Prostate Cancer Survivors May Have Elevated Colorectal Cancer Risk

A large cohort study showed that the risk of colorectal cancer (CRC) is increased following a diagnosis of prostate cancer (PC). This suggests CRC screening should be considered following a PC diagnosis, especially among those undergoing radiotherapy.

“Second primary malignancies are important causes of morbidity and mortality in cancer survivors and can be due to shared etiologic (environmental and genetic) factors or prior cancer treatment,” wrote study authors led by Harminder Singh, MD, MPH, of the University of Manitoba in Winnipeg, Canada. Previous studies on CRC risk in PC patients have yielded mixed results, but suffered from a variety of limitations.

“If men with a history of PC are truly at higher than average risk of developing CRC, then the standard CRC screening paradigm may need to be altered for them,” the authors wrote. They conducted a historical cohort study based on data collected within the province of Manitoba, covering a total of 14,164 men with PC and 69,051 controls without PC, for a total of 559,081 person-years. The results were published online ahead of print in Cancer.

Over the course of the follow-up period, 2.8% of the PC survivors were diagnosed with CRC, compared with 2.6% of the non-PC cohort. The hazard ratio (HR) for PC survivors being diagnosed with CRC was 1.14 (95% CI, 1.02–1.27; P = .021). The risk was elevated throughout the follow-up period, but it was “marginally not significant” between 31 days and 1 year after PC diagnosis, and beyond 5 years. The highest risk was seen from diagnosis of PC to 30 days, with an HR of 3.04 (95% CI, 1.42–6.51; P = .004).

The elevated CRC risk was driven by an elevated risk specifically for cancer of the rectum, with an HR of 1.36 (95% CI, 1.09–1.71; P = .008). No other subsite showed any elevated risk for PC patients.

The use of radiation therapy for PC was also associated with an elevated risk of CRC. For rectal/rectosigmoid CRC, the HR was 2.06 compared with men with PC not treated with radiation (95% CI, 1.42–2.99; P < .001). This risk increased over time; after 10 years from radiation therapy for PC, the HR was 4.91 (95% CI, 1.81–13.31; P = .002). For nonrectal/rectosigmoid CRC, the HR for the full follow-up period was 1.46 (95% CI, 1.07–1.99; P = .017).

“Screening for CRC and its precursor lesions should be considered soon after the diagnosis of PC, especially in men to be treated with radiation therapy,” the authors concluded.

Source: cancernetwork – home of the journal ONCOLOGY; March 09, 2016 | Prostate Cancer, Colorectal Cancer, Radiation Oncology, Screening; By Dave Levitan
New Startup to Assist Cancer Moonshot Initiative

In January, President Obama announced the Cancer Moonshot Initiative with Vice President Joe Biden declaring that one of its greatest challenges the effort will face is the siloed nature of clinical data. That call — to unify science, data and research results across the scientific community — resonated with Tamr, as that’s exactly what the Boston-based startup does daily for large enterprise organizations across industries.

Tamr, Inc. announced that it will extend its data preparation platform and data science expertise to assist researchers affiliated with the White House’s Cancer Moonshot Task Force. The Task Force, seeks to double the rate of progress in the fight against cancer by clearing out many of the bureaucratic hurdles that stand in the way of scientific research. Genetic history, medical records and tissue bank data is often not shared amongst scientists, researchers and oncologists, leading to lengthy delays in researching potential cures. Further, even if this data is accessible to the wider scientific community, the sheer variety of formats and standards often limit its immediate usefulness.

Tamr suggested three ideas that could overcome standardization and integration challenges:

1. **Think outside the (federal) box for data “command and control.”** This is a problem that will take innovation and energy to solve. A “SpaceX” approach with a public/private partnership among government entities, cancer centers and the pharma and tech industries would be energizing. The benefits of the Moonshot will accrue to all parties, creating an opportunity to align data interests in a framework optimized for speed and innovation.

2. **Solve for interoperability and unification from the start.** Most cancer research organizations can’t even look at all the data they already have on studies they’ve run, much less effectively incorporate data from the outside. Without a plan for unifying this data for analysis quickly, it will be extremely difficult to make sense of what’s in front of you.

3. **Invest today in the tech of tomorrow.** In the case of interoperability, this means machine learning technology like Tamr’s that automates the vast majority of data preparation and unification across thousands of sources.

Source: MIT Startup Offers Free Data Science License to Cancer Moonshot Initiative, HIT Consultant Media, 3/23/16

---

**80% by 2018 Reaches 750 Pledges**

80% by 2018 is a movement in which hundreds of organizations have committed to eliminating colorectal cancer as a major public health problem and are working toward the shared goal of reaching 80% screened for colorectal cancer by 2018.

National Colorectal Cancer Roundtable (NCCRT) members are rallying around the shared goal of reaching 80% screened for colorectal cancer by 2018. The success of this goal is dependent on a strong foundation built with support from stakeholder organizations.

