

Cancer Facts & Figures for African Americans 2005-2006



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Acknowledgments

The production of this report would not have been possible without the efforts of Durado Brooks, MD, MPH; Vilma Cokkinides, PhD, MSPH; Ted Gansler, MD; Asma Ghafoor, MPH; Joseph Hill; Wendi Klevan; Taylor Murray; Robert Smith, PhD; Susan Summers; Michael Thun, MD, MS; Janet Weaver; and Harriet Zoller.

Cancer Facts & Figures for African Americans is a publication of the American Cancer Society, Atlanta, Georgia.

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This publication attempts to summarize current scientific information about cancer. Except when specified, it does not represent the official policy of the American Cancer Society.

Suggested citation: American Cancer Society. *Cancer Facts & Figures for African Americans 2005-2006*. Atlanta: American Cancer Society, 2005.



National Home Office: American Cancer Society, Inc., 1599 Clifton Road, NE, Atlanta, GA 30329-4251, (404) 320-3333

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Cancer Statistics for African Americans



Introduction

According to the US Census Bureau, there will be more than 38 million African Americans in the United States in 2005.¹ This includes approximately 36 million individuals whose ancestors were brought involuntarily to the US during the 1800s, as well as more recent immigrants born in other countries (Table 1).² Together, these groups will comprise 12.9% of the total US population in 2005.

This report presents statistics on cancer incidence, mortality, survival, and risk factors for all persons who

describe themselves as African American or black, recognizing the enormous diversity within the African American population and the limitations of presenting data by race or ethnicity rather than by social or economic characteristics, which may more directly affect cancer risk. Currently, race and ethnicity are the only demographic characteristics besides age and sex on which information is collected systematically in US health statistics. Although factors such as education, income, and health insurance may underlie much of the variation in cancer risk that exists among racial and ethnic groups, these factors can only be examined in nonpopulation-based (special) studies. Differences in risk associated with race or ethnicity are likely to reflect social and economic differences which dwarf biological or inherited genetic characteristics.³

Currently, the African American population in the US bears a disproportionate burden of cancer; African Americans have the highest mortality rate of any racial and ethnic group for all cancers combined and for most major cancers. Death rates for all major causes of death

Table 1. Foreign-Born Black Population by Place of Birth, Census 2000

| | |
|-----------------|------------------|
| Total | 2,099,865 |
| Africa | 512,628 |
| Caribbean | 1,250,611 |
| Central America | 136,535 |
| South America | 113,374 |
| Others | 867,717 |

Note: The above numbers may be underestimated due to undocumented immigrants.

Source: US Census Bureau. www.census.gov.

Table 2. Leading Causes of Death, by Rank, Among African Americans and Whites, 2001

| All Ages Cause of Death | No. of Deaths | | Death Rate* | | % of Total Deaths | |
|----------------------------|-------------------|------------------|-------------------|--------------|-------------------|--------------|
| | African Americans | Whites | African Americans | Whites | African Americans | Whites |
| Heart diseases† | 77,652 | 610,596 | 317.2 | 241.9 | 27.0 | 29.4 |
| Cancer | 62,166 | 479,647 | 243.8 | 193.3 | 21.6 | 23.1 |
| Cerebrovascular diseases | 18,999 | 140,464 | 78.9 | 55.3 | 6.6 | 6.8 |
| Accidents | 12,448 | 85,861 | 37.5 | 35.9 | 4.3 | 4.1 |
| Diabetes | 12,305 | 57,179 | 49.3 | 22.9 | 4.3 | 2.7 |
| All causes | 287,621 | 2,079,371 | 1101.9 | 831.8 | 100.0 | 100.0 |

| Children Aged 1-14 Cause of Death | No. of Deaths | | Death Rate* | | % of Total Deaths | |
|--------------------------------------|-------------------|--------------|-------------------|-------------|-------------------|--------------|
| | African Americans | Whites | African Americans | Whites | African Americans | Whites |
| Accidents | 983 | 3,369 | 10.6 | 7.7 | 35.5 | 38.1 |
| Assaults | 263 | 446 | 2.9 | 1.0 | 9.5 | 5.0 |
| Birth defects | 224 | 1,133 | 2.4 | 2.6 | 8.1 | 12.8 |
| Cancer | 206 | 669 | 2.2 | 1.5 | 7.4 | 7.6 |
| Heart diseases | 147 | 328 | 1.6 | 0.7 | 5.3 | 3.7 |
| All causes | 2,768 | 8,840 | 30.0 | 20.2 | 100.0 | 100.0 |

*Rates are per 100,000 and age-adjusted to the 2000 US standard population. †Diseases of veins, lymphatics, and lymph nodes, other and unspecified disorders of the circulatory system were excluded.

Source: National Center for Health Statistics, Centers for Disease Control and Prevention.

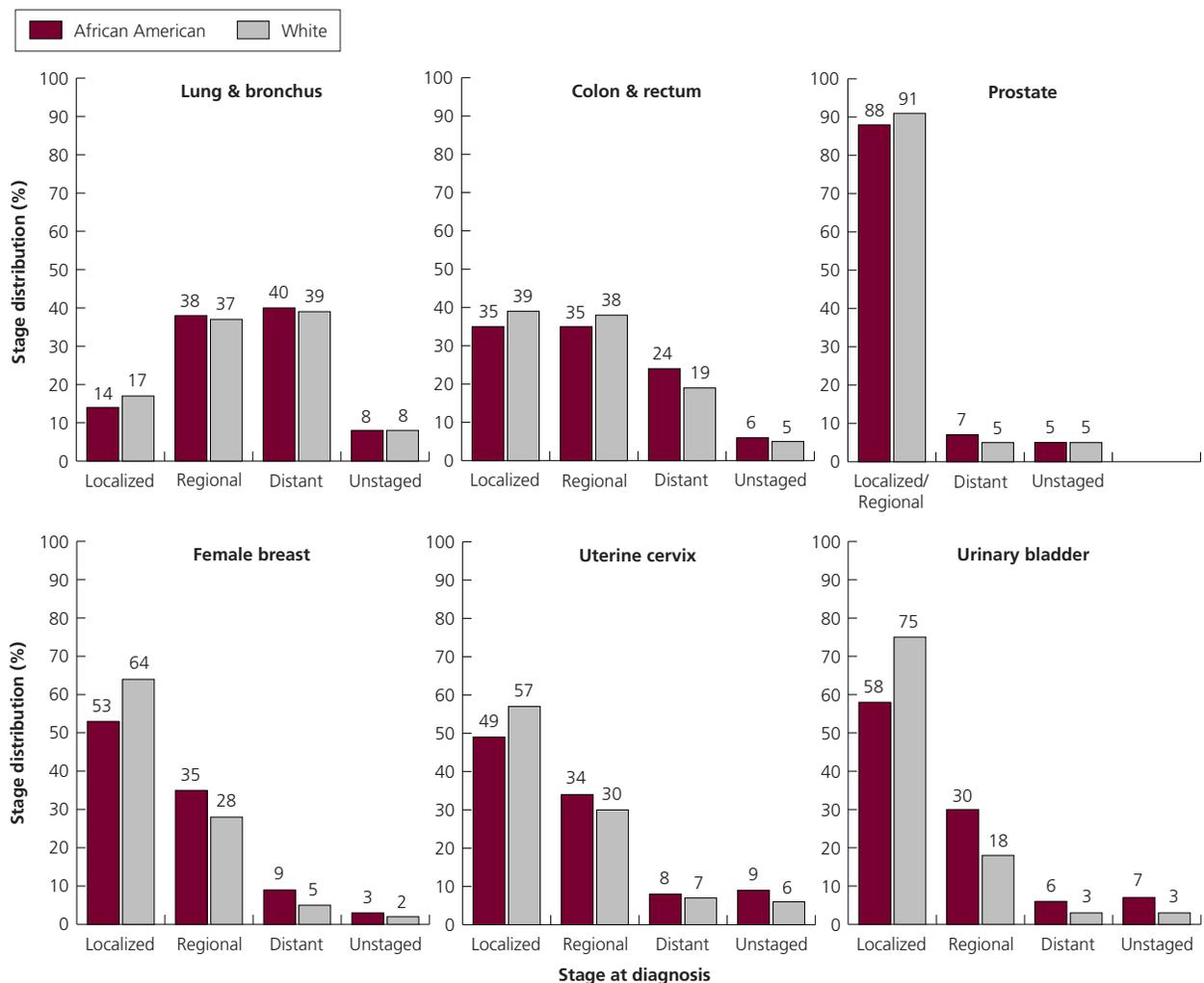
are higher for African Americans than for whites (Table 2), contributing to a lower life expectancy for both African American men (68.6 years versus 75.0) and women (75.5 years versus 80.2).⁴ Prevention, early detection, and treatment can reduce premature mortality and death rates from all major diseases among African Americans. The purpose of presenting cancer statistics for African Americans is to highlight areas where better prevention, early detection, and treatment can reduce

their disproportionate burden of suffering and death from cancer.

Cancer is a group of diseases characterized by excessive growth and spread of abnormal cells. It affects all populations in the US and ranks second only to heart disease as the leading cause of death (Table 2).

In 2005, approximately 1.4 million cases of invasive cancer will be diagnosed in the US.⁵ African Americans

Figure 1. Stage Distribution* for Selected Cancers in African Americans and Whites, 1995-2000



Percentages may not exactly total 100% due to rounding.

*Based on patients diagnosed between 1995-2000 and followed through 2001.

Local: An invasive malignant cancer confined entirely to the organ. **Regional:** A malignant cancer that 1) has extended beyond the limits of the organ of origin directly into surrounding organs or tissues; 2) involves regional lymph nodes by way of lymphatic system; or 3) has both regional extension and involvement of regional lymph nodes. **Distant:** A malignant cancer that has spread to parts of the body remote from the primary tumor either by direct extension or by discontinuous metastasis to distant organs, tissues, or via the lymphatic system to distant lymph nodes.

Source: Surveillance, Epidemiology, and End Results (SEER) Program, 1975-2001, Division of Cancer Control and Population Sciences, National Cancer Institute, 2004.

Table 3. African American to White Cancer Incidence Rate* Ratios, US, 1997-2001

| Males | | | | Females | | | |
|----------------------------------|------------------------------|-------------------|-------------------------------------|----------------------------------|------------------------------|-------------------|-------------------------------------|
| Cancer† | African American Rate | White Rate | African American/White Ratio | Cancer† | African American Rate | White Rate | African American/White Ratio |
| Myeloma | 12.9 | 6.7 | 1.9 | Myeloma | 10.2 | 4.2 | 2.4 |
| Stomach | 19.4 | 10.2 | 1.9 | Stomach | 9.8 | 4.5 | 2.2 |
| Larynx | 12.1 | 6.8 | 1.8 | Esophagus | 3.9 | 2.0 | 2.0 |
| Liver and intrahepatic bile duct | 11.6 | 6.7 | 1.7 | Larynx | 2.7 | 1.5 | 1.8 |
| Prostate | 274.3 | 171.2 | 1.6 | Uterine cervix | 12.2 | 7.8 | 1.6 |
| Lung and bronchus | 120.7 | 82.3 | 1.5 | Liver and intrahepatic bile duct | 3.9 | 2.6 | 1.5 |
| Esophagus | 11.3 | 8.1 | 1.4 | Pancreas | 14.2 | 9.5 | 1.5 |
| Pancreas | 17.4 | 12.6 | 1.4 | Kidney and renal pelvis | 10.0 | 8.2 | 1.2 |
| Oral cavity and pharynx | 20.1 | 15.9 | 1.3 | Colon and rectum | 56.1 | 46.8 | 1.2 |
| Kidney and renal pelvis | 18.9 | 16.5 | 1.1 | Lung and bronchus | 55.3 | 53.5 | 1.0 |
| Colon and rectum | 73.1 | 64.4 | 1.1 | Oral cavity and pharynx | 5.9 | 6.6 | 0.9 |
| Hodgkin lymphoma | 2.8 | 3.3 | 0.8 | Breast | 118.6 | 143.2 | 0.8 |
| Leukemia | 13.0 | 17.0 | 0.8 | Leukemia | 8.0 | 10.1 | 0.8 |
| Non-Hodgkin lymphoma | 18.4 | 24.5 | 0.8 | Urinary bladder | 7.8 | 10.2 | 0.8 |
| Brain and other nervous system | 4.9 | 8.8 | 0.6 | Ovary | 10.3 | 15.0 | 0.7 |
| Thyroid | 2.1 | 4.1 | 0.5 | Uterine corpus | 17.8 | 26.6 | 0.7 |
| Urinary bladder | 20.0 | 41.2 | 0.5 | Non-Hodgkin lymphoma | 11.2 | 16.9 | 0.7 |
| Testis | 1.5 | 6.5 | 0.2 | Thyroid | 6.1 | 11.1 | 0.5 |
| Melanoma of the skin | 1.5 | 26.3 | 0.1 | Brain and other nervous system | 3.2 | 6.1 | 0.5 |
| All malignant neoplasms | 697.3 | 568.3 | 1.2 | All malignant neoplasms | 400.2 | 435.1 | 0.9 |

*Rates are per 100,000 and age-adjusted to the 2000 US population standard. †Site selected if cases greater than 50.

