NATIONAL MEN'S HEALTH WEEK

2004 BRIEFING PAPER
Men and Cancer

MHF MEN'S HEALTH FORUM

Preface

Men are more likely than women to suffer from nine of the ten most common forms of cancer affecting both sexes - yet there remains an almost complete absence of strategic thinking about the relationship between gender and cancer. None of the various national targets relating to cancer makes any mention of the specific need to reduce the incidence of cancer in men. Consequently, there is virtually no planning at either national or local level that takes into account the clear need for policies, programmes or other dedicated forms of action targeted at men. The only major exception has been in prostate cancer where there have been a number of successful initiatives and the establishment of a powerful lobby group in the form of the Prostate Cancer Charter for Action. While these developments in prostate cancer have been extremely welcome they may, at the same time, have unwittingly reinforced the notion that tackling cancer in men is primarily a matter of tackling male-specific cancers. This is emphatically not the case. Action is urgently required across a broad range of cancers.

The NHS Cancer Plan (2000) is a good example of the failure to address this central issue. It offers a challenging and creative framework for the improvement of cancer prevention, diagnosis, treatment and care - but it is marred by its failure to take account of men's (and indeed, women's) specific needs, concerns and sensibilities. All the evidence suggests that men think differently from women about their bodies and their health - for example in relation to what and how they eat and drink; their reasons for smoking; how they respond to health education messages or use health services; and how they act when they become aware of symptoms.

This document advocates the development of innovative and targeted work with men. Such an approach would have the potential to contribute greatly to the fulfilment of local and national cancer targets. It would require political will - but it would also be hard-headed and practical. The Men's Health Forum (MHF) believes that it would not only have a beneficial effect on cancer outcomes but would also contribute to the reduction of health inequalities. It is self-evident that we cannot hope to improve the health of all unless we learn how to improve the health of men.

Explanatory note

The MHF makes comparisons between men's and women's health only when it is unavoidably necessary to do so. We do not advocate shifting attention away from female health or re-allocating resources from women to men. Moreover, we do not believe that women's health should function as "gold standard" for men's health – the MHF is committed to improved health for both men *and* women.

Women have much greater risk of dying from a sex-specific cancer than men, which increases their risk of cancer overall to a level roughly equivalent to that experienced by men. Two of the five most common cancers in women are sex-specific (cancers of the uterus and ovary) and, while the most common cancer in women - breast cancer – can affect both sexes, it is exceptionally rare in men and is generally regarded for statistical purposes as being sex-specific. For this latter reason, breast cancer is not included in the statistics in this document, which concentrates on cancers common to both sexes. Prostate cancer is included in the tables in paragraphs 1.2 and 1.3 because, although it obviously cannot affect both sexes, it is now the most common cancer in men. It is therefore helpful in establishing a baseline for comparing the statistics for other cancers in men. It is not of course, included in the total of the ten "shared" cancers.

1. Background

Incidence of cancer in men

1.1 Every year around 80,000 men die from cancer in the UK and 134,000 are diagnosed. One man in three will receive a diagnosis of cancer at some point in his lifetime and one in four will die from the disease. Cancer is now the single most frequent cause of male deaths in the UK[1]. The following table shows the numbers of diagnoses of the nine most common cancers in men:

Numbers of men diagnosed with the most common forms of cancer (England) 2000

Cancer type	Numbers of cases	%age of all male cancers
Prostate cancer	23,109	21%
Lung cancer	19,035	17%
Colorectal cancer	15,538	14%
Bladder cancer	6,587	6%
Stomach cancer	4,999	4%
Non-Hodgkin's lymphoma	4,095	4%
Oesophageal cancer	3,700	3%
Leukaemia	3,268	3%
Kidney cancer	3,170	3%
Other cancers	28,042	25%

Cancer Research UK: www.cancerresearchuk.org/statistics

1.2 Men have higher incidence rates for all forms of cancer that affect both sexes with only one important exception (malignant melanoma). In total, men are almost twice as likely to develop one of the cancers in the group of the ten most common "shared" cancers.

