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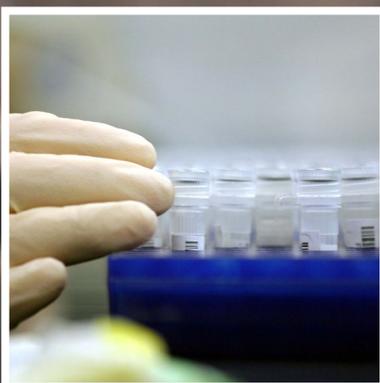
The Scottish Cancer Prevention Network
Newsletter

VOL 5 . ISSUE 1

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Editorial

Welcome to our first newsletter of 2014 and our fifth year of production. In this issue we cover a wide range of topics and have a spotlight on two main topics. The first is issues of promoting healthy behaviours in older years and the benefits to be had from both smoking cessation and increasing physical activity at any life stage. The second area (and one that is never far from public health horizons) is that of health inequalities. The articles by Alastair Munro and Gerry McCartney highlight the importance of socioeconomic deprivation in determining mortality from various forms of cancer as well as other conditions. It follows that specifically targeted interventions are unlikely to reduce the inequalities gradient and to achieve this the fundamental causes of deprivation need to be addressed. While we all recognise that this is critically important, and a major challenge for Scotland in the future, it is important that we are not paralysed by this observation. Tackling the underlying causes of deprivation is an extremely long-term project and if we wait for this to be achieved we will miss the opportunity to develop and introduce interventions that can significantly improve rates of prevention and early detection in common cancers. In trialling such interventions, however, it behoves us to study the relative effects across the deprivation gradient and to strive to ensure that inequality is not exacerbated. A good example of this is the potential introduction of a faecal immunochemical testing for bowel cancer screening. This test, while more sophisticated biochemically than the old card based test, is much simpler to perform and initial studies indicate that uptake has increased in all the deprivation quintiles, and indeed the magnitude of the increase is greater in the lower socioeconomic categories. Thus we have an intervention that, while it does not eliminate inequalities, benefits the whole of society across the socioeconomic divide. While we await policy change that will ameliorate deprivation related inequalities, this is the way we must go in cancer prevention and screening, so that all members of our society can benefit in equal measure.

Professor Bob Steele
Professor Annie S. Anderson

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Cancer Survival.. why a wider lens is needed

Professor Alastair Munro, Cancer Research Division, Ninewells hospital & Medical school, Dundee

Two recent reports from the OECD (<http://www.oecd.org/health/cancer-care.htm>) and from the EUROCARE study ([http://www.thelancet.com/journals/lanonc/article/PIIS1470-2045\(13\)70546-1/fulltext](http://www.thelancet.com/journals/lanonc/article/PIIS1470-2045(13)70546-1/fulltext)) suggest that, comparatively speaking, cancer survival rates in the UK vary between the mediocre and the abysmal. There have been the usual knee jerk responses: blaming GPs for failing to make timely diagnoses; complaints about lack of access to new cancer drugs, and so on. The analysis of these datasets requires a rather more subtle approach. The origins of the disparities in outcomes are complex and involve the technical aspects of data acquisition and analysis, the general health and well-being of the populations concerned

as well as the nature and provision of cancer services. Lack of access to new drugs is neither a necessary, nor a sufficient, explanation for the results reported on the OECD and EUROCARE report. The drugs don't always work: systemic therapies are over-researched and overfunded; local treatments, and social and behavioural interventions, are underfunded and under-researched. We have fiddled obsessively with the mote in our left eye whilst ignoring the beam in our right eye and are now left wondering why, despite all our best efforts, we don't see so well. Cancer is a social disease. Solutions have as much to do with sociology and psychology as they have to do with molecular biology and targeted therapies.

If there is one clear message to emerge from these studies it is the importance of obtaining and maintaining high quality data on cancer incidence, management, and outcomes. These reports only tell us part of the story and, in order to draw useful conclusions, we need richer detail than is currently provided. And this at a time when the Office for National Statistics is cutting back on its services (BMJ 2013; 347 doi: <http://dx.doi.org/10.1136/bmj.f6739>). Much of this, ultimately, comes down to politics – as Rudolf Virchow, the founder of cellular pathology, pointed out over 150 years ago “Medicine is a social science, and politics is nothing else but medicine on a large scale.”

Health Inequalities... a continuing challenge

Dr Gerry McCartney, Public Health Consultant, NHS Health Scotland

The ‘fundamental causes’ explanation of health inequalities argues that unless inequalities in income, resources and power are narrowed, all-cause mortality inequalities will persist despite substitution of new for old causes. We examined this question using Scottish mortality data. We calculated trends in absolute and relative inequalities for 46 causes of death for men and women across Carstairs deprivation deciles (1983-1999) and for men aged 20-64 years across social classes (1976-1999).

