

SCPN 

The Scottish Cancer Prevention Network
Newsletter

VOL 4 . ISSUE 3

IN THIS ISSUE

**Changes
in Cancer
Incidence in
Scotland**

PAGE 6



**Towards a
Generation
free from
Tobacco**

PAGE 8



**Cancer
Prevention
Activities in
Primary Care**

PAGE 4

Welcome

For many women breast cancer is perceived as something that will or not be part of their fate. Bad luck and family history are known to dominate perceptions of risk. A recent survey, undertaken by YouGov on behalf of Breakthrough Breast Cancer Scotland reported that a significant number of women in Scotland do not know about the lifestyle changes they can make to reduce their risk of breast cancer: 40% of women are unaware that regular physical activity can reduce risk; 36% do not know maintaining a healthy weight throughout your life can also reduce risk; while 41% do not know that drinking alcohol regularly can increase chances of getting breast cancer. The charity have been clear that they believe that with clearer messaging and better support around lifestyle changes, women in Scotland can start to 'stack the odds' against developing breast cancer.

For many people working in Public Health, major efforts are rightly directed at population solutions to facilitating behaviour change in communities, notably in relation to health inequalities. In most hospital and clinic based services treatment related messages dominate health communications. Everybody is very busy doing their jobs so it is not surprising that raising awareness of opportunities for cancer prevention never quite reaches the average female questionnaire respondent. Few people would disagree with ensuring that the messages on tobacco and lung cancer are known but clearly the evidence on other aspects of lifestyle and breast cancer seem to get little airtime. The incidence of breast cancer in Scotland has increased by 13.7% in the last ten years; surely its time for us all to work together in bottom up and top down approaches to make a difference in breast cancer risk for ourselves, friends, colleagues, mothers and sisters.

Professor Annie S. Anderson
Professor Bob Steele

Contents

3. SCPN and DCE – competitors or co-creators in long term health?

Adherence to WCRF/AICR guidelines and risk of death in Europe
4. Cancer Prevention Activities in Primary Care

Biscuits - a salty story!
5. Promoting healthy food choices... Scottish Government takes an international lead

Fruit and vegetable intake and risk of breast cancer by hormone receptor status
6. Which cancers have seen the largest changes in age - standardised incidence rates in Scotland during the most recent decade?
8. Towards a Generation free from Tobacco

Ask the Expert
9. Sit less and walk more

SHAAP – an update of activities
10. Cancer fatalism: its role in preventative behaviours

We can eliminate occupational cancer

Revised Dietary Goals for Scotland
11. Art prize article

NICE guidance on tobacco harm reduction

Older women urged to attend cervical cancer screening.

A Second Chance

Save the Date

Annual SCPN conference
'Be active against cancer'
Date: World Cancer Day, February 4th
Venue: The Melting Pot,
Rose Street, Edinburgh



SCPN and DCE - competitors or co-creators in long term health?

David Linden, DCE Programme Director

About a quarter of all cancers can be prevented, but for those who do develop cancer, an early diagnosis still offers the best chance of cure. Even for those with advanced disease, earlier diagnosis provides the opportunity to more effectively employ disease-modifying treatments and to put in place symptom management approaches. With Scotland's cancer survival deficit occurring primarily in the first year after diagnosis, late presentation and advanced stage at treatment are thought to be important contributors to the current position.

The Detect Cancer Early Programme is regularly challenged about its impact on survival, given the lead time bias arguments and international data quality comparisons. But there are potentially other benefits from the programme – a more health literate general population, improved awareness of cancer presentations and screening programmes, better data on cancer staging, reduced emergency department presentations and lengths of stay in hospital, collaborative working between public health, primary care and the acute sector and improved patient experience with

reduced variation in referral practice.

Working in the health sector, it is easy to forget that warning signs and symptoms are not always second nature to the general population – several studies have demonstrated poor levels of cancer awareness. Nor are health matters always uppermost on the agenda when faced with other life pressures particularly in the socio-economically deprived.

The DCE Programme aims to tackle stigma and perceptions about cancer 'fate' and, if successful, along with promoting awareness of screening and warning signs and symptoms, will lead to more people making contact with both screening and symptomatic services. If these contacts result in a 'near miss' event (cancer ruled out despite worrying symptoms), then there is an ideal opportunity to deliver clear, concise and simple messages about lifestyle risk factors.