Source: Surveillance, Epidemiology, and End Results (SEER) Program, 1975-2001, Division of Cancer Control and Population Sciences, National Cancer Institute, 2004.

Table 4. African American to White Cancer Mortality Rate* Ratios, US, 1997-2001

| Males | | | | Females | | | |
|----------------------------------|------------------------------|-------------------|-------------------------------------|----------------------------------|------------------------------|-------------------|-------------------------------------|
| Cancer† | African American Rate | White Rate | African American/White Ratio | Cancer† | African American Rate | White Rate | African American/White Ratio |
| Prostate | 70.4 | 28.8 | 2.4 | Myeloma | 6.6 | 2.9 | 2.3 |
| Larynx | 5.4 | 2.3 | 2.3 | Stomach | 6.3 | 2.8 | 2.3 |
| Stomach | 13.3 | 5.8 | 2.3 | Uterine cervix | 5.6 | 2.6 | 2.2 |
| Myeloma | 9.0 | 4.4 | 2.0 | Esophagus | 3.2 | 1.7 | 1.9 |
| Oral cavity and pharynx | 7.5 | 3.9 | 1.9 | Larynx | 0.9 | 0.5 | 1.8 |
| Esophagus | 11.7 | 7.4 | 1.6 | Uterine corpus | 6.9 | 3.9 | 1.8 |
| Liver and intrahepatic bile duct | 9.3 | 6.1 | 1.5 | Pancreas | 12.8 | 8.9 | 1.4 |
| Small intestine | 0.7 | 0.5 | 1.4 | Colon and rectum | 24.5 | 17.1 | 1.4 |
| Colon and rectum | 34.3 | 24.8 | 1.4 | Liver and intrahepatic bile duct | 3.8 | 2.7 | 1.4 |
| Lung and bronchus | 104.1 | 76.6 | 1.4 | Breast | 35.4 | 26.4 | 1.3 |
| Pancreas | 16.0 | 12.0 | 1.3 | Urinary bladder | 2.9 | 2.3 | 1.3 |
| Kidney and renal pelvis | 6.3 | 6.2 | 1.0 | Oral cavity and pharynx | 2.0 | 1.6 | 1.3 |
| Hodgkin lymphoma | 0.6 | 0.6 | 1.0 | Ovary | 9.2 | 7.5 | 1.2 |
| Leukemia | 9.0 | 10.5 | 0.9 | Kidney and renal pelvis | 2.7 | 2.8 | 1.0 |
| Thyroid | 0.4 | 0.5 | 0.8 | Lung and bronchus | 39.9 | 41.6 | 1.0 |
| Urinary bladder | 5.6 | 7.9 | 0.7 | Leukemia | 5.4 | 6.0 | 0.9 |
| Non-Hodgkin lymphoma | 7.4 | 10.8 | 0.7 | Non-Hodgkin lymphoma | 4.6 | 7.2 | 0.6 |
| Brain and other nervous system | 3.3 | 6.0 | 0.6 | Brain and other nervous system | 2.3 | 4.0 | 0.6 |
| Melanoma of the skin | 0.5 | 4.4 | 0.1 | Melanoma of the skin | 0.5 | 2.0 | 0.3 |
| All malignant neoplasms | 352.2 | 250.5 | 1.4 | All malignant neoplasms | 200.4 | 169.1 | 1.2 |

*Rates are per 100,000 and age-adjusted to the 2000 US population standard. †Site selected if deaths greater than 50.

Source: National Center for Health Statistics, Centers for Disease Control and Prevention.

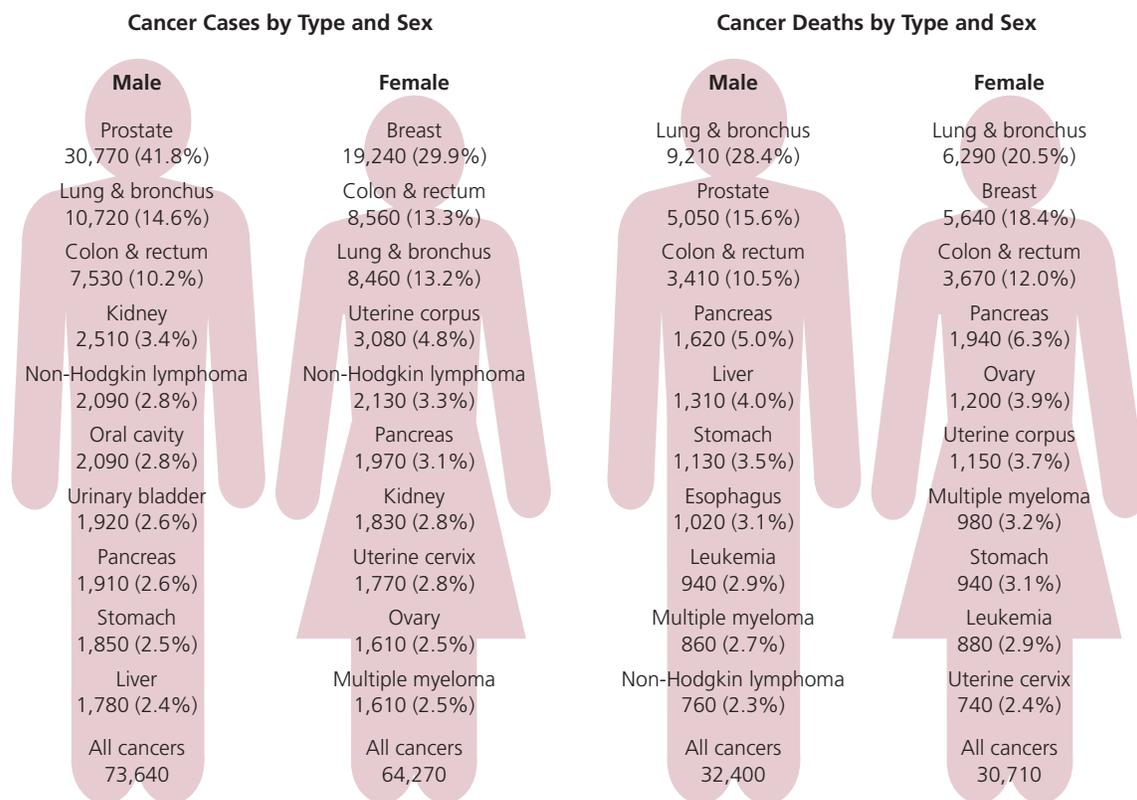
will account for a disproportionate number of these cancers. African American men, in particular, have a 20% higher incidence rate and a 40% higher death rate from all cancers combined than white men (Tables 3 and 4). Both the stage of disease at diagnosis and the availability of appropriate and timely treatment influence survival rates. The proportion of African Americans who are diagnosed with more advanced stage of disease is higher than that of whites (Figure 1).⁶ Factors that may contribute to the survival differential include lower quality of health care when accessible,⁷ a higher prevalence of coexisting conditions, and differences in tumor biology. (For more in-depth review and discussion, please refer to the section on Socioeconomic Status under Risk Factor Statistics, page 13.)

Although African Americans have experienced high mortality rates from cancer for many years,⁸ this situation is improving.^{5,8} The death rates from all cancers in men and women combined have decreased substantially among African Americans since 1993, as have incidence rates since 1992. Increased efforts to improve economic status in combination with education about the relationship of lifestyle choices to cancer could further lessen the burden of cancer among African Americans.⁹

New Cases and Deaths

Estimated new cases: About 137,910 new cancer cases are expected to be diagnosed among African Americans in 2005. The number of expected cancer cases has increased from past estimates largely due to the aging and growth of the population. The most commonly

Figure 2. Leading Types of New Cancer Cases* and Deaths Among African Americans, 2005 Estimates



*Excludes basal and squamous cell skin cancers and in situ carcinoma except urinary bladder. Estimates are rounded to the nearest 10. Percentages may not total 100% due to rounding.

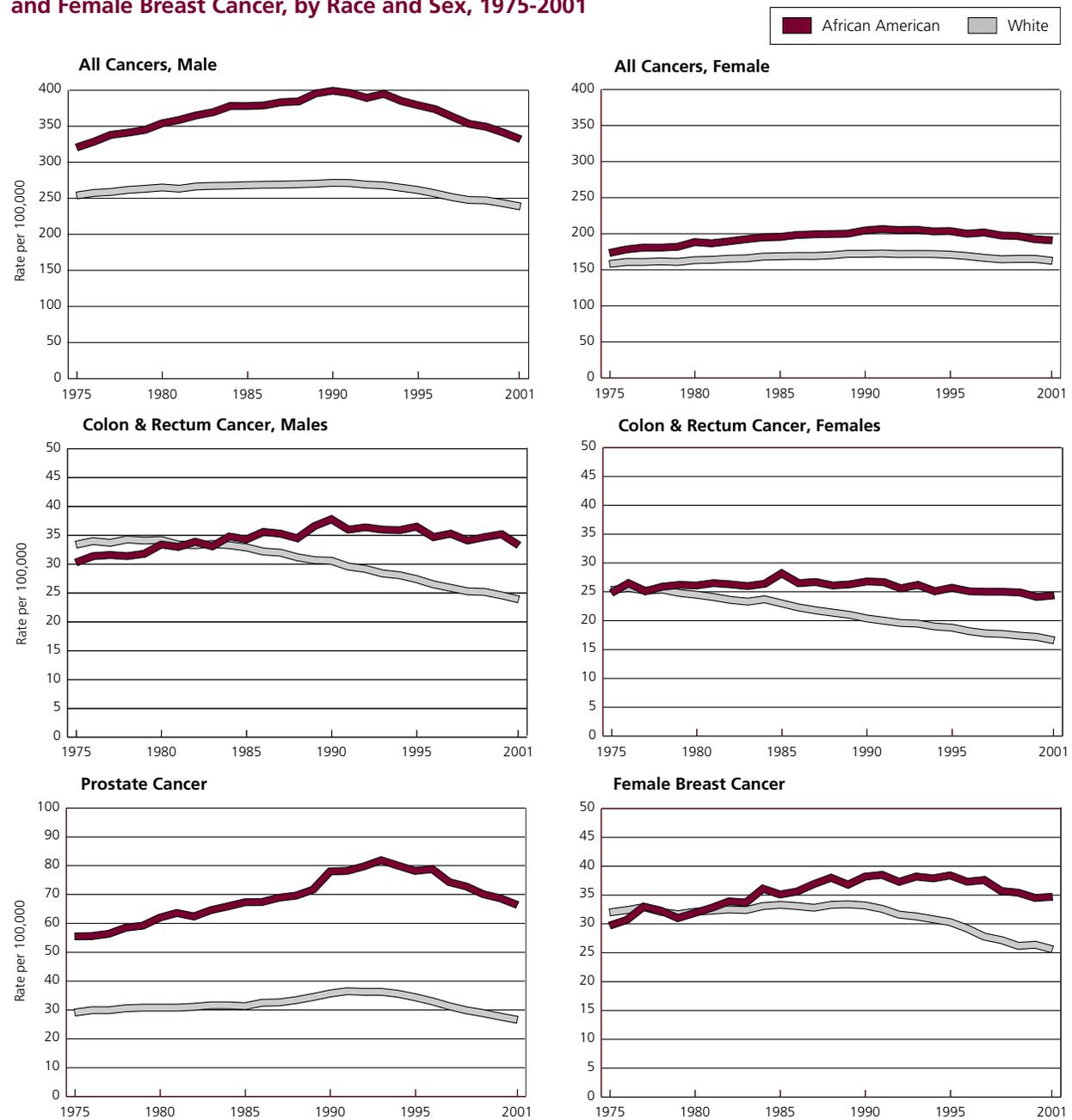
Estimates of new cases are projected based on incidence rates from the National Cancer Institute Surveillance, Epidemiology, and End Results (SEER) Program, 1979-2001. Estimated deaths are based on US Mortality Public Use Tapes, 1969-2002, National Centers for Health Statistics, Centers for Disease Control and Prevention, 2004.