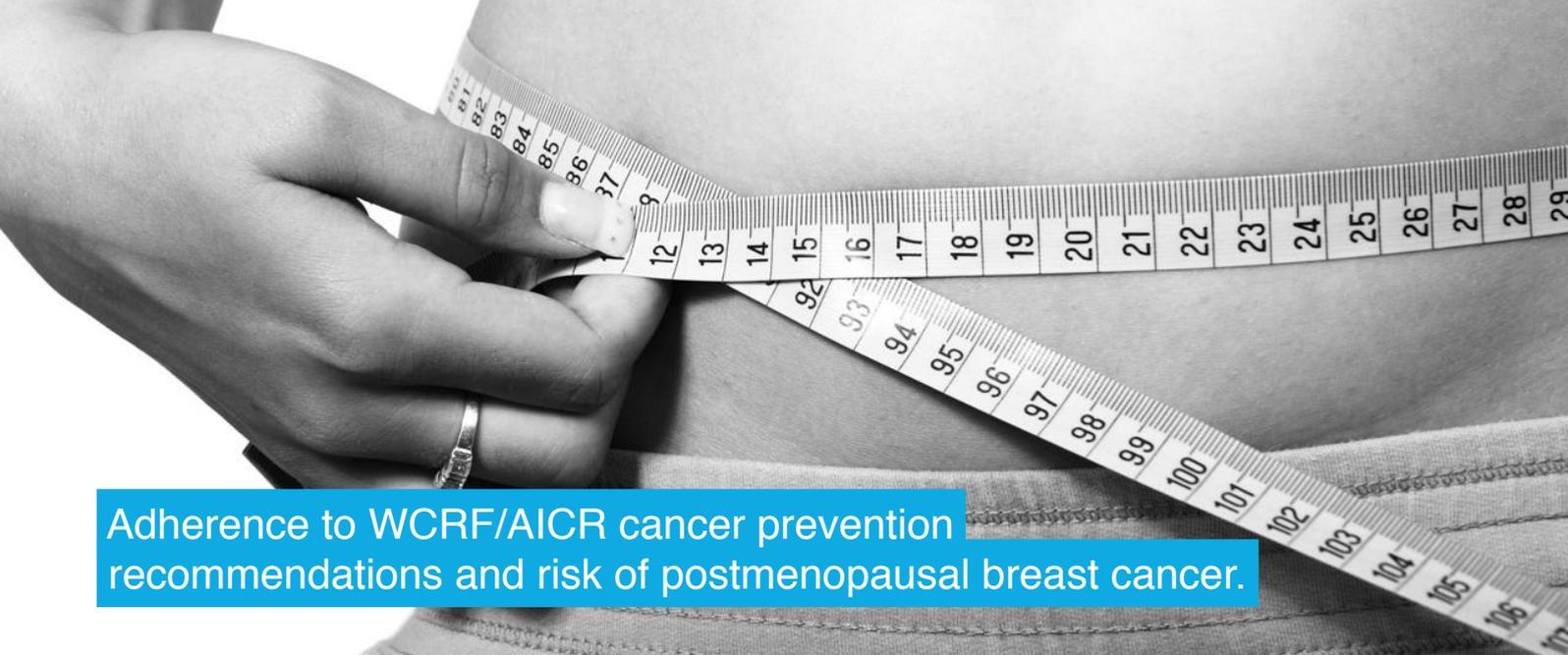
Inequalities in mortality decreased in both absolute and relative terms for certain causes of death (eg, tuberculosis and rheumatic heart disease for women), but increased

over the same time period for others (eg, alcohol-related mortality and suicide). New socioeconomic gradients also emerged for many specific causes of death (eg, malignant melanoma, mortality associated with perinatal complications, and colorectal cancer). There was a clear socioeconomic gradient for avoidable mortality, in proportion to preventability, but not for non-avoidable mortality.

This analysis suggests that the ‘fundamental causes’ thesis is supported by the Scottish data. A focus on individual intermediate mediators (e.g. tobacco) is unlikely to reduce health inequalities, as this will require reduced inequalities in income, resources, and power. Continued

action to reduce exposure to the full range of determinants of health, from polluted environments to harmful health behaviours, remains necessary to improve the average health of the population. To reduce the likelihood that these actions will exacerbate health inequalities it is important to focus on regulatory and legislative measures, such as housing quality standards, minimum pricing for alcohol and smoking bans, rather than interventions which rely on individual agency.

Further information is available at www.scotpho.org.uk/publications/reports-and-papers



Adherence to WCRF/AICR cancer prevention recommendations and risk of postmenopausal breast cancer.

In 2007, the World Cancer Research Fund (WCRF) and American Institute for Cancer Research (AICR) developed eight diet and physical activity recommendations related to cancer prevention. A recent study by Hastert⁽¹⁾ examined whether adherence to these recommendations was associated with reduced breast cancer incidence in a cohort of over 30,000 postmenopausal women in the United States and, if so, which recommendations were most strongly associated with reduced risk. Questionnaire data were collected on medical history, self-reported height and weight, physical activity over the previous 10 years,

reproductive history, medication use, and a 126-item FFQ covering diet in the year before baseline. Results showed that meeting a minimum of five recommendations was associated with a 60% reduction in breast cancer risk compared to women who met none. After adjusting for potential confounders, each recommendation met was associated with an 11% (95%CI 5–16%) reduction in breast cancer risk. Further analyses suggested that this association was primarily due to meeting recommendations related to body fatness, plant foods, and alcohol consumption i.e. ensuring BMI

remained between 18.5 and 25kg/m², consuming predominantly plant foods and limiting alcohol intake to no more than one drink a day. Adherence to these key individual recommendations resulted in a 13%, 21% and 32% decrease in risk respectively, in comparison to women who did not meet any of the recommendations. The authors concluded that meeting the WCRF/AICR cancer prevention recommendations related to body fatness, plant foods, and alcohol is associated with substantial reductions in risk of invasive breast cancer in postmenopausal women.

1. Hastert TA, Beresford SAA, Patterson RE, et al. (2013) Adherence to WCRF/AICR cancer prevention recommendations and risk of postmenopausal breast cancer. *Cancer Epidemiol Biomarkers Prev* ; 22:1498-1508. <http://www.ncbi.nlm.nih.gov/pubmed/23780838>

Outcomes of a one-to-one telephone support service provided by volunteers to women with breast cancer

The psychological impact of breast cancer can have a detrimental effect on quality of life and women may seek emotional support from a range of sources to deal with life with cancer and beyond. Whilst support provided by family, friends, healthcare professionals and voluntary organisations is important, for some women, information and insights provided by someone who has been through a similar experience is also valued (peer support).

