

CANCER CONNECTION



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COMPREHENSIVE CANCER CONTROL UPDATE

Indiana One of a Dozen Funded to Implement Policy Agenda

The Indiana Comprehensive Cancer Control Program received notification of award from the Centers for Disease Control and Prevention on Tuesday, Sept. 28 - Indiana was one of 11 states (and one tribe) funded for *Demonstrating the Capacity of Comprehensive Cancer Control Programs to Implement Policy and Environmental Cancer Control Interventions*. This funding supports the implementation of a focused policy agenda:

- Pass a comprehensive smokefree air law
- Increase cigarette tax
- Increase the number of Complete Streets policies
- Require school corporations to provide at least 30 minutes a day of physical activity in elementary schools

"I look forward to working very closely with the Indiana Cancer Consortium as we implement the proposed policy agenda over the next five years," said Keylee Wright, Director of the Indiana Comprehensive Cancer Control Program. "The impact these policy initiatives can make in reducing the burden of cancer and other chronic diseases is very exciting! We have a lot of work ahead of us, but a healthier Indiana is worth the effort."

Indiana Receives Funding to Establish Public Health Training Center

The Department of Public Health at IU School of Medicine recently received funding from the U.S. Department of Health and Human Services to establish a Public Health Training Center for the state of Indiana. The Public Health Training Centers help improve the public health system through education and training of public health workers. This is a very prestigious award that will strengthen Indiana's public health workforce and provide the IU School of Medicine Department of Public Health with membership in the national network of Public Health Training Centers.

The following is an excerpt taken from the Sept. 30, 2010, press release from the Department of Health and Human Services:

"Today's awards represent a dramatic increase in support for Public Health Training Centers," said Secretary Sebelius. "Investing in prevention and public health is the foundation for improving the health and well-being of all Americans." Funded organizations (1) plan, develop, operate, and evaluate projects that support goals established by the Secretary in preventive medicine, health promotion, and disease prevention; or (2) improve access to and quality of health services in medically underserved communities. Other Public Health Training Center activities include assessing the learning needs of the public health workforce; providing accessible training; and working with organizations to meet strategic planning, education, and resource needs.



ICC Fall Meeting 2010

SAVE THE DATE!

Indiana Cancer Consortium Fall Meeting
 Tuesday, October 26, 2010
 10 a.m. to 3 p.m.
 Fairbanks Hall
 340 W. 10th St.
 Indianapolis, IN 46202

INDIANA CANCER
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 2010 - 2014



For a map of Fairbanks Hall, go to <http://www.iupui.edu/building/FS.html>.

To register for the ICC Fall Meeting, please visit <http://iccfallmeeting.eventbrite.com>.

ICC Membership Renewal

In August, the ICC asked all partners to renew their memberships. If you have yet to renew your membership, please complete the membership application at <http://indianacancer.org/membership/membership-form-2/>. This will take less than a minute to complete. Your participation is extremely valuable as we continue to implement cancer control activities throughout the state of Indiana.

If you know anyone who would be interested in ICC membership, feel free to forward this information. If you have any questions or need more information, please contact Nikki Davis at 317-234-2887 or nicdavis@isdh.in.gov.

Primary Prevention Action Team Update

The Primary Prevention Action Team is partnering with Ball State University (BSU) to address the ICC's priority objective of increasing the percentage of high school students in Indiana who engage in 60 minutes or more of moderate or vigorous physical activity daily by 2014. Over the next year, BSU students will develop, implement, and evaluate a communications campaign to increase awareness of the importance of physical activity for health promotion and disease prevention for students. Currently, the BSU students are finalizing survey instruments and securing schools to implement the intervention.

The Primary Prevention Action Team's next meeting date is on Tuesday, Oct. 12, at 3 p.m. (EST). All meetings are located at the Indiana Minority Health Coalition at 3737 N. Meridian St., 3rd floor, Indianapolis. If you are unable to attend the meeting in person, there is an option to join via conference call. To join the action team or for more information, please contact Nikki Davis at 317-234-2887 or nicdavis@isdh.in.gov.

Indiana Campaign for Smokefree Air

The Indiana Campaign for Smokefree Air is committed to protecting all Hoosier workers from exposure to secondhand smoke by working toward the adoption of a comprehensive smokefree workplace law that covers ALL workplaces.

For more information on the Indiana Campaign for Smoke-free Air, please visit <http://worksmokefree.com/>.

