

Tackling the excess incidence of cancer in men

Proceedings of the expert symposium held at
Leeds Metropolitan University on November 16th 2006



David Wilkins

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In 2004 National Men's Health Week was dedicated to the theme 'Men and Cancer'. During that week, the Men's Health Forum (MHF) published a short briefing paper drawing attention to the fact that men are very much more likely than women to develop nine of the ten most common cancers that can affect both sexes. Overall, the male mortality rate for all ten of these cancers is almost double the female mortality rate. The paper explored potential reasons for these differences in incidence and mortality. It concluded that:

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 gender. The conclusion here is clear – that present policies for the prevention of cancer are failing men.

As a consequence of the publication of the MHF report, Professor Mike Richards, National Cancer Director, invited the MHF to take the lead in organising a small, high level, national symposium to debate the following question:

Why are cancer incidence and mortality so much higher in men than in women?



The symposium brought together a group of the leading practitioners, academics and thinkers in the field, along with patient groups and men who have had cancer. In its first session the symposium heard a series of presentations by expert speakers that addressed some of the most important issues underlying the central question. All the speakers accepted that reducing the gap between men and women is of absolutely central importance in seeking to reduce cancer incidence and mortality in the population as a whole. There was agreement too, that cancer prevention campaigns and treatment programmes are currently being hampered by misconceptions and lack of knowledge in relation to cancer in men.

The session concluded that, although there are some potential biological explanations for the gap between the sexes in respect of some particular cancers, most of the explanations that are well understood at present are to do with lifestyle differences between men and women (differences in smoking, alcohol use, dietary intake and so on). For most cancers however, the explanation of the gap is partial at best – and in some cases there is no explanation at all. The known evidence suggests that the most widely-believed explanation for the difference in mortality rates – that men are more likely than women to delay seeking help once they have developed potential cancer symptoms – is incorrect. It is probable that cancer prevention programmes and campaigns are less effective with men than women, although the reasons why this is so are not fully understood.

The second session of the symposium was devoted to an open debate which drew on the expertise and ideas of all those present. A series of 8 recommendations for future action was agreed. These recommendations are explained fully at the end of this report but in summary they are as follows:

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- ▶ **Because the knowledge base is currently so poor, there should be an urgent systematic review of the existing evidence in relation to men and cancer.**
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- ▶ **There is a particular need for a study to examine why some patients delay presenting with cancer symptoms, and how and why this varies according to gender.**
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- ▶ **Work should be undertaken to examine how men respond to the “vocabulary” of cancer both when they do not have the disease and post-diagnosis. This might ideally happen as part of the development of the National Bowel Cancer Screening Programme, which is just getting underway.**
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- ▶ **Greater emphasis should be placed on symptom recognition as a component of health improvement campaigns, with particular attention being paid to the need for “male-sensitive” communication strategies.**
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- ▶ **It might be useful to examine the extent to which cancer patients are offered choices and asked to make decisions during the course of their treatment. It might be that men and women are offered different kinds of choices and/or that they deal with choices and decisions differently.**
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- ▶ **The psycho-social responses to cancer diagnosis and treatment may vary between men and women, and may impact differentially on the patient’s progress post-diagnosis. “Male-sensitive” forms of support may have the potential to be particularly effective.**
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- ▶ **There is significant scope to extend the range of settings in which men are offered advice, information, routine health checks and even, potentially, basic treatment. Cancer prevention programmes should be instituted that take an “outreach” approach to engaging with men.**
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- ▶ **The National Curriculum should include education – particularly targeted at boys – about how to take maintain good health and how to use health services effectively.**
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▶ Background to the symposium	4
<hr/>	
▶ Professor Mike Richards Chair's introduction to the day's proceedings	5
<hr/>	
▶ Presentation 1: Professor David Forman The epidemiology: what is known and what is not known?	7
<hr/>	
▶ Presentation 2: Professor Alan White: Risk of developing cancer	10
<hr/>	
▶ Presentation 3: Professor David Weller Choosing health: men's behaviour in relation to cancer services	13
<hr/>	
▶ Presentation 4: Dr Una Macleod Men's knowledge, behaviour and attitudes	16
<hr/>	
▶ Presentation 5: Professor Henrik Møller Do men and women with similar cancers receive similar treatment?	20
<hr/>	
▶ David Howe, Neil Walsh Speaking from personal experience	22
<hr/>	
▶ Summary of speakers' conclusions	24
<hr/>	
▶ Summary of debate; and recommendations arising	25
<hr/>	
▶ Appendix 1: Programme for the expert symposium	27
<hr/>	
▶ Appendix 2: Text of the letter of support from the Secretary of State for Health	29
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The speakers' presentations from the symposium can all be viewed online by following the link on the home page of the Men's Health Forum website at: www.menshealthforum.org.uk