Although the evidence on lifestyle and cancer risk are clear, our messages about preventative action may be less clear – if health professionals are confused about what to

communicate it is unsurprising that the general population finds the advice muddled. We need to make preventative messages clear for those working in the health sector so that the opportunities delivered by the increased contact with the NHS from Detect Cancer Early are used to best effect to promote cancer prevention awareness and action. The conversations might feel uncomfortable at first, but the more they are delivered, the easier it becomes and the more they are heard, the more they are likely to be acted upon.

The Detect Cancer Early Programme is not the panacea for improving Scotland's survival deficit. This objective will only be achieved by a combination of approaches – addressing co-morbidities, general physical and emotional well-being, access to treatments and quality of care at and around treatment delivery – but it is clear that primary and secondary cancer prevention measures will contribute to general health and well-being that will in turn help achieve long term survival benefit.

Adherence to WCRF/AICR guidelines and risk of death in Europe

In 2007, The World Cancer Research Fund (WCRF) and the American Institute for Cancer Research (AICR) set out healthy living, weight management and physical activity guidelines for cancer prevention. The EPIC study (378,864 participants from

9 European countries) recently reported that greater adherence to WCRF/AICR guidelines significantly increased longevity and quality of life, with a significantly lower risk of dying from cancer, circulatory disease, and respiratory disease.

After 12 years of follow-up those adhering best to guidelines had a 34% lower hazard of death from all causes than those adhering least well to guidelines.

Vergnaud AC, Romaguera D, Peeters PH et al. (2013) Adherence to the World Cancer Research Fund/American Institute for Cancer Research guidelines and risk of death in Europe: results from the European Prospective Investigation into nutrition and Cancer cohort study. *Am J Clin Nutr*; 97: 5 1107-1120



Cancer Prevention Activities in Primary Care

Last month saw the launch of a report by Cancer Focus Northern Ireland (NI) investigating the current and potential role of the GP and Primary Care Nurse (PCN) in cancer prevention. Cancer prevention is the promotion of healthy behaviours as well as the avoidance of risk factor behaviours. These concepts are inherent in health promotion theory and practice. A recommendation in the cancer control programme was that the role of primary care professionals should be developed, particularly in relation to health promotion, screening and symptom recognition.

In this study, firstly a questionnaire survey was carried out with all GPs (n=1249, response rate 23%) and PCNs (n=500, response rate 45%) in NI. Subsequently one to one interviews were held with GPs (n=14) and PCNs (n=14).

Results showed that most cancer prevention activities in Primary care

are delivered by PCNs (over 80% reported providing cancer prevention activities routinely for all domains). Over 90% of GPs reported providing cancer prevention activities routinely with regard to smoking and cervical screening but fewer for obesity, alcohol use and only 50% for diet and physical activity. The least provided service by both GPs and PCNs was advice in relation to UV exposure. Less than 50% of GPs and PCNs routinely provided general written information on cancer prevention. Screening was highly promoted by both groups. Positive views were expressed on the need to further develop the GP and PCN role with regard to cancer prevention and that a multidisciplinary approach should be adopted.

Barriers to cancer prevention activities were primarily lack of demand, however lack of time and resources were also cited. In addition, the absence of a 'cancer prevention' element within the Quality Outcomes

Framework, which determines much of the activities undertaken within Primary Care, reduces the likelihood of cancer prevention being an area of particular focus.

Both groups felt they had the knowledge to deliver activities but required updating and support to allow them to do so. Most respondents indicated that patients were open to advice, felt it appropriate to come from the GP/PCN and felt optimistic that advice would be followed. Some however felt raising cancer risk may cause anxiety in patients and may impact on the clinician-patient relationship.

A very detailed and meticulous report with much food for thought for those working in Primary Care. http://eprints.ulster.ac.uk/24926/1/Research_Report_Actual_%26_Potential_Roles_of_the_GP_%26_PCN_in_the_prevention_of_cancer.pdf

Biscuits - a salty story!



It is estimated that children eat up to 46 packets of biscuits each year adding significant quantities of sugar and salt to their diets. Health organisations are calling for clearer labelling and reduced salt in biscuit products. Consensus Action on Salt & Health has found that 110 types of biscuits are saltier than salted popcorn. Researchers tested 479 sweet biscuits and discovered that 90% receive an amber traffic light for

salt and red for sugar. In addition, they comment that GDA labelling may be misleading consumers by indicating unrealistic portions (82% gave just 1 biscuit per portion) or by making salt content difficult to calculate.