Steady Diet of Good Ideas

Donna Rettew, Post-Tribune Correspondent

Sept. 12, 2010 – Post-Tribune – Schools in Northwest Indiana offer more than just reading, writing, and arithmetic these days.

The Family Nutrition Program (FNP), administered by the Purdue University Cooperative Extension Service and the U.S. Department of Agriculture, teaches kids in qualifying school districts how to make better food choices. Professor Popcorn visits elementary schools in Porter County where at least half of the students receive free or reduced-price lunches. Last year, 11 schools were involved.

The nutrition and food safety program for children is also available at local YMCAs, Boys and Girls Clubs, parks, and public libraries all year.

Linda Curley of Valparaiso helps present the program, which offers five, 30-minute lessons for children in kindergarten through sixth grade. She encourages eating healthy foods, using safe food-handling techniques, and making physical activity a part of their lifestyles. Teachers interested in learning more about the program are encouraged to contact her.

"Our numbers are growing because of the downturn in the economy," Curley said. "Many more families are struggling to make ends meet. Professor Popcorn programming has been offered to schools in Porter County for many years. We have had great success with the curriculum and receive positive feedback from teachers and students who have had the program in their classrooms."

Curley has been a Family Nutrition Program assistant for four years and is working toward a master's degree in human development and family sciences.

To read the entire article, please visit the Post-Tribune at http://www.post-trib.com/news/neighbors/2694232_01nkidsfood0912.article.

Breast and Cervical Cancer Committee

The Indiana Cancer Consortium is reviving the Breast and Cervical Cancer Committee and needs you to help make the committee a success!

The Breast and Cervical Cancer Committee will focus its efforts on implementing related objectives from the Indiana Cancer Control Plan 2010-2014, including:

- Increase the percentage of women aged 40 and older who receive annual breast cancer screening
- Increase the percentage of women aged 18 and older who have had a Pap smear in the last three years
- Reduce barriers to screenings and diagnostic services for disparate populations
- Minimize barriers and increase access for cancer patients to receive evidence based treatment services and appropriate follow-up in the state of Indiana
- Increase access to resources for cancer survivors

If you are interested in working on this committee, please send an email by Friday, Oct. 29, to Nikki Davis at nicdavis@isdh.in.gov. We look forward to your participation.

Free Mammograms:

October is Breast Cancer Awareness Month

Women age 40 or older should get a mammogram every year. *

If you can't afford one, Little Red Door Cancer Agency may be able to help.

Contact Little Red Door at 317-925-5595 to see if you qualify for the program.

*Younger women may need a mammogram if they find a lump or have a family history of breast cancer.



Little Red Door Cancer Agency
1801 N. Meridian St.
Indianapolis, IN 46202
317-925-5595
www.littlereddoor.org
email: mail@littlereddoor.org

Prostate Cancer Initiative

September was National Prostate Cancer Awareness Month, a perfect time for the ICC to recharge its efforts to increase prostate cancer awareness, education, and quality of life for survivors in Indiana. The ICC Prostate Cancer Coordinating Committee had its first meeting on Sept. 9.

The Prostate Cancer Coordinating Committee's activities are guided by the Indiana Cancer Control Plan 2010-2014. The committee will focus its efforts on the following objectives:

Early Detection

- Increase the percentage of men age 40 and older who have had a discussion with their health care providers regarding the risks and benefits of prostate cancer screening
- Reduce barriers to screenings and diagnostic services for disparate populations

Treatment

- Minimize barriers and increase access for cancer patients to receive evidence based treatment services and appropriate follow-up in the state of Indiana

Quality of Life

- Increase access to resources for cancer survivors

The next Prostate Cancer Coordinating Committee meeting is on Oct. 7, from 3 to 4 p.m. at the Indiana University School of Nursing, Room 339 (1111 Middle Dr., Indianapolis). If you are interested in joining the committee, please contact Teasa Thompson at 317-233-7448 or TThompson1@isdh.in.gov.

REMINDER: Eligible Women Can Receive FREE Cancer Treatments

Eligible women may apply for the state's Breast and Cervical Cancer Program which offers access to free treatment for breast and cervical cancer. To qualify for this program, women must:

- Need treatment for breast and cervical cancer;
- Reside in Indiana;
- Be under the age of 65;
- Have a family income less than 200 percent of the federal poverty level; and
- Have no credible health insurance.

In 2009, SEA 554 was passed which extended Medicaid coverage to eligible women who were diagnosed outside of the Breast and Cervical Cancer Program.

