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Health behaviours in older cancer survivors in the English Longitudinal Study of Ageing

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ABSTRACT

Objectives: To assess health behaviours in cancer survivors in a population-based sample of older adults in the United Kingdom (UK).

Methods: Data were from wave 1 of the English Longitudinal Study of Ageing. Prevalence of smoking, alcohol consumption and physical activity was compared in cancer survivors and those with no cancer diagnosis. Associations between health behaviours and quality of life (QoL) and depressive symptoms were compared in both groups.

Results: There were 716 (6.2%) cancer survivors in the sample. Cancer survivors were more likely to be former smokers ($p < 0.001$) and less likely to do moderate or vigorous physical activity ($p < 0.05$) than those with no cancer diagnosis. Physical activity was associated with better QoL and lower depressive symptoms, and smoking with poorer QoL and higher depressive symptoms, in both groups.

Discussion: Levels of health behaviours among cancer survivors in the UK are suboptimal. Effective strategies to promote healthy lifestyles are needed in this vulnerable population.

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1. Introduction

The number of cancer survivors worldwide was estimated to be over 25 million in 2002¹ and a recent study using United Kingdom (UK) cancer registry data put the number of survivors in the UK at 2 million.² Although these trends are immensely encouraging for anyone facing a diagnosis of cancer, they also introduce a new health challenge because cancer survivors have a significant risk of second primary cancers and other chronic conditions including coronary heart disease, diabetes and osteoporosis.³ Improvements in survivorship therefore raise the issue of tertiary prevention.

The adverse sequelae of a cancer diagnosis have multiple causes including iatrogenic effects and pre-existing behavioural and genetic risk, but whatever the cause, it is likely that behaviours which minimise risk of cancer and heart disease

have the potential to improve survival and quality of life (QoL).⁴ The most convincing evidence on the role of health behaviours in survivorship has come from the studies of weight control and physical activity. A recent analysis concluded there was strong evidence that overweight and obesity are significant risk factors for specific second cancers and other comorbidities (i.e. CVD and diabetes).⁵ There is also evidence for a protective association between post-diagnosis physical activity and recurrence, cancer-related mortality and overall mortality, in breast and colorectal cancer survivors.^{6,7} In addition, Hamer et al. showed that physical activity was inversely associated with total mortality following a diagnosis of cancer in a population-based Scottish sample.⁸ Evidence regarding continued smoking in cancer survivors shows reduced overall survival,⁹ increased risk of second primary malignancy¹⁰ and reduced QoL¹¹; however, research is

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mostly limited to head, neck and lung cancer survivors. Alcohol's role in survivorship is complex because it is associated with raised risk for certain cancers, but at the same time is cardio-protective in modest quantities¹²; nonetheless alcohol intake should clearly be modest at most. In addition to effects on morbidity and mortality, there is evidence that healthful behaviours in cancer survivors are related to better QoL¹³ and lower depression,¹⁴ giving an additional reason for promoting healthy lifestyles in this vulnerable group.

The recent review by the World Cancer Research Fund concluded that cancer prevention recommendations for the general population should also be applied to cancer survivors, including advice to maintain a healthy body weight, engage in regular moderate physical activity, eat at least five portions of fruit and vegetables a day, limit alcohol consumption and not to smoke.¹ The survivorship literature indicates that these recommendations may be even more important because of the raised risk of other adverse health outcomes in cancer survivors. Research to assess health behaviours in cancer survivors is therefore vital to identify the scale of the problem.

Large-scale, population-based studies have been conducted in the United States (US)^{15,16} and Australia.¹⁷ Generally they have found similar levels of physical activity, alcohol consumption and smoking in survivors as in the general population. To date, no studies of health behaviours in cancer survivors in England have been reported. The aim of the present analyses was to assess the prevalence of smoking, alcohol consumption and physical activity in older adults with a history of cancer compared with those with no cancer history using data from a population-based sample. We also assessed whether smoking and inactivity were related to poor QoL and greater depressed mood in the same way in cancer survivors as in people with no history of cancer.

2. Methods

2.1. Participants

Data for these analyses were from wave 1 of the English Longitudinal Study of Ageing (ELSA) carried out in 2002. This nationally representative, population-based sample was drawn from people aged 50 or over who had taken part in the Health Survey for England in 1998, 1999 or 2001. Data from 11,515 adults aged 50–99 are used for these analyses. Details of the ELSA methodology have been published previously,¹⁸ but briefly involve a nurse assessment, an interview during a home visit, and a self-completion questionnaire to return by post which includes simple items on smoking, alcohol and physical activity, as well as established measures of depression and quality of life.

2.2. Measures

2.2.1. Demographic

Participants reported their gender, age, race/ethnicity (coded as white versus non-white) for these analyses and marital status (coded as married or cohabiting versus single, divorced, separated or widowed). Education was used as an indicator of socioeconomic status (SES). Participants were di-

vided into three groups: higher education, intermediate qualification and no educational qualification.

2.2.2. Health behaviours

Smoking was assessed by asking participants if they smoked currently, were former smokers or had never smoked. Alcohol consumption was assessed by asking if they had consumed any alcohol in the last 12 months. Among those who reported having alcohol, respondents were divided into those who had two or more versus less than two drinks per day. Physical activity status was categorised as taking part in vigorous or moderate activity more than once a week versus once or less a week.

2.2.3. Cancer history and arthritis

Participants were asked if they had ever been told by a doctor or other health professional that they had 'cancer or any other kind of malignancy'. All those who answered yes were categorised as cancer survivors. This is in accordance with the National Cancer Institute's definition of a cancer survivor which states that from the time of diagnosis and for the balance of life, a person diagnosed with cancer is a survivor.¹⁹ Those reporting a history of cancer were also asked to specify the kind(s) of cancer with which they were diagnosed and if they received treatment for their disease in the last 2 years. Arthritis was assessed as a confounder of opportunities for physical activity, and participants reported if they had ever been told by a doctor of other health professional if they had arthritis (including osteoarthritis and rheumatism).

2.2.4. Quality of life and depression

Quality of life was assessed using the CASP-19. This is a 19-item Likert-scaled index containing sub-domains from which the acronym is derived; control, autonomy, self-realisation and pleasure. The CASP-19 was developed specifically to assess the quality of life in early old age, and is based on a needs satisfaction perspective. Scores range from 0 to 57 with a higher score indicating higher QoL. The four sub-domains have shown good internal reliability (Cronbach's alphas between 0.6 and 0.8) in a non-institutionalised population of older adults. The scale correlates well with the Life-Satisfaction Index ($r = 0.63$, $p = 0.01$) demonstrating concurrent validity.²⁰

Depressive symptoms were assessed using the Centre for Epidemiologic Studies Depression Scale (CES-D).²¹ A shortened 8-item version with binary response options which was developed for the Health and Retirement Study (HRS) was used, as in several previous publications from ELSA and HRS.^{22–25} Cronbach's α is 0.82, and the scale shows good sensitivity and specificity in comparison with the Short Form Composite International Diagnostic Interview clinical screener for depression.²² Scores could range from 0 to 8, with higher scores indicating a greater number of depressive symptoms.

2.3. Statistical analysis

Demographic characteristics of cancer survivors and those with no cancer history were compared using *t*-tests for continuous variables and non-parametric methods for categorical variables. Results are also presented adjusting for age

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