<http://www.actiononsalt.org.uk/news/surveys/2013/Biscuits/100901.html>



Promoting healthy food choices... Scottish Government takes an international lead

Scottish Government has openly invited all food industry businesses to work in partnership to implement a range of voluntary commitments to improve Scotland's dietary health. A draft voluntary framework highlights four main principles:

- put children's health first in all food-related decisions
- rebalance promotional activities to significantly shift the balance towards healthier choices
- support consumers and communities through education and information
- formulate healthier products and menus across retail and catering

The most novel part of this plan relates to food promotions and marketing. The government is now developing a Scottish Standard, spanning all food marketing and advertising. The British Standards Institute (BSI) will develop a Publicly Available Specification (PAS) for the marketing of food and drink over the next 12-18 months to support the Scottish Dietary Goals. Both retail and catering price promotions will be included in this scheme which is a significant move towards the recommendations set out in the National Food and Drink Policy.

Clearly, much is dependent on what that standard is in relation to

nutritional composition. For example, standards may relate to the number of "green traffic lights" or a nutrient profile system or other similar standards.

Setting a PAS is consistent with the WHO Recommendations on the Marketing of Food to Children and the UN's General Assembly's political declaration on the prevention and control of non-communicable disease. A standard of this kind will be an **international first**.

<http://www.scotland.gov.uk/Resource/0042/00422516.pdf>

Fruit and vegetable intake and risk of breast cancer by hormone receptor status

Oestrogen receptor negative (ER-) breast cancer accounts for 15-20% of breast cancers. Unlike ER+ cancer, ER- cancer has few known or modifiable risk factors. It is believed that fruit and vegetable consumption reduces breast cancer risk but, for this tumour type, evidence has proved inconclusive as few studies focus on ER- tumours and few cases are presented in mixed studies. A research team from Harvard have recently examined pooled data to study the relationship between the consumption of fruit and vegetables and the risk of breast cancer by hormone receptor status¹.

Researchers found no association between fruit and vegetable consumption and risk of breast cancer overall or for ER+ breast cancer specifically, but did find that high fruit and especially vegetable consumption was protective of ER- breast cancer. The reason behind this association with ER- but not ER+ is not yet known, but further research has now been called for.

Further work has also reported that higher intakes of berries and peaches were associated with lower risk of ER- breast cancer in post-menopausal

women². However, the authors say that these results are exploratory and need to be confirmed in more studies.



1. Jung S, Spiegelman D, Baglietto L et al. (2013) Fruit and vegetable Intake and Risk of Breast Cancer by Hormone Receptor Status. JNCI J Natl Cancer Inst. 105;(3): 219-236
2. Fung TT, Chiuve SE, Willett WC et al. (2013) Intake of specific fruits and vegetables in relation to risk of estrogen receptor-negative breast cancer among postmenopausal women. Breast Cancer Res Treat 138;(3): 925-30



Which cancers have seen the largest changes in age-standardised incidence rates in Scotland during the most recent decade?

Following the publication of cancer incidence data for 2011 on 30th April 2013, Lesley Bhatti and David Brewster summarise, for each sex, the five cancers that have increased and decreased in incidence rates the most during the period 2001–2011.

Most major types of cancer are more common in older people so that, all else being equal, older populations are likely to have higher rates of cancer. When comparing the risk of cancer between populations or in the same population over time, it is important to take account of the age structures of the populations being compared. By allowing for the effect of age, age-standardised incidence rates are an important indicator of risk. In the analysis reported below (Tables 1 and 2), ten year percentage changes in age-standardised incidence rates were estimated by Poisson regression modelling. Only changes that were statistically significant ($P < 0.05$) are included in this article.

It is important to bear in mind that recent patterns of cancer mainly reflect trends in prevalence of risk (or protective) factors going back several decades. The most striking recent increase in males has occurred in a relatively rare male cancer, cancer of the penis. This is most probably associated with increased exposure to oncogenic strains of the human papillomavirus (HPV), although smoking and immune suppression may