To start the process of enrollment, women need to call the Indiana Family Helpline at 800-433-0746. If a provider would like to contact a case worker, please email Robin Cole at rocole@isdh.in.gov.

For more information on cancer screenings, please visit <http://www.in.gov/isdh/24967.htm>.

New Breast Cancer Committee to Establish Federal Research Agenda National Cancer Institute

Aug. 16, 2010—A newly formed advisory committee will develop and coordinate a strategic federal research agenda on environmental and genetic factors related to breast cancer. The 19-member Interagency Breast Cancer and Environmental Research Coordinating Committee (IBCERCC) was established by the National Institute of Environmental Health Sciences, in collaboration with the National Cancer Institute, to review all breast cancer research efforts conducted or supported by federal agencies.

The committee will develop recommendations for the secretary of the U.S. Department of Health and Human Services, the National Institutes of Health, and other federal agencies, to improve existing research programs related to breast cancer research. Additionally, the IBCERCC will create a comprehensive plan to expand opportunities for collaborative, multi-disciplinary research, and develop a summary of advances in federal breast cancer research.

To the entire article, please visit <http://www.cancer.gov/newscenter/pressreleases/IBCERCC>.

Robotic Surgery Device to Treat Throat Cancer Will Higgins, IndyStar

Sept. 14, 2010—IndyStar—A new surgical procedure to treat throat cancer using robotics can greatly reduce recovery time, patient discomfort, and at the same time save money, said Indianapolis Dr. Tod Huntley.

"This is a paradigm shift in the way we treat patients," said the surgeon with the Center for Ear, Nose, Throat, and Allergy at St. Vincent Hospital, on the Far Northside.

Throat cancer, usually found in people 50 and older with a history of tobacco and alcohol dependence, is diagnosed about 290,000 times worldwide each year.

Huntley and his partner, Dr. Ed Krowiak, have performed a couple dozen surgeries since last spring. They were the first private-practice physicians to use the new technique.

To read the entire article, please visit <http://www.indystar.com/article/20100914/BUSINESS06/9130393/Robotic-surgery-device-to-treat-throat-cancer>.

Quality of Life Action Team Update

The Quality of Life Action Team has recently welcomed it's newest co-chair, Gail Hamm. Gail is the Program Director of Cancer Services of Northeast Indiana located in Fort Wayne. She has been a great leader and participant with the action team. Thanks, Gail!

The action team has been planning a half-day seminar for Nov. 4 from 1 to 4:20 p.m. (Please see the save the date below.) The purpose of this seminar is to gather and educate providers (primary care physicians, oncologists, oncology nurses, oncology organizations, and physicians' organizations) on hospice and palliative care.

The next Quality of Life Action Team meeting is on Monday, Nov. 1, at 11 a.m. (EST). The meetings are held at the Little Red Door Cancer Agency (1801 N. Meridian Street, Indianapolis) . If you are unable to attend the meeting in person, there is an option to join via conference call. To join the action team or for more information, please contact Teasa Thompson at 317-233-7448 or TThompson1@isdh.in.gov.



Choices for the End of Life

SAVE THE DATE!

Indiana Cancer Consortium's Quality of Life
Action Team presents:

Choices for the End of Life

This seminar is for health care professionals.
Application is being made for three CEHs for social workers.

Thursday, Nov. 4, 2010
1 to 4:20 p.m.

Cancer Services of Northeast Indiana
6316 Mutual Dr.
Fort Wayne, IN 46825

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To register or for more information, please visit <http://iccqualityoflife.eventbrite.com>.

Karen Stump Melanoma



In May of 2006, I felt a lump under my skin on my left cheek. My primary physician felt it was a cyst and sent me to a plastic surgeon to have it removed. The plastic surgeon agreed it was a cyst - but it was so deep, he had trouble removing it. Test results confirmed the cyst was stage IV melanoma. I wasn't too familiar with melanoma, but after reading the pamphlet in the doctor's office - which called it fatal - I was really scared.

He suggested I go to Goshen Cancer Center and meet with Doug Schwartzentruber, M.D. Dr. Schwartzentruber is excellent. He performed additional surgery on my face to remove any remaining cancer cells. He cut from the inner corner of my eye past my lip, and removed a small part of my lip. He also cut inside from my

nose to the end of my gums. I then had radiation to ensure all cells were gone.

