

## Breast Cancer Control in Minnesota

Breast cancer is a leading cause of illness and death for women in Minnesota. Each year, approximately 3,200 Minnesota women are diagnosed with breast cancer, and 700 women die of the disease. Because most known risk factors for breast cancer are not easy to modify, public health efforts have focused on encouraging and enabling women to receive routine mammograms and clinical breast examinations. Since 1992, more than 75,000 under- and uninsured low-income women in Minnesota have received free breast and cervical cancer screening through the Minnesota Breast and Cervical Cancer Control Program (MBCCCP).

Although clinical trials indicating that routine screening reduces the risk of breast cancer mortality have been questioned recently, subsequent research and statements by the

National Cancer Institute (NCI), the American Cancer Society, and other leading cancer organizations have reaffirmed both the efficacy and importance of mammography. In fact, there is good evidence that earlier detection, combined with improved treatment, is making gains in controlling this cancer.

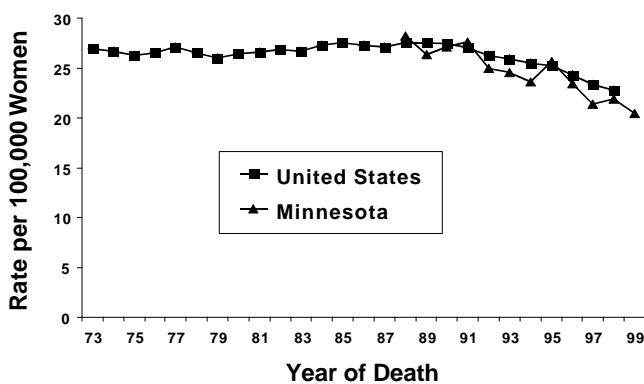
While national incidence rates of invasive breast cancer have been fairly stable since the late 1980s, breast cancer mortality rates started declining in 1989, and the rate of decline has increased to 3.4% per year since 1995.<sup>1,2</sup> Minnesota breast cancer mortality rates have declined at a similar rate (Figure 1). An NCI study found that while the decrease in breast cancer mortality in the United States was consistent with a known increase in mammography use, neither improvements in treatment nor increased

screening alone accounted for these gains.<sup>3</sup>

Routine screening results in a larger proportion of breast cancers being diagnosed at an early stage. Some critics, however, believe that many small, early-stage tumors found through mammography never would become clinically relevant. If this were true, the proportion of breast cancers diagnosed at a late stage (i.e., after regional spread to adjacent tissues such as lymph nodes or metastasis to distant locations such as lungs, brain, etc.) could decrease as a result of increased mammography, without a decrease in the number of women with late-stage disease. Therefore, the incidence rate of late-stage disease is critical to assessing meaningful improvements in cancer detection.

NCI data show that the rate of regional disease declined from 37 per 100,000 women in 1987 to 30 per 100,000 in the mid-1990s (Figure 2).<sup>4</sup> The most recent stage-specific breast cancer rates reported in Minnesota are very similar to national data. These findings are not definitive proof that mammography is saving lives, and simultaneous changes **continued...**

**Figure 1. Breast Cancer Mortality in Minnesota and the United States by Year, 1973-1999**



Source: Minnesota data are from the Minnesota Cancer Surveillance System. U.S. data are from the Surveillance, Epidemiology, and End Results (SEER) program.<sup>2</sup> Rates are age-adjusted to the 1970 U.S. population.

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in screening, treatment, and risk factor prevalence make isolating specific effects difficult. However, decreases in rates of breast cancer mortality and late-stage disease strongly suggest that screening is contributing to breast cancer control.