also increase susceptibility. Primary cancer of the liver has also increased strikingly in males, although to a lesser extent in females (+21%). Risk factors driving this increase are likely to include alcohol misuse, infection with blood-borne hepatitis viruses, and non-alcoholic fatty liver disease. Increases in incidence of squamous cell carcinoma of the skin and melanoma of the skin have been seen in both sexes, and are likely to reflect, at least in part, past exposure to ultraviolet radiation. Although the increase in thyroid cancer incidence observed in both sexes may reflect a genuine increase in risk, perhaps associated with exposure to environmental ionising radiation, at least part of the increase is widely believed to have resulted from increased rates of 'incidental' diagnosis of some cancers. The increase in incidence of kidney cancer was less dramatic in males (+28.3%) than females. Risk factors for kidney cancer include smoking and obesity, but advances in medical imaging may also have led to an increase in 'incidental' diagnosis of some tumours. Risk factors for cancer of the tongue, which has also increased more in females than males (+29.5%), include alcohol, tobacco (smoked or chewed), and (particularly for the posterior portion of the tongue) infection with HPV.

Striking decreases in stomach cancer have been observed in both sexes. The aetiology of most cases of leukaemia

is poorly understood, and therefore the reasons for the recent reported decrease in incidence of leukaemia are unclear. At least part of the decrease in bladder cancer incidence is likely to be due to a change in classification and coding of this disease. The change occurred around the year 2000. It led to an apparent decrease in the incidence of invasive bladder cancer, and a corresponding decrease in survival (due to the reclassification of better prognosis tumours as uncertain or in situ). However, some of the decrease in bladder cancer incidence could also reflect historic decreases in smoking prevalence as well as decreased exposure to occupational carcinogens associated with improvements in industrial hygiene. Similarly, recent decreases in incidence of laryngeal cancer and lung cancer (in males) probably also reflect past changes in smoking prevalence, which have differed between the sexes. The decrease in ovarian cancer incidence may reflect, at least in part, increased use of the oral contraceptive pill from the 1960s onwards, since this appears to protect against the development of ovarian cancer.

Further information on cancer incidence trends is available on the ISD website at:

<http://www.isdscotland.org/cancer>
www.isdscotland.org/cancer

Table 1: Estimated 10-year % changes in age-standardised incidence rates of the five cancers that have increased the most, by sex, Scotland, 2001–2011

Cancer	No of cases in 2011	10-year % change	P-value
Males			
Penis	61	+62.3	<0.0001
Liver	308	+61.5	<0.0001
Squamous cell carcinoma of skin	1,976	+58.1	<0.0001
Melanoma of skin	573	+57.8	<0.0001
Thyroid	49	+55.9	0.0012
Females			
Thyroid	191	+73.7	<0.0001
Kidney	352	+51.2	<0.0001
Melanoma of skin	629	+45.8	<0.0001
Tongue	82	+45.6	0.0011
Squamous cell carcinoma of skin	1,006	+35.4	<0.0001

Table 2: Estimated 10-year % changes in age-standardised incidence rates of the five cancers that have decreased the most, by sex, Scotland, 2001–2011

Cancer	No of cases in 2011	10-year % change	P-value
Males			
Stomach	423	-31.2	<0.0001
Leukaemia	378	-27.0	<0.0001
Bladder	544	-16.8	<0.0001
Larynx	245	-15.3	0.0173
Lung	2,591	-14.3	<0.0001
Females			
Stomach	277	-33.9	<0.0001
Leukaemia	251	-27.0	<0.0001
Larynx	46	-18.8	0.0427
Bladder	247	-14.5	0.0071
Ovary	583	-10.1	0.0009

**YOUR NETWORK
NEEDS YOU!**

You, as SCPN members, will shortly be receiving an invitation to take part in our annual survey. Please take a few minutes to complete this online survey as the feedback we receive helps us target our activities to

make them as useful as they can be to our members and gives us great ideas on how we can make things better. Watch this space ... an email is coming your way soon..



Towards a Generation free from Tobacco

Sheila Duffy ASH Scotland

Scotland's new five year tobacco strategy, 'Creating a Tobacco-free Generation', was launched on March 27th this year. It sets out a plan for action across the key themes of health inequalities, prevention, protection and cessation. Headlining the strategy was a commitment to setting 2034 as a target date for reducing smoking prevalence to 5%. Other measures included a requirement for smoke-free hospital grounds by March 2015, a commitment to a national marketing campaign on the dangers of second-hand smoke in enclosed spaces, and a strong commitment to introducing standardised packaging of tobacco products. For the strategy, see: <http://www.scotland.gov.uk/Publications/2013/03/3766>

More to be done...