Background to the symposium

During National Men's Health Week 2004, the Men's Health Forum (MHF) published a brief report (downloadable from www.menshealthforum.org.uk) drawing attention to the fact that, for nine of the ten most common cancers that are not specific to either sex, incidence rates are very much greater in men than in women. Men have higher mortality rates for all ten of these cancers individually, and overall are almost twice as likely to die from them. This pattern is repeated to a greater or lesser extent for most of the more uncommon cancers too. In the case of some individual cancers, some of the reasons for these differences between the sexes are fully (or partly) understood. These differences have however rarely been explored in the context of the bigger picture about the impact of gender on service provision, service take-up, and health outcomes.

As a consequence of the publication of the MHF report, Professor Mike Richards, National Cancer Director, invited the MHF to take the lead in organising a small, high level, national symposium to explore the following question:

Why are cancer incidence and mortality so much higher in men than in women?

The MHF established a partnership with three other organisations to organise and host the symposium: Cancerbackup, Macmillan Cancer Support, and the Centre for Men's Health at Leeds Metropolitan University. The event itself took place on November 16th 2006 at Leeds Metropolitan University.

Within the context of the central question highlighted above, the symposium had three subsidiary objectives:-

- ▶ **To describe the extent of current knowledge in the area of men and cancer.**

- ▶ **To identify the gaps in knowledge.**

- ▶ **To "kick start" the development of an effective strategy in response to the problem**

The symposium brought together a group of the leading practitioners, academics and thinkers in the field, along with patient groups and men who have had cancer. The day was structured to allow everyone the opportunity to participate fully in the debate. The symposium was audio-taped and this document summarises its proceedings and presents its recommendations. The programme for the day is at Appendix 1.

Introduction to the day's proceedings



Simon Lee

Simon Lee, Vice-Chancellor of Leeds Metropolitan University (LMU) welcomed delegates to the day's event and stressed the University's continuing commitment to the work of its Centre for Men's Health. He commended delegates' willingness to travel to Leeds to participate in the symposium and expressed his gratitude to Professor Mike Richards for chairing the event. He hoped that further events in this important and developing field of study would take place at LMU in the future.



Professor Mike Richards

Professor Mike Richards congratulated the four partner organisations on staging the symposium. He hoped the event would mark the beginning of a process in which a dedicated work programme on cancer in men could be developed. In Professor Richards's view, three questions would underpin debate during the day.

▶ **What do we know about cancer in men?**

▶ **What *don't* we know about cancer in men?**

▶ **What can we do about the concerns that will inevitably arise during the day's discussions?**

Professor Richards reiterated that the symposium's starting point was the attention that had recently been drawn to the major differences in cancer incidence between men and women of those cancers that are not specific to one sex or the other. The incidence of these cancers is very significantly higher in men in virtually all cases – but we don't have a clear picture of why this should be:

▶ **What about patterns of age distribution – can that tell us anything?**

▶ **Do lifestyle differences between men and women offer any clues?**

▶ **Do men really leave it later than women to present for medical help, as is often believed?**

▶ **If so, is that explained by lack of awareness about potential symptoms or by fear of a positive diagnosis?**