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diagnosed cancers among African American men continue to be prostate (41.8%), lung (14.6%), and colon and rectum (10.2%). Among African American women, the most common cancers will be breast (29.9%), colon and rectum (13.3%), and lung (13.2%) (Figure 2).

Trends in incidence rates: In African Americans, the incidence rate for all cancers combined increased from the mid-1970s to the early 1990s, with rates increasing faster in men than in women. After the early 1990s, however, rates decreased in African American males and stabilized in African American females.

Figure 3. Trends in Death Rates* for All Cancer Sites Combined, Colon and Rectum, Prostate, and Female Breast Cancer, by Race and Sex, 1975-2001



*Rates are per 100,000 population and age-adjusted to the 2000 US standard population and are 2-year moving averages.

Source: US Mortality Public Use Data Tapes, 1969-2001, National Center for Health Statistics, Centers for Disease Control and Prevention, 2004.

Table 5. Death Rates* for Selected Cancers in African American Males and Females, 1997-2001

| | All Malignant Cancers | | Lung & Bronchus | | Colon & Rectum | | Prostate | Female Breast | Uterine Cervix |
|----------------------|-----------------------|--------------|-----------------|-------------|----------------|-------------|-------------|---------------|----------------|
| | Male | Female | Male | Female | Male | Female | | | |
| Alabama | 368.2 | 183.2 | 106.9 | 30.1 | 33.6 | 22.2 | 82.7 | 33.2 | 6.1 |
| Arizona | 293.1 | 177.8 | 89.2 | 39.8 | 28.3 | 20.6 | 65.0 | 37.4 | † |
| Arkansas | 365.8 | 195.8 | 120.3 | 36.1 | 34.0 | 25.8 | 75.7 | 36.9 | 6.8 |
| California | 311.5 | 197.6 | 92.6 | 44.6 | 31.4 | 23.7 | 61.4 | 34.2 | 4.9 |
| Colorado | 297.8 | 180.6 | 80.3 | 42.8 | 28.4 | 22.6 | 67.7 | 32.9 | † |
| Connecticut | 313.8 | 177.0 | 87.2 | 37.1 | 27.4 | 22.1 | 66.3 | 33.2 | 3.4 |
| Delaware | 339.6 | 222.4 | 102.2 | 52.3 | 32.5 | 28.8 | 69.3 | 35.3 | 7.0 |
| District of Columbia | 374.6 | 221.7 | 101.9 | 47.0 | 36.1 | 26.0 | 63.2 | 41.8 | 5.8 |
| Florida | 319.1 | 175.7 | 90.4 | 30.3 | 30.1 | 21.7 | 69.8 | 30.9 | 6.8 |
| Georgia | 356.4 | 178.8 | 104.8 | 30.4 | 32.2 | 23.3 | 79.2 | 33.3 | 4.9 |
| Illinois | 368.5 | 222.6 | 113.7 | 48.5 | 38.8 | 27.2 | 69.7 | 39.6 | 6.5 |
| Indiana | 373.7 | 218.3 | 115.8 | 54.5 | 40.1 | 27.5 | 76.1 | 38.1 | 5.0 |
| Iowa | 380.1 | 214.2 | 116.4 | 64.8 | 48.8 | 21.9 | 79.6 | 36.6 | † |
| Kansas | 376.2 | 201.0 | 113.6 | 35.8 | 41.6 | 23.5 | 75.9 | 38.0 | † |
| Kentucky | 381.3 | 227.7 | 131.0 | 62.8 | 38.6 | 27.7 | 66.9 | 36.4 | 6.3 |
| Louisiana | 389.0 | 211.2 | 127.0 | 42.0 | 39.5 | 24.9 | 68.1 | 38.3 | 6.1 |
| Maryland | 351.8 | 199.1 | 102.8 | 43.4 | 37.5 | 25.8 | 71.7 | 35.1 | 4.6 |
| Massachusetts | 306.0 | 172.7 | 85.2 | 33.4 | 32.7 | 21.5 | 58.0 | 26.7 | 4.1 |
| Michigan | 330.6 | 205.1 | 101.3 | 48.0 | 32.5 | 24.6 | 64.3 | 36.2 | 4.0 |
| Minnesota | 348.5 | 207.9 | 109.5 | 53.5 | 30.0 | 18.2 | 68.6 | 33.5 | † |
| Mississippi | 372.9 | 191.5 | 123.5 | 34.7 | 31.2 | 25.5 | 79.4 | 36.6 | 6.5 |
| Missouri | 376.9 | 220.6 | 120.7 | 51.7 | 38.4 | 27.5 | 67.7 | 35.7 | 6.3 |
| Nebraska | 365.3 | 201.9 | 128.3 | 40.8 | 45.2 | 23.0 | 44.7 | 42.9 | † |
| Nevada | 290.1 | 200.8 | 91.0 | 50.7 | 41.6 | 23.5 | 53.5 | 32.2 | † |
| New Jersey | 341.3 | 198.3 | 98.0 | 40.9 | 33.7 | 24.0 | 67.3 | 34.9 | 6.0 |
| New Mexico | 256.3 | 179.3 | 66.0 | 28.7 | 35.8 | † | 62.5 | 40.6 | † |
| New York | 273.9 | 169.3 | 71.5 | 30.8 | 29.4 | 21.1 | 60.7 | 31.7 | 5.4 |
| North Carolina | 370.1 | 186.9 | 113.8 | 30.7 | 31.4 | 24.7 | 81.1 | 35.7 | 5.5 |
| Ohio | 362.6 | 213.0 | 114.4 | 51.3 | 37.1 | 25.9 | 68.3 | 37.8 | 5.0 |
| Oklahoma | 365.6 | 203.5 | 104.3 | 45.5 | 46.6 | 25.5 | 72.0 | 38.7 | 4.7 |
| Oregon | 317.7 | 170.0 | 106.2 | 28.4 | 26.9 | 19.9 | 56.7 | 32.2 | † |
| Pennsylvania | 373.0 | 222.3 | 114.2 | 53.9 | 37.0 | 26.4 | 68.1 | 38.3 | 6.0 |
| Rhode Island | 317.8 | 168.5 | 99.9 | 29.9 | † | 25.6 | 61.4 | 26.6 | † |
| South Carolina | 369.9 | 184.4 | 102.9 | 27.7 | 33.4 | 21.4 | 82.9 | 36.5 | 6.2 |
| Tennessee | 389.2 | 216.0 | 123.3 | 44.6 | 43.1 | 30.4 | 74.8 | 36.2 | 7.1 |
| Texas | 367.5 | 204.8 | 119.0 | 42.9 | 37.6 | 26.1 | 67.8 | 37.0 | 6.6 |
| Virginia | 365.8 | 205.0 | 108.1 | 40.3 | 33.9 | 25.7 | 76.3 | 37.8 | 5.1 |
| Washington | 310.4 | 192.4 | 92.3 | 41.9 | 27.0 | 22.8 | 63.1 | 34.0 | † |
| West Virginia | 335.6 | 211.3 | 74.8 | 50.6 | 45.6 | 31.7 | 68.6 | 37.1 | † |
| Wisconsin | 369.7 | 200.6 | 121.5 | 47.5 | 32.5 | 24.9 | 62.4 | 31.6 | 4.7 |
| United States | 347.3 | 196.5 | 104.1 | 39.9 | 34.3 | 24.5 | 70.4 | 35.4 | 5.6 |

*Rates are per 100,000 population and age-adjusted to the 2000 US standard population.

†Rates are suppressed when they are based on fewer than 16 deaths.

Source: US Mortality Public Use Data Tapes, 1969-2001, National Center for Health Statistics, Centers for Disease Control and Prevention.

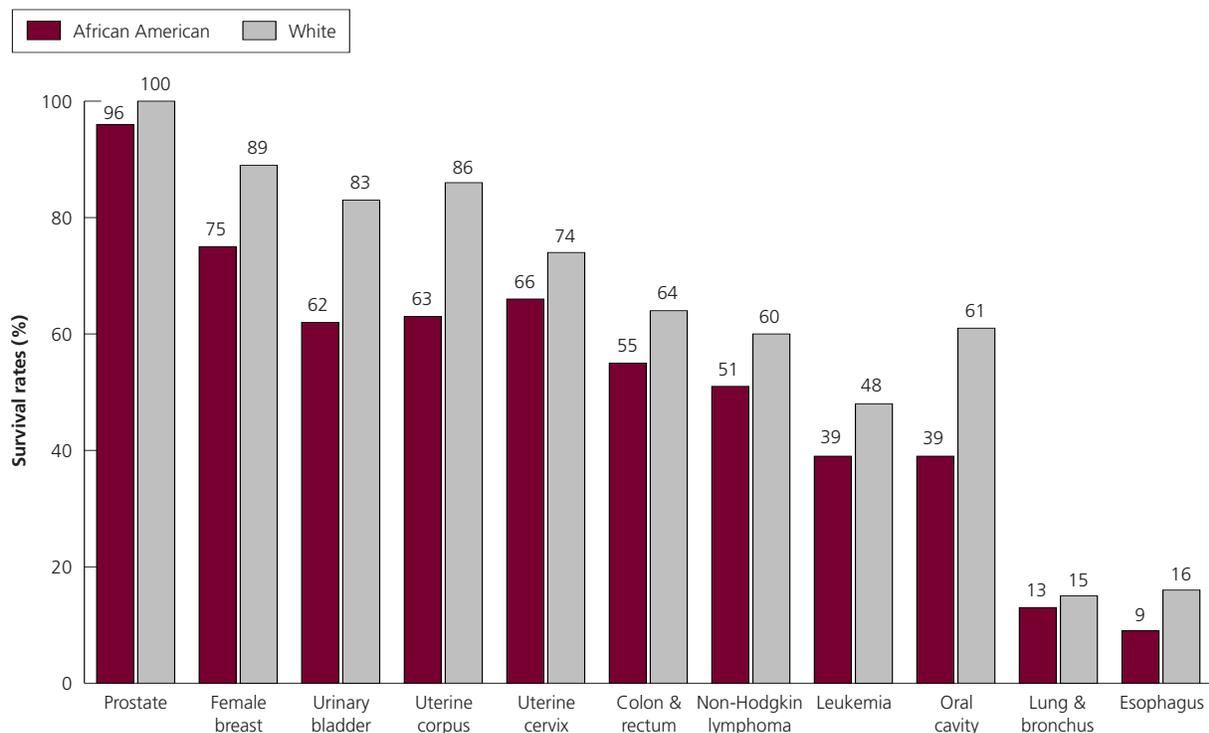
Estimated cancer deaths: About 63,110 African Americans are expected to die from cancer in 2005. Figure 2 shows the expected number of deaths from the 10 leading causes of cancer death for African American men and women. Lung cancer accounts for the largest number of cancer deaths among both men (28.4%) and women (20.5%), followed by prostate cancer in men (15.6%) and breast cancer in women (18.4%). For both men and women, cancer of the colon and rectum and cancer of the pancreas are expected to rank third and fourth, respectively, as the leading sites for cancer deaths.

