

## Foreword



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Cancer. This word still conjures up a very frightening and dismal meaning in most of our minds, despite decades of medical advances that allow for early detection and superior surgical, radiation, and chemotherapeutic treatments to either cure the cancer or prolong the patient's life. Nonetheless, since cancer is the second leading cause of mortality in the United States (cardiovascular disease being the first),<sup>1</sup> we primary care providers (PCPs) are challenged with the responsibility of educating our patients about the available modalities for prevention and screening of the cancers that are most likely to afflict them. This assumes, of course, that our patients will present for annual interval health maintenance examinations, or that adequate time allows for such a discussion during the routine office visit. Male patients present a particularly difficult challenge, since many men aged between 18 and 44 years do not routinely seek preventive services, but rather they present upon the urging of another or during an emergency or acute illness. After all, isn't our *raison d'être* as the frontline in medicine to prevent cancers and find them as early as possible to allow for the best treatments?

The United States Preventive Services Task Force, the American Cancer Society, and nearly every specialty organization have developed guidelines based upon the best evidence in the literature as well as expert panel opinions to aid us in screening our patients for various cancers.<sup>2</sup> Many of these we have committed to memory; others we may still have trouble making sense of with regard to when to offer initial screening or follow-up testing after an abnormal yet noncancerous result.

Offering annual Papanicolaou testing for cervical cancer in women is considered the standard recommendation for most women, and the advent of vaccination with the quadrivalent human papillomavirus recombinant vaccine (Gardasil) provides great hope that someday this disease could be significantly minimized or even eradicated. Colonoscopy for the detection of colorectal cancer in screening has decreased morbidity and mortality, yet we are now faced with the concept of a potential manpower shortage of gastroenterologists and others trained in this procedure to adequately screen an ever-aging population at risk. Reflexively ordering a mammogram to screen for breast cancer in women over 40 is relatively easy, rarely debated,

and uncontested by most insurance carriers, yet instructing women about self-breast examinations has not been shown to be effective as a cancer screening tool, and it often leads to increased anxiety and the potential for unnecessary breast biopsies (read: do we still instruct our patients to do this, or do we just forget it?). Reflexively ordering a prostate-specific antigen test in every man is considered to be inappropriate without shared decision making and risk stratification based on his age, ethnicity, and family history. What may be most challenging for PCPs in the fight against cancer occurs when there is a lack of evidence, which often leaves us confused about whether or not to perform a clinical examination or send a patient for a test that may lead to a potentially invasive and risky component. As the hallowed astronomer Carl Sagan once proclaimed, “absence of evidence is not evidence of absence.” So now what do we do?

The role of the PCP will need to expand in the future, to better coordinate the needs of the patient with cancer and of the patient who survives cancer. It is no longer sufficient to have a medical system in which the PCP simply “finds the cancer” and then sends the patient off to be cared for by the various specialists for the rest of his or her life. Our role is expanding on many levels, from integrated care to hospice and palliative care. At the same time, however, we are facing a shortage of primary care physicians.<sup>3</sup> Our specialty remains vital to educating our communities about the importance of prevention and detection of the cancers that could affect every man, woman, and child. Without a sufficient supply of PCPs, education on cancer prevention and screening for early detection will certainly suffer.

This issue of *Primary Care: Clinics in Office Practice*, dedicated to teaching PCPs what they need to know about cancer to supplement their daily practices, commences with excellent articles dedicated to overviews of cancer risk assessment and the notion of cancer burden on practitioners of primary care. Subsequent articles project what the future of cancer screening will look like and highlight its inherent implications for everyday primary care practice. I am impressed with the detailed reviews dedicated to highlighting the link between obesity and cancer and to behavioral interventions in tobacco dependence. It is simply not sufficient for us to tell our patients to lose weight and quit smoking: as PCPs we need to use the leverage of our influential position to educate our patients on motivational change to set and reach goals to avoid malignant consequences. Cancer continues to be more heavily prevalent in the lower socioeconomic groups, and the article dedicated to cancer control in low- and middle-income countries aims to address the various challenges in mitigating such disparities in morbidity and mortality. The remainder of this issue focuses on the evidence behind prevention and screening for breast, prostate, colorectal, and cervical cancers. Drs. Wender and Snyderman deserve great accolades for compiling a unique and timely collection of outstanding review articles to serve as a reference for all PCPs as we approach the topics of cancer prevention and detection with our patients. The breadth of subtopics in this issue renders this and its counterpart issue of the *Primary Care Clinics* necessary for PCPs and learners of medicine at all stages. Although this material is written predominantly as a medical reference, savvy patients stand to learn a great deal from it to enhance and prolong their lives.

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