▶ **Do men and women understand the whole concept of cancer in a different way?**

▶ **What did the large scale pilot for the National Bowel Cancer Screening Programme tell us about men's and women's attitudes to screening?**

▶ **Do men and women get equivalent treatments once they have been diagnosed with cancer?**

▶ **Do men have more co-morbidity than women, adversely affecting their prognosis?**

▶ **Where there is a choice of treatments, do men and women choose different options?**

▶ **Are there biological differences between men and women in the way that tumours develop?**

▶ **Are there differences in the psychology of men and women that affect their attitudes post diagnosis and which might act upon their recovery?**

Professor Richards hoped that by the end of the day the symposium would be able to identify actions we could take within the existing cancer programme and give some indication of where further research is necessary. He suggested that a paper arising from the symposium could potentially be taken to the cancer research bodies in order to initiate a discussion about future research priorities.

Finally, Professor Richards drew attention to a letter from the Secretary of State for Health, Rt Hon Patricia Hewitt MP, to Peter Baker, Chief Executive of the Men's Health Forum. The letter congratulated the organisers of the symposium and acknowledged that there is more to be done both to understand why the incidence of cancer is higher in men and to identify practical ways forward. The text of the letter from the Secretary of State is at **Appendix 2**.

The epidemiology: what is known and what is not known?

Professor David Forman

Centre for Epidemiology and Biostatistics, Leeds University

Director, Northern and Yorkshire Cancer Registry and Information Service

The intention of Professor Forman's presentation was to provide background information and data, and to put in place the statistical foundation for the day's debate.

Almost exactly the same number of men and women in the UK develop cancer each year (138,000 men, 137,000 women) although cancers in men are more likely to cause death (80,000 male deaths compared with 73,000 female deaths). Overall, cancer causes 28% of male deaths and 23% of female deaths.

Because there are more women than men in the population however, it is necessary to examine age-standardised incidence and mortality rates (rather than total numbers) in order to make judgements about relative risk. The incidence rate among men is 406 cases per 100,000 population per annum, the incidence rate among women is 342 per 100,000 population. As might be expected the mortality rate is also markedly higher among men (221 deaths per 100,000 population per annum compared with 146 deaths among women). Professor Forman suggested that it is these differences in incidence and mortality between the sexes that we must seek to understand. The rest of his presentation would concentrate on what we know and what we do not know about the causes of these differences.

Professor Forman chose to concentrate on the 35–69 age group because that is the age band within which all the common cancers tend to develop and for which figures are most reliable. It is observable that the differences previously described are partly a function of age. Under 50 years, the incidence of all cancers is higher in women (dominated by the incidence of breast cancer in younger women). At age 55 or so, the rates cross over

and from then onward incidence in men is higher than incidence in women. Death rates show a broadly similar pattern, although the excess of women over men at younger ages is smaller than the excess in incidence rates.

An important piece of information to absorb at the outset is that – with one or two exceptions – 5-year survival post-diagnosis is roughly equal for men and women. This suggests immediately that the explanation for the discrepancy in mortality rates is more complex than the common assumption that men tend not to present for treatment until a more advanced stage in the development of the disease.

Prostate, lung and colo-rectal cancers account for roughly half of all cancers in men. The distributive pattern is much the same in women if breast cancer is substituted for prostate cancer. Incidence of prostate cancer has increased dramatically in recent years. This is probably because greater use of PSA antigen testing has identified cases of prostate cancer which might never otherwise have come to light during the man's lifetime (many men die *with* prostate cancer not *from* it). This is evidenced by the fact that mortality rates have remained more or less static in the past ten years – i.e. there is no underlying increase in risk of death from prostate cancer.

More can be learned from the cancers that are not "sex-specific". The two that are most important statistically are lung cancer and colo-rectal cancer. Incidence and mortality rates for lung cancer have always been higher in men because of higher smoking rates among men in earlier decades. These rates have fallen significantly in recent years as a consequence of reductions in numbers of men smoking. This has had a disproportionately

beneficial effect on male cancer rates overall and partly masks the size of the differences in those cancers that have less obvious causes. Incidentally, lung cancer is now emerging as a issue of greater concern for women since rates of smoking in women have not declined at the same rate as those in men.