There was no mention in the new strategy of possible legislation to protect people from tobacco smoke in vehicles; however Jim Hume MSP has launched a Private

Members' Bill on Smoking in Cars with children under 16 present. ASH Scotland supported the launch and the principle of a debate on legislation, though ASH Scotland's position is a wider one to cover smoking in vehicles with more than one person, so that all are protected. The consultation will run to 30 August, and details are at:

<http://www.scottish.parliament.uk/parliamentarybusiness/Bills/63843.aspx>

Also omitted from the national strategy was a firm position on a tobacco policy for the 2014 Glasgow Commonwealth Games. Details of the campaign are on the ASH Scotland website, including a briefing note, the opportunity to register support, and the letter sent to the organising committee, which was supported by health organisations in 16 commonwealth countries. ASH Scotland is calling for a comprehensive tobacco-free policy in venues, to support the drive towards a

generation free from tobacco.

<http://www.ashscotland.org.uk/commonwealthgames>

and in Europe...

On 21 June the European Tobacco Products Directive cleared a key hurdle and goes forward with recommendations for 65% picture health warnings on packs, a ban on characterising tobacco flavours such as menthol, the possibility for member states to introduce standardised packaging, and health warnings for nicotine containing products below a certain threshold, with medicines regulation for those above.

Clearly there is plenty to debate and move forward with as we reach towards a future in which a child born anywhere in Scotland this year reaches the age of majority in communities where smoking is minimal and tobacco use a thing of the past.

Ask the Expert

YN Lau, CJ Fleming

Department of Dermatology, Ninewells Hospital and Medical School, Dundee, Scotland

Question

Is it true that skin cancers only develop in areas exposed to the sun e.g. if the back is never exposed we should not be worried about lesions which might appear on this part of the body?

Answer

Definitely not - skin cancers can occur at any site in the body including mucous membranes (e.g. lip, conjunctivae,

genitals). Basal cell carcinoma (BCC) and squamous cell carcinoma (SCC) occur most commonly in sun-exposed sites (head and neck) with BCC showing preponderance for intermittently sun-exposed areas. (eg back or chest)¹. In melanoma, the trunk is the commonest primary site for males and the lower limbs for females². Apart from sun exposure, other risk factors for development of skin cancers include chemical carcinogens, previous

phototherapy/light treatment, radiation, genetic susceptibility, chronic injury and scarring, and immunosuppression³. Early detection of skin cancers is dependent on good awareness of risk factors.

Patients with a new suspicious lesion or a continuing change in an old lesion should seek medical advice, regardless of the site of the lesion.

1. Armstrong BK, Kricker A. (1996) Epidemiology of sun exposure and skin cancer. *Cancer Surv*;26: 133-53.
2. MacKie RM, Bray C, Vestey J et al. (2007) Melanoma incidence and mortality in Scotland 1979-2003. *Br J Cancer*. Jun 4;96(11):1772-7.
3. Quinn AG, Perkins W. Non-melanoma skin cancer and other epidermal skin tumours. In: Burns T, Breathnach S, Cox N, Griffiths C (eds) *Rook's Textbook of Dermatology*. Volume 3. 8th Ed. Singapore: Wiley-Blackwell; 2010. Chap 52.3-52.12



Sit less and walk more

The evidence for the effect of regular activity on physical and mental health is substantial and convincing and the role of physical activity for cancer treatment and prevention is clear (<http://www.dietandcancerreport.org>). New evidence is emerging that suggests that not only do we need to be more active for good health, but we also need to think of sitting less. Long periods of sitting may be detrimental to metabolic and cardiovascular health and could possibly increase risk of cancer (http://www.wcrf.org/cancer_prevention/health_professionals/informed_articles/47_sedentary_behaviour.php).

Most people may realise this because sitting for ages on a plane or in an office makes us feel uncomfortable, but we are only now realising how important it is to minimise sitting time. The new evidence suggests that, even if you are a regularly active

person, too much sitting is not good for you.

Changing our day to day habits is incredibly difficult, even when there are so many potential benefits. In a short engagement programme in the Scottish parliament, funded by Edinburgh Beltane (<http://www.publicengagement.ac.uk/about/beacons/edinburgh-beltane>), I raised awareness of the possible dangers of too much sitting and learned from those who worked in the parliament about how they might consider sitting less and walking more at work. Those involved provided the following top tips for reducing sitting time in the workplace:

- Use stairs rather than lift
- Leave desk at regular intervals
- Get outside for a breath of fresh air at lunchtime
- Speak directly to colleagues rather than email or phone

- Do not eat lunch at desk
- Walk to distant water coolers, printers, photocopiers and toilets rather than using the closest ones
- Ask chairperson to encourage standing and stretching during meetings

You could take a look at the project blog to learn more: <http://sitless.wordpress.com/#sitless>

Could you do less sitting? Challenge yourself to 'sit less' by picking one of these top tips and trying it for your self for a week or two. Then send your comments and ideas to SCPN!