Age standardised incidence rates for the ten most common forms of cancer affecting both sexes per 100,000 population (England) 2000

	Incidence in men	Incidence in women
Lung cancer	67.4	34.0
Colorectal cancer	55.5	35.4
Bladder cancer	23.1	6.5
Stomach cancer	17.6	6.9
Non-Hodgkin's lymphoma	15.3	10.9
Oesophageal cancer	13.4	5.7
Leukaemia	12.2	7.0
Kidney cancer	11.8	5.7
Cancer of the pancreas	10.4	7.8
Malignant melanoma	9.7	11.2
All ten "shared" cancers	**236.4**	**131.1**
All cancers (exc. non malignant skin cancer)	401.4	338.4
Prostate cancer	80.4	

Cancer Research UK (Statistics tables for specific cancer sites): www.cancerresearchuk.org/statistics

Cancer Mortality in Men

1.3 A pattern similar to that of incidence rates is repeated in mortality rates; men are almost twice as likely in total to die from the cancers in the "shared group" and have higher death rates for all ten cancers individually (although incidence of malignant melanoma is lower in men than women, the death rate is higher):

Age standardised mortality rates for the ten most common forms of cancer affecting both sexes per 100,000 population (England) 2002

	Mortality in men	Mortality in women
Lung cancer	55.8	28.4
Colorectal cancer	24.0	14.7
Bladder cancer	9.1	3.0
Stomach cancer	10.9	4.3
Cancers of the head and neck	5.9	2.0
Non-Hodgkin's lymphoma	7.5	4.7
Oesophageal cancer	13.0	5.1
Leukaemia	6.8	4.3
Kidney cancer	6.1	2.3
Cancer of the pancreas	9.6	7.3
Malignant melanoma	2.7	1.9
All ten "shared" cancers	**151.4**	**78.0**
All cancers (exc. non malignant skin cancer)	226.5	158.9
Prostate cancer	27.0	

Cancer Research UK (Statistics tables for specific cancer sites): www.cancerresearchuk.org/statistics

What are the explanations?

1.4 Limitations in the present understanding of cancer necessarily limit the accuracy of estimates, but it is widely accepted that the majority of cancers are preventable. The European Commission's *Code Against Cancer* for example, suggests that "the evidence that cancer is preventable is compelling". The Code goes on to say that:

. . . upwards of 80 per cent, or even 90 per cent, of cancers in western populations may be attributable to environmental causes, defining "environment" in its broadest sense to include a wide range of ill-defined, dietary, social and cultural practices. Although all of these avoidable causes have not yet been clearly identified, it is thought that risk determinants exist for about one half of cancers[2].

1.5 In the absence of any clear biological reason why incidence rates and death rates for the "shared" cancers should be so much higher in men than women, there appear to be two potential explanations.

1.6 The first is that the present range of cancer prevention policies and programmes is very much less successful with men. A recent article in the international *Journal of Men's Health and Gender*, sums up the central issues for men:

. . . . the male excess disease burden can be effectively reduced by various prevention measures. As well as avoiding (or quitting) smoking, these include, moderating alcohol consumption, avoiding obesity, undertaking regular physical exercise, and maintaining a diet high in fruit and vegetables[3]

1.7 The second is that men are less good at early detection of symptoms, and less likely to seek help when symptoms are present. Although there is limited research evidence to back up this hypothesis, it is very commonly believed to be the case by experienced clinicians. One study in Oxford in 2002, which did address the issue directly found that, of 45 men diagnosed with testicular cancer, some had put off seeking help for weeks or even months after first becoming aware of the symptoms[4]. A male patient whose case study appears on the Beating Bowel Cancer website may speak for many men when he says:

I must confess that I had noticed symptoms for about 10 months before I actually went to the doctor[5]

Comparisons between men

1.8 Before considering what needs to be done about the disparities in incidence and mortality between men and women, it is also worth briefly considering the evidence about incidence and mortality among different groups of men.