A research project was undertaken in collaboration with Breast Cancer Care, Guy's and St Thomas' NHS Foundation Trust and King's College London to

determine the effectiveness of a one-to-one telephone support service for women newly diagnosed with breast cancer and evaluate the process of service delivery.

Women discussed in the qualitative element of this study what they got from the service, which included: talking/relating to someone who has been through a similar experience, feeling listened to, reassurance, reduced isolation and feeling prepared for the next step in the cancer experience. There was some evidence to support these outcomes in the quantitative analysis. In particular, in the group of women who received

the service there was a reduction over time in perceived isolation (not statistically significant) whilst there was a statistically significant increase in perceived isolation for those women who did not receive the service.

The service is available to anyone with a primary breast cancer diagnosis and their partner/family members. Support is provided by around 200 carefully trained volunteers with a personal experience of breast cancer. For more details call **0845 077 1893** or email UKpeersupportteam@breastcancercare.org.uk

Never Too Late to Start Feeling Great: Get Active!

A new resource on increasing physical activity has been developed by the World Cancer Research Fund for use with older adults. Cancer risk increases with age, with around 4 out of 5 cancers diagnosed in people over the age of 55. Many of these, including bowel and breast cancer are related to time spent active and as a result it is recommended that every effort should be made to increase (and maintain) levels of physical activity during later years and it's never too late to start! Even a small increase in physical activity can have positive effects on cancer risk and it is therefore important that sedentary activities are reduced and movement is increased as part of daily routines. To reduce the risk of developing cancer, the WCRF recommendation is to participate in at least 30 minutes of moderate physical activity each day and as long as it is carried out regularly, the type of exercise does not matter. Within the WCRF publication "Never Too Late to Start Feeling Great: Get Active!" (1) are

great examples of indoor and outdoor activities, including chair based exercises for the less able, which cost very little or are completely free to do. As well as a great range of illustration for every sort of exercise, the leaflet also includes a number of useful hints on how to be more active at home, for example:

- Walk around when talking to someone on the phone
- Break up 'sitting time' by standing up every 30 minutes e.g. during adverts or to change the channel on the television
- Don't use the remote control – get up to change the television channel instead.
- Stair home based stretching and movement exercises
- Walk and Talk...have a gossip whilst walking

In addition to reducing cancer risk, following the WCRF physical activity guidelines can have positive effects on

mood and fitness, highlighting even more benefits to staying active in later years.



Further evidence for the benefits of taking up or maintaining physical activity in retirement is provided by Hamer et al (2) who demonstrated that those who exercised in later life were three times more likely to age healthily than those who maintained a sedentary lifestyle.

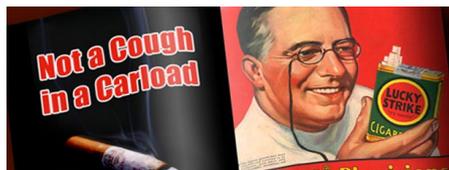
1. <http://www.wcrf-uk.org/PDFs/NeverTooLateGetActive.pdf>
2. Hamer M, Lavioie KL, Bacon SL. (2013) Taking up physical activity in later life and healthy ageing: the English longitudinal study of ageing. Br J Sports Med Published online first Nov 25 2013 doi:10.1136/bjsports-2013-092993 <http://bjsm.bmj.com/content/early/2013/10/28/bjsports-2013-092993>

It's never too late to stop smoking

By Sheila Duffy, ASH Scotland

Why do older people continue to smoke?

An international survey (1) which examined factors associated with older smokers' intention to quit found that older smokers perceived themselves as being less vulnerable to the harm of smoking; were less concerned about the health effects of smoking; were less confident about being able to quit successfully; and did not perceive any health benefit of quitting, and hence were less willing to want to quit. On top of these beliefs hardly a month passes without media reports of people who reach their 100th birthday in good health despite being smokers.



There are benefits from quitting at any age

Older smokers sometimes believe that they are too old to benefit from quitting because the damage is already done(2). However, a June 2012 systematic review (3) has shown that the benefits of smoking cessation are evident in all age groups, including those aged 80 years and older. Smoking and exposure to second-hand smoke are risk factors for cardiovascular disease, diabetes and stroke which are in turn underlying risk factors for dementia (4). Given that advancing age is the biggest factor for developing dementia, giving up smoking confers an additional benefit for older age groups in that it can improve cognition and delay the onset of dementia.

Smoking cessation support for older people

Older people may have greater barriers preventing them from engaging with cessation services, suggesting a need for interventions tailored to meet the needs of older smokers. For example can they get to and then get into the places where smoking cessation services are based; can they access Internet and text based support advertised in the media; do they know how to download stop smoking 'apps'? Additionally, public health efforts designed to encourage smoking cessation for older people should emphasise improvements in health in addition to decreased mortality (5). It is vital that we in public health continue to deliver the message that, regardless of their age, smokers can substantially reduce their risk of disease, including cancer, by quitting.