One year later, a spot the doctors were monitoring under my left eye began growing and tracking on a nerve to my brain. Dr. Schwartzentruber suggested Interleukin-2 (IL-2), which is an immunotherapy treatment. I went into the hospital for six weeks of treatment from May through October. The tumor had shrunk. In November, my husband and I were on vacation and I began to have double vision. The cancer had spread and was tracking on my optic nerve back to my brain. I had radiation in December - Tomotherapy. That was my last treatment. It effectively shrunk the tumor and it has remained stable. I feel I have received excellent care at Goshen Cancer Center. They treat the whole person.

Cancer is life changing. I've learned that it is important to not only eat properly, exercise, and take care of my body, but also my mind by meditating, doing yoga, and staying positive.

There have been so many people that have impacted my life since being diagnosed. My husband and family have been wonderful. Also, I couldn't have gotten through this without my friends, especially a couple who are also cancer survivors.

I have learned to appreciate every day and to try not to "sweat" the small stuff! I have grown in my faith and love to help others going through their cancer journey.

I feel it's extremely important to have a positive attitude and have HOPE! Also, please have any suspicious lumps or moles checked and wear sunscreen!!!

Indiana State Cancer Registry: For All Your Cancer Data Needs **First in a series of three articles on the Indiana State Cancer Registry**

Bridget Rans Strong
Director, Indiana State Cancer Registry

The Indiana State Cancer Registry (ISCR) is a vital, but often overlooked, component of several programs at the Indiana State Department of Health (ISDH). But what exactly is the ISCR, and what does the program collect and do? This series on cancer collection and use within ISDH will shed light to those questions and hopefully inspire many to use more data as necessary.

The ISCR is a central cancer registry funded both by the National Program of Cancer Registries (NPCR) and Indiana state funds. It was established in 1985 "for the purpose of recording all cases of malignant disease and other tumors and precancerous diseases required to be reported by federal law or federal regulation or the NPCR that are diagnosed or treated in Indiana, and compiling necessary and appropriate information concerning those cases, as determined by the state department, in order to conduct epidemiologic surveys of cancer and to apply appropriate preventive and control measures." (IC 16-38-2-1). In Indiana, the following are among the required reporting facilities: hospitals, physicians' offices, dentists, clinics, medical and pathology 5 laboratories, ambulatory surgery centers, and other facilities that might diagnose, treat, or care for a patient with cancer.

So what is the purpose of the registry, and what is reportable? The purpose of the registry is to record all cases of malignant disease, except for certain skin and cervical cancers. In addition, in 2004 other tumors and precancerous cancers, such as benign brain and central nervous system tumors, were required to be reported. The cases are either diagnosed or treated in Indiana, and the ISCR compiles necessary and appropriate information concerning those cases in order to conduct epidemiological surveys of cancer. For every patient seen, there are approximately 466 total data fields to complete, and Indiana requires 116 data fields. Out of those, the NPCR requires 94 data fields to complete. These numbers are set to increase later this year. To code these data fields, each tumor requires a variety of coding manuals, each with its own unique set of rules and codes, to be used to correctly code each of the data items. For instance, to determine the histology (cell type) code and classification of a second tumor reported, (whether it should be counted as the same or different primary tumor), a specific manual must be consulted.

As can be imagined, a lot of data is generated. The ISCR receives over 75,000 cancer records per year. However, many of these can be consolidated into one record, such as getting information on a single patient from a hospital, a pathology lab, and a surgery center. Certified tumor registrars, or CTRs, work with all of this data. Four full-time and several part-time CTRs work at the ISCR. One of the state CTRs, a designated education trainer, receives specialized training from the Centers for Disease Control and Prevention, and then conducts workshops and meetings to train hospital CTRs around the state. The education trainer has been especially important this year, as there have been many changes in the rules of staging in 2010. Another CTR oversees quality control. Since the cancer registry is evaluated annually on a national level, the accuracy and completeness of data preformed by this position is vital and necessary to ensure that the ISCR continues to meet standards and improve.

The next article will explore various ways the ISCR receives data and describe new advances in the field.

Disparities in Cancer Outcomes: The Role of Race and Ethnicity

Esther R. Smith-Howell, B.S.N., R.N.

Indiana University School of Nursing

The Indiana Cancer Consortium has adopted an objective to help understand the important, but complicated, issue of disparities in cancer outcomes. This, the fourth in a series of articles in the *Cancer Connection*, addresses disparities in cancer outcomes based on race and ethnicity.