1.9 The evidence that socio-economic status is a factor in cancer mortality is beyond dispute. Poor men are twice as likely to die from cancer than men who are better off (although the pattern is not consistent across all cancers – for example, colon cancer does not conform to a social class gradient).[6]

1.10 There are marked regional differences in both cancer incidence (lung cancer in men in South & West Region is 75% of the national rate, whilst in the North West it is 117%[7]) and cancer survival (the survival rate for prostate cancer varies from 51.1% in Trent Region to 64% in London Region[8]).

1.11 International comparisons also show significant differences in the incidence of particular cancers (colorectal cancer is twice as common in UK men as in men in Greece, for example, and male stomach cancer rates are markedly lower in the Scandinavian countries[9]).

1.12 There is very little data about cancer incidence in minority communities in the UK but it is well established that the African and Caribbean population has an incidence rate for prostate cancer almost three times as high as the population as a whole[10].

Conclusions

1.13 The disparity between men and women in the incidence of cancer is extremely marked. Such disparities would undoubtedly (and rightly) be the subject of targeted strategies if they were related to social class or ethnic origin rather than sex. The conclusion here is clear - that present policies for the prevention of cancer are failing men. Improving population health, by definition, involves finding ways to improve the health of men. We can - and must - do better.

1.14 Men are not a homogeneous group. Incidence and mortality rates vary according to an interwoven series of demographic criteria independent of male sex. We are failing all men – but we are failing some men more than others. In cancer, as in all other causes of death, it seems right to re-iterate the MHF's own consistently drawn conclusion that we must aspire to a position where men in all groups experience health as good as those in the groups whose health is the best. A minimum goal, therefore, should be the achievement of incidence and mortality levels that match those of professional men in the UK and/or men in comparable countries with lower rates.

2. Policy Recommendations

Introduction

2.1 It is a central contention of the MHF that it would be beneficial for both men and women if all health policy took proper account of gender differences and if health improvement targets were "gender specific"[11].

2.2 Action is needed at two levels – national and local. Nationally, the Department of Health should take the lead by developing policies that take gender specifically into account. Locally, primary care trusts (PCTs) should aim to develop targeted male-specific strategies and programmes for the prevention of cancer. A lack of action at the national level does not prevent PCTs putting in place local policies and services targeted at men. PCTs have the flexibility and responsiveness to take account of the needs of their local populations and it is in locally determined provision that we see the greatest potential for improvements to be made. We urge PCTs particularly, to act on the recommendations for local action in the Action Plan below.

Action Plan

The following five point plan is based on the broad principles established in the MHF's policy document *Getting It Sorted: A policy programme for men's health* (published in April 2004) which aims to provide a platform for developing policy and practice for the improvement of men's health at both local and national levels.

1. Setting male-specific cancer targets

PCTs should set long-term local targets for reducing the incidence of cancer in men, and medium-term targets for measurable reduction in known cancer risk behaviours in men – for example smoking, poor diet and alcohol consumption. The Department of Health should encourage local action of this kind by developing a sound knowledge-base for work with men in general and the reduced incidence of male cancers in particular.

2. Developing outreach and partnerships

There is good research evidence to suggest that men will engage with health initiatives that take place in the workplace. PCTs should therefore develop partnerships with local employers to deliver advice and information to men in this setting. Additionally, PCTs should investigate the viability of outreach

services combining basic health checks for men with the early detection of potential cancer symptoms. Such services could be offered not only in workplaces but also in sports venues, social clubs, pubs, barbers' shops and other "male-friendly" environments. Some specialist cancer charities have already developed expertise in this approach and the outcomes have been positive.

3. Understanding male attitudes

It is axiomatic among many health professionals that men are more likely than women to "deny" the likelihood of developing cancer and more likely to attempt to ignore potential symptoms. There remains however, a distinct lack of robust evidence in this area. If this commonly-held perception is accurate, it could be absolutely fundamental to the issue of tackling cancer in men. Research into men's attitudes and behaviour is urgently needed to establish a strong evidence-base for effective cancer prevention strategies.