Trends in death rates: After increasing from 1975 to 1993, the death rate among African Americans from all cancers combined declined by an average of 1.6% per year from 1993 to 2001. The decline was larger in men (2.2% per year since 1994) than in women (1.3% per year

since 1997). Similar trends were observed among whites, with a greater reduction in the rate among men (1.4%) than women (0.6%).

In men, the death rate from all cancers combined was substantially higher among African Americans than whites from 1975 through 2001; this gap diminished slightly after peaking around 1990 (Figure 3). Similar trends were seen among women, although the racial gap is much smaller. In both men and women, the difference in colorectal cancer mortality rates between African Americans and whites widened substantially over the last 25 years, with whites showing a large decline in mortality that was not experienced by African Americans. The same was true for breast cancer in women. For prostate cancer, death rates have been consistently higher among African Americans, although the widest gap was seen in the early 1990s.

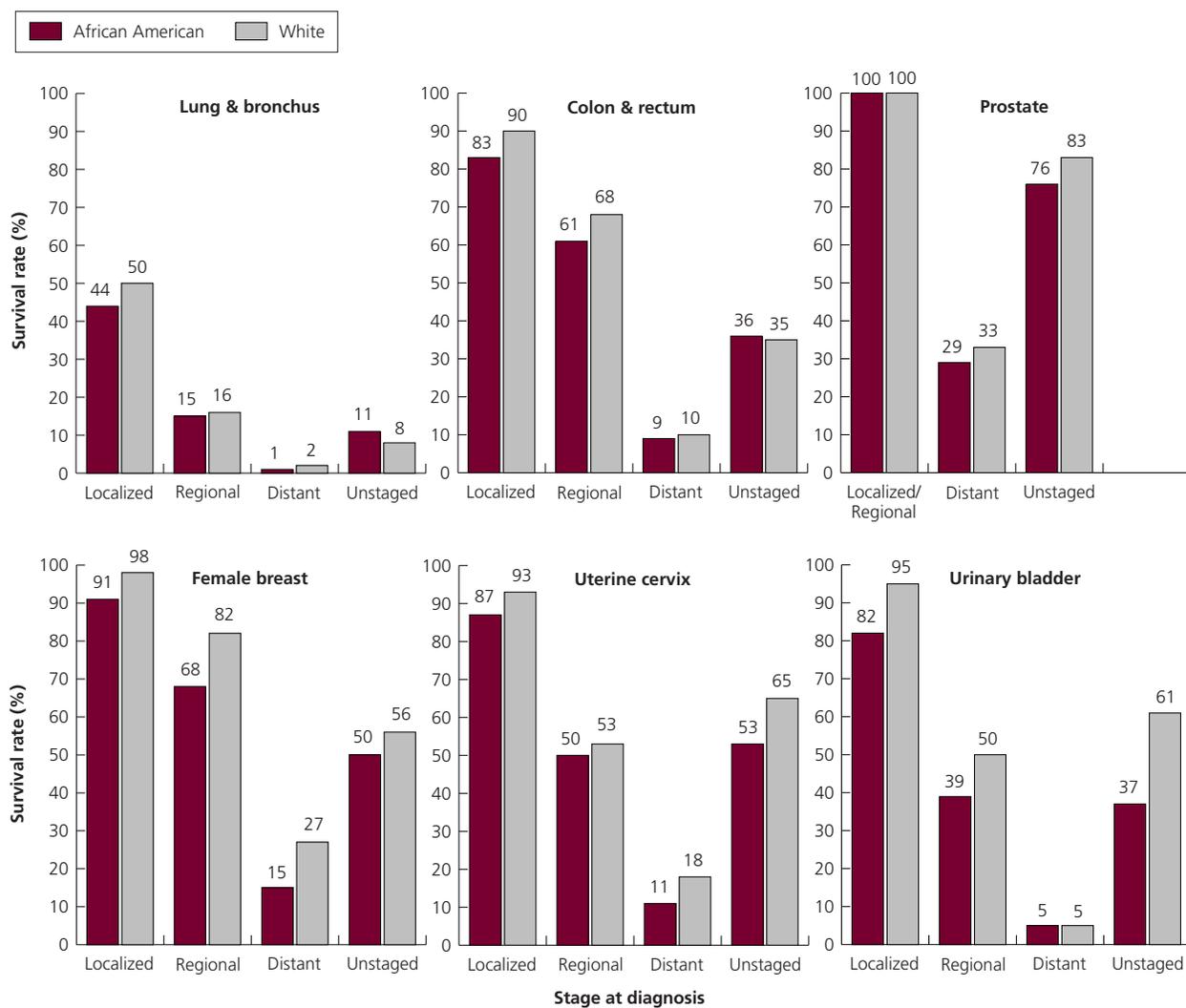
Figure 4. Five-Year Relative Survival Rates* for Selected Cancers, by Race, 1995-2000



*Based on cancer patients diagnosed between 1995-2000 and followed through 2001.

Source: Surveillance, Epidemiology, and End Results (SEER) Program, 1975-2001, Division of Cancer Control and Population Sciences, National Cancer Institute, 2004.

Figure 5. Five-Year Relative Survival Rates* Among Patients Diagnosed with Selected Cancers by Race and Stage, 1995-2000



*Five-year relative survival rate among cancer patients diagnosed between 1995-2000 and followed through 2001.

Source: Surveillance, Epidemiology, and End Results (SEER) Program, 1975-2001, Division of Cancer Control and Population Sciences, National Cancer Institute, 2004.

Survival

Rates and trends: Five-year relative survival rates are commonly used to monitor progress in the early detection and treatment of cancer. Five-year relative survival rates indicate the likelihood of surviving 5 years from the time of diagnosis in a given population, taking into account deaths from other causes. However, 5-year relative survival rates are less informative when used to predict individual prognosis. The overall 5-year cancer survival rate among African Americans has improved,

from approximately 27% in 1960-1963 to 55% in 1995-2000. However, in general, African Americans have a decreased likelihood of surviving 5 years after diagnosis than whites for all cancer sites (Figure 4), and at all stages of diagnosis (Figure 5). Much of this difference is believed to be due to factors associated with poverty,¹⁰ which include reduced access to medical care;¹¹ diagnosis at a later stage, when the disease has spread to regional or distant tissues;⁶ and disparities in treatment.^{12,13} Identifying and understanding these factors has become an active and important area of research.

Selected Cancers



Female Breast

New Cases

An estimated 19,240 new cases of breast cancer are expected to occur among African American women in 2005 (Figure 2). Breast cancer is the most common cancer among African American women. The incidence rate of breast cancer is about 17% lower in African American women than in white women; among younger African American women (under age 40), the incidence is higher than among white women. Over the past 25 years, trends in breast cancer incidence among African American women show four distinct phases: a period of stable rates from 1975 to 1978, followed by a rapid increase between 1978 and 1986, a less rapid increase from 1986 to 1999, and a leveling off in 1999 to 2001 (Figure 6).⁸ The increase in breast cancer incidence rates can be attributed to the increased use of mammography,^{14,15} and possibly to an increased prevalence in obesity and the use of hormone replacement therapy.¹⁴

Deaths

An estimated 5,640 deaths from breast cancer are expected to occur among African American women in 2005. Breast cancer is the second most common cause of cancer death among African American women, surpassed only by lung cancer. Breast cancer death rates among African American women increased 1.6% annually from 1975 to 1991 and declined thereafter (Figure 6), particularly in women younger than 50.⁸ The steady decline in female breast cancer mortality since 1991 has been attributed, in part, to early detection and the increased use of adjuvant chemotherapies.^{16,17} However, there has been notable divergence between long-term breast cancer mortality rates for white and African American women (Figure 3). During the early 1980s, breast cancer death rates for white and African American women were approximately equal, but by 2000, African American women had a 32% higher death rate than white women. Breast cancer mortality is higher among African American women than white women despite a lower incidence rate. The reasons for this survival differential have been studied extensively. Several studies have documented treatment differences

between African American and white women.¹⁸⁻²⁰ Others found survival differences decrease when controlling for socioeconomic factors, such as lack of insurance coverage.^{10,21} Tumor and clinical characteristics such as estrogen receptor status, tumor size, tumor stage at diagnosis, and neutropenia (a condition characterized by too few of one type of white blood cell) may also influence the types and courses of treatment and survival.

Survival

The 5-year relative survival rate for breast cancer diagnosed from 1995 to 2000 among African American women was 75%, compared with 89% among whites (Figure 4). One study showed that about three-fourths of the racial differences in survival with respect to female breast cancer between these two populations may be explained by stage at diagnosis, specific characteristics of the tumor, the presence of additional illness, and sociodemographic factors.²² Of all breast cancers diagnosed among African American women, 53% are diagnosed at a localized stage, compared to 64% among white women (Figure 1). Within each stage, 5-year survival is also greater among white women (Figure 5). More general information about breast cancer is available in the American Cancer Society publication *Breast Cancer Facts and Figures* (8610.01) or through the American Cancer Society Web Site at www.cancer.org.

Colon and Rectum

New Cases

An estimated 16,090 cases of colorectal cancer are expected to occur among African Americans in 2005. Colorectal cancer is the second most common cancer in African American women and the third most common cancer in African American men. Colorectal cancer incidence among African Americans has stabilized over the past 20 years (Figures 6 and 7). However, incidence rates among African American men and women are higher than those among whites. Factors that increase risk for colorectal cancer include obesity and cigarette smoking. Factors that protect against colorectal cancer include

occupational or recreational physical activity, a diet high in vegetables and fruits, use of anti-inflammatory drugs,²³ hormone replacement therapy containing estrogen and progesterone (in women),²⁴ and colorectal cancer screening with removal of polyps before they progress to cancer.^{25,26}

