

AN EPIDEMIOLOGY PUBLICATION OF THE OREGON DEPARTMENT OF HUMAN SERVICES

## THE FACE OF CANCER IN OREGON

CANCER TAKES AN immense toll on Oregonians, both in loss of life and in human suffering. In this issue of the *CD Summary*, we outline the impact of cancer in the state, discuss some basic steps you and your patients can take to lessen this impact, and review how we're doing statewide in implementing some of these steps.

### HOW BIG IS THE PROBLEM?

In 2001, 7,088 Oregonians died of cancer. Cancer is the second leading cause of death in the state, behind cardiovascular disease, and accounts for 24% of all deaths in Oregon. While many of these deaths are among older Oregonians, cancer mortality is by no means confined to the elderly. Age-specific breast cancer incidence rates increase sharply around age 40 and actually drop after age 80. A total of 1,960 Oregonians younger than 65 died of cancer in 2001. In all, 18,628 cases of cancer among Oregonians were reported to the Oregon State Cancer Registry (OSCaR) in 2001.\*

The burden of cancer in Oregon goes beyond a simple recitation of data on incidence and mortality. Half of Oregon hospice referrals in 2002 were for cancer (about 4,000 people), and there were 12,316 hospitalizations in the state with cancer as the principal diagnosis. These hospitalizations cost Oregonians \$261 million. When we include outpatient medical costs, loss of productivity, missed work, etc., the annual economic impact of cancer in Oregon exceeds \$2 billion.

from it (523) than from lung cancer, it was still the third most frequent cause of death from cancer. Of those for which stage was determined, one-fourth of women diagnosed with breast cancer in 2001 had regional spread or distant metastases at diagnosis. This lower proportion of advanced-stage disease is likely due, at least in part, to screening through mammography and clinical breast exam. Still, there is room for improvement: only 58% of Oregon women over 40 report having a mammogram and clinical breast exam in the past two years.†

### SELECTED CANCER SITES

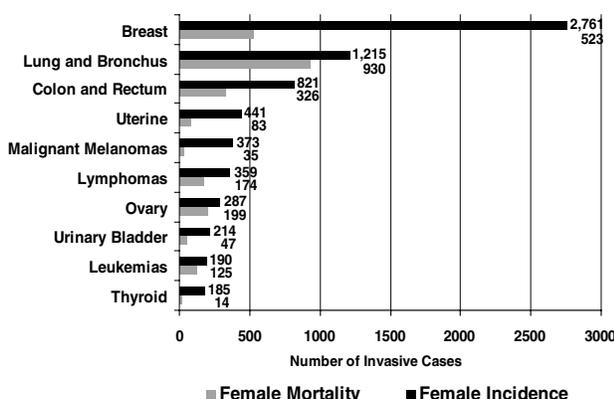
The figures below show the leading sites of cancer and mortality among men and women in Oregon.

Lung cancer was the leading cause of cancer mortality in the state, accounting for 28% of all cancer deaths. The age-adjusted lung cancer-specific death rate (55.9/100,000) for Oregon in 2001 was comparable to the national average of 55.2 in 2000. With 2,478 Oregonians diagnosed in 2001, the lungs ranked as the third most common site of diagnosed cancer, behind breast (3,372) and prostate (2,657). In cases where stage was determined, over three-quarters of Oregonians diagnosed with lung cancer had regional spread or distant metastases at diagnosis.

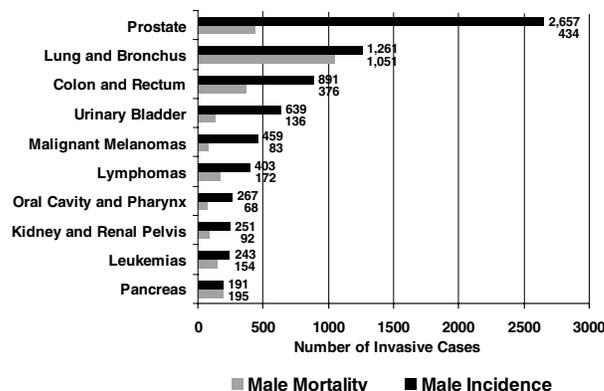
Female breast cancer was the most frequently diagnosed reportable cancer in 2001, and though far fewer people died

Prostate cancer was the most commonly diagnosed cancer among men and was the second most frequent overall (2,657 cases). 434 Oregon men died from prostate cancer, and of those diagnosed in 2001 for whom stage was determined, 17% had regional or distant spread at diagnosis. Screening with prostate-specific-antigen testing and/or digital rectal exam could lower the number of late-stage diagnoses still further. However, because of its lack of specificity and ambiguous data about its effectiveness in improving health outcomes, such screening is not universally recommended at this time.<sup>1</sup>

Leading Sites of Cancer Incidence and Mortality Oregon Females, 2001



Leading Sites of Cancer Incidence and Mortality Oregon Males, 2001



\* Excludes non-reportable in-situ cervical cancer, basal cell carcinoma or squamous cell carcinoma of the skin. Non-melanoma skin cancers are by far the most common malignancies.