Professor Nanette Mutrie
Chair of Physical Activity for Health
University of Edinburgh
www.ed.ac.uk/education/pahrc
email: nanette.mutrie@ed.ac.uk
twitter: [@nanettemutrie](https://twitter.com/nanettemutrie)

SHAAP – an update of activities

Eric Carlin, Project Director SHAAP

Scottish Health Action on Alcohol Problems (SHAAP) was established in 2006 to provide a clear, strong medical voice on alcohol harms. Whilst promoting evidence based treatment interventions SHAAP has also prioritised its activities into campaigning on alcohol pricing and marketing. SHAAP also believes that longer term policy developments are required to support individual behaviour change. To achieve these aims they have recently embarked on various activities some of which are summarised in this brief report.

- SHAAP continues to promote and disseminate the recent publication [Alcohol and Cancer Risks: A guide for professionals](#). All GPs across Scotland received an electronic link to the

document and a hard copy has been sent out to all practice nurses.

- In April SHAAP hosted a successful debate on the impact of 'big business' on health, with a specific focus on alcohol, tobacco and diet. An accompanying document was published which is available for download at <http://tinyurl.com/lp86mmo>
- Doctors and health campaigners have welcomed the Court of Session judgement (03/05/13) that Minimum Unit Pricing (MUP) of alcohol in Scotland falls within the competence of the Scottish Parliament and is compatible with EU law. This ruling was established despite efforts by the Scotch Whisky Association (SWA)

and other alcohol industry partners to block the implementation of MUP of alcohol in Scotland. A briefing on the court ruling has been produced jointly by SHAAP, Alcohol Focus Scotland and the BMA and is available at <http://tinyurl.com/ksjl6ke>. SHAAP continues to work with European partner agencies to campaign for MUP at the European Parliament.

- SHAAP also produce regular Research and Policy Briefings the latest of which was published at the end of June and have introduced a new Media Monitoring Service that is available daily with a weekly summary. To join the mailing list for either of these services email shaap@rcpe.ac.uk

Website of the month.....

SCPHRP, a valuable resource for those interested in Public Health in Scotland, have recently set up a Facebook page [https://](https://www.facebook.com/Scphrp-Scottish-Collaboration-for-Public-Health-Research-and-Policy/277285845640807)

[www.facebook.com/pages/Scphrp-Scottish-Collaboration-for-Public-Health-Research-and-Policy/277285845640807](https://www.facebook.com/Scphrp-Scottish-Collaboration-for-Public-Health-Research-and-Policy/277285845640807)

to join their Twitter presence @ SCPHRP and Website: <https://www.scphrp.ac.uk/> Highly recommended!

Cancer fatalism: its role in preventative behaviours

Gozde Ozakinci, PhD, Lecturer in health psychology, University of St Andrews

Cancer is still perceived as the Big C with all the scary and threatening trimmings. Cancer fatalism is “the belief that death is inevitable following a diagnosis of cancer”¹. It appears that, despite progress in cancer treatments and prevention, fatalistic views prevail. Emerging evidence seems to suggest that there is an important relationship between fatalistic beliefs and cancer prevention:

- Older adults who report higher cancer fatalism are less likely to attend colorectal screening².
- Fatalistic beliefs have also been

associated with other types of lifestyle behaviours such as exercise and healthy eating³.

- Cancer fatalism also has a relationship with avoiding information on cancer¹. This study suggests that those with negative views of cancer are more likely to avoid information, which denies them the opportunity to learn about the positive developments in the cancer domain; hence, pessimistic views of cancer are maintained.
- The socioeconomically deprived have stronger fatalistic views about cancer,

less positive views about the value of early detection and are more fearful about seeking help for a suspicious symptom⁴. Therefore, fatalistic views may have a negative impact on early detection which may go some way to explaining inequalities in cancer survival.

In short, addressing fatalistic views of cancer may potentially have an important place in public health campaigns regarding cancer prevention efforts.