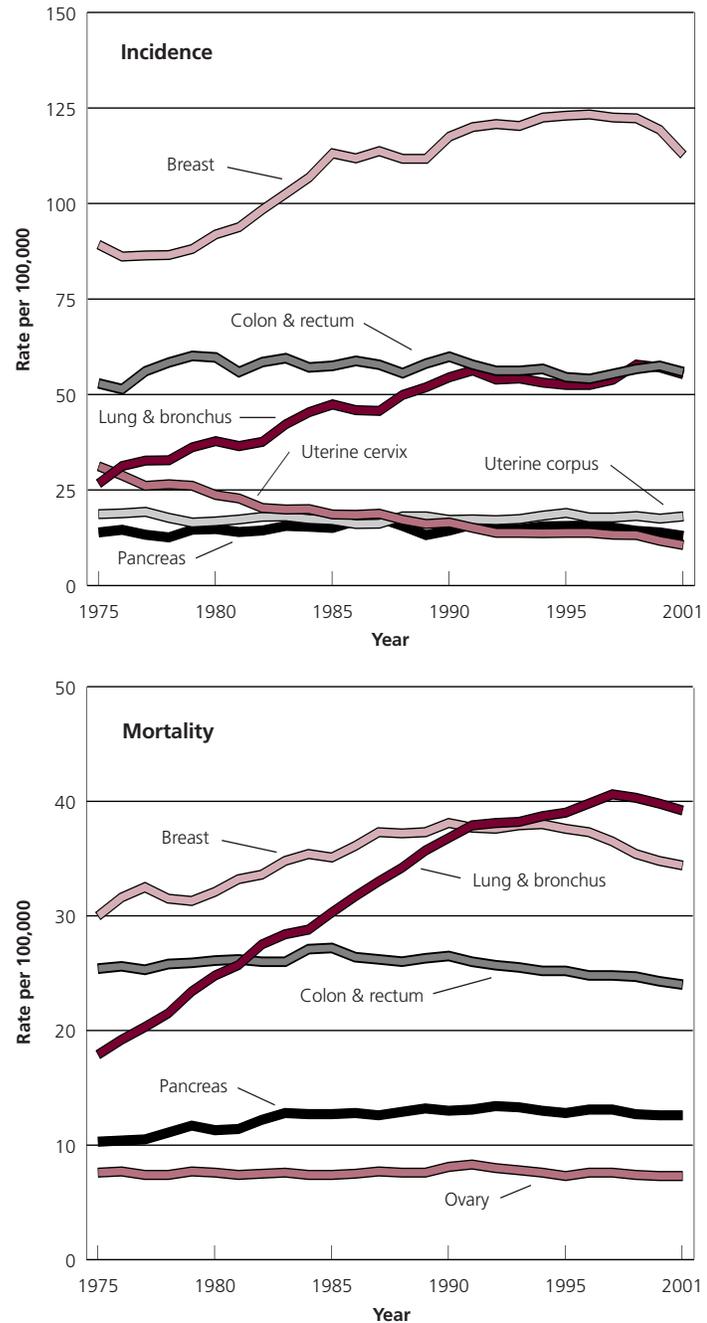
Deaths

An estimated 7,080 deaths from colorectal cancer are expected to occur among African Americans in 2005. Colorectal cancer is the third leading cause of cancer deaths among both African American men and women. Overall, death rates from colorectal cancer have declined since 1990 (Figures 6 and 7); however, the reduction in death rates has been smaller in African Americans than in whites (0.8% vs. 1.9%), thus contributing to the diverging trends in death rates (Figure 3).⁸ The decrease in death rates may be attributed to detection and removal of precancerous polyps, the early detection of tumors through screening, and improved treatment. They also may reflect the increased use of hormone replacement therapy in women and anti-inflammatory drugs, both of which appear to reduce the risk of colon cancer.

Survival

The 5-year relative survival rate for colorectal cancer among African Americans improved from 45% during 1974-1976 to 55% during 1995-2000; however, this improvement was smaller than that in whites (50% to 64% over the same period).⁸ The disparity in survival is due partly to later stage at diagnosis, as 35% of colorectal cancers in African Americans and 39% in whites are diagnosed at a localized stage.^{6,8}

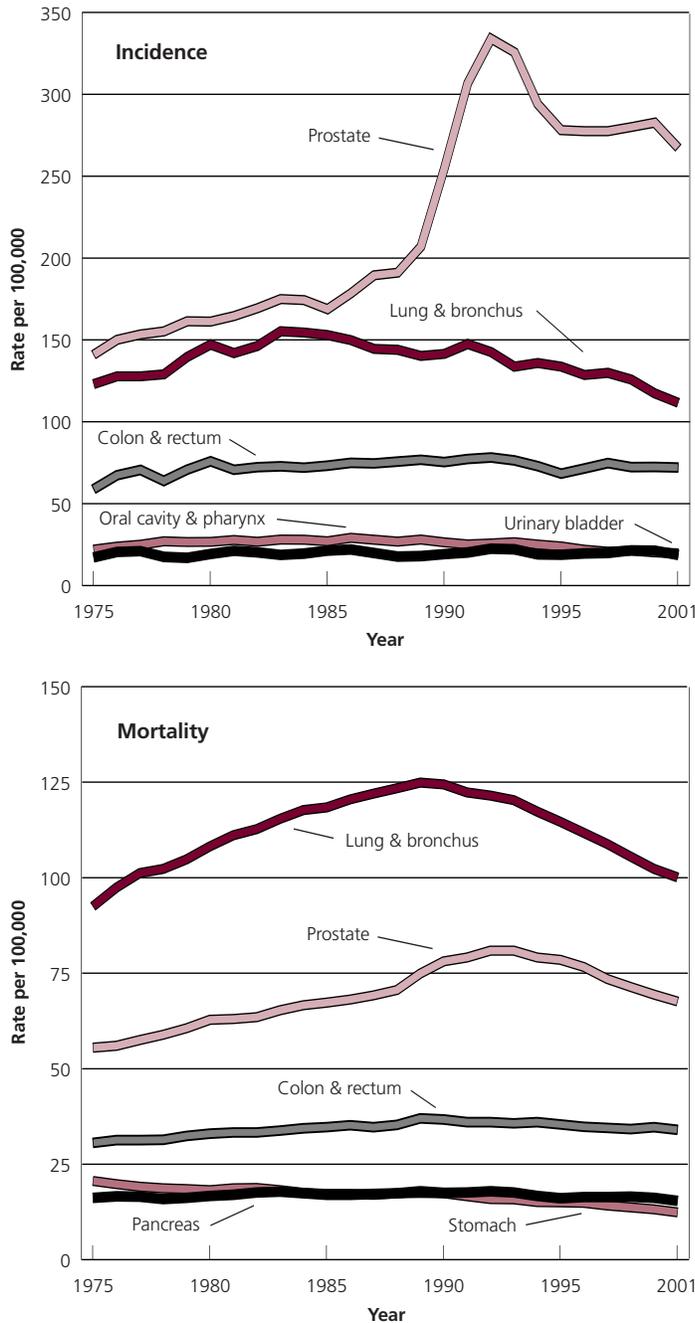
Figure 6. Age-Adjusted Incidence and Mortality Rates* for Selected Cancers, African American Females, 1975-2001



*Rates are age-adjusted to the 2000 US standard population and are 2-year moving averages.

Source: Incidence – Surveillance, Epidemiology, and End Results Program, 1975-2001, Division of Cancer Control and Population Sciences, National Cancer Institute, 2004. Mortality – US Mortality Public Use Data Tapes, 1969-2001, National Center for Health Statistics, Centers for Disease Control and Prevention, 2004.

Figure 7. Age-Adjusted Incidence and Mortality Rates* for Selected Cancers, African American Males, 1975-2001



*Rates are age-adjusted to the 2000 US standard population and are 2-year moving averages.

Source: Incidence – Surveillance, Epidemiology, and End Results Program, 1975-2001, Division of Cancer Control and Population Sciences, National Cancer Institute, 2004. Mortality – US Mortality Public Use Data Tapes, 1969-2001, National Center for Health Statistics, Centers for Disease Control and Prevention, 2004.

Lower 5-year relative survival rates for each stage are also seen in African Americans (Figure 5), presumably reflecting disparities in treatment or other factors.²⁷

Lung and Bronchus

New Cases

An estimated 19,180 cases of lung cancer are expected to occur among African Americans in 2005, accounting for about 14% of cancer diagnoses in this group. Cancer of the lung is the second most common cancer in African American men and the third most common cancer in African American women. The average incidence rate of cancers of the lung and bronchus during 1997-2001 was 47% higher in African American men than in white men (Table 3), whereas the incidence rate is comparable between African American and white women. The rate of lung cancer among African Americans has continued to decrease since 1984 in men,⁸ and has become stable among African American women since 1990 (Figures 6 and 7), after increasing for many decades.

Deaths

An estimated 15,500 deaths from lung cancer are expected to occur among African Americans in 2005. Lung cancer kills more African Americans than any other cancer. Among males, the death rate from cancers of the lung and bronchus between 1997 and 2001 was 36% higher in African Americans compared to whites (Table 4). During the mid-to-late-1970s, lung cancer death rates increased by an average of 3.1% per year among African American men, and 7.1% per year among African American women.⁸ Lung cancer death rates continued to increase in the 1980s, but not as rapidly (Figures 6 and 7). From 1993 to 2001, the lung cancer death rate in African American men decreased substantially, by 2.6% per year, while the

rate in women continued to increase by 1.3% per year through 1998 and stabilized afterward.⁸ The decline in men and the stabilization in women are the result of decreases in smoking prevalence over the previous 30 years.²⁸

Survival

The 5-year relative survival rate from lung cancer is slightly lower in African Americans than in whites, 13% and 15%, respectively.⁸ When lung cancer is detected at a localized stage, the 5-year relative survival rate among African Americans is 44%; however, only 14% of lung cancer cases are detected at that stage.⁸ Symptoms of lung cancer generally do not appear until the disease is advanced. Five-year survival rates for early-stage lung cancer are lower for African Americans than for whites. Studies have shown that African Americans diagnosed with early-stage lung cancer are less likely than whites to receive surgery, which can result in long-term cure, even when economic factors are accounted for.²⁹

Prostate

New Cases

An estimated 30,770 cases of prostate cancer are expected to occur among African American men in 2005, accounting for approximately 42% of all cancers diagnosed in this population. Between 1997 and 2001, the prostate cancer incidence rate was on average 60% higher in African American men than in white men (Table 3). During 1989-1992, the incidence rate of prostate cancer among African American men increased 19.5% per year, followed by a decrease of approximately 2.6% per year between 1992 and 2001⁸ (Figure 7). This dramatic, but short-term, increase in prostate cancer incidence rates between 1989 and 1992 was likely due to earlier diagnosis through increased use

of the prostate-specific antigen (PSA) blood test.³⁰ However, the reasons for the historically higher incidence rates among African American men compared to white men are less clear.

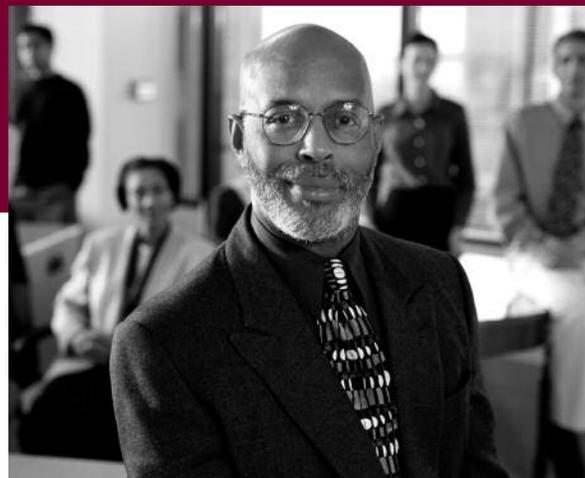
Deaths

Prostate cancer is the second leading cause of cancer deaths in African American men. It is estimated that 5,050 deaths from prostate cancer will occur in African American men in 2005. African American men have the highest mortality rate of any ethnic and racial group in the US. The death rate from prostate cancer is 2.4 times higher in African American than in white men (Table 4). After a long period of increase, prostate cancer death rates in African American men peaked in 1993 and decreased by 2.7% per year subsequently (Figure 7).⁸ The decline in the rate of prostate cancer deaths, however, lagged behind that of white men; prostate cancer death rates in white men began decreasing in 1991, and decreased at a faster rate between 1994 and 2001. Some of the decreases in prostate cancer mortality are likely due to screening³⁰ and use of hormone therapy to treat early- and advanced-stage disease;^{31,32} however, the precise magnitude of each of these factors is difficult to estimate.

Survival

The overall 5-year relative survival rate for prostate cancer among African Americans is 96% for the years 1995 to 2000 (Figure 4), compared to close to 100% among whites. Eighty-eight percent of all prostate cancers among African Americans are diagnosed at the localized and regional stages compared to 91% in whites; the 5-year relative survival rate for African Americans who are diagnosed at these stages is close to 100%. The 5-year survival rate drops to 29% when the cancer has spread to distant sites.⁸

Risk Factor Statistics



Socioeconomic Status

Poverty, together with related social and cultural factors, influences the entire spectrum of cancer from prevention and early detection to treatment, quality of life, and survival.³³ African Americans make up only 13% of the total US population, yet they comprise 24% of the nation's poor.³⁴ Socioeconomic factors that affect cancer prevention and early detection include behaviors such as tobacco avoidance, maintenance of physical activity and a healthy body weight, and regular access to high-quality screening tests with timely and appropriate follow up.