† 2002 Behavioral Risk Factor Surveillance System (BRFSS)



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## SPECIFIC ISSUES

For several cancers, age-adjusted incidence rates in Oregon are among the nation's highest. Of the 43 states with cancer registries meeting CDC standards, Oregon ranks 5<sup>th</sup> for lung cancer among women, 3<sup>rd</sup> for female breast cancer, 3<sup>rd</sup> for melanoma among men and 1<sup>st</sup> for melanoma among women. These higher rates for melanoma in Oregon may reflect differences in completeness of reporting by different states, and may also be influenced by the large percentage of the state's population that is white and therefore at higher risk.

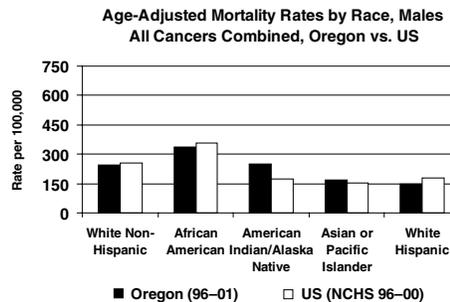
Cancer disproportionately affects certain groups of Oregonians. It is more common among the elderly; and, as Oregon's population ages, a larger fraction of the state's population will be at risk for cancer due to age. Age-adjusted cancer incidence rates for Oregon men are 26% higher than those for women, while mortality rates for men are 42% higher. Cancer mortality rates for African Americans are also higher than rates for other Oregonians, largely driven by higher numbers of cancer deaths among African American men (see graph).

## ADDRESSING KNOWN CANCER RISK FACTORS

Many of these cancers are potentially preventable and there are some straightforward strategies to lessen their burden.

### Promote Tobacco Cessation

21% of adult Oregonians smoke. Determining which patients use tobacco and getting them in touch with resources that will help them quit could make a huge difference in cancer burden. Stopping all tobacco use could eliminate 80–



90% of lung cancers (the leading cause of cancer-related death) as well as a large number of oral cancers, bladder cancers, pancreatic cancers and some gastrointestinal cancers. If you don't have a system in place at the office to help tobacco users quit, feel free to refer them to the Oregon Quit Line (1-877/270-STOP or 1-877/2NO FUME for Spanish speakers).

## Screening for Pre-Malignant Conditions

While 86% of adult women in Oregon report having a Pap test in the past 3 years to screen for cervical cancer (on par with the national average), colorectal cancer screening rates are considerably lower (see CD Summary, Jan. 27, 2004). Only 38% of Oregonians over 50 reported having a colonoscopy or sigmoidoscopy in the past five years, and only 21% said they'd done fecal occult blood testing in the prior year.

## OTHER POINTS TO PONDER

There are strong links between certain infections and subsequent development of cancer. Chronic hepatitis B and hepatitis C infections are associated with hepatocellular carcinoma. Prevention of these infections through immunization (hepatitis B) or avoidance of exposure (hepatitis

B and C) could potentially limit the spread of this deadly malignancy. Certain high-risk strains of human papilloma virus (HPV) cause cervical cancer. Efforts to develop an HPV vaccine are currently under way.

## CANCER AND PUBLIC HEALTH IN OREGON—NEW DEVELOPMENTS

Several changes made to Oregon statutes concerning OSCaR took effect this year. Starting in 2004, benign brain tumors became reportable to OSCaR. Pathology labs have also been added as mandatory reporting facilities. If you'd like additional information about these changes, or copies of the amended statutes, please contact OSCaR staff at 503/731-4858.

OSCaR has also released its annual report, *Cancer in Oregon 2001*. It is full of information about cancer incidence, mortality, and risk factors among Oregonians and is on our website at <http://www.healthoregon.org/oscar/arpt2001/index.cfm>

The Oregon Partnership for Cancer Control (OPCC), a coalition of health-care organizations, advocacy groups, public health and community representatives, is forming to develop Oregon's first comprehensive statewide plan for cancer control. The group is interested in addressing the needs of all of Oregon's diverse populations, wherever they are and wherever in the state they live. An overview of this initiative is available at <http://www.healthoregon.org/cancer>. If you have further questions, please contact Patricia Schoonmaker at 503/731-4273.