1. Yong H, Borland R and Siahpush M. Quitting-related beliefs, intentions and motivations of older smokers in four countries: findings from the International Tobacco Control Policy Evaluation Survey. Addictive Behaviors 2005;30(4):777-88. www.sciencedirect.com/science/article/pii/S0306460304003016 [Accessed 11.12.13]
2. Lam TH. Absolute risk of tobacco deaths: one in two smokers will be killed by smoking: comment on "Smoking and all-cause mortality in older people". Archives of Internal Medicine 2012;172:845-6.
3. Gellert C, Schöttker B, Brenner H. Smoking and all-cause mortality in older people: systematic review and meta-analysis. Archives of Internal Medicine, volume 172(11): pp. 837-844, June 2012. <http://archinte.jamanetwork.com/article.aspx?articleid=1182214> [Accessed 11.12.13]
4. Pond D. Dementia: an update on management. Australian Family Physician 2012, Dec;41(12):936-9. www.ncbi.nlm.nih.gov/pubmed/23210115 [Accessed 12.12.13]
5. Ostbye T, Taylor DH, Jung SH. A longitudinal study of the effects of tobacco smoking and other modifiable risk factors on ill health in middle-aged and old Americans: results from the Health and Retirement Study and asset and health dynamics among the oldest old survey. Preventive Medicine 2002;34:334-45. www.ncbi.nlm.nih.gov/pubmed/11902850?dopt=Abstract&access_num=11902850&link_type=MED [Accessed 12.12.13]

Approaching half a century of Cancer Incidence in Five Continents

Coinciding with the publication of data from the 10th volume, Dr David Brewster charts the history of the scientific monograph series, *Cancer Incidence in Five Continents*.

In 1946, a meeting of 12 cancer control experts in Copenhagen made the following suggestions to the Interim Commission of the World Health Organization (WHO)(1)

1. Great benefit would follow the collection of data about cancer patients from as many different countries as possible
2. Such data should be recorded on an agreed plan so as to be comparable
3. Each nation should have a central registry to arrange for the recording and collection of such data
4. There should be an international body whose duty it should be to correlate the data and statistics obtained in each country

The last of these suggestions was eventually realised in 1965 by the establishment, in Lyon, of the International Agency for Research on Cancer (IARC), a specialized cancer research centre of WHO. As a natural consequence of this development, an International Association of Cancer Registries (IACR) was proposed during an informal meeting at the Ninth International Cancer Congress held in Tokyo in 1966 (2). The IACR was officially founded in 1968 to serve as a membership organization for cancer registries “concerned with the collection and analysis of data on cancer incidence and with the end results of cancer treatment in defined population groups” (1,2).

The first and second suggestions were discussed again among members of the Geographical Pathology Committee of the International Union against Cancer (UICC) during a symposium in Mexico in 1964. This led to the publication of the first volume of a series of scientific monographs, *Cancer Incidence in Five Continents*, in 1966. The rationale for collating and comparing cancer incidence statistics from different countries was summarised in the introduction to volume I of *Cancer Incidence in Five Continents* (3), as follows:

“In the development of knowledge about the cause of a disease, the first and most difficult stage is the search for clues on which hypotheses can be based. In this search, no road can be guaranteed to lead to success, but if past experience is any guide, one of the most rewarding is likely to be that which leads to a comparison of the frequency with which the disease occurs in different communities in different areas and at different times.”

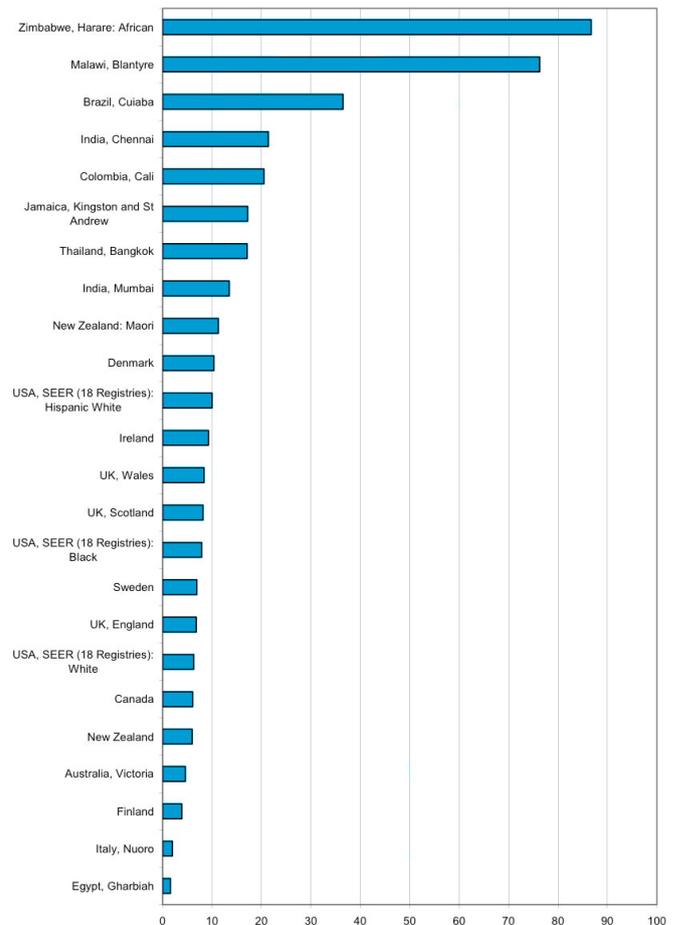
The first volume of *Cancer Incidence in Five Continents* aimed to cover the years of incidence 1960-62.3 Subsequent volumes have attempted to cover successive five year periods of incidence. Volumes I and II were published under the auspices of UICC; from volume III onwards, the monograph has been published by IARC as part of a highly effective collaboration.