1. Miles, A., S. Voorwinden, et al. (2008). Psychologic predictors of cancer information avoidance among older adults: the role of cancer fear and fatalism. *Cancer Epidemiol Biomarkers Prev* 17(8): 1872-1879.
2. Miles, A., S. Rainbow, et al. (2011). Cancer fatalism and poor self-rated health mediate the association between socioeconomic status and uptake of colorectal cancer screening in England. *Cancer Epidemiol Biomarkers Prev* 20(10): 2132-2140.
3. Niederpeppe, J., Levy, AG. (2007). Fatalistic beliefs about cancer prevention and three prevention behaviors. *Cancer Epidemiol Biomarkers Prev* 16(10): 998-1003.
4. Beeken, R. J., A. E. Simon, et al. (2011). Cancer fatalism: deterring early presentation and increasing social inequalities? *Cancer Epidemiol Biomarkers Prev* 20(10): 2127-2131.

We can eliminate occupational cancer

John Cherrie - Research Director, Institute of Occupational Medicine, Edinburgh

Occupational cancers from dusts, chemicals and other workplace hazards are still an important public health concern. Each year in Britain there are around 13,500 additional diagnosed cases of cancer caused by past working conditions¹. Lung cancer may be caused by exposure to asbestos, soot from diesel engines and dust containing crystalline silica. In addition about 2,000 cases of breast cancer annually may be attributed to hormonal disruptions caused by long-term work on the night shift².

In Scotland there are some work-related cancer “hot-spots”. West Dunbartonshire has six times the average incidence of

mesothelioma and the highest male death rate in the UK. Mesothelioma is a cancer that is closely related to past asbestos exposure, in this case from the shipyards and other local industries.

All work-related cancers could be prevented. In the future we expect that the incidence of occupational cancers will decrease. There is good evidence that working conditions are generally improving and exposures that cause cancers are decreasing. Due to improvements in technology, in most industries the average level of exposure to hazards is reducing by about 50 percent every decade³. If these improvements can be

accelerated, in 20 years we could see an end to almost all workplace exposures that lead to cancer, and have eliminated occupational cancer as a public health priority⁴.

Almost all occupational cancers are now caused by just ten hazardous exposures – these must be our priority for action. We need to convince managers, workers and others with a stake in the workplace that improving controls and reducing exposure to these agents is an important way to protect lives.

1. Rushton L, Hutchings SJ, Fortunato L, et al. (2012). Occupational cancer burden in Great Britain. *Br J Cancer* 107: S3–S7.
2. Slack R, Young C, Rushton L, with the British Occupational Cancer Burden Study Group. (2012). Occupational cancer in Britain. *Br J Cancer* 107: S27–S32.
3. Creely KS, Cowie H, van Tongeren M, et al. (2007). Trends in inhalation exposure - a review of the data in the published scientific literature. *Ann Occup Hyg* 51:665–678.
4. Cherrie J. (2008). We can eliminate occupational cancer from chemicals. *Occup Med (Lond)* 58: 314–315.

Revised Dietary Goals for Scotland

The revised Goals replace the Scottish Dietary Targets, which were set in the 1996 Scottish Diet Action Plan and take account of the need to build in population approaches in relation to reducing obesity and cancer risk.

Two new dimensions that are included at a population level are:

1. To achieve an average reduction in calorie intake by 120 kcal/person/day with a lowering of energy density to 125 kcal/100g. This should be achieved by reducing intake of high fat and/or sugary products and by

replacing with starchy carbohydrates (e.g. bread, pasta, rice and potatoes), fruits and vegetables.

2. To ensure that average intake of red and processed meat should not be greater than 70g per person per day (and the number of people with high intakes should not increase)

If Scots achieved these two goals alone this could have significant impact on cancer risk, notably bowel cancer. The emphasis on increasing wholegrains is also long overdue. Let’s look forward to seeing the supportive environments we are going to need to change Scottish dietary culture.

<http://www.scotland.gov.uk/Resource/0042/00421385.pdf>

If you would like to know more about how well Scots are doing in terms of dietary change than see the report produced last year by colleagues at the University of Dundee:

Estimation of Food and Nutrient Intakes from food survey data in Scotland
http://www.foodbase.org.uk/admin/tools/reportdocuments/749-1-1324_Final_Report_2001-2009.pdf



A Second Chance

With an increasing number of cancer survivors, there is a need to facilitate optimal lifestyles to improve well-being, minimise treatment effects and stack the odds against cancer recurrence. A recent qualitative investigation on the meanings of Body Weight, Diet, and Physical Activity to women who have experienced cancer reported that survivors were uncertain about the relationship between cancer recurrence and body weight, with some doubting the links between obesity and

cancer. Participants were eager to make lifestyle changes but were uncertain as to how best to initiate this change. Many felt that doctors were not taking their concerns seriously, with one participant explaining her doctor's unwillingness to bring up her weight - "you're getting some bad news and people don't want to bring up weight, you don't need any more negatives in your life".

