Disparities in Cancer Screening Practices among Minority and Underrepresented Populations

Tamryn F. Gray, Joycelyn Cudjoe, Jeanne Murphy, Roland J. Thorpe Jr, Jennifer Wenzel, and Hae-Ra Han

Objectives: *To review current evidence about cancer screening challenges that lead to cancer health disparities in minority populations.*

Data Sources: *Research reports, published journal articles, web sites, and clinical practice observations.*

Conclusion: *There are significant disparities that exist in cancer screening practices among racial and ethnic minority and underrepresented populations, resulting in disproportionately higher cancer mortality rates in these populations.*

Implications for Nursing Practice: *Nurses are positioned to lead in educating, promoting, and bringing awareness to cancer screening recommendations*

Tamryn F. Gray, MSN, RN, BMTCN, CNL: *PhD Student, School of Nursing, Johns Hopkins University, Baltimore, MD.* Joycelyn Cudjoe, BSN, RN: *PhD student, School of Nursing, Johns Hopkins University, Baltimore, MD.* Jeanne Murphy, PhD, CNM: *Postdoctoral Cancer Prevention Fellow, Breast and Gynecologic Cancer Research Group, Division of Cancer Prevention, National Cancer Institute, Rockville, MD.* Roland J. Thorpe, Jr, PhD: *Associate Professor, Department of Health, Behavior, and Society, Bloomberg School of Public Health, Johns Hopkins University, Baltimore, MD, and Hopkins Center for Health Disparities Solutions, Johns Hopkins University, Baltimore, MD.* Jennifer Wenzel, PhD, RN, CCM, FAAN: *Associate Professor, Department of Acute and Chronic Care, School of Nursing, Johns Hopkins University, Baltimore, MD.* Hae-Ra Han, PhD, RN, FAAN: *Professor, Department of Community-Public Health, School of Nursing, Johns Hopkins University, Baltimore, MD.*

Address correspondence to Tamryn F. Gray, MSN, RN, BMTCN, CNL, School of Nursing, Johns Hopkins University, 525 N. Wolfe Street, Baltimore, MD 21205. e-mail: tfgray@jhu.edu

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and current cancer prevention guidelines for at-risk individuals, and help them to implement these guidelines to reduce incidence and mortality.

KEY WORDS: *cancer incidence, cancer screening, screening, cancer prevention and control, health disparities, minorities.*

Cancer is the second leading cause of death in the United States (US)[1] and accounts for nearly one of every four deaths.[2] By 2030, the US population is expected to grow 10%, but the incidence of cancer will increase by 45%, to 2.3 million individuals diagnosed each year.[3] Most of the increase is predicted to occur within the minority and older-adult populations.[3-5] With the projected increases in cancer incidence and prevalence among underrepresented populations, it is important to understand cancer screening practices within these populations and its role in cancer health disparities.

Health disparities are differences in the incidence, prevalence, mortality, and burden of disease and other adverse health conditions among specific groups in the US.[6] Despite advances in cancer medicine and the resultant 20% decline in cancer death rates for Americans since 1991, there remain distinct cancer health disparities. For example, minorities and the poor continue to bear the disproportionate burden of cancer, especially in terms of stage at diagnosis, incidence, and mortality,[6] with blacks having the highest death rate and shortest survival rate of any racial or ethnic group for most cancers.[7] Sexual and gender minorities (SGM), including those in the lesbian, gay, bisexual, transgender/transsexual, and queer community, represent another growing and medically underserved population in the US.[8] In fact, SGM are now designated as health minority populations by the National Institutes of Health.[9] SGM span across various racial and ethnic minority groups, and the cancer incidence rates remain largely unknown.[8,10,11] In general, the causes of cancer-related disparities in risk are complex and overlapping, and can include differences in behavioral, environmental, and genetic risk factors, socioeconomic factors, and unequal access to care. There are multiple risks involved for SGM because stigma may be higher in this population, in addition to the cultural beliefs and lower perceived risks often associated with racial and ethnic minorities. These patients should not be isolated or ignored with regards to risk communication and screening recommendations.

Cancer prevention and early detection represent the key defenses to combat cancer.[12] Notably, since the "War on Cancer" began in 1971, changes in screening and treatment have contributed to an almost 4-fold increase in the number of survivors.[13] The overall goal of screening is to provide treatment when the disease is still curable, resulting in fewer deaths, improved quality of life, and longer life expectancy.[14] Racial and ethnic minorities experience barriers to effective cancer screening, including patients' abilities and/or willingness to participate in screening procedures, and mistrust of health care providers in minority communities. In addition, there are knowledge gaps about cancer screening between providers and patients, and clinicians may not adequately address patient concerns.[6] Barriers that affect the timing in which cancer can be detected may impact available treatment options for individuals diagnosed with a life-threatening cancer diagnosis. Further, the complexities of cancer and the nuances associated with screening guidelines lead to confusion, especially when the guidelines change over time.[6] For example, groups like SGM may benefit from modified screening approaches, yet most screening recommendations do not include information specific or relevant to them, contributing to the avoidance or delay of seeking preventative health care.[8] Additionally, this population is often less likely to have routine cancer screenings and may not undergo testing if symptoms develop because of fear of disclosure, stigma related to their sexual orientation or gender identity, and possible discrimination in quality care and treatment.[15,16]

The purpose of this article is to review disparities in cancer incidence, prevalence, and mortality relevant to the practice of oncology nurses and other clinicians. Screening recommendations specific to each type of cancer will be highlighted, along with illustrative case studies. We also present information about cancer prevention, early detection, and implications important to nursing practice. Each case study includes a brief description about an individual who is from an underrepresented, at-risk, and racial and ethnic minority background.