Cancer Incidence in Five Continents has become established as the definitive source of global population-based cancer incidence information. Publication of data in *Cancer Incidence in Five Continents* is widely perceived to represent a quality standard for cancer registries worldwide as data from each contributing

cancer registry are judged against a series of indicators of data quality, and on this basis data are included or excluded. The monographs provide source material for epidemiological research, and underpin the IARC GLOBOCAN product (4), which is a major source of information supporting global cancer control efforts. The development of the online IARC software CI5plus (5), based on data submitted for *Cancer Incidence in Five Continents*, facilitates long-term time trend analyses.

The tables of data from the tenth volume of *Cancer Incidence in Five Continents* have recently been published on the IARC website (See Figure for example)(6). A bound monograph, including more background information, will be published by WHO Press in 2014. Volume X covers the period of incidence from 2003-2007 and includes data from 290 cancer registries in 68 countries.

In the search for hypotheses about the causes of cancer, the significance of international comparisons of cancer incidence cannot be overstated. Identification and confirmation of risk factors or protective factors is a crucial step towards the ultimate goal of primary prevention. At the same time, it is important to remember that this represents only one of many potential uses of cancer registration data in the field of cancer control (7).



Age Standardised incidence rates of cancer of the cervix uteri for selected populations 2003-2007

1. Wagner G. History of Cancer Registration. In: Jensen OM, Parkin DM, MacLennan R, Muir CS, Skeet RG (eds). *Cancer Registration Principles and Methods*. IARC Scientific Publications No 95. Lyon: International Agency for Research on Cancer, 1991.
2. Wagner G. *Cancer Registration: Historical Aspects*. In: Parkin DM, Wagner G, Muir CS (eds). *The Role of the Registry in Cancer Control*. IARC Scientific Publications No 66. Lyon: International Agency for Research on Cancer, 1985.
3. Doll R, Payne P, Waterhouse J (eds). *Cancer Incidence in Five Continents, Volume I*. Geneva: International Union Against Cancer, 1966.
4. Globocan. Available at: <http://globocan.iarc.fr/>
5. CI5plus. Available at: <http://ci5.iarc.fr/CI5plus/ci5plus.htm>
6. Forman D, Bray F, Brewster DH, Gombe Mbalawa C, Kohler B, Piñeros M, Steliarova-Foucher E, Swaminathan R and Ferlay J (eds). *Cancer Incidence in Five Continents, Vol. X* (electronic version) Lyon, IARC, 2013. <http://ci5.iarc.fr/CI5-X/ci5-X.htm> (The printed version of this volume: IARC Scientific Publications No. 164 will be available in 2014).
7. Brewster DH, Coebergh JW, Storm HH. (2005) Population-based cancer registries: the invisible key to cancer control. *Lancet Oncol*; 6: 193-195.



Detect Cancer Early - Primary Care Engagement

Emma Anderson, Scotland Operations Manager

Just under 4000 people are diagnosed with bowel cancer each year in Scotland and it's the second biggest cancer killer with 1500 people dying from the disease. Prevention, early diagnosis, effective treatment and aftercare for patients are key to making sure that fewer people die of the disease and patients experience the best care possible.

Detect Cancer Early is the Scottish Government's campaign promoting the early detection of breast, bowel and lung cancer because the chance of survival is much greater if the cancer is diagnosed early rather than at a later stage.

You will have been hard pushed not to have seen one of the much talked about TV ads or heard the campaign's key messages 'Don't Get Scared, Get Checked' on the radio. Awareness

road shows have also been sweeping the country with staff and volunteers, giving people across the country vital information about the campaign, which symptoms to look out for and encouraging anyone who has concerns to go to the doctor and get checked out.

Bowel Cancer UK and Roy Castle Lung Foundation joined forces to organise the primary care engagement sessions for the campaign. Primary care play a key role as the gate keepers to the health service for most people so it's important that they:

- are aware of any campaign work that might impact on their services
- understand how they can be involved in the campaign
- know where they can access resources to help their patients

A total of seven engagement sessions took place during September and October 2013. Glasgow, Ayr, Inverness, Edinburgh, Dumfries, Stirling and Dundee were the chosen locations and a total of 426 primary care professionals either attended a session or tuned in to the live webcast of the Glasgow event.

To find out more about the work of Bowel Cancer UK check out our website www.bowelcanceruk.org.uk. To view the films of the primary care engagement sessions please sign up as a member on the website and you will have access to the footage and supporting literature. Our Scotland office in Edinburgh can help with any enquiries regarding our work and resources - **0131 225 5333**.

HPV ACTION – a campaign for vaccinating boys

The Joint Committee on Vaccination and Immunisation (JCVI) is currently considering whether the human papilloma virus (HPV) vaccination programme in the UK should be extended beyond its present target group of 12/13 year old girls. HPV Action, a collaboration of 22 patient and professional organisations, has been launched with the aim of promoting the argument for vaccinating both girls and boys against HPV which they say would prevent many more cases of cancer (cervical, vaginal, vulval, penile, anal

and oropharyngeal) as well as genital warts and recurrent respiratory papillomatosis (RRP). The Australian government introduced gender neutral HPV vaccination in 2013 and vaccinating boys is also recommended by the Centers for Disease Control (CDC) in the USA and the Canadian National Advisory Committee on Immunization. In addition HPV vaccination of boys is currently advocated by Cancer Research UK, the Faculty of Public Health and the World Medical Association. HPV Action plan to lobby political, medical and public

opinion via the media and an online petition (<http://tinyurl.com/ojjcoxz>).

