April Is Cancer Control Month

What Is Cancer Control?
Cancer control month highlights advances in fighting cancer. This includes prevention, early detection, and treatment of cancer. One way to control cancer is to find cancer cells and get rid of them. Cancer screenings can help find cancer early. The earlier the cancer is found, the better the prognosis. The American Cancer Society’s recommendations for cancer screening can be found on the next page.

What are the Key Statistics about Cancer?
- After heart disease, cancer is the second leading cause of death in the United States.
- About 1,685,210 new cancer cases are expected to be diagnosed in 2016.
- Over a lifetime, about 1 in 2 men and 1 in 3 women in the United States will develop cancer.
- Cancer rates and deaths have been on the decline since the early 1990’s.
- One third of cancers detected will be related to overweight or obesity, physical inactivity, and nutrition.
Who’s at Risk?
While everyone is at risk for cancer, some people are at greater risk than others are. Age is the greatest risk factor for cancer, since nearly 77% of cancers are detected at age 55 and older. Also, people who use tobacco, drink heavily, are physically inactive, eat a poor diet, are regularly exposed to carcinogens (cancer causing agents) in their occupation, or have prolonged and unprotected exposure to sunlight are all at increased risk for certain cancers.

Everyone should follow cancer prevention and screening guidelines. Those at highest risk for specific cancers should pay close attention to symptoms and screening recommendations and should seek prompt medical attention if they occur. Below are screening guidelines published in the American Cancer Society’s 2016 Cancer Facts and Figures.

<table>
<thead>
<tr>
<th>Cancer Site</th>
<th>Population</th>
<th>Test or Procedure</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Breast</strong></td>
<td>Women, ages 40-54</td>
<td>Mammography</td>
<td>Women should undergo regular screening mammography starting at age 45 years.</td>
</tr>
<tr>
<td></td>
<td>Women, ages 55+</td>
<td></td>
<td>Women ages 45 to 54 should be screened annually.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Women should have the opportunity to begin annual screening between the ages  of 40 and 44.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Transition to biennial screening, or have the opportunity to continue annual screening. Continue screening as long as overall health is good and life expectancy is 10+ years.</td>
</tr>
<tr>
<td><strong>Cervix</strong></td>
<td>Women, ages 21-29</td>
<td>Pap test</td>
<td>Screening should be done every 3 years with conventional or liquid-based Pap tests.</td>
</tr>
<tr>
<td></td>
<td>Women, ages 30-65</td>
<td>Pap test &amp; HPV DNA test</td>
<td>Screening should be done every 5 years with both the HPV test and the Pap test (preferred), or every 3 years with the Pap test alone (acceptable).</td>
</tr>
<tr>
<td></td>
<td>Women, ages 66+</td>
<td>Pap test &amp; HPV DNA test</td>
<td>Women ages 66+ who have had ≥3 consecutive negative Pap tests or ≥2 consecutive negative HPV and Pap tests within the past 5 years, with the most recent test occurring in the past 5 years should stop cervical cancer screening.</td>
</tr>
<tr>
<td></td>
<td>Women who have had a total hysterectomy</td>
<td></td>
<td>Stop cervical cancer screening.</td>
</tr>
<tr>
<td><strong>Colorectal</strong></td>
<td>Men and women, ages 50+</td>
<td>Guaiac-based occult blood test (gFOBT) with at least 50% sensitivity or fecal immunochromatographic test (FIT) with at least 50% sensitivity, OR</td>
<td>Annual testing of spontaneously passed stool specimens. Single stool testing during a clinical office visit is not recommended, nor are “throw in the toilet bowl” tests. In comparison with guaiac-based tests for the detection of occult blood, immunochromatographic tests are more patient-friendly and are likely to be equal or better in sensitivity and specificity. There is no justification for repeating FOBT in response to an initial positive finding.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Stool DNA test, OR</td>
<td>Every 3 years</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Flexible sigmoidoscopy (FSG), OR</td>
<td>Every 5 years, or consideration can be given to combining FSG performed every 5 years with a highly sensitive gFOBT or FIT performed annually.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Double contrast barium enema, OR</td>
<td>Every 5 years</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Colonoscopy, OR</td>
<td>Every 10 years</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CT Colonography</td>
<td>Every 5 years</td>
</tr>
<tr>
<td><strong>Endometrial</strong></td>
<td>Women at menopause</td>
<td></td>
<td>Women should be informed about risks and symptoms of endometrial cancer and encouraged to report unexpected bleeding to a physician.</td>
</tr>
<tr>
<td><strong>Lung</strong></td>
<td>Current or former smokers ages 55-74 in good health with 30+ pack-year history</td>
<td>Low-dose helical CT (LDCT)</td>
<td>Clinicians with access to high-volume, high-quality lung cancer screening and treatment centers should initiate a discussion about annual lung cancer screening with apparently healthy patients ages 55-74 who have at least a 10 pack-year smoking history, and who currently smoke or have quit within the past 15 years. A process of informed and shared decision making with a clinician related to the potential benefits, limitations, and harms associated with screening for lung cancer with LDCT should occur before any decision is made to initiate lung cancer screening. Smoking cessation counseling remains a high priority for clinical attention in discussions with current smokers, who should be informed of their continuing risk of lung cancer. Screening should not be viewed as an alternative to smoking cessation.</td>
</tr>
<tr>
<td><strong>Prostate</strong></td>
<td>Men, ages 50+</td>
<td>Prostate-specific antigen test with or without digital rectal examination</td>
<td>Men who have at least a 10-year life expectancy should have an opportunity to make an informed decision with their health care provider about whether to be screened for prostate cancer, after receiving information about the potential benefits, risks, and uncertainties associated with prostate cancer screening. Prostate cancer screening should not occur without an informed decision-making process.</td>
</tr>
</tbody>
</table>