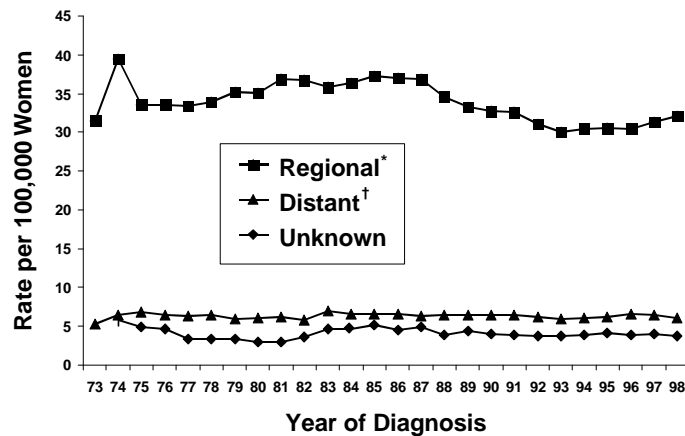
Despite these gains, health disparities exist. Black women, in particular, are more likely than non-Hispanic white women to die from breast cancer, although their risk of developing the disease is lower (Figure 3). Breast cancer control requires a multifaceted approach involving routine screening, research into causes and cures, and interventions to reduce modifiable risk factors and to assure timely and appropriate treatments.

For more information on the MBCCCP, visit their web site at <http://www.health.state.mn.us/divs/dpc/cc/mbcccp.htm> or call (612) 676-5500.

#### References

1. Howe HL, Wingo PA, Thun MJ, *et al*. Annual report to the nation on the status of cancer (1973 through 1998), featuring cancers with recent increasing trends. *J Natl Cancer Inst* 2001;93:824-842.
2. Reis LAG, Eisner MP, Kosary CL, *et al* (eds). SEER Cancer Statistics Review, 1973-1998. National Cancer Institute, Bethesda MD, 2001.
3. Chu KC, Tarone RE, Kessler LG, *et al*. Recent trends in U.S. breast cancer incidence, survival, and mortality rates. *J Natl Cancer Inst* 1996;88:1571-1579.
4. SEER 9 registries public use file, 1973-1998. August 2000.

**Figure 2. Late-Stage Breast Cancer Incidence, SEER, 1973-1998**

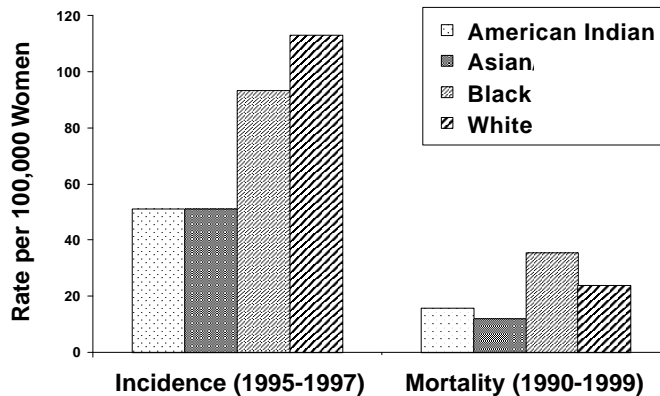


Source: Surveillance, Epidemiology, and End Results (SEER) program,<sup>4</sup> which covers 10-14% of the U.S. population. Rates are age-adjusted to the 1970 U.S. population.

\*Regional refers to spread to adjacent tissue, e.g., lymph nodes.

† Distant refers to metastasis to distant locations, e.g., lungs.

**Figure 3. Breast Cancer Incidence and Mortality in Minnesota by Race/Ethnicity**



Source: Minnesota Cancer Surveillance System. Rates are age-adjusted to the 1970 U.S. population.

## Cervical Cancer Control in Minnesota

Approximately 200 cases of invasive cervical cancer are diagnosed among Minnesota women each year, and about 50 women die of this disease. Because it is largely preventable through screening, cervical cancer has been the focus of cancer control efforts by public health agencies, health care providers, and advocacy organizations. Routine screening with Pap tests can prevent cervical cancer by identifying precancerous and *in situ* lesions before they become life-threatening. Each year, nearly 10,000 under- and uninsured low-income women receive free cervical cancer screening through the

Minnesota Breast and Cervical Cancer Control Program (MBCCCP).