African Americans are more likely to be diagnosed at a later stage of cancer than whites, possibly due to factors such as less knowledge about cancer symptoms and reduced access to cancer screening services. Later stage at detection, in turn, contributes to lower cure rates and shorter survival (Figure 5).

Table 6. Educational Attainment (%) of the Population 15 Years and Older, Non-Hispanic African Americans and Whites, 2002

| | African Americans | Whites |
|----------------------------|-------------------|--------|
| Less than high school | 26.9 | 16.2 |
| High school graduate | 31.6 | 31.1 |
| Some college | 27.1 | 26.7 |
| College graduate | 9.9 | 17.3 |
| Master's degree and beyond | 4.1 | 8.5 |

Note: "Some college" category includes some college (no degree) or an associate's degree.

Source: Educational attainment of the population 15 years and older by age, sex, race, and Hispanic origin: March 2002. US Census Bureau: Table 1. <http://www.census.gov/population/socdemo/education/ppl-169/tab01.pdf>.

Tobacco Use

Tobacco is the most preventable cause of premature death in the US³⁵ and is responsible for about 30% of all cancer deaths.³⁶ In addition to lung cancer, cigarette smoking is associated with cancers of the lip, mouth and pharynx, larynx, esophagus, stomach, colon, rectum, pancreas, cervix, bladder, liver, and kidney, as well as myeloid leukemia. Both incidence and death rates from lung cancer are higher among African American men

than among white men, due in part to differences in smoking behaviors. The rate of adult (≥ 18 years) smoking has been consistently higher in African American men than white men, although the percentage of adults who smoke, as well as the disparity across race, have decreased over time. Although African Americans begin smoking at an older age and smoke fewer cigarettes per day than white men do, they smoke cigarettes more intensely and are more likely to smoke mentholated brands,³⁷ which have been shown to have higher carbon monoxide concentrations than regular cigarettes and may be associated with a greater absorption of nicotine.³⁸ The relative importance of these factors, in addition to differences in nutritional status and/or inherited genetic susceptibilities,³⁹ to the higher lung cancer rates in African Americans is unclear.

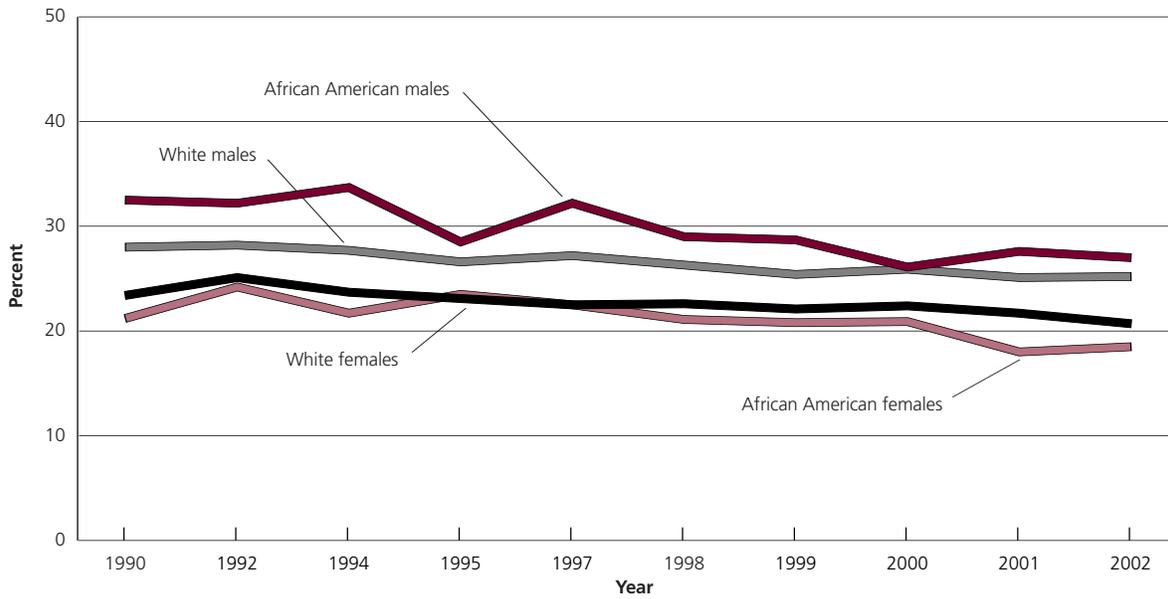
Adult Cigarette Smoking

In 2002, 5.2 million African Americans were smokers.⁴⁰ The prevalence of current cigarette smoking among adults (≥ 18 years) was higher among African American men (27.0%) than white men (25.2%), while the prevalence was lower among African American women (18.5%) than white women (20.7%) (Figure 8a).⁴¹ In both groups the prevalence is much higher than the Healthy People 2010 goal of 12%.³⁹

Youth Tobacco Use

An estimated 3,000 young persons begin smoking each day.³⁹ For more than a decade, African American youth have had the lowest prevalence of cigarette smoking compared with other racial and ethnic groups. According to the Youth Risk Behavior Surveillance Survey (YRBSS), the prevalence of current cigarette smoking among African American high school students increased from 1991-1997 and then decreased until 2001. However, in 2003, following national trends in adolescent smoking, an increase was seen in current smoking in African American males (Figure 8b).⁴²

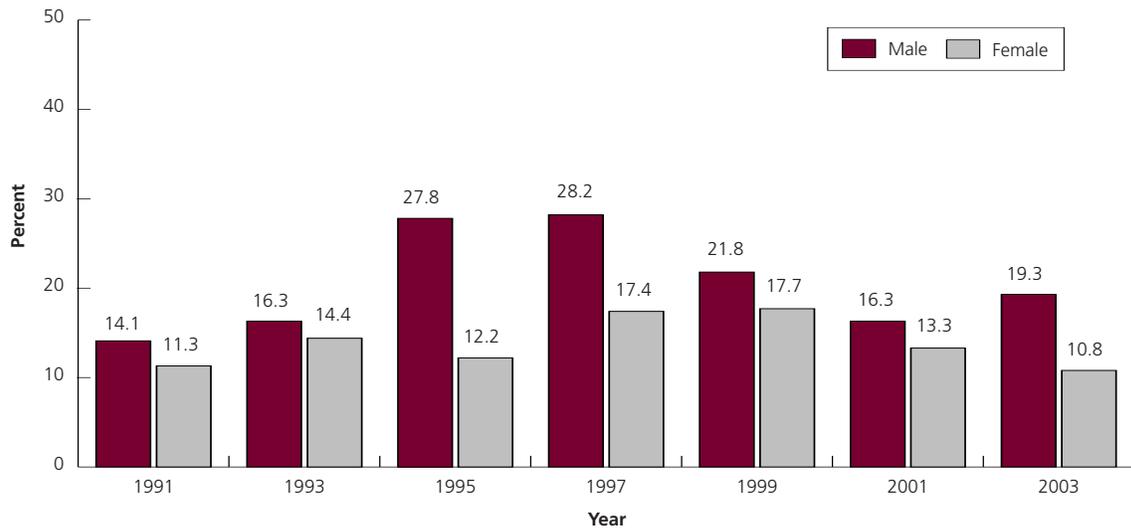
Figure 8a. Trends in the Percentage of Current Cigarette Smokers*, Adults ≥18 Years, US, 1990-2002



*Persons who reported having smoked more than 100 cigarettes and who reported now smoking every day or on some days.

Sources: National Health Interview Survey (NHIS), 1990-2002. National Center for Health Statistics, Centers for Disease Control and Prevention.

Figure 8b. Trends in the Percentage of Current Cigarette Smokers*, Non-Hispanic African American High School Students, US, 1991-2003



*Smoked cigarettes on one or more of the 30 days preceding the survey.

Sources: Youth Risk Behavior Surveillance Survey, 1991-2003. National Center for Chronic Disease and Health Promotion. *Morb Mort Wkly Rep.* 2004;53(23). Centers for Disease Control and Prevention.

Overweight, Obesity, and Physical Activity

Overweight and Obesity

An estimated 108 million adults are overweight or obese in the United States.⁴³ In addition to diabetes, heart disease, and stroke, obesity increases the risk of many cancers, including cancer of the breast (among postmenopausal women), colon, rectum, endometrium, adenocarcinoma of the esophagus, gallbladder, pancreas, liver, gastric cardia, and kidney.^{42,44} According to the definition of overweight (Body Mass Index ≥ 25 kg/m²), 61% of all US adults are considered overweight, and about 30% are obese (Body Mass Index ≥ 30 kg/m²).⁴³ This trend in adult obesity is moving away from the Healthy People 2010 goal of an obesity prevalence of 15%.³⁹

The prevalence of overweight among US adults has increased dramatically over the past two decades. During the most recent time period (1999-2002), the prevalence of overweight was substantially higher in African American women (77%) than white women (57%), and 49% of African American women were obese compared to 31% of white women. In contrast, during this time period, the proportion of overweight was slightly higher in white men (69%) than in African American men (63%)⁴⁵ (Figure 9).

Physical Activity

Studies have shown that regular physical activity is associated with lower risk of colon cancer and female breast cancer.⁴⁴ The American Cancer Society recommends that adults engage in at least moderate activity for 30 minutes or more on 5 or more days of the week, and adds that 45 minutes of more moderate to vigorous activity on 5 or more days may further reduce the risk of breast and colon cancers. In 2002, only one-third of all adults participated in moderate or vigorous physical activity 5 or more times a week.⁴⁵

Data from the 2003 Behavioral Risk Factor Surveillance System (BRFSS) show that more than one-third of African American adults (32.7%) report no leisure-time physical activity, with African American women more likely than African American men to be physically inactive (35.7% vs. 28.9%, respectively). While low for both sexes, African American men were more likely than African American women to report both regular, sustained physical activity (41.4%, 32.3%, respectively), as well as regular, vigorous activity levels (men 27.2%, women 15.4%) (Table 7).

Body Mass Index for Adults

Different measures are used to determine whether a person is considered normal weight, overweight, or obese, taking into account height. A common scale is the body mass index (BMI), or ratio of weight (in kilograms) to height (in meters, squared). For adults aged 20 years and older, overweight is defined as a BMI of 25.0 to 29.9 kg/m²; obesity is defined as a BMI of 30.0 kg/m² or greater.