The paper suggests that experiencing a stressful chronic illness may often stimulate

reflection and alteration in lifestyle choices, acknowledging 'a second chance', with one woman describing surviving cancer as a "wakeup call to take better care of yourself". Improvements in education about the role of physical activity and diet in cancer prevention, increased support from health professionals and community cancer groups could help to encourage lifestyle change.

Maley M, Warren BS, Devine CM. (2013) A Second Chance: Meanings of Body Weight, Diet, and Physical Activity to Women who have experienced Cancer. *JNEB*: 45;(3);1499-4046

NICE guidance on tobacco harm reduction

On 5th June NICE published the final version of its guidance on tobacco harm reduction. While NICE doesn't apply directly in Scotland, it is generally influential here. The guidance covers recommendations on cutting down to quit, longer use of nicotine replacement and temporary abstinence from smoking with the help of one or more licensed nicotine-containing products (the products may be used as long as needed to prevent relapse). For more detail, see

<http://www.nice.org.uk/guidance/index.jsp?action=byID&o=14178>

Art prize



The second annual SCPN prize for creative communication has been awarded to Callum Reid who recently graduated with a degree in Fine Art from Duncan of Jordanstone College of Art and Design. Callum's sculpture, entitled simply 'Obesity', is constructed from expanding foam and depicts a memorable representation of human excess.

As Callum has a family history of obesity and cancer, he believes that such a poignant

subject is especially deserving of reflection. Callum has an interest in capturing elements of society which are not widely addressed and using art to stimulate debate. He sees physical excess as a symptom of our commercially driven society and his work provides a very visible reminder of this. He feels obesity should be more widely discussed in day to day life and hopes his work will act as a platform and reminder of a very tricky societal problem.

Research into the psychology of obesity led Callum to become a firm believer that obesity is a consequence of both cognitive and cultural influences. He hopes the sculpture can be used in a positive way to help stimulate discussion on the condition and its consequences. He says "Fundamentally, I think art is there to make people think and to ask questions....."

Find out more: www.facebook.com/theSCPN

Older women urged to attend cervical cancer screening

A third of Scottish women aged 50-70 believe cervical screening to be irrelevant and unnecessary according to the Scottish Cervical Screening Statistics 2011-12. Despite a 41% rise in diagnosis in this age group over the last 10 years the statistics demonstrate a decrease in the women screened, which dropped from 83% to 74% in the last year alone.

It was found that 31% of older women did not consider screening necessary for everyone, rising to 67% amongst those who had never attended screening. Half of the women also explained that the invites for screening, which are sent every 3 years to 20 – 60 year olds, did not explain the tests importance with clarity and lacked age appropriate information. Cervical

screening annually saves approximately 5,000 lives in the UK, meaning these women are putting themselves at risk of a cancer which is now largely preventable. <http://www.isdscotland.org/Health-Topics/Cancer/Publications/2012-08-28/2012-08-28-Cervical-Screening-Report.pdf>

Thank You

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

Eoin McCann

Design & Graphics
emccann@mail.com

Dr Maureen Macleod (SCPN Fellow)
Jill Hampton (Network administrator)
Emily Gash

You can visit SCPN online at:

**cancerprevention
scotland.co.uk**

Or follow SCPN on
Twitter (@thescpn)

Facebook (www.facebook.com/theSCPN)

Kindly Supported by the
Scottish Cancer Foundation

Professor Annie S Anderson
a.s.anderson@dundee.ac.uk

Professor Robert JC Steele
r.j.c.steele@dundee.ac.uk

Centre for Research into Cancer Prevention and
Screening (CRIPS)

Subscribe now for free to guarantee your next copy

For non-subscribers simply go onto our website at www.cancerpreventionscotland.co.uk and fill in your details to receive your copy of the SCPN newsletter in PDF format by email. If you are having problems receiving our newsletter, check the spam settings on your mailbox and ensure your email provider is not blocking our emails or placing our email into a spam/junk folder.

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.