Michigan Cancer Consortium
Your Michigan Cancer Information Resource

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Cancer Causes and Control Releases a Special Issue: *Comprehensive Cancer Control in the US: Twenty Years of Progress*

MCC Calendar of Events

The Michigan Journal of Public Health Releases a Special Issue Highlighting the Work and Celebrating the 20th Anniversary of the MCC

In December, the Michigan Journal of Public Health (MJPH) released a special issue dedicated to the Michigan Cancer Consortium (MCC) to celebrate its 20 year anniversary and accomplishments. MCC 2018 Co-Chairs Tom Rich, MPH, and Dana Zakalik, MD, along with the Michigan Public Health Association's (MPHA) President, Lorena Disha, introduce the special issue with an editorial.

The MJPH promotes public health practice, research, and policy. Contributions range from the field of practice, original research, opinion, and commentary. MPHA is responsible for the publicizing and publication of the journal.

This MJPH Special Issue features the following articles:

The Comprehensive Cancer Control National Partnership Celebrates the 20th Anniversary of the National Comprehensive Cancer Control Program

An Introduction to the Priorities of the Michigan Cancer Consortium

Working to Improve Human Papilloma Virus Vaccination Uptake in Michigan

Collaborative Efforts to Improve Cancer Survivor Quality of Life

Increasing Colorectal Cancer (CRC) screening in Michigan

Expressway to Cancer Clinical Trials: Reducing Administrative Barriers to Enrollment

Lessons Learned from Revising the Cancer Plan for Michigan

Evaluating the Needs of Cancer Survivors through Focus Groups and Surveillance Data

The full issue can be found on the Michigan Journal of Public Health Volume 9: Issue 1 website.

Uterine Cancer Incidence and Mortality — United States, 1999–2016

December 2018, Centers for Disease Control and Prevention

This report indicates that the rate of new uterine cancer cases increased during 1999–2015, with larger increases observed among black, American Indian/Alaska Native, Asian-Pacific Islander, and Hispanic women than among white women. This contrasts with the recent decreases in incidence rates that have been observed for many cancer types, such as lung and colorectal cancers. One contributing factor to increasing incidence could be excess body weight; women who are overweight or have obesity are approximately two to four times as likely to develop endometrial cancer as are women with healthy weight. During 2013–2016, approximately 40% of women in the United States had obesity, including 56% of black women and 49% of Hispanic women. The U.S. Preventive Services Task Force recommends that clinicians offer or refer adults with obesity to intensive, multicomponent behavioral interventions. Community-based strategies to promote healthy body weight include helping persons meet dietary and physical activity guidelines by supporting healthy eating and active living in such settings as communities, worksites, schools, and early care and education facilities. Other factors such as insufficient physical activity, increasing prevalence of diabetes, and decreasing use of estrogen plus progestin menopausal hormone therapy might also contribute to increases in endometrial cancer incidence.

This report also found that uterine cancer death rates were higher in 2016 than in 1999 and that black women were approximately twice as likely to die from uterine cancer as were women in other racial/ethnic groups. The odds of surviving uterine cancer are much higher when it is detected at an early stage, when treatment is more effective. The 5-year relative survival estimate for localized uterine cancer is 80%–90% compared with <30% for distant uterine cancer. This report found that black women were more likely to receive a diagnosis at distant stage and with more aggressive histologic types than were other women, which might in part account for the higher death rate among black women.

Although population-based screening tests are recommended for several cancers, including breast, cervical, colorectal, and lung cancers, at present, population-based screening tests are not recommended for uterine cancer. An important early symptom of uterine cancer is abnormal vaginal bleeding, including bleeding between periods or after sex or any unexpected bleeding after menopause (i.e., any bleeding except intermittent bleeding within 1 year after cessation of menses or cyclic bleeding associated with use of cyclic postmenopausal hormone therapy). Approximately 90% of women with uterine cancer report abnormal vaginal bleeding. A lower percentage of women with uterine sarcomas have abnormal vaginal bleeding (approximately 56%) or nonspecific symptoms, such as pelvic pain (22%); consequently, a higher percentage of sarcomas are not detected until the cancer has already spread. Uterine cancer outcomes could be improved by increasing awareness among women that abnormal vaginal bleeding should be evaluated promptly by a health care provider. It is also important for health care providers to perform timely evaluation and follow-up of women's concerns and symptoms. Transvaginal ultrasonography or endometrial tissue sampling are appropriate for initial evaluation of postmenopausal bleeding; further evaluation could include hysteroscopy combined with endometrial sampling. To help women make informed choices, health care providers can educate women about different procedural options (including surgical choices); discuss the benefits and risks of each procedure; and discuss the risk for cancer.

For the complete article visit Uterine Cancer Incidence and Mortality – United States, 1999-2016.