*Cancer Site*: Breast, Cervix, Colorectal, Endometrial, Lung, Prostate

*Population*: Women, ages 40-54, Women, ages 55+, Women, ages 21-29, Women, ages 30-65, Women, ages 66+, Women who have had a total hysterectomy, Men and women, ages 50+, Men, ages 50+

*Test or Procedure*: Mammography, Pap test, Pap test & HPV DNA test, Pap test & HPV DNA test, Stop cervical cancer screening, Guaiac-based occult blood test (gFOBT), Stool DNA test, Flexible sigmoidoscopy (FSG), Double contrast barium enema, Colonoscopy, CT Colonography, Prostate-specific antigen test with or without digital rectal examination

*Recommendation*: Women should undergo regular screening mammography starting at age 45 years. Women ages 45 to 54 should be screened annually. Women should have the opportunity to begin annual screening between the ages of 40 and 44. Transition to biennial screening, or have the opportunity to continue annual screening. Continue screening as long as overall health is good and life expectancy is 10+ years. Screening should be done every 3 years with conventional or liquid-based Pap tests. Screening should be done every 5 years with both the HPV test and the Pap test (preferred), or every 3 years with the Pap test alone (acceptable). Women ages 66+ who have had ≥3 consecutive negative Pap tests or ≥2 consecutive negative HPV and Pap tests within the past 5 years, with the most recent test occurring in the past 5 years should stop cervical cancer screening. Women should be informed about risks and symptoms of endometrial cancer and encouraged to report unexpected bleeding to a physician. Clinicians with access to high-volume, high-quality lung cancer screening and treatment centers should initiate a discussion about annual lung cancer screening with apparently healthy patients ages 55-74 who have at least a 10 pack-year smoking history, and who currently smoke or have quit within the past 15 years. A process of informed and shared decision making with a clinician related to the potential benefits, limitations, and harms associated with screening for lung cancer with LDCT should occur before any decision is made to initiate lung cancer screening. Smoking cessation counseling remains a high priority for clinical attention in discussions with current smokers, who should be informed of their continuing risk of lung cancer. Screening should not be viewed as an alternative to smoking cessation. Men who have at least a 10-year life expectancy should have an opportunity to make an informed decision with their health care provider about whether to be screened for prostate cancer, after receiving information about the potential benefits, risks, and uncertainties associated with prostate cancer screening. Prostate cancer screening should not occur without an informed decision-making process.