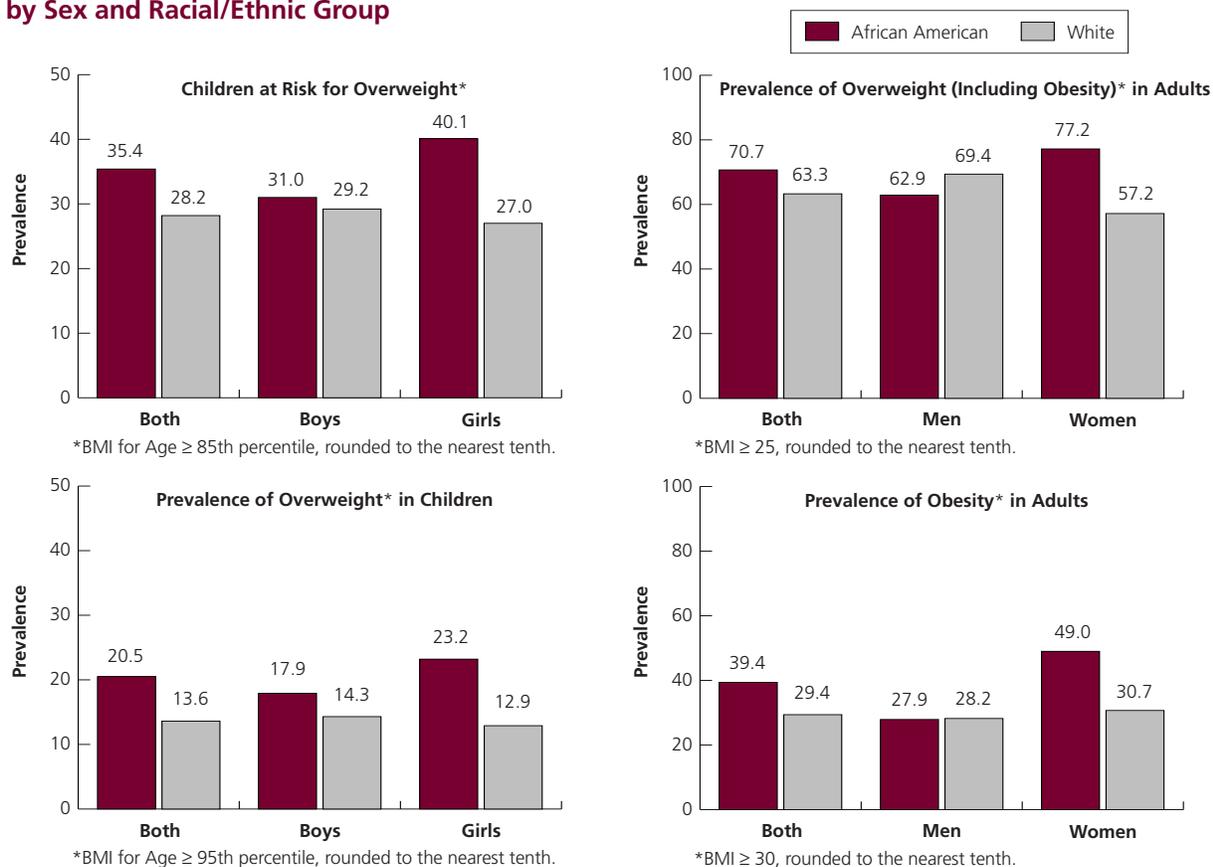
This table relates BMI to pounds and inches rather than kilograms and meters. BMI corresponds to an individual's height (in the left column) and weight category (in pounds). An adult aged 20 or older is considered overweight or obese if his or her weight falls within the corresponding area of the table. For example, a 5'4 woman is considered overweight if she weighs between 145 and 173 pounds. She is considered obese if she weighs 174 pounds or more. A 5'10 man is considered overweight if he weighs between 174 and 206 pounds and obese if he weighs 207 pounds or more.

| Height (feet, inches) | Body weight (pounds) | |
|--------------------------|----------------------|--------|
| | Overweight* | Obese† |
| 6'4 | 205 | 246 |
| 6'3 | 200 | 240 |
| 6'2 | 194 | 233 |
| 6'1 | 189 | 227 |
| 6'0 | 184 | 221 |
| 5'11 | 179 | 215 |
| 5'10 | 174 | 207 |
| 5'9 | 169 | 203 |
| 5'8 | 164 | 197 |
| 5'7 | 159 | 191 |
| 5'6 | 155 | 186 |
| 5'5 | 150 | 180 |
| 5'4 | 145 | 174 |
| 5'3 | 141 | 169 |
| 5'2 | 136 | 164 |
| 5'1 | 132 | 158 |
| 5'0 | 128 | 153 |
| 4'11 | 124 | 148 |
| 4'10 | 119 | 143 |

*Overweight defined as BMI of 25 to 29.9 kg/m².

†Obese defined as BMI of 30 kg/m² or greater.

Figure 9. Prevalence of Obesity and Overweight in Children (6-19) and Adults (≥20), 1999-2002, by Sex and Racial/Ethnic Group



Source: National Health and Nutrition Examination Survey. National Center for Health Statistics, Centers for Disease Control and Prevention. Prevalence of Overweight and Obesity Among US Children, Adolescents and Adults, NHANES 1999-2002, *JAMA*. 2004;2847-2850.

Table 7. Physical Activity, Adults 18 and Older, by Race and Sex, United States, 2003

| | % African American* | % White* |
|--------------------------------------|---------------------|----------|
| No leisure-time physical activity† | | |
| Total | 32.7 | 20.9 |
| Male | 28.9 | 19.2 |
| Female | 35.7 | 22.3 |
| Vigorous/moderate physical activity‡ | | |
| Total | 36.3 | 49.1 |
| Male | 41.4 | 50.6 |
| Female | 32.3 | 47.7 |
| Vigorous physical activity§ | | |
| Total | 20.6 | 27.5 |
| Male | 27.2 | 31.4 |
| Female | 15.4 | 23.8 |

Estimates exclude missing, don't know/not sure, or refused responses and are age-adjusted to the 2000 US population 18 years and older.

*Non-Hispanic. †No leisure-time physical activity or exercise during the past 30 days other than the respondent's regular job. ‡Moderate physical activity is (regular) leisure-time physical activity (moderate activity 30+ min/5+ times a week or vigorous activity 20+ min/3+ times a week). Moderate activity causes some increase in breathing or heart rate. §Activity (such as running, aerobics, or heavy yard work) that causes large increases in breathing or heart rate at least 3 times a week, 20 minutes or more per session.

Source: Behavioral Risk Factor Surveillance System Public Use Data Tape 2003, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, 2004.

Use of Screening Tests

Screening tests are used to detect some cancers at stages when they are still highly curable. In fact, for some cancers, early detection tests can lead to the prevention of cancer through the identification and removal of pre-cancerous lesions. Screening can also greatly improve the chances of cure, extend life, reduce the extent of treatment needed, and improve quality of life for cancer patients.



Breast and Cervical Cancer Screening

The American Cancer Society recommends that women 40 and older get an annual mammogram and an annual clinical breast examination by a health care professional (close to and preferably before the scheduled mammogram). While the Society no longer recommends breast self-exams (BSE), women may choose to do BSE. All women should become familiar with both the appearance and feel of their breasts so that they are able to notice any changes. Women ages 20-39 should have a clinical breast examination (CBE) by a health care professional every 3 years.

In 1987, only 23.8% of African American women aged 40 and older reported having mammography screening

within 2 years prior to the interview. In 2000, that number had increased to 67.9%.⁴⁵ In 2002, the proportion of African American women aged 40 and older who reported receiving a mammogram within the past year was 62.9% (Table 8).

The American Cancer Society recommends that all women should begin cervical cancer screening about 3 years after they begin having vaginal intercourse, but no later than age 21. See screening guidelines, page 18.

In 2002, the rate of Pap testing was similar among African American women (91.2%) and white women (89.2%). The percentage of women reporting having a Pap test within the last 3 years has slightly increased over the last 15 years.⁴⁶

Table 8. Use of Cancer Screening Examinations, by American Cancer Society Guidelines, 2002

| | | African American* | White* |
|--------------------------------------|--|-------------------|--------|
| Breast cancer, 2002 | Mammogram [†] | 62.9 | 61.9 |
| | Clinical breast exam (CBE) [‡] | 65.7 | 67.1 |
| | Mammogram & CBE [§] | 55.9 | 55.3 |
| Cervical cancer, 2002 | Pap test [¶] | 91.2 | 89.2 |
| Colon and rectum cancer, 2002 | Fecal occult blood test (FOBT) [#] | 21.2 | 22.9 |
| | Flexible sigmoidoscopy ^{**} | 40.8 | 41.8 |
| Prostate cancer, 2002 | Prostate-specific antigen (PSA) test ^{††} | 52.9 | 56.2 |
| | Digital rectal exam (DRE) ^{‡‡} | 54.0 | 54.1 |

Age group adjusted to the 2000 US standard population.

*Non-Hispanic. [†]A mammogram within the past year for women 40 years and older. [‡]A clinical breast exam within the past year for women 40 and older. [§]Both a mammogram and clinical breast exam within the past year for women 40 and older. [¶]A Pap test within the past 3 years for women 18 and older. [#]A fecal occult blood test using a home kit within the past year for adults 50 and older. ^{**}A flexible sigmoidoscopy or colonoscopy within the past 5 years for adults 50 and older. ^{††}A prostate-specific antigen (PSA) test within the past year for men 50 and older. ^{‡‡}A digital rectal exam (DRE) within the past year for men 50 and older.

Source: Behavioral Risk Factor Surveillance System Public Use Data File 2000, 2001, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, 2001, 2002.

American Cancer Society, Surveillance Research

Screening Guidelines

For the Early Detection of Cancer in Asymptomatic People

| Site | Recommendation |
|-------------------------------|--|
| Breast | <ul style="list-style-type: none"> Yearly mammograms are recommended starting at age 40. The age at which screening should be stopped should be individualized by considering the potential risks and benefits of screening in the context of overall health status and longevity. Clinical breast exam should be part of a periodic health exam, about every 3 years for women in their 20s and 30s, and every year for women 40 and older. Women should know how their breasts normally feel and report any breast change promptly to their health care providers. Breast self-exam is an option for women starting in their 20s. Women at increased risk (e.g., family history, genetic tendency, past breast cancer) should talk with their doctors about the benefits and limitations of starting mammography screening earlier, having additional tests (i.e., breast ultrasound and MRI), or having more frequent exams. |
| Colon & rectum | <p>Beginning at age 50, men and women should begin screening with 1 of the examination schedules below:</p> <ul style="list-style-type: none"> A fecal occult blood test (FOBT) or fecal immunochemical test (FIT) every year A flexible sigmoidoscopy (FSIG) every 5 years Annual FOBT or FIT and flexible sigmoidoscopy every 5 years* A double-contrast barium enema every 5 years A colonoscopy every 10 years <p><i>*Combined testing is preferred over either annual FOBT or FIT, or FSIG every 5 years, alone. People who are at moderate or high risk for colorectal cancer should talk with a doctor about a different testing schedule.</i></p> |
| Prostate | <p>The PSA test and the digital rectal examination should be offered annually, beginning at age 50, to men who have a life expectancy of at least 10 years. Men at high risk (African American men and men with a strong family history of 1 or more first-degree relatives diagnosed with prostate cancer at an early age) should begin testing at age 45. For both men at average risk and high risk, information should be provided about what is known and what is uncertain about the benefits and limitations of early detection and treatment of prostate cancer so that they can make an informed decision about testing.</p> |
| Uterus | <p>Cervix: Screening should begin approximately 3 years after a woman begins having vaginal intercourse, but no later than 21 years of age. Screening should be done every year with regular Pap tests or every 2 years using liquid-based tests. At or after age 30, women who have had 3 normal test results in a row may get screened every 2 to 3 years. Alternatively, cervical cancer screening with HPV DNA testing and conventional or liquid-based cytology could be performed every 3 years. However, doctors may suggest a woman get screened more often if she has certain risk factors, such as HIV infection or a weak immune system. Women 70 years and older who have had 3 or more consecutive normal Pap tests in the last 10 years may choose to stop cervical cancer screening. Screening after total hysterectomy (with removal of the cervix) is not necessary unless the surgery was done as a treatment for cervical cancer.</p> <p>Endometrium: The American Cancer Society recommends that at the time of menopause all women should be informed about the risks and symptoms of endometrial cancer, and strongly encouraged to report any unexpected bleeding or spotting to their physicians. Annual screening for endometrial cancer with endometrial biopsy beginning at age 35 should be offered to women with or at risk for hereditary nonpolyposis colon cancer (HNPCC).</p> |
| Cancer-related checkup | <p>For individuals undergoing periodic health examinations, a cancer-related checkup should include health counseling, and, depending on a person's age and gender, might include examinations for cancers of the thyroid, oral cavity, skin, lymph nodes, testes, and ovaries, as well as for some nonmalignant diseases.</p> |

American Cancer Society guidelines for early cancer detection are assessed annually in order to identify whether there is new scientific evidence sufficient to warrant a reevaluation of current recommendations. If evidence is sufficiently compelling to consider a change or clarification in a current guideline or the development of a new guideline, a formal procedure is initiated. Guidelines are formally evaluated every 5 years regardless of whether new evidence suggests a change in the existing recommendations. There are 9 steps in this procedure, and these "guidelines for guideline development" were formally established to provide a specific methodology for science and expert judgment to form the underpinnings of specific statements and recommendations from the Society. These procedures constitute a deliberate process to ensure that all Society recommendations have the same methodological and evidence-based process at their core. This process also employs a system for rating strength and consistency of evidence that is similar to that employed by the Agency for Health Care Research and Quality (AHCRO) and the US Preventive Services Task Force (USPSTF).