4. Initiating male-oriented public health programmes

PCTs must develop community-wide public health programmes for the prevention of male cancer and self-identification of early warning signs. These programmes might centre on either the known relationship between lifestyle and cancer – for example, male-specific smoking cessation programmes - or on those aspects of early detection directly relevant to men – such as the tendency of malignant melanomas to develop more commonly on men's backs where they may take longer to come to be detected (i.e. unlike in women, where the most common site is the legs).

5. Addressing inequalities between men

Tackling the huge differences in cancer incidence between the most well-off and the least well-off, is an established national policy priority Many commendable policy initiatives are already in place which are attempting to address these inequalities - but few, if any, take a gender perspective. PCTs are ideally placed to take account of the local cultural differences that may have an impact on the differences between groups of men – not just social class differences but also differences between ethnic communities and between men of different ages. Male-specific initiatives need to be placed within these contexts in order to be fully effective. Carrying out robust local health needs assessments that include seeking the views of local men - and acting on the findings in partnership with local communities - is the only route to developing an approach that effectively addresses local inequalities in cancer and, of course, a very broad range of other health problems. Our goal must be nothing less than the achievement of optimal health and well-being for all men.

REFERENCES

1. *About Cancer* www.cancerresearch.co.uk.
2. Europe Against Cancer, *European Code Against Cancer (third version).* (European Community, 2003). Available online at www.cancercode.org.
3. Bray F and Atkin W, " International cancer patterns in men: geographical and temporal variations in cancer risk and the role of gender". *Journal of Men's Health and Gender* 2004.
4. Chapple A, Ziebland S, McPherson A, "Qualitative study of men's perceptions of why treatment delays occur in the UK for those with testicular cancer". *British Journal of General Practice* 2003
5. "Paul's Story" www.beatingbowelcancer.org.
6. Drever F and Whitehead M (eds), *Health Inequalities Decennial Supplement*. (Office for National Statistics, London) 1997.
7. Office for National Statistics, *Cancer - comparative incidence ratios for select sites by sex and NHS Regional Office 1998*. National Statistics Online www.statistics.gov.uk.
8. Office for National Statistics: *Five-year relative survival rate by health authority, persons diagnosed in 1993-5 and followed up to December 31st 2000: selected cancers, England.* National Statistics Online www.statistics.gov.uk.
9. White A and Cash K, A report on the state of men's health across 17 European countries. (European Men's Health Forum, Brussels 2003).
10. Presentation to the Annual Meeting of the British Association of Urological Surgeons, June 2003. See www.prostate-cancer.org.uk/acp.
11. Men's Health Forum, *Getting It Sorted: A Policy Programme for Men's Health* (MHF, London 2004).

ABOUT THE MEN'S HEALTH FORUM

The Men's Health Forum aims to improve men's health in England and Wales through:

Policy development • Research • Professional training • Providing information services • Stimulating professional and public debate • Working with MPs and Government • Developing innovative and imaginative projects • Collaborating with the widest possible range of interested organisations and individuals

The Men's Health Forum's mission is to provide an independent and authoritative voice for male health and to tackle the issues affecting the health and well-being of boys and men in England and Wales. Our vision is a future in which all boys and men in England and Wales have an equal opportunity to attain the highest possible level of health and well-being. The Men's Health Forum believes male health problems should not be tackled by re-allocating resources from female health or shifting attention away from female health.

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The MHF's analysis of the current policy situation and our recommended framework for action to improve men's health is contained in our 2004 publication: *Getting It Sorted: A Policy Programme for Men's Health*. *Getting It Sorted* can be downloaded from the Men's Health Forum website (www.menshealthforum.org.uk) in pdf format or ordered in printed form (£10 inc. p&p) by ringing the MHF office on 020 7388 4449.