Their full case for gender neutral HPV vaccination can be accessed at http://www.hpvaction.org/uploads/1/7/8/5/17850843/hpv_action.case_for_action.pdf





SCPN Conference World Cancer Day February 4th 2014 - Be Active Against Cancer

In the year when the Commonwealth games is being held in Scotland we thought it appropriate to focus on physical activity and weight management in cancer prevention and in people living with cancer. The day is designed to move from theory to practice and we have a wide range of speakers. We hope the audience will be participative and share questions and experiences for some great discussion. Most places for the conference are now taken but we have a waiting list, so please contact Jill Hampton if you would like further information (j.z.hampton@dundee.ac.uk)

Here is a brief introduction to our speakers, activity habits and recommended music choices for an enjoyable, active playlist (we may even hear some music at the meeting!)

Professor Annie Anderson is Co-Director of the Scottish Cancer Prevention Network and Professor of Public Health Nutrition in the Cancer Research Division, University of Dundee. She enjoys a half hour brisk walk round Ninewells Hospital most lunch times. On sunny days her playlist recommendation for her outing would include Paul Simon singing Under

Ask the expert

Is it true the sunshine we get through closed car windows can have detrimental effects on our skin?

Answer from Dr Colin Fleming, Consultant Dermatologist, NHS Tayside

African skies

Dr Cindy Gray is a Lord Kelvin Adam Smith Fellow in the Institute of Health and Wellbeing, University of Glasgow. Lack of public transport in the village where she lives means she is a reluctant car driver, but enjoys parking at a distance from work and making the last 15 minutes there and back an active brisk walk through the Botanic Gardens. Playlist recommendation Boo Radleys Wake up Boo! – a great start to the day!

Professor Nanette Mutrie is Director of the Physical Activity for Health Research Centre at the University of Edinburgh. One of her favourite activities is walking with her dog. In a year they clock up over 1,000 miles of walking and so the goal is that by the time the dog is 5 they will have walked 5,000 miles! Cue the song 5,000 miles by the Proclaimers.

Dr Anna Campbell, Lecturer in Sports Biomedicine, Institute of Sport and Exercise University of Dundee. Anna is a well known advocate for promoting increased activity for breast cancer patients. She is happy to join in all forms of activity and always with a smile! Her recommendation is In The

Mood by Jive Bunny.

Professor Martin Wiseman is Medical and Scientific Adviser for WCRF International. He is an enthusiastic runner (and walker). His playlist recommendation is Johnny B Goode sung by Chuck Berry or Johnny Winter.

Professor Bob Steele is Chairman of the Scottish Cancer Foundation, Director the Scottish Bowel Screening Programme and swims most days. He likes music to cool down to. Playlist recommendation : By the Sleepy Lagoon (composed by Eric Coates).

Ms Martine Stead, is Deputy director of the Institute for Social marketing, University of Stirling. She also plays in a ceilidh band and reckons that a good-going ceilidh is probably one of the best ways of exercising to music - so she recommends a Strip the Willow! For more see <http://www.skelpitlug.com/music-samples>

In addition, we will have presentations by Dr Aileen Keel (Deputy CMO) and Michael Mathieson MSP (Minister for Public Health)

On the whole newer glass types in cars tend to be more pure, with fewer contaminants, allowing greater passage of ultraviolet as well as visible light. Most windscreens and window glass are only slightly contoured, so there is little magnification of light through glass. Both UVB and UVA

have a role in development of skin cancer, but most UVB is blocked by car windows. Thus the risk of skin cancer and burning of skin is partly but not completely reduced by window glass. If individuals have sun sensitivity however this may be triggered through glass.

1. Hampton PJ, Farr PM, Diffey BL, Lloyd JJ. (2004) Implication for photosensitive patients of ultraviolet A exposure in vehicles. Br J Dermatol; 151(4):873-6.



Is prostate cancer in more affluent men due to greater Prostate Specific Antigen Testing?

Dr Colin McCowan, University of Glasgow

Prostate cancer is the most common malignant cancer in men within the UK and estimated to be responsible for almost 1 in 4 male cancers. Prostate cancer is unusual as it seems to be more common in more affluent men, contrary to the pattern in most other cancers. Prostate Specific Antigen (PSA) tests are most commonly used in the UK to help detect prostate cancer in men who attend their doctor with signs and symptoms of a problem. However it is still unclear whether greater numbers of affluent men getting tested explains the larger number of cancers in this group. This research, carried out by Rhian

Morgan (Medical Student) as her 5th Year project, looked at 96,484 men in the Tayside region of Scotland who had a PSA test between Jan 2003 and December 2008 (1). The study linked PSA test results to a marker of social class based on home postcode, cancer registry and death certificate records. The number of tests, positive tests, diagnosis of cancer and death from prostate cancer were all examined. The records were anonymised to protect the privacy and confidentiality of the patients. The most affluent 20% of men were more likely to have had a PSA test and also to be diagnosed with prostate

cancer, after adjusting for age which is a known risk factor. However social class did not seem to be linked with a higher risk of a positive PSA test or dying from prostate cancer. The higher incidence of prostate cancer in more affluent men was partly due to their increased use of PSA testing. However, despite the increased incidence of prostate cancer in more affluent men, higher SES was not associated with increased risk of prostate cancer death. These results, allied to those of RCTs of prostate cancer screening, question the wisdom of PSA testing for the early diagnosis of prostate cancer.

1. Morgan RM, Steele RJC, Nabi G, McCowan C. (2013) Socioeconomic variation and prostate specific antigen testing in the community: a UK- based population study. *Journal of Urology*. ISSN 0022-5347 (doi:10.1016/j.juro.2013.04.044).