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Colorectal Screening

Beginning at age 50, the American Cancer Society recommends that both men and women should choose one of several testing schedules. See screening guidelines, page 18.

The use of colorectal screening tests among African Americans has also increased over the past several years. In 1987, only 4% of African Americans reported having had a colorectal screening examination within the past three years. By 2002, more than 40% had had a flexible sigmoidoscopy or colonoscopy.⁴⁷ Similar increases in screening were seen for the fecal occult blood test. Although use of colorectal screening tests has improved among African American adults, overall

the percentage of US adults reporting recent screening still remains low.

Prostate Screening

The Society recommends that African American men be offered prostate cancer screening beginning at age 45. See screening guidelines, page 18.

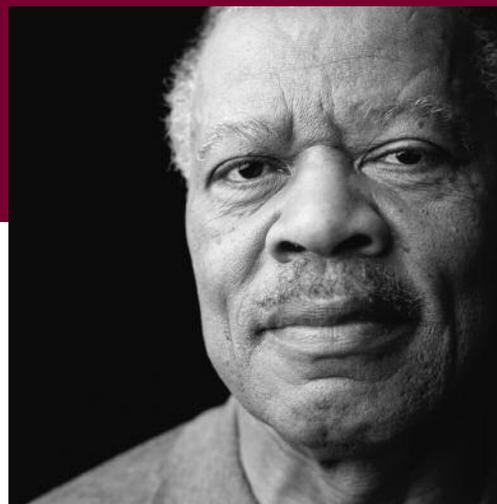
The use of the prostate-specific antigen (PSA) blood test to screen for prostate cancer is lower in African Americans compared to white males (52.9% and 56.2%, respectively), but use of the digital rectal exam (DRE) is similar. In 2002, 54% of African American men 50 and older reported having had a digital rectal exam within the past year (Table 8).

Research and Programs to Reduce Cancer Disparities

What research is currently being done on African Americans and cancer?

Special Populations Networks/Community Networks Program

The Special Populations Networks/Community Networks Program is an initiative of the National Cancer Institute's Center to Reduce Cancer Health Disparities. This initiative links cancer researchers and community-based programs to learn more about the causes of cancer disparities in minority communities and to develop and test ways to address and eliminate those causes. This is done by awarding research grants to researchers for public health projects that may focus on many communities nationwide or on projects in a single county, tribal nation, or specific population subgroup. <http://crchd.nci.nih.gov/initiatives>



National Cancer Institute's grant to study cancer among African Americans

The National Cancer Institute has awarded a multi-million dollar grant to Vanderbilt Medical Center to determine why African Americans are more likely to develop and die from cancer. The grant provides an anticipated \$22 million over 5 years to fund the Southern Community Cohort Study, which will enroll and follow 105,000 people from 6 southeastern states,

two-thirds of whom will be African American. The cohort will be tracked to identify genetic, environmental, and lifestyle factors that may contribute to cancer development. <http://www.mc.vanderbilt.edu/reporter/?ID=1764>

Department of Defense consortium to study prostate cancer death rates

A new consortium of top US cancer researchers is conducting a study to determine why prostate cancer death rates are more than twice as high in African American men as in white men and why the death rate from prostate cancer varies by state. The study is funded by a 3-year, \$9.9 million grant from the US Department of Defense Prostate Cancer Research Program.

What resources are available for African Americans?

Let's Talk About It®: A program that addresses prostate cancer in African American men which was developed in collaboration with the 100 Black Men of America organization. The program provides a support group to encourage discussion of prostate cancer. Volunteers organize free monthly meetings where speakers and participants learn and share information about prostate cancer treatment, side effects, and how to cope with the disease.

Body & Soul – A Celebration of Healthy Living: A wellness program developed for African Americans through collaboration with the National Cancer Institute and churches. The program encourages participants to eat 5 to 9 servings of vegetables and fruits every day for better health. Body and Soul works by combining pastoral leadership, educational activities, and peer counseling in a church environment that supports healthy eating.

Phi Beta Sigma: The American Cancer Society and Phi Beta Sigma fraternity have created Sigma's Waging War Against Cancer (SWWAC), a project focusing on awareness, early detection, and prevention of prostate and colorectal cancer among African American men.

Look Good...Feel Better® provides cosmetic offerings to women to help restore their appearance and self-image during chemotherapy and radiation treatment.

What programs/organizations support the elimination of health disparities between racial and ethnic minorities?

National Breast & Cervical Cancer Early Detection Program (NBCCEDP) provides breast and cervical cancer screening, diagnosis, and treatment to low-income, medically underserved, and uninsured women. <http://www.cdc.gov/cancer/nbccedp>

Racial and Ethnic Approaches to Community Health (REACH 2010): The aim of this CDC initiative is to eliminate disparities in health status experienced by racial and ethnic minority populations. There are 40 REACH 2010 projects, of which some specifically target breast and/or cervical cancer in African Americans. <http://www.cdc.gov/reach2010/>

- **Boston Public Health Commission:** This program focuses on African American women who have inadequate health care and who are especially hard to reach with conventional methods.
- **University of Alabama at Birmingham:** The Alabama Breast and Cervical Cancer Coalition B Phase II: This program targets African American women aged 40 and older who reside in medically underserved counties in Alabama.

Comprehensive Cancer Control (CCC) Leadership Institutes: The CDC, in partnership with the American Cancer Society, the National Cancer Institute, the American College of Surgeons, the North American Association of Central Cancer Registries, the Chronic Disease Directors, the Intercultural Cancer Council, and C-Change, provides the foundation for a unique and integrated approach for comprehensive cancer control. <http://www.cdc.gov/cancer/ncccp/institutes.htm>

University of Texas, MD Anderson Cancer Center: The Center for Research on Minority Health is a comprehensive investigational, educational, and outreach unit that focuses on decreasing incidence and mortality in ethnic minorities and medically underserved populations. <http://www.mdanderson.org/>

United States Conference of Mayors (USCM): The USCM's Mayors' Cancer Awareness Program is a long-term effort designed to educate and disseminate

information about early detection and treatment programs for racial and ethnic minorities and medically underserved populations. The mayors develop strategies to reach these populations and to promote early detection and the accessibility of treatment options. http://www.usmayors.org/uscm/uscm_projects_services/health/breast_cancer/cix1002.pdf

Baylor University Intercultural Cancer Council (ICC): The ICC serves as a link to information on cancer prevention and control that focuses on racial and ethnic minorities and medically underserved populations, as well as organizations and individuals working with these populations. <http://www.iccnetwork.org>

Morehouse School of Medicine Prevention Research Center (PRC): Along with community partnerships,

PRC identifies the most successful approaches to promote colorectal cancer screening among African Americans. <http://www.msm.edu/prc/>

National Medical Association (NMA): This is the largest and oldest national organization representing African American physicians and their patients in the United States. The NMA is committed to the elimination of health disparities and the promotion of healthy lifestyles among African Americans and other underserved populations. It conducts national consumer education programs on cancer, cardiovascular diseases, stroke, HIV/AIDS, and clinical trials, as well as other issues that affect the lives of African Americans. <http://www.nmanet.org>

Age Adjustment to the Year 2000 Standard

Epidemiologists use a statistical method called “age adjustment” to compare groups of people with different age composition. For example, without adjusting for age, it would be inaccurate to compare the cancer rates of the state of Florida, which has a large elderly population, to that of Alaska, which has a younger population. This is especially true when examining cancer rates, since cancer is generally a disease of older people. Without adjusting for age, it would appear that the cancer rates for Florida are much higher than Alaska. However, once the ages are adjusted, it appears their rates are similar.

Cancer Facts & Figures for African Americans 2005-2006 used the most recent US census (2000) as the basis for age adjustment. In issues before 2002, our statistics were based on the 1970 census. The current practice is used by federal agencies that publish statistics.

The impact of this change on a particular cancer will vary depending on the ages at which that particular cancer generally occurs. For all cancers combined, the average annual age-adjusted incidence rate for 1994-1998 will increase approximately 20% when adjusted to the year 2000 standard compared to the year 1970 standard. For example, the incidence of colon cancer, which occurs mostly in older age groups, will increase by up to 25% using the year 2000 standard. This change is the result of increased representation of older ages in the year 2000 standard compared to the year 1970 standard.

The purpose of shifting to the year 2000 standard is to more accurately reflect contemporary incidence and mortality rates, given the aging of the US population. On average, Americans are living longer because of the decline in infectious and cardiovascular diseases. Using the year 2000 standard in age adjustment instead of the 1970 standard allows age-adjusted rates to be closer to the actual, unadjusted rate in the population.

Sources of Statistics

New Cancer Cases: The estimated numbers of new US cancer cases among African Americans in 2005 were calculated by fitting the estimated numbers of cancer cases that occurred each year in the US from 1979 through 2001 to a statistical forecasting model. The estimated numbers of US cases from 1979 through 2001 were calculated using cancer incidence from the regions of the US included in the Surveillance, Epidemiology, and End Results (SEER) program of the National Cancer Institute and population data collected by the US Bureau of the Census.

Incidence Rates: Incidence rates are defined as the number of people per 100,000 population who develop a disease during a given period of time. Incidence data for the report were collected by the SEER program along with the population data collected by the US Bureau of the Census. All incidence rates in this publication are age-adjusted to the 2000 US standard population.

Cancer Deaths: The estimated numbers of US cancer deaths among African Americans in 2005 were calculated by fitting the number of cancer deaths from 1979 through 2002 to a statistical forecasting model. Data on the number of deaths were obtained from the National Center for Health Statistics (NCHS) of the Centers for Disease Control and Prevention.

Death Rates: Death rates are defined as the number of people per 100,000 dying of a disease during a given period of time. Death rates were computed using mortality data from the National Center for Health Statistics, along with population data from the US Bureau of the Census. All death rates in this publication are age-adjusted to the 2000 US standard population.

Survival Rates: A survival rate represents the proportion of patients who remain alive for a specific amount of time, such as 5 years, after their diagnoses. To adjust for normal life expectancy (factors such as dying of heart disease, accidents, diseases of old age), a relative survival

rate is calculated. The relative survival rate is obtained by dividing the observed survival among a group of cancer patients by the expected survival for persons in the general population who are similar to the patient group with respect to age, gender, race, and calendar year of observation.

Behavioral Risk Factor Surveillance System (BRFSS): The BRFSS is an ongoing system of surveys conducted by state health departments in cooperation with the Centers for Disease Control and Prevention. The methods used are generally comparable from state to state and from year to year, allowing states to compare their risk factor prevalence with national data. The interviews are conducted by telephone, and interview questions cover selected health issues and preventive health measures.

National Health Interview Survey (NHIS): The NHIS is an annual nationwide sample survey conducted by the National Center for Health Statistics since 1957. It consists of personal interviews in a population-based national sample of households. Data are collected on the personal, sociodemographic, and health characteristics of the members of these households.

Youth Risk Behavior Surveillance System (YRBSS): The YRBSS is a survey of the Centers for Disease Control and Prevention. The survey is conducted biannually and is designed to provide national, state, and local prevalence estimates on health risk behaviors among youth and young adults who attend public and private high schools. Behaviors that were included in the survey are tobacco use, alcohol and other drug use, unintentional and intentional injuries, sexual behaviors, unhealthy dietary behaviors, and physical inactivity.

Note: Data for risk factors and use of screening tests are for non-Hispanic African Americans, while data for cancer incidence and mortality are for Hispanic and non-Hispanic African Americans.

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