When a Cancer Genetic Test Result is Not Just about Cancer Risk

January 2019, Michigan Cancer Genetics Alliance

Next generation sequencing technology makes it possible to test dozens of genes simultaneously, which has led to the development of a wide variety of multigene panel tests. There are multigene panels for hereditary cancer syndromes, neuromuscular disorders, genetic causes of intellectual disability, and reproductive carrier testing. Multigene panels not only include the more common causes of hereditary conditions but can include rarer causes as well.

When a clinician orders a multigene hereditary cancer panel, the primary reason is to evaluate whether there is an increased risk of developing cancer, but sometimes the result also indicates a reproductive risk for a rare genetic syndrome. Conversely, when a clinician orders a multigene reproductive carrier testing panel, the main reason is to identify possible reproductive risks, but sometimes the result also indicates an increased risk of cancer. Table 1 includes examples of genes associated with an increased risk of cancer and a well-characterized genetic disorder. In most cases, individuals who have a mutation (pathogenic or likely pathogenic variant) in one of their two copies of the gene (heterozygotes) are at increased risk of developing cancer but do not have symptoms of the genetic disorder. Individuals who have a mutation in both copies of their gene (biallelic mutations) have the genetic disorder.

If a hereditary cancer panel shows a mutation in one of these genes with reproductive risks, the patient should be counseled about their risk of cancer, the appropriate medical management plan, and risks to their relatives. But the National Comprehensive Cancer Network also recommends counseling them about the potential reproductive risk[2], which involves discussing the natural history of the disorder, the magnitude of risk, and the option of partner testing to refine risk. The individual or family member who is a carrier of the gene mutation is only at risk of having an affected child with the biallelic genetic disorder if their partner is also a carrier. And equally, if a reproductive carrier testing panel identifies a mutation in a gene associated with cancer risk, the same steps need to be taken. The patient needs to be counseled about both the reproductive risk and cancer risk and managed appropriately.

Knowing that certain genes can pose two types of risk, it is important to discuss both types of risk when providing informed consent for genetic testing. Obtaining signed informed consent for pre-dispositional and carrier testing is required by law in Michigan[3].

Gene	Heterozygote Risk[1,2]	Biallelic Risk (Disease and Phenotype)[1]
ATM	4-fold increased risk of cancer, most commonly breast cancer	Ataxia Telangiectasia: Progressive cerebellar ataxia, conjunctival telangiectases, neurological degeneration, immunodeficiency, and increased risk of malignancy, most commonly lymphomas and leukemias.
NBN	Increased risk of breast cancer	Nijmegen Breakage Syndrome: Microcephaly, growth retardation, immunodeficiency, short stature, increased risk of cancer most commonly lymphomas
BRIP1	Increased risk of ovarian cancer	Fanconi Anemia: Bone marrow failure and increased risk of malignancy. Majority also have physical features which can include short stature, microcephaly, limb malformations, skin pigmentation changes, eye and genitourinary tract anomalies
BRCA2	Increased risk breast, ovarian, pancreatic, prostate cancers	
PALB2	Increased risk breast cancer	
RAD51C	Increased risk ovarian cancer	

When a Cancer Genetic Test Result is Not Just about Cancer Risk (Continued from Page 3)

References:
1. Online Mendelian Inheritance in Man. Available at https://www.omim.org/. Accessed 12.21.18
2. NCCN Guidelines Version 2.2019, Genetic/Familial High-Risk Assessment: Breast and Ovarian, available at https://www.nccn.org/professionals/physician_gls/pdf/genetics_screening.pdf. Accessed 12.21.18.
3. Informed Consent for Genetic Testing Patient Education Information for Use with the Michigan Model Consent form for Genetic Testing. Available at https://www.michigan.gov/documents/InformedConsent_69182_7.pdf. Accessed 12.21.18

Cancer Causes and Control Releases Special Issue on Comprehensive Cancer Control Programs

Cancer Causes and Control released a Special December Issue, *Comprehensive Cancer Control in the US: Twenty Years of Progress,* which features work from around the United States, including articles about Michigan programs. To read this issue visit the Cancer Causes and Control Volume 29, Issue 12 website.

2019 MCC Meetings

Board Meetings (12pm - 3pm):
Wednesday, March 27
Wednesday, June 26
Wednesday, September 25

MCC Website

Be sure to visit the MCC website to find provider and patient resources

Health Equity Corner

Webinar is Now Available!
DISCO App: An Intervention to Reduce Financial Toxicity in a Diverse Population of Patients with Cancer

The MCC's Health Equity Committee sponsored a webinar addressing financial toxicity on December 6, 2018. Lauren Hamel, PhD, Assistant Professor Population Studies, Karmanos Cancer Institute/Wayne State University presented attendees with preliminary data, including acceptability and feasibility, of a pilot intervention for cancer financial toxicity through patient-oncologist treatment cost discussions. Additionally, attendees were presented with an update on financial toxicity literature, including both direct and indirect costs of cancer treatment and its influence on patients with cancer. A recording of this webinar can be found at the financial toxicity webinar website.