Mesothelioma in Scotland

Professor Andrew Watterson, University of Stirling

Asbestos-related diseases, especially mesothelioma and lung cancer, continue to present significant public health threats in Scotland particularly (but not exclusively) to skilled, semi-skilled and unskilled workers in older buildings containing asbestos insulation.¹ Despite predictions that deaths would peak some time ago, mesothelioma deaths have risen in recent years. ISD (2013)² recorded the following official mesothelioma mortality figures:-

Year	Total Numbers	Gender M/F
2011	162	141/21
2010	177	144/33
2009	164	130/34
2008	162	144/18
2007	140	122/18
2007-2011	805	681/124

Most deaths occur in the over 50 age group. Across the NHS Regions, during this period, the West of Scotland had 339 deaths, the South East 190 and the North 152. With lung cancer deaths due to asbestos estimated at a rate of 2 cases per mesothelioma death, the impact of past and possibly

current exposure to asbestos could still be substantial. Preventing exposure to the considerable quantities of asbestos remaining in both work and wider environments including schools and other buildings should be a priority.³ A UK Committee recently reported on childhood exposures and estimated the lifetime risk of developing mesothelioma for a five year old child was about 5 times greater than for an adult exposed at the age of thirty.⁴ The Control of Asbestos Regulations 2012 was belatedly brought in by the UK government to meet effective EU legal requirements fully.⁵ There are also concerns about how reductions in general health and safety inspections especially in certain types of workplaces may impact on asbestos controls as well as threats to welfare rights now available for those with such cancers. The HSE has, however, finally announced a new asbestos campaign for 2014 with commercial partners aiming to distribute asbestos information kits, accessing regional radio advertising, digital channels and through the HSE website. The mortality statistics many years down the line will tell how effective such preventive measures have been.

1. Gorman T, Johnston R, McIvor, and Watterson A. (2004) Asbestos in Scotland. *International Journal of Occupational and Environmental Health*; 10(2): 183-92.
 2. ISD (2013) Lung cancer and mesothelioma statistics. March 2013 <http://www.isdscotland.org/Health-Topics/Cancer/Cancer-Statistics/Lung-Cancer-and-Mesothelioma/#lung>
 3. Gorman T and Watterson A. (2004) Confronting the continuing problem of asbestos in Scotland: a public sector health initiative. *New Solutions*; 14(1): 77-98.
 4. Committee on Carcinogenicity of Chemicals in Food, Consumer Products and the Environment (2013) statement on the relative vulnerability of children to asbestos compared to adults. CC/13/S1
 5. HSE (2012) Control of Asbestos Regulations (2012). <http://www.hse.gov.uk/asbestos/regulations.htm>

Does Scotland need more of these sorts of marketing messages?



YES Please!

NO Thank you!

Please send us any examples of good or bad marketing images you've come across j.z.hampton@dundee.ac.uk

Winter fruits and Vegetables

Get the New Year off to a flying and economical start after all the excesses of Christmas and make the most of seasonal root vegetables. They're simple and cheap to throw together in your own soups and stews and make a hearty cancer preventing lunch or dinner.

Seasonal Fruit – Forced/early rhubarb, Pears, Apples.

Seasonal Vegetables - Beetroot, Broccoli (purple), Brussels sprouts, Cabbage, Carrots, Cauliflower, Chard, Chicory, Celeriac, Jerusalem Artichoke, Kale, Leeks, Mushrooms, Onions, Parsnips, Potatoes, Radish, Rocket, Shallots, Spinach, Spring Onions, Squash, Swede, Turnips.

A nourishing and warming curry from Hugh Fearnley-Whittingstall that even tastes fantastic the next day with a chapatti for a packed lunch. (Source <http://www.fifediet.co.uk/2013/01/21/winter-kale-and-potato-curry/>)

Kale & Potato Curry (Serves 4)

Ingredients

2 tablespoons of oil
1 onion, halved and finely sliced

3 garlic cloves, peeled
1 chilli, deseeded and finely chopped or use ½ -1 teaspoons of dried chillies
3cm piece of ginger, peeled and chopped
1 teaspoon garam masala
½ teaspoon of mustard seeds
½ teaspoon of ground cumin
¼ teaspoon of ground turmeric
3 cardamom pods, bashed
350g potatoes, peeled and cut into bite sized chunks
500g kale, stalks removed and leaves roughly shredded

Yoghurt sauce (optional)

250g plain low fat yoghurt
a small bunch of coriander roughly chopped
salt and pepper

Method

In a large saucepan gently heat the oil, then add the onion and cook until golden. Meanwhile, pound the chilli, garlic and ginger together with a pinch of salt to taste in a pestle and mortar. Stir this into the onion and cook for a few minutes. Next add the remaining spices and continue to stir for a minute or so.

Add the potatoes and fry whilst

continually stirring and coating in the spice mixture for 5 minutes. Pour in enough water to cover the potatoes, roughly 450ml. Allow the mixture to come to a simmer, cover and then cook for around 10 minutes, just before the potatoes are ready. Add the kale and, if necessary, a bit of boiled water and simmer for 2-3 minutes, or until just tender.

Mix together the yoghurt, tomato purée and some of the hot liquid from the curry in a bowl. Remove the curry from the heat, whisk in the yoghurt mixture, and then return to a gentle heat to warm through, (too high a heat will curdle the yoghurt). Add the coriander and serve with chapattis, naan or rice



Ask the expert.....