Colo-rectal cancer shows a substantially elevated risk in men – not only in the UK but in all European populations. The reasons why this should be so are much less clear than in the case of lung cancer, although dietary differences between men and women may offer a partial explanation. This pattern (higher incidence in men with no single explanation) is repeated in every cancer that one looks at – with just one exception which Professor Forman would come to later. In some cases, the reasons are better understood than others. For example in oral cancer, which has a very large difference in incidence between men and women, the explanation is probably to do with a combination of smoking and alcohol consumption, both of which are higher in men. The difference is also seen however, in cancers where the cause is very largely unknown; for example cancers of the brain and central nervous system, and non-Hodgkin's lymphoma. Stomach cancer has some known causes (dietary causes and infection with *Helicobacter pylori*) but even taking those factors into account, there is still a gap between men and women which cannot be explained (i.e. those risk factors are fairly evenly distributed between the sexes but the gender differential is still there).

We can conclude then, that there is a "generic pattern" which remains consistent whether we understand the causes or not. This overarching pattern holds true internationally, despite significant variations in incidence

rates between countries – for example, in the tenfold difference in gastric cancer incidence between Japan (higher) and USA (lower), there remains a consistent gap between incidence in men and incidence in women in both countries. Of course, this pattern needs to be seen in the wider context of "all cause" mortality which is higher at all ages for men than women. There may be an underlying biological explanation for this but, if so, it is not fully explained, Further research is certainly needed.

The link between social deprivation and higher cancer incidence rates is well known. However, a look at the local data for Yorkshire suggests that if sex-specific cancers such as prostate cancer and cervical cancer are eliminated from the figures, the social class gradient for women becomes rather less marked while the social class gradient for men becomes more so. If lung cancer is eliminated, the social class difference for women virtually disappears, while for men it is remains very noticeable. In other words, there appears to be a more direct link between deprivation and cancer in men than in women.

Malignant melanoma is virtually the only cancer where incidence is higher in women than men – probably because women are more likely than men to experience sun exposure without appropriate protection. Male death rates for melanoma are however, higher, than female death rates – so again, what we might call the "normal pattern" in mortality still remains. As melanoma is eminently treatable if caught early, this suggests that men may fail to recognise, or to act upon, symptoms. There is good data from the Northern and Yorkshire Cancer Registry on stage of diagnosis. Professor Forman and his colleagues have looked at



Professor David Forman

these data for malignant melanoma and they broadly support this theory i.e. they show that men are rather more likely to present for treatment at a later stage in the development of their disease and hence with a worse prognosis.

The wider picture, though is much more complicated. A multivariate analysis of the figures suggests that age is a particularly significant complicating factor – over 75 year-olds have a 5-year death rate that is 5 times higher than those under 45. Likewise there is a 6-fold difference in 5-year survival between people (of both sexes) with the thinnest tumours (which have the best prognosis) at diagnosis and those with the thickest. There is also a social class gradient; those from the lowest social classes have the worst survival rates. However, even if *all* these aforementioned factors are controlled for, and stage of presentation, and the location of the melanoma on the body are taken into account, women are still 31% more likely to survive their cancer than men. This suggests that although social reasons (e.g. late presentation, social class, age etc.) offer clear explanations for some of the difference, there are still some unknown factors involved. These unknown factors are probably biological in origin and are certainly related to gender in some way – but they are not at all understood.

Professor David Forman: Conclusions

- ▶ Nearly all common cancers show elevated incidence rates in men compared with women.
- ▶ For a few sites of cancer, excess incidence and mortality in men can be wholly or partly explained by men's great exposure to known risk factors: e.g. smoking, alcohol.
- ▶ For many sites of cancer, the reasons for the male excess remains unclear.
- ▶ This male excess may result from unidentified risk factors or from a general biological predisposition.
- ▶ Cancer in men in the UK appears more strongly related to social deprivation than cancer in women.
- ▶ Men have poorer survival from malignant melanoma for reasons that are not solely due to stage at presentation.