We are asking all NCCRT member organizations and others to consider pledging your organization’s commitment to the 80% by 2018 effort by reviewing the pledge and completing the online pledge form. The pledge represents a commitment to work toward increasing the number of people screened for colorectal cancer and substantially reducing colorectal cancer as a major public health problem. Please take these steps to indicate that your organization is embracing this shared goal. By working together, demanding more of ourselves, and collectively pushing harder, we will make greater progress, prevent more cancers, and save more lives.

Sources: National Colorectal Cancer Roundtable promotion email and website
**Tobacco 21 - Updates**

**Study: Tobacco 21**

A multivariate analysis of the effects of a law adopted in Needham, Massachusetts, revealed a 47% reduction in the smoking rate among high school students, along with a reported decline in area retail tobacco purchases. These decreases were significantly greater than those in 16 comparison communities without Tobacco 21 laws.

The study results further show that a federal Tobacco 21 law enjoys support across the political spectrum, including about 76% of respondents identifying as Republican and nearly 80% of Democrats. It may also be reassuring for policymakers to know that support among our respondents for a Tobacco 21 law equals or exceeds support for other widely adopted tobacco-control laws such as smoking bans in restaurants and bars. In other words, legislators of both red and blue stripes should feel comfortable supporting these laws without fear of voter backlash.


**California Lawmakers Vote to Raise Smoking Age To 21**

The California Senate voted in March to raise the legal age to buy tobacco products from 18 to 21. The measure is part of a larger package of legislation aimed at cracking down on tobacco. If Gov. Jerry Brown signs the bill, California will become the second state, after Hawaii, to raise the age limit for buying cigarettes and other tobacco products.

More than 100 cities around the country, including New York and Boston, have already raised the age limit. A week ago, the California Assembly approved the measure, which — in addition to raising the age limit — regulates electronic cigarettes the same as tobacco products, expands smoke-free areas, increases smoking bans and allows counties to levy higher taxes on cigarettes than the 87-cent per pack state tax. According to NPR member station KQED, the Assembly's vote came a few days after the San Francisco Board of Supervisors increased the age to buy tobacco products to 21.

California lawmakers passed the bill despite lobbying from tobacco interests, the Associated Press reports. But proponents of the bill say raising the age to 21 moves legally purchased tobacco that much farther from younger kids.

"This will save the medical system in the outgoing years millions of dollars," said Democratic Assemblyman Jim Wood, according to KQED. "It will save thousands of lives."

As the AP reported, a 2015 study by the Institute of Medicine “found that if the minimum legal age to buy tobacco were raised to 21 nationwide, tobacco use would drop by 12 percent by the time today's teens reached adulthood. In addition, there would be 223,000 fewer premature deaths and 50,000 fewer deaths from lung cancer."

Taken from: NPR, California Lawmakers Vote to Raise Smoking Age To 21, March 10, 2016, Laura Wagner

**Chicago Raises Smoking Age to 21, Bans Chewing Tobacco At Ballparks**

Source: CBS Chicago, March 16, 2016
ACS CAN Update

Submitted by Andrew Scheppers, American Cancer Society Cancer Action Network, Inc.

The Legislature has been fully occupied with the budget for the coming fiscal year. In February, the governor presented his budget message to the Legislature with few initial changes to health and wellness programs.

ACS CAN recently formed a coalition with other health advocates called Prevention Michigan Tobacco-Free Campaign. The coalition’s goal is to raise awareness about the health risks of tobacco use and to educate policymakers about the importance of tobacco prevention efforts such as tobacco taxes. Tobacco prevention funding in Michigan is currently lower than what the CDC recommends. ACS CAN is working to change this.

Also recently, the Legislature passed a bill that will allow patients to synchronize their medications so that they only have to visit the pharmacy once a month. This will relieve caregivers and patients of the burden of having to make multiple trips to the pharmacy and potentially miss a prescription refill.

Finally, ACS CAN is working to improve pharmaceutical access through legislation on oral parity. This bill would lower out-of-pocket costs for cancer patients whose doctors prescribe oral chemotherapy instead of intravenous chemo. Michigan is one of only a handful of states that does not have legislation like this on its books. ACS CAN is working with a coalition to pass this legislation, which is currently in the Senate Insurance Committee.

If you have any questions on what ACS CAN is doing don’t hesitate to reach out at Andrew.schepers@cancer.org.

Cancer Reports, Study

The American Society of Clinical Oncology® released the State of Cancer Care in America: 2016. The report highlights many promising cancer care developments, including new drugs and technologies, declining mortality rates, expanded access to healthcare generally and a shift towards value-based care. It also highlights major challenges for patients and physicians, including uneven health insurance coverage, rapidly rising costs, and other barriers to accessing new treatments.

The Annual Report to the Nation on the Status of Cancer, 1975-2012, co-authored by several national organizations, shows that death rates continued to decline for all cancers combined, as well as for most cancer sites for men and women of all major racial and ethnic populations. The report also examines trends in liver cancer which run counter to the other cancers. Liver cancer incidence and death rates have increased. See the report and infographic at the above link.


Save the Dates!

Be sure to save these dates in 2016

MCC Board Meetings
- June 22
- September 28

MCC Annual Meeting
Wednesday, November 9

Please note: MCC Annual Meetings are open to representatives of all MCC member and partner organizations, as well as other interested comprehensive cancer control stakeholders.