Nationwide, cervical cancer incidence and mortality rates have decreased by 40-50% since 1973.<sup>1</sup> Rates in Minnesota are slightly lower than those reported by the National Cancer Institute. However, these statistics do not reflect the reality of cervical cancer among minority women in Minnesota. Data from the Minnesota Cancer Surveillance System (MCSS) show that rates of invasive cervical cancer in Minnesota are three to four times higher among African American, Asian,

and American Indian women than among white women.<sup>2</sup> Rates among women of color in Minnesota are higher than those among women of the same race in areas covered by the national Surveillance, Epidemiology, and End Results (SEER) program.<sup>1</sup> The risk of cervical cancer increases with age among women of color, underscoring the need for routine screening among older women (Figure 1).

Women of color also are less likely to be diagnosed at an early stage when the cancer is confined to the cervix and **continued...**

therefore easier to cure. MCSS data for 1995-1997 show that 53% of invasive cervical cancers among minority women in Minnesota were diagnosed at this early stage, compared to 63%

among white women. The annual cervical cancer mortality rate in Minnesota is nearly six times higher among women of color (8.8 per 100,000 women) than among non-

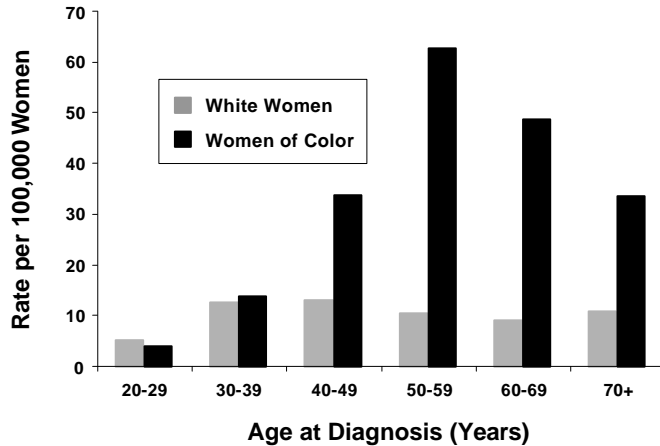
Hispanic white women (1.5 per 100,000). Groups at especially high risk are Southeast Asian immigrants, American-born African Americans, and American Indians. These statistics indicate that cervical cancer control efforts need to focus on these women, their communities, and their health care providers.

For more information on the MBCCCP, visit their web site at <http://www.health.state.mn.us/divs/dpc/cc/mbcccp.htm> or call (612) 676-5500.

**References**

1. Reis LAG, Eisner MP, Kosary CL, *et al* (eds). SEER Cancer Statistics Review, 1973-1998. National Cancer Institute, Bethesda MD, 2001. ([http://seer.cancer.gov/Publications/CSR1973\\_1998](http://seer.cancer.gov/Publications/CSR1973_1998)).
2. Cancer in Minnesota: racial and ethnic disparities. Minnesota Department of Health, October 2001. (<http://www.health.state.mn.us/divs/dpc/cc/info/disparit.pdf>).

**Figure 1. Invasive Cervical Cancer Incidence by Age and Race/Ethnicity, Minnesota, 1995-1997**



Source: Minnesota Cancer Surveillance System.

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# Improving Asthma Management Among Diverse Communities - May 8, 2002

**How do you explain asthma to your Somali patient who doesn't relate to the concept of chronic disease?** The Minnesota Department of Health (MDH) is collaborating with the American Lung Association of Minnesota to provide a 1-day conference to assist physicians and other health care providers in understanding the importance of providing culturally competent care to their patients who live with asthma. Topics to be addressed at the confer-

ence include: asthma in Minnesota, providing asthma care for diverse populations, changing health care systems to improve asthma care, incorporating cultural beliefs into chronic disease management, and success stories from the community.

The "Improving Asthma Management Among Diverse Communities" conference will take place May 8, 7:30 A.M.-4:15 P.M., at the Four Points Sheraton,

St. Paul. Information, including a conference brochure and registration materials, will be mailed to pulmonologists, pediatricians, family practice physicians, school nurses, nurse practitioners, respiratory therapists, and others. For more information, contact Mari Drake at the American Lung Association (651/223-9564 or [mari.drake@alamn.org](mailto:mari.drake@alamn.org)) or Kelly Raatz at MDH (612/676-5142 or [kelly.raatz@health.state.mn.us](mailto:kelly.raatz@health.state.mn.us)).

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