Racial and ethnic disparities have been well documented in cancer treatments and outcomes. African American men have a 14 percent higher incidence rate and a 34 percent higher mortality rate from all cancers compared to Caucasian men. Although African American women have a 7 percent lower cancer incidence rate, they have a 17 percent higher cancer death rate than Caucasian women⁷. Additionally, African Americans suffer lower five-year survival rates at every stage of diagnosis, for virtually every cancer, when compared to Caucasian Americans⁷. These disparities can be attributed to differences in access to quality health care and comorbid conditions. African Americans are less likely to be diagnosed with cancer in the early stages, when it is still confined and can be more effectively treated⁷. Evidence has shown that when African Americans receive similar cancer treatments as Caucasian Americans, health outcomes are comparable to those of Caucasian Americans⁷.

For racial and ethnic groups, apart from African Americans and Caucasian Americans, cancer mortality and incidence rates are lower for all cancers combined. While these ethnic populations generally have a lower incidence for most cancers, they suffer disproportionately high mortality and incidence rates from cancers related to infectious diseases⁷. Cancers located in the cervix, stomach, and liver usually have greater incidence in ethnic groups. Evidence has shown that Hispanic women have exhibited the highest cervical cancer rates of all races and ethnicities¹⁶. Stomach and liver cancer mortality rates are highest among Asian and Pacific Islanders, whereas American Indians and Alaskan Natives presently have the greatest kidney cancer incidence and mortality rates of all other ethnic and racial groups⁷. To accomplish the American Cancer Society's goal of reducing overall cancer mortality rates in the U.S. population by 2015, it is essential that cancer disparities in racially diverse and ethnic subgroups be addressed and eliminated.

Factors Contributing to Racial and Ethnic Cancer Disparities

Evidence of racial and ethnic disparities in cancer care exists and often reflects inequalities and bias present within the larger milieu of American society. Ethnic minority populations are disproportionately affected by worse health care outcomes, as a result of behavioral, social, economic, cultural, biological, and environmental factors¹³. Despite the many factors that influence health disparities for ethnic individuals, numerous studies have shown that even when the two predominant factors, socioeconomic status and access to health care, are controlled, ethnic and racial disparities persist^{5,10}. This suggests that the cause of disparities within ethnic populations is multifaceted and far more complex than can be explained by these two variables alone.

According to the Institute of Medicine, racial and ethnic health care disparities are the result of a complex interaction of economic, social, and cultural factors¹³. To better understand the complex nature of cancer care disparities in U.S. ethnic populations, it is essential to view the problem from a multilevel perspective. Factors influencing cancer disparities are interrelated and include institutional factors such as the healthcare and financial systems, social factors like racism and bias, environmental factors such as occupational setting, individual factors such as socioeconomic status and lifestyle choices, and biological factors such as genetic inheritance¹⁵.

Institutional Factors

The institutional structure of the healthcare system can be a barrier to receipt of health care by racial and ethnic minorities. Structural barriers include language barriers, limited prescriptive availability, and limited access to

health care due to lack of health insurance and availability of health services⁹. Non-English speaking residents may face language barriers at institutions with limited interpretation and translation services, resulting in poor patient-provider communication. In 2001, the Robert Wood Johnson Foundation surveyed 1,000 health care providers and 500 Hispanic patients from various parts of the U.S. and found that Latino patients experienced poorer health care outcomes due to language barriers. As many as 19 percent of Hispanic patients surveyed stated they did not seek health care when they needed it because of language barriers¹¹. Studies have also shown limited prescriptive availability to be a factor contributing to racial and ethnic cancer care disparities. Cleeland et al. (2008) found that only one in four pharmacies in non-white neighborhoods in New York stocked morphine, compared to 72 percent of pharmacies in Caucasian neighborhoods². Inadequate opioid availability in low-income, ethnically diverse neighborhoods contributes to racial disparities in pain management, which have been well documented in cancer care⁹.

Limited access to health care is typically due to financial and institutional barriers such as limited availability of health services and inadequate or a complete lack of health insurance¹⁴. Several studies have shown lack of health insurance coverage to be associated with reduced access and not being adherent to cancer screening recommendations. Patients with less education, no health insurance and recent U.S. immigrants have been less likely to follow colorectal screening test recommendation¹⁴. Having inadequate health insurance and no usual source of medical care are both associated with lower colorectal cancer screening rates⁶. Additionally, mammography screening has been shown to be lower among women who immigrated to the U.S. within the past 10 years or who had no health insurance, at 41.1 percent and 39.5 percent respectively¹⁴. Health insurance is an integral factor to accessing quality health care.

