Cancer Prevention

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Cancer remains the #2 killer in our society, after heart disease, and accounts for 23 percent of all deaths (2001 data). Lung cancer remains the number one cancer cause of death and number two cause of all cases for both sexes. Prostate cancer ranks #2 as a cause of death and #1 as a cause for all cases among men. Breast cancer holds the same relative positions among women. Colorectal cancer ranks third for death and third for all cases among both men and women.

Overall death rates for cancer have remained relatively unchanged over many years, while those for heart disease and stroke have shown much more impressive declines. There is a great deal that can be done in terms of life style and screening to lessen the chances of falling victim to cancer. Some of the most pertinent action steps are summarized below:

Lung cancer

Lung cancer death rates and case rates have begun to fall as a result of lower tobacco usage rates in the overall population. Avoidance of tobacco is the most critical and useful lifestyle choice to be made to lower risk for this disease, and, also, has well-known benefits in terms of heart disease prevention. Unfortunately, there is little evidence to support screening strategies for the general population. Periodic chest x-rays have not been helpful in early detection, although they may be pertinent in case finding among those who are already displaying symptoms of disease. So, the key to lung cancer prevention is: Don't Smoke!

Prostate cancer

Annual digital rectal exams and prostate specific antigen testing beginning at about age 50 are recommended for all men. Current evidence suggests that aggressive screening has led to a shift toward earlier stage tumors being detected, and thus an improvement in outcomes. Certain men (African American and those with positive family histories of prostate cancer) should be screened beginning at about age 45. For those individuals whose life expectancy is less than ten years as a result of other disease conditions, screening is not recommended since there is less convincing evidence of benefit. Reluctance on the part of men to submit to screening has resulted in relatively low screening rates and limited the benefit which could accrue thereby. So let's assume the position, fellows.

Breast cancer

Breast self exam beginning in early adulthood is a well-known, but not frequently enough practiced, technique. It is estimated that the typical woman notes a breast lump six months prior to alerting her doctor to its presence. Early action (and avoidance of this delay) is essential to achieve the optimum result. On the professional side, annual mammograms and clinical breast exams by a trained professional are the key screening maneuvers. Mammography should begin at about age 40 for women in the general population. Clinical breast exams should commence at about age 20, and continue every 1-3 years thereafter. Clinical breast exam and mammography can be accomplished most efficiently and effectively if performed in tandem. For women whose breast cancer risk is higher than that of the general population (e.g., those with a positive family history of breast cancer), screening tests should begin earlier and be conducted more frequently.

Colorectal cancer

Multiple screening strategies are available for colorectal cancer. These include: colonoscopy every ten years; fecal occult blood test (FOBT) yearly; flexible sigmoidoscopy every five years; a combination of FOBT and flex sig every five years; and double-contrast barium enema every five years. Any of the above strategies may be suitable for the general population, but those at higher risk (e.g., a positive family history of colorectal cancer) should pursue an individualized, more aggressive schedule of screening as recommended by their physician. As with prostate cancer, relatively low rates of screening, due to discomfort, distaste, or expense, have limited the impact that these effective screening strategies could have on early detection and successful treatment of colorectal cancer.

Cervical cancer

Annual well-woman exams, including pelvic exam and Pap smear, should commence between 18-21 years of age or at onset of sexual activity. These screening programs have been well established for some time and have resulted in significant improvements in outcome for this disease. Ironically, women with the fewest risk factors for cervical cancer are those most likely to pursue effective screening. Conversely, those at greatest risk are least likely to be screened regularly or at all. For those women who are at low risk, after three consecutive normal annual exams, it may be possible to reduce the frequency of subsequent exams. Likewise, less frequent screening may be pursued for those women who have undergone hysterectomy for benign disease. One's individual circumstances should be reviewed with your own physician for specific recommendations.

Skin cancer

Rising frequencies of all types of skin cancer, but especially melanoma, indicate the need for adequate protection when exposed to direct sunlight. Monthly self-exam of the skin, coupled with clinical examination of the skin by a trained professional during periodic health assessments, can lead to early detection and successful treatment of skin cancer.

Conclusion

I have offered a brief overview of pertinent screening techniques for some of the most common and important forms of cancer. You should consult with your personal physician for advice about screening that is appropriate for your own individual risk profile and life situation. In addition, additional guidance may be sought at two helpful Web sites as follows: American Cancer Society <www.cancer.org> and MD Anderson Hospital <www.mdanderson.org>. Live well and prosper in 2005!