For more information, contact the MCC at 877-588-6224.
Burden of Lung Cancer Pushes Kentucky’s Cancer Rates to Nation’s Highest

Taken from: USA Today, Laura Ungar, December 22, 2015

In the end, lung cancer left Jerome Grant voiceless, a breathing tube in his windpipe. He could say nothing when his wife Dawn spoke her last words to him: “I love you, you know that?” He gave her a thumbs up. Then he closed his eyes and was gone.

The 52-year-old Louisville man was one of about 10,000 Kentuckians a year taken by cancer in a state where the disease consistently kills at the highest rate in the nation. Experts say the biggest culprit is lung cancer, which strikes and kills Kentuckians at rates 50% higher than the national average. But Kentucky’s death rates also rank in the Top 10 nationally for breast, colorectal and cervical cancers.

“It’s really been driven by three major things: obesity, smoking and lack of screening,” said Louisville gastroenterologist Dr. Whitney Jones. “Our state is completely inundated with risk factors.”

Smoking, a stubborn vestige of the state’s tobacco legacy, is at the root of most lung cancers, although other environmental causes such as radon play a part as well. Obesity, a risk factor for several cancers, also hits Kentucky hard, afflicting more than three in 10 residents. Poverty, lack of education and doctor shortages mean residents are less likely to get screenings that can find cancer early — or effective treatment.

Indeed, cancer preys upon the rural poor across the nation, and Kentucky is both rural and poor. Although it’s nationally known for giving half a million residents insurance through the Affordable Care Act, the law’s rollout faces an uncertain future, since newly elected Gov. Matt Bevin has pledged to scale back Kentucky’s Medicaid expansion and dismantle its online insurance-shopping site. And coverage is only one key to health care; it doesn’t automatically give people the other necessary keys, such as health “literacy,” doctors who will take them, time off from low-wage jobs or reliable transportation to appointments.

Despite attempts to curb deaths by the state and its health care system — and signs of hope such as increases in cancer screenings among Medicaid patients — Kentucky remains far behind other states in reducing the toll of this dreaded malady that touches nearly every family.

So too many continue to suffer the same sort of devastating loss Dawn Grant did when cancer left her a widow in her 50s. Every day she misses the “good, generous, kind person” who was stepfather of her two children, caregiver for his sick father and a motorcycle enthusiast who filled her life with adventure.

“I just thought we’d grow old together,” she said. “But all of a sudden, you’re on your own.”

Kentucky’s lung cancer numbers from the National Cancer Institute are staggering. Incidence per 100,000 people: 92.4, compared with 60.4 nationally. Mortality per 100,000: 68.8 — around 120 in the hardest-hit Appalachian counties — compared with 45 nationally.

Thomas Tucker, director of the Kentucky Cancer Registry, said lung cancer is by far the biggest reason for the state's continual struggle with cancer mortality. “The problem with lung cancer,” he said, “is we’ve always found it late.”

One reason is that most lung cancers don’t cause symptoms, so people don’t know they’re sick until the disease has spread so far they can’t be cured. Until recently, there’s been no screening test, and today’s preventive low-dose CT scans for longtime smokers are far less routine than tests like mammograms or colonoscopies and are not always covered by private insurance.

Complete USA Today article.
MCC Announces Launch of Cancer Plan Dashboard

The Michigan Cancer Plan for 2016-2020 was released in November 2015. Since then, there has been tremendous interest from stakeholders to stay updated on the Cancer Plan objectives. The MCC is proud to announce the launch of the Cancer Plan Dashboard, which features the most up-to-date information on all 36 objectives in the Plan. The Dashboard lets you view real-time data and is updated as new data are available. Take a look at the new Cancer Plan Dashboard.

National Cancer Survivorship Resource Center Announces New Head and Neck Cancer Survivorship Care Guideline

The National Cancer Survivorship Resource Center, a collaboration between the American Cancer Society, The George Washington University Cancer Institute, and the Centers for Disease Control and Prevention (CDC), funded by a five-year cooperative agreement through the CDC, is pleased to share that the new American Cancer Society Head and Neck Cancer Survivorship Care Guideline was published online in CA: A Cancer Journal for Clinicians.


In addition to the article, tools and resources are available now and coming soon to support implementation of the guideline recommendations. The Journal offers a CA Patient Page, which is a tool to help patients understand how to use the guidelines to talk to their doctor about care coordination, healthy behaviors, surveillance and screening, and symptom management. Clinicians can access the free CA Patient Page at http://onlinelibrary.wiley.com/doi/10.3322/caac.21344/epdf.

Help spread the word to your network of colleagues, especially those in primary care. View, share or print the ACS press release at pressroom.cancer.org/HeadAndNeckSurvivorship2016. Share, retweet, or like ACS social media messages from the ACS Journals and ACS News accounts: Facebook at https://www.facebook.com/ACSJournals/?fref=ts; Google+ at https://plus.google.com/102231633578632425378; Twitter CAOnline at https://twitter.com/CAonline/status/712353480023867392; and Twitter ACSNews at https://twitter.com/ACSNews/status/712355873771929600.