Risk of developing cancer

Professor Alan White

Centre for Men's Health, Leeds Metropolitan University

Professor White explained that he would move on from the starting point established by Professor Forman – that men are at greater risk of both developing and dying from the majority of cancers that might otherwise be assumed to affect both sexes equally. He would consider some possible explanations why this might be so. He would concentrate on some of the known causes of cancer and, in doing so, examine the evidence for factors that had particular relevance for men.

Professor White began by briefly examining the number of patients registered with cancer in different age groups. More men than women are registered for nearly all (non sex-specific) cancers at all ages. This confirms that the explanations are more complex than the assumption that more men than women die from cancer simply because men tend to delay seeking help. Professor White also drew attention to the incidence rates for cancer in children, where we see a broadly similar pattern to incidence rates in adults (although one that is perhaps not quite as clear cut – for example, kidney cancer is more common in girls than boys).

In thinking about causes of cancer, it is first important to recognise that there are two broad classes of cancer (although, as will be seen, there is overlap between them). The two classes are *germline cancers* (those that are attributable to inherited factors) and *somatic cancers* (those whose causes are acquired during the lifespan).

Germline

Various genetic mutations can be passed down through families making family

members of both sexes more susceptible to cancer (although the susceptibility may vary between men and women). Of particular interest in thinking specifically about men may be the association between some specific cancer risks and the known “vulnerability” of the XY (male) chromosome. Some authorities have also suggested that cancer cells may replicate more quickly in men. This latter point would not be addressed in the presentation but it was worth noting that it would probably bear further examination.

Professor White drew attention to some of the specific genetic mutations that have importance for men. BRCA2 is linked with breast cancer in women but men can have this mutation too. It is associated with the small risk of breast cancer in men but, more importantly for present purposes, with an increased risk of prostate cancer, stomach cancer and melanoma. There is a clear association between prostate cancer and the Y-chromosomal haplogroups, evidenced by the variation in rates between racial groups (for example, the incidence rate of prostate cancer in African-American males is double that of Caucasian men and ten times higher than Japanese men). Further evidence for inherited risk is the CHEK2 mutation, which doubles the risk of prostate cancer in general but quadruples the risk in men with family history of the disease. Likewise, standardised incidence ratios for testicular cancer suggest a familial association (risk increased 3.8-fold when a father had testicular cancer and 7.6-fold when a brother had the disease). Testicular cancer is further associated with increased familial risk of leukaemia, distal colon cancer, kidney cancer, melanoma, connective tissue tumours and lung cancer.

Somatic

It is believed that around 37% of cancers can be attributed to a group of specific lifestyle and environmental risk factors: smoking; alcohol use; low fruit and vegetable intake; overweight and obesity; physical inactivity; and urban air pollution (plus, in developing countries; unsafe sex, indoor smoke, and contaminated injections). Smoking is believed to be associated with 29% of cancer incidence in the UK – not just with lung cancer but with at least ten other cancers, including cancer of the oral and nasal cavities, oesophageal cancer and cancer of the bladder. As previously mentioned by Professor Forman, smoking is historically a particularly important risk factor for men. It is still the case that more men than women smoke in all age groups but rates of smoking in men are falling. As Professor Forman also pointed out, cancer risks associated with smoking may become more prevalent in women than men in decades to come.

Alcohol consumption is associated with a quantifiably increased risk of a number of cancers. One established explanation for this is that alcohol can cause damage to human cells. Animal studies suggest that alcohol consumption can also stimulate angiogenesis, unhelpfully increasing blood supply to existing cancers. Since excess alcohol consumption is more common in men than women, this adverse relationship between alcohol and cancer is more particularly a male problem. Excessive alcohol consumption is also associated with certain personal circumstances (e.g. being single, divorced or separated) which adds a complicating social dimension to the issue.