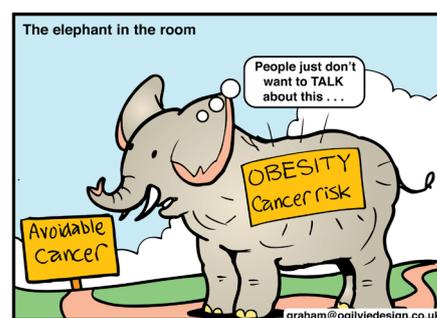
I get a regular email newsletter on cancer and lifestyle that promotes a cancer nutritional risk profile based on blood testing service. How useful is this for cancer patients?

Answer from Professor Martin Wiseman (Medical and Scientific Adviser WCRF International, Visiting Professor of Human Nutrition, University of Southampton Previously Head, Nutrition Unit, Department of Health, England).

It's hard enough helping cancer patients with nutritional advice when the evidence base is so limited. It really doesn't help when they are also bombarded with unjustified overoptimistic claims that are naturally appealing. That's why it's so disappointing to see the continuing prominence of a high profile website (and its associated commercial activities) targeted at cancer patients. The site promotes something called the Cancer Risk Nutritional Profile, and on the basis of a blood test, claims to "measure the

essential micronutrients implicated in the cancer pathway", and advise "what foods to avoid or eat more of to restore nutritional harmony". For £295, once you have persuaded your GP to take your blood and you have posted it to the lab, an oncologist will review your results and offer his advice. Sounds good, doesn't it? That's the trouble. While superficially it seems to make sense that measuring your blood levels of nutrients is a useful guide to what you need to do to "restore nutritional harmony", that is a gross oversimplification. Certainly as part of an overall clinical assessment (including history and examination) measurement of blood concentrations of nutrients can be a useful guide. But out of context they can be seriously misleading. You can have low body stores of several nutrients without them appearing at low concentration in the blood; and the concentrations of others are affected by systemic inflammation, either increasing or decreasing their concentrations without any change in nutritional state.

Of course it is important to have good nutritional state; but that is more than just micronutrient status – body composition and physical activity are at least as important. In fact, for cancer prevention, maintaining healthy body weight and being physically active are the most important nutritional factors. The search for an influence of specific micronutrients has been strikingly unsuccessful, while taking supplements has not only largely failed to show an impact on cancer development, it has often, unpredictably, shown adverse effects. So it is disappointing to see the scientific explanation on the website (which contains the necessary grains of truth amongst the less substantiated claims) followed by pages of supplements for sale. **Beware!**



Alcohol and health.. can you get it right?

Eilidh Sharp, Robert Gordon's University, Aberdeen

1. Approximately what percentage of new cancer cases are estimated to be related to alcohol consumption?
 - a. 1%
 - b. 6%
 - c. 13%
2. A UK unit of alcoholic drink is equal to how many millilitres of pure alcohol?
3. How many units of alcohol can be consumed by men each week as stated by current guidelines for so called "sensible" alcohol consumption?
4. How many units of alcohol can be consumed by women each week as stated by current guidelines for so called "sensible" alcohol consumption?
5. True or false? Alcohol consumption, even within current "sensible" guidelines, can increase risk for oral, pharyngeal and breast cancer.
6. True or false? In 2010 the number of cancer cases in which alcohol was thought to be a related risk factor was higher in males than in females.
7. Approximately what proportion of liver cancer in men and women is estimated to be associated to alcohol consumption?
 - a. 1 in 3
 - b. 1 in 5
 - c. 1 in 10

Recent publications by SHAAP include a briefing paper titled "Alcohol and Adolescence" (available from: http://www.shaap.org.uk/UserFiles/File/alcohol_and_adolescence.pdf).

Don't miss their upcoming "Alcohol Occasional" February seminars taking place at the Royal College of Physicians premises, 9 Queen Street Edinburgh, EH2 1JQ:

- "Alcohol Without the Hangover? Using Science to reduce the harms of Alcohol" by Professor David Nutt on the 19th February 2014, 17.30 – 19.30.
- "Young women, pre-drinking and pleasure" by Dr Angus Bancroft (Edinburgh University) on the 27th February 2014, 12.30-14.00.

1. 6% 2. 10ml 3. 21 units 4. 14 units 5. True 6. False 7. 1 in 10

Answers

Source: Scottish Health Action on Alcohol Problems. Alcohol and Cancer Risks. A Guide for Health Professionals. SHAAP, 2013. http://www.shaap.org.uk/UserFiles/File/Reports%20and%20Briefings/Alcoholcancerriskfinal_shaapfinal2013.pdf (accessed 16th December 2013).

Thank You

To all our readers, we hope you have enjoyed the articles in this issue and we appreciate your continued interest.

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You can visit SCPN online at:

www.cancerprevention.scotland.co.uk

Or follow SCPN on
Twitter (**@thescpn**)

Facebook (www.facebook.com/theSCPN)

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We want to know what you think

We hope that you have enjoyed this newsletter and we are always interested in feedback to help us continually improve all aspects of the newsletter. You can help us by telling us what you would like to read about in future issues. We would like your comments and suggestions - just email a.s.anderson@dundee.ac.uk

Find out more on our website

If you would like to know a little more about the kind of work that we do you can visit our website at www.cancerpreventionscotland.co.uk. Here you will be able to find up-to-date news, scheduled dates for your diary, all previous newsletters and information regarding how to sign up to the SCPN RSS feed for instant access to recent news.

Contact us

If you are interested in the kind of work that we do or would like to contribute to our newsletter please telephone us on 01382 383299, email a.s.anderson@dundee.ac.uk or write to Centre for Research into Cancer Prevention and Screening (Crips), Level 7, Mailbox 7, University of Dundee, Ninewells Hospital and Medical School, Dundee, DD1 9SY.