*American Cancer Society Recommendations for the Early Detection of Cancer in Average-risk Asymptomatic People*
Can Cancer Be Found Early or Controlled?
Scientific or medical discoveries have a major impact on controlling cancer. Some examples of controlling cancer are:

**Genetic Testing**
Researchers have found changes (mutations) in genes may cause cancer. Some genetic changes may increase a person’s chance of getting cancer. People who are concerned about cancer in their family should talk to their doctor. The doctor may send them to a cancer genetics specialist. People with a strong family history of cancer may be recommended to have a blood test. These tests may show if they have inherited any of these genetic changes. Genetic counseling helps people decide if testing is right for them as well as understand and deal with the results.

Genetic counseling is available through The Hereditary Oncology Prevention and Evaluation (HOPE) program at Rutgers Cancer Institute of New Jersey. Please call 732-235-7110 to schedule an appointment or for more information about the program.

**Gene Therapy**
Cells normally have genes that help prevent cancer from developing. A large part of cancer cells have changes in these genes. This is still experimental, but it may be possible to treat cancer by placing a healthy gene into the cancer cells.

**Vaccines**
Scientists are studying cancer vaccines that can stop (or in some cases, prevent) certain cancers. Vaccines help the immune system to fight the cancer.

**Chemopreventive Agents**
New chemopreventive agents (agents given to prevent cancer) are being developed. They can act alone or with other medications to reduce the risk of certain cancers.

**Early Detection**
The development of new and more accurate cancer screening methods will allow earlier detection of some precancerous lesions and early-stage cancers. This allows physicians to treat people before the disease progresses.

**Lifestyle Changes**
The development of new findings about lifestyle changes, especially concerning diet, nutrition, and physical activity, may prevent some cancers.

**Chemotherapy**
Clinical trials are in progress to test new chemotherapy drugs or combinations. Other studies are testing new ways to combine proven drugs to make them even more effective. These medications can help control or cure cancer once it has developed.
Immunotherapy
New treatments have been developed that work with the immune system. This type of treatment can help fight cancer or control the side effects caused by some cancer treatments. You may also hear this referred to as biological therapy, biotherapy, or biological response modifier (BRM) therapy.

Antiangiogenesis Agents
Tumors cannot grow without a blood supply. Researchers are studying antiangiogenesis therapy, which is the use of drugs or other substances to stop cancerous tumors from developing new blood vessels.

Cancer Prevention Trials at Rutgers Cancer Institute of New Jersey
If you would like further information about clinical trials for preventing cancer, please call Rutgers Cancer Institute of New Jersey at 732-235-8675. For additional information about nationwide cancer prevention trials, you can call the National Cancer Institute at 1-800-4CANCER or visit their Web site at www.cancer.gov.
Where Can I Find Further Information?

Resource and Learning Center
732-235-9639
www.cinj.org/rlc
Provides reliable, relevant and current information about all aspects of cancer.

Agency for Healthcare Research and Quality (AHRQ)
http://www.ahrq.gov/patients-consumers/index.html

The American Cancer Society
1-800-ACS-2345
www.cancer.org

American Institute for Cancer Research
1-800-843-8114
www.aicr.org

MedlinePlus
www.medlineplus.gov

National Cancer Institute
1-800-4-CANCER
www.cancer.gov

National Center for Chronic Disease Prevention and Health Promotion
800-232-4636
http://www.cdc.gov/chronicdisease/index.htm

National Institute of Health
301-496-4000
www.nih.gov

NJ Cancer Education and Early Detection Prevention and Health Promotion (NJCEED)
(609) 292-8540
http://www.state.nj.us/health/cancer/njceed/index.shtml

RLC website QR code. Scan with smartphone / device.