Social Factors

Positive patient-provider exchange is a central factor in the promotion of improved ethnic cancer care outcomes. The patient-provider interaction can promote positive discourse, or serve as a barrier to optimal patient care. Patient and provider perceptions have been shown to be barriers to ethnic populations' access to and receipt of quality cancer care¹³. Patient and provider perceptions are barriers to quality cancer care due to provider bias against minorities and patient mistrust of providers and the healthcare system as a whole¹³. Research has shown that ethnic individuals express less positive perceptions of physicians than Caucasian Americans⁴. Several factors account for ethnic individuals' poor perception, including patients' reaction to past mistreatment by health care providers, and health care providers' misinterpretation of patients' symptoms^{13,3}. Crawley et al (2008) suggests that individuals could delay or avoid getting screened for cancer due to past racial or ethnic-based experiences in the medical-setting³. Furthermore, physician recommendations may be influenced by perceptions of a patient's willingness to adhere to treatment suggestions, personal preference, and biases¹². Though additional research is needed to explain the impact of provider bias and patient mistrust, existing literature has provided sufficient evidence that patient-provider interaction and provider behavior contribute to racial and ethnic health disparities (van Ryn, 2002).

Environmental & Individual Factors.

It is impossible to separate the influence of socioeconomic status from other factors that influence ethnic and racial disparities in cancer care outcomes. Disparities in cancer among racial and ethnic minorities reflect barriers to the receipt of cancer prevention and early detection services (e.g. screening), and high-quality treatment, with poverty being one of the principal risk factors⁴. In 2008, 25 percent of African Americans and Hispanics lived below the poverty line, compared to only 10 percent of Caucasian Americans. Additionally, 20 percent of African Americans and 33 percent of Hispanics were uninsured compared to 10 percent of Caucasians¹.

In addition to low socioeconomic status and poverty, occupation also serves as a cancer risk factor and impacts racial and ethnic cancer disparities. Approximately 2.4 percent to 4.8 percent of deaths in the U.S. are related to occupation¹⁴. Many of the deaths that occur are due to lung cancer, bladder cancer, and mesothelioma. Manual and industrial workers are often exposed to occupational carcinogens like asbestos, and are at increased risk for cancer development¹⁴.

Modifiable cancer risk factors that vary by race, ethnicity, and socioeconomic status include cigarette smoking, nutrition, physical inactivity, and obesity¹⁴. Poor, ethnic minority communities are often targeted by tobacco company marketing, have limited access to fresh foods and healthy nutrition, and are provided with fewer opportunities for safe recreational physical activity¹⁴. The prevalence of adult cigarette smoking is highest among American Indian and Alaskan Native women and men, at 38.6 percent and 27.4 percent respectively. Research has shown that diets consisting mostly of plants protect against many cancers and weight gain, while inadequate physical activity has the opposite effect, increasing the risk of cancer and contributing to obesity^{17 & 14}. Hispanic men and women have the highest prevalence of no leisure-time physical activity, at 51.9 percent and 56.5 percent respectively. African American women and American Indian/Alaskan native men and women have higher obesity rates (over 35 percent) than the general population¹⁴. Racial and ethnic cancer disparities are perpetuated in part by the effects of poor lifestyle choices that arise in part from poverty and limited community resources.

Biological Factors

Genetic factors contribute to cancer care disparities in ethnic populations. Several ethnic and racial populations are disproportionately burdened with higher frequency of genes that increase risk of cancer¹. Women of Ashkenazi Jewish descent have a relatively higher risk of breast and ovarian cancer due to mutations in the BRCA1 and BRCA2 genes common in this ethnic group¹. Additionally, African American men suffer the highest prostate cancer mortality rates, while African American women suffer the highest mortality rate as a result of breast cancer⁷. High mortality rates in these ethnic populations can be attributed, in part, to more aggressive forms of breast and prostate cancers¹.

Future Implications

To achieve the American Cancer Society 2015 goal of reducing U.S. cancer mortality and incidence rates, concerted efforts must be given to eliminating the disproportionate rates of cancer among racial and ethnic minorities¹⁴. Growing awareness of disparities in racial and ethnic cancer care outcomes has stimulated federal health care agencies to prioritize funding for research focused on eradicating cancer disparities among ethnically underserved populations¹⁴. It is critical that research efforts continue to explore factors that influence ethnic populations' access to and utilization of quality cancer care. Better understanding of the complex interplay of the factors that contribute to racial and ethnic disparities can inform policy-making, improve cancer treatment, and enhance cancer care outcomes for adversely affected populations.

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