be clarified that there are different indications for performing mammography, both of which depend on medical indication.²³

The health professional can request diagnostic mammography, when it is suspected, regardless of the age of the patient. The doctor and the nurse, should recommend to the patient, between 50 and 69 years, mammography for tracking. In this case, the objective is the monitoring of healthy women, with regular examinations, in order to diagnose early cases of the disease and decrease the mortality rate in the age group with the highest risk and incidence.²³⁻⁴

Only 33% (29) of the women said they performed breast self-examination frequently and this can be justified by changes in the indications of this routine. The National Cancer Institute and the Brazilian Society of Mastology do not stimulate breast self-examination (BSE) as an isolated strategy for the early detection of breast cancer. The recommendation is that the examination of the breasts by the woman herself should be part of health education that contemplates

the knowledge of the body itself, not as a specific diagnostic strategy.²⁵

Scientific evidence suggests that BSE is not efficient for screening and does not contribute to the reduction of breast cancer mortality. In addition, it causes negative consequences such as increased numbers of benign lesions biopsies, false sense of security on falsely negative tests and negative psychological impact, on false positive tests. Therefore, the examination of the breasts, performed by the woman herself, does not replace the physical examination performed by a health professional (doctor or nurse) qualified for this activity.^{19,25-6}

CONCLUSION

Although mammography is high among Recife women from primary care, there is still a percentage of women who had never had a mammogram. The factors strongly associated with not performing the test for early detection are related to the lack of knowledge of the importance; the age group is not included in the screening of breast cancer; and distance of housing and place of offer.

Although there are no modifiable factors, such as the age group established by the Ministry of Health, there are others that can be clarified with Health Education, by encouraging the accomplishment of such an examination and the need for a diagnosis of a pathology, in the beginning, in which the possibilities for healing rise dramatically.

The incentive to perform mammography, for an early diagnosis, raises the possibilities of cure, and it is extremely important policies that allow and increase the access / accessibility of women, according to the age group, to the accomplishment of said examination.

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Submission: 2017/04/12

Accepted: 2017/10/11

Publishing: 2017/12/01

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