Black-White Mortality Disparities Increasing for Some Cancers

A new analysis of temporal trends in cancer mortality rates demonstrated that black-white racial disparities have decreased in recent years for tobacco-related cancers. However, the same analysis also reported that racial disparities continue to increase in relative terms for cancer sites that are likely affected by screening and treatment. The elimination of racial disparities in cancer mortality is an objective of both the American Cancer Society (ACS)’s 2015 challenge goals and the Federal Healthy People 2010 initiative. These findings, published in Cancer Epidemiology Biomarkers and Prevention (2008;17:2908-2912), suggest the need for coordinated efforts to improve the prevention, screening, and treatment of cancer for all Americans.

“Fifty years of campaigning against smoking have resulted in substantial progress against tobacco-related cancers,” said Michael Thun, MD, MS, one of the coauthors of the study and vice president of Epidemiology and Surveillance Research at the ACS. “Health policies that make cigarettes less attractive and more expensive are effective at discouraging smoking.”

John Oliver L. DeLancey, MPH, a member of the Department of Epidemiology and Surveillance Research at the ACS and lead author of the study, noted that “currently, 19.8% of Americans overall smoke, down from 20.8% in 2006. This is a promising trend, but the prevalence is still higher than we would like to see.”

However, Dr. Thun expresses concern about the lingering racial disparities for cancers for which there are effective screening methods. “This was the main finding of this study, and we are concerned about the slow progress in this area,” he said.

Using data for 1975 through 2004 from the National Center for Health Statistics, the investigators calculated age-standardized mortality rates for adults aged 35 years and older. They compared both the annual death rates and the rate ratios of age-standardized death rates for whites and African Americans to assess black-white racial disparities in cancer mortality. The analyses included all cancers combined, lung cancer, and a combination of 7 tobacco-related cancers (oral cavity, pharynx, larynx, esophagus, pancreas, bladder, and kidney). They also analyzed data for cancers of the breast, prostate, and colon/rectum, malignancies for which the death rates are potentially affected by screening and/or treatment.

Between the early 1990s and 2004, decreases were observed in the death rates per 100,000 population from all cancers combined and for those of the lung/bronchus, other smoking-related cancers, colorectal cancer, prostate cancer, and breast cancer. The magnitude of the decline in rates was greater in men than in women, and only death rates for lung cancer in women did not decrease.

The disparity in overall cancer death rates between African Americans and whites narrowed, more notably among men than women. Most of the reduction noted in the disparity between African Americans and whites could be accounted for by more rapid decreases in mortality from lung cancer and the 7 other tobacco-related cancers noted in black men compared with white men. The investigators noted that disparities in death rates between black and white men for smoking-related cancers began to diminish in the early 1990s, approximately 15 years after smoking rates began to decline more in black men compared with white men. In 1974, the smoking prevalence among black men was 11 percentage points higher than among white men.

Although disparities in mammography rates between African American and white women have nearly disappeared, white women are more likely to receive appropriate treatment.
points higher than that for white men; by 2004, the difference was only 2 percentage points.

The researchers used rate ratios to compare annual death rates in African American men and women with those in white men and women. The investigators again considered all cancers combined, lung/bronchus cancer, other smoking-related cancers, colorectal cancer, breast cancer, and prostate cancer. They determined that since the early 1990s, the rate ratios for all cancers combined, lung cancer, and other smoking-related cancers declined, especially in men. For example, the rate ratio comparing black men with white men for all cancers combined dropped from 1.48 (95% confidence interval [95% CI], 1.46-1.50) in 1993 to 1.35 (95% CI, 1.34-1.37) in 2004. The corresponding rate ratios in women were 1.21 (95% CI, 1.19-1.22) in 1997 to 1.17 (95% CI, 1.15-1.18) in 2004.

The investigators also examined trends in mortality for the three cancers more likely to be affected by screening and/or treatment. They found that black-white racial disparities had increased since 1975 for colorectal, breast, and prostate cancers. For both breast and colorectal cancers, the mortality rate ratios in 1975 were less than 1, indicating higher death rates among whites. By 2004, the rate ratio for breast cancer had increased to 1.34. Similarly, the colorectal cancer mortality rate ratios for women and men increased to 1.45 and 1.43, respectively. Although the death rate for prostate cancer for blacks in 1975 was nearly double the rate of whites, the rate ratio increased even further, to 2.40 in 2004.

“The problem of cancers whose rates are potentially affected by screening—such as colorectal, breast, and prostate cancers—is complicated by large holes in the healthcare system,” said Dr. Thun. A report published by the ACS in 2007 (Lancet Oncol. 2008;9:222-231) demonstrated that, compared with those with health insurance, people without health insurance were less likely to undergo screening for cancer, more likely to have an advanced stage of cancer at the time of diagnosis, and less likely to survive.

Screening is no guarantee of a good outcome or appropriate treatment, said Dr. Thun. “People can fall through the cracks, and poor people are more likely to have barriers to quick follow-up and treatment. These barriers include lack of adequate health insurance, cultural issues surrounding testing and treatment, and fear.” Dr. Thun pointed out that even seemingly minor, everyday problems, such as scarcity of or difficulty with transportation, can make it difficult for people in lower socioeconomic classes to obtain appropriate medical help. This is illustrated by the fact that although disparities in mammography rates between African American and white women have nearly disappeared, white women are more likely to receive appropriate treatment for breast cancer.

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Family Physicians and Referrals of Low-risk Women for BRCA1/2 Genetic Services

A recent survey of family physicians suggests that concern about harming the physician-patient relationship may lead them to refer a majority of patients for genetic counseling and/or testing in clinical situations that are not consistent with current guidelines. The study by Della Brown White, PhD, and colleagues from the National Human Genome Research Institute (NHGRI) in Bethesda, Maryland, appeared in the November issue of Cancer Epidemiology Biomarkers and Prevention (2008;17:2980-2986).

The NHGRI researchers conducted a web-based survey to assess the attitudes and likely practices of family physicians regarding referral to genetic counseling and testing for breast and ovarian cancer susceptibility. “We know that as a general rule, once people self-refer for services, they usually get them,” said Dr. White, a post-doctoral fellow at the NHGRI. “But we wondered what would happen if patients asked for a service that was not appropriate for them,” she added. To determine what is appropriate for women who seek services related to BRCA1/2 status, the investigators used the United States Preventive Services Task Force (USPSTF) guidelines regarding BRCA1/2 testing.

The physicians who participated in this study were drawn from a longitudinal survey of members of the American Academy of Family Physicians (AAFP) who helped evaluate the AAFP’s Annual Clinical Focus on Genomics in 2005. A total of 284 of these physicians participated in a follow-up survey and logged onto a website and completed questions related to the referral of a hypothetical patient for genetic services. The study itself was a cross-sectional,