

CONTROLLING CANCER IN OREGON

In 2004, a group of clinicians, public health professionals, and concerned citizens came together and developed the Oregon Comprehensive Cancer Plan.¹ It comes none-too-soon: cancer recently passed heart disease to become the leading cause of death in Oregon. The plan addresses issues such as how best to ensure access to evidence-based, state-of-the-art cancer treatment, and strategies to decrease disparities in cancer burden. Still, when push came to shove, prevention of cancer whenever possible, and early detection of cancer when it could not be prevented, emerged as clear priorities. In this issue of the *CD Summary*, we review a few things clinicians can do to decrease the burden of cancer among Oregonians.

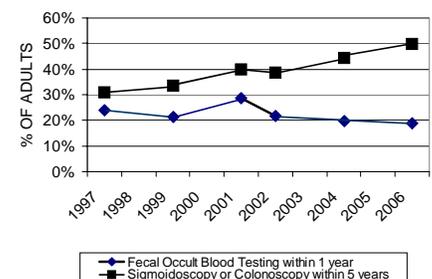
Lung cancer is the leading cause of cancer mortality in Oregon, killing more than 2,000 people in 2004. It claims the lives of nearly twice as many Oregon women as breast cancer. Based on physician reporting from death certificates, more than 80% of all Oregon lung cancer deaths in 2004 were linked to smoking. While overall cigarette consumption in Oregon has fallen 41% since 1996 (the year before the state Tobacco Prevention and Education Program was established), 19% of adults still smoke, and age-adjusted smoking prevalence is higher in certain groups, including among African Americans (30%) and Native Americans (38%). Age-adjusted lung cancer incidence is also higher for these groups (84.8 and 81.5/100,000 respectively) than it is for non-

Latino whites (70.6/100,000). There are also differences in smoking prevalence by region; several counties on the south and central coast have smoking rates significantly higher (6-10 percentage points higher!) than the state average. Not surprisingly, lung cancer incidence in these counties follows a similar pattern. Clinicians who *ask* patients if they smoke, *advise* them to quit if they do, *assess* their readiness to quit, *assist* them in their efforts (with nicotine replacement, in-office support, or referral to the Oregon Quit Line), and who *arrange* for follow-up on the issue can greatly increase the likelihood that patients will be able to break the smoking habit and lessen their overall risk of lung cancer (as well as a host of other nasty conditions). A publication outlining simple-to-implement provider strategies is available through the Oregon Tobacco Education Clearinghouse at: <http://oregon.gov/DHS/ph/tobacco/otec/index.shtml>.

Colorectal cancer (CRC) is the second leading cause of cancer mortality. It killed 646 Oregonians in 2004. Prevention of CRC is the top priority of the Oregon Comprehensive Cancer Plan, in part because of this large burden of mortality, and in part because, through readily available screening, such cancers could be caught at an early stage, or even prevented.² Unfortunately, there is room for improvement: 55% of CRC is diagnosed at a late stage, when treatment is more difficult and survival less likely. Further, while rates of recommended endoscopy among Oregonians age \geq

50 years have increased over the past few years (see Fig. 1), half of

Figure 1. Percentage of Oregonians Age 50 Years or Older Who Reported Colorectal Screening, by Year, Oregon 1997-2004



Oregonians for whom these procedures are recommended still don't get them, and only one in five Oregonians \geq 50 years of age had done recommended fecal occult blood testing in the prior year. From a clinician's point of view, this one's straightforward: colorectal cancer screening is not fun, but it works. By discussing the benefits of and offering screening, particularly endoscopy, it is possible to catch CRC before it becomes symptomatic, and if adenomatous polyps are discovered, their removal can prevent CRC from developing in the first place.

While, happily, it is not as lethal as the cancers above, **breast cancer** is the most commonly diagnosed malignancy in the state, with seven cases diagnosed among Oregon women every day. Routine mammography has been proven to decrease breast cancer mortality, particularly among women age \geq 50 years³ The U.S. Preventive Services Task Force recommends screening mammography every 1-2 years for all women age \geq 40. Mammography saves lives by helping to catch breast



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cancer early, when it is most readily and successfully treated. Here in Oregon, 27% of breast cancers among women are diagnosed when they are already late-stage. The percentage of late-stage breast cancer diagnosis is higher among some Oregonians. While the situation has improved for African American women in recent years, 30% of breast cancers among these women are still diagnosed at a late stage. Rates of late-stage breast cancer diagnosis for Native Americans (33%) and Latinas (36%) are higher yet, and age-adjusted rates for recommended mammography screening among these latter two groups are lower (58% and 66%, respectively) than rates among white, non-Latinas (73%). This is not just an issue of women “skipping a year” and thus interrupting a regular screening regimen. In 2004, one in eight Oregon women age 40-64 reported never having had a mammogram. As seen in Figure 2, screening rates among women age 40-49 lag behind those among older women. By reviewing the proven benefits of mammography with all female patients age ≥ 40 years, and recommending screening, clinicians can increase screening rates, decrease the percentage of late-stage breast cancers, and ultimately, decrease breast cancer mortality.

The precipitous decline in **cervical cancer** in this country over the past 5 decades is a true public health success story (here in Oregon, age-adjusted incidence and mortality rates for 2004 were 5.5 and 1.5/100,000, respectively). Conversely, given the effectiveness of cervical cancer screening, *any* case of invasive cervical cancer represents a public health failure. Timely screening can prevent cervical cancer by detecting pre-cancerous dysplastic lesions so that they can be treated before they progress. Still, 102 cases of invasive cervical cancer were diagnosed among Oregon women in 2004, 41% of these at a late stage. One in seven report not having a Pap within the recommended interval. Among Asians and Pacific Islanders almost one in four haven't. For many of these women, this is not just an issue of being “a little late” in getting a Pap as part of a well-established screening regimen: 6% of all women and a surprising 22% of women age 18-24 years report nev-

er having had a Pap. Among all women, one in seven say they have not had a Pap in the last three years. Reviewing the benefits of cervical cancer screening with patients and helping them get recommended screening can make a difference. A vaccine for human papillomavirus, which covers strains responsible for 70% of cervical cancers, is now also available. It is licensed for young women age 9-26 years. While routine vaccination at pre-adolescent visits is recommended (ages 11&12), we encourage the vaccine for all 9 through 26 year old girls and women. (See previous CD Summary on this topic, *Human Papillomavirus Vaccine: A Potent Ally in Cervical Cancer Prevention*, Oct. 17, 2006) The vaccine is available at no or very low cost for certain patients through the Vaccines for Children program. To get more information, contact the Oregon Immunization Program at <http://www.oregon.gov/DHS/ph/imm/index.shtml>.

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2. Pignone M, Rich M, Teutsch SM, et al. Screening for Colorectal Cancer in Adults at Average Risk. *Ann Intern Med* 2002;137:132-41.
3. Humphrey LL, Helfand M, Chan BKS, Woolf SH. Breast cancer screening: summary of the evidence. *Ann Intern Med* 2002;137:344-6.

Figure 2. Women Who Have Had A Mammogram Within the Past 2 Years, by Age Group, Oregon, 2006 BRFSS