A diet high in fibre, fruit and vegetables has been shown to have a protective effect against cancer. Studies also suggest that some cancer risks are associated with particular foods (e.g. the association between eating red meat and cancers of the digestive system). Men and boys are markedly less likely than women and girls to eat the recommended five portions of fruit and vegetables daily. Numerous studies also have suggested a much lower interest in nutrition among men.

Ten percent of all deaths are believed to be associated with obesity. Several cancers are among the group of conditions whose risks are known to be exacerbated by obesity – including kidney cancer, cancer of the gall bladder, pancreatic cancer and prostate cancer. Among the known ways in which obesity contributes to the development of cancer are that obesity can cause acid reflux (a risk factor for oesophageal cancer); and hyperinsulinaemia (a predisposing factor for colon cancer).

Professor White commended the work of the Men's Health Forum which has, by pointing out that more men than women in the UK are overweight, consistently challenged the popular notion that weight is predominantly a "women's issue". In fact, two thirds of men are overweight compared with just over half of women – and it is estimated that by 2010 three quarters of UK men will be overweight. The differences between male and female physiology mean that men are more likely than women to gain fat around their abdomen. Abdominal fat is particularly associated with the secretion of numerous "fat toxins" at least one of which – leptin – is associated with increased cancer risk (in this case, prostate cancer).

Professor White had time only to offer pointers towards a number of other issues that potentially help explain some of the excess incidence of cancer in men:

- ▶ There is good evidence associating both excess exercise (perhaps as typically seen in young men interested in body-building) and too little exercise with increased risk of cancer. The numbers of men in sedentary occupations has grown very significantly in recent decades.

- ▶ Improvements in health and safety in the workplace have greatly reduced the likelihood of disease associated with known carcinogenic materials but it is probably true to say that men are much more likely than women to come into contact with a wide variety of potentially hazardous chemicals and materials including ultraviolet radiation; ionising radiation; pesticides; medical drugs; solvents; fibres; fine particles and dust; dioxins; polycyclic aromatic hydrocarbons (PAHs); metals; diesel exhaust particles; toxins from fungi; and vinyl chloride benzidine.

- ▶ Women are known to have both stronger humoral immune systems than men and stronger cellular immune systems. This means they have a more vigorous antibody reaction and greater resistance to viral and parasitic infections. Whether women also have more effective resistance to tumours might bear further investigation.

Finally, another factor that often attracts insufficient attention is the extent to which men are likely to develop and die from

particular cancers at younger ages than women. Colo-rectal cancer is a good example. Men tend to develop and die from this disease 5 – 10 years earlier than women. As already pointed out, there is a genetic component to colo-rectal cancer and known gene mutations are associated with it. Many of the known risk factors (obesity, poorer nutrition, higher alcohol intake and smoking) are seen to a greater extent in men. Diabetes, a disease which is known often to be diagnosed late in men is also linked to a higher risk of colo-rectal cancer. Do these factors potentially explain the difference in age of onset, as well as potentially explaining the difference in incidence rates? Certainly, no single factor can currently be seen as definitive, whether in relation to age or gender – this confirms the case that we need an all round approach to cancer prevention.



Professor Alan White

Professor Alan White: Conclusions

- ▶ **Men are at increased risk of many cancers.**
- ▶ **The causes of cancer are many and varied – both inherited and acquired.**
- ▶ **There are some known biological and lifestyle factors that seem to make men specifically vulnerable to developing cancer.**
- ▶ **But no systematic study of men's increased risk of cancer has yet been undertaken – indeed, no single specific paper on men and cancer is to be found in the literature at all.**

Choosing health: men's behaviour in relation to cancer services

Professor David Weller

General Practice Section, Division of Community Health Sciences

University of Edinburgh

Professor Weller explained that he had been involved with studies into faecal occult blood testing (FOBT) for colo-rectal cancer and prostate specific antigen (PSA) testing for prostate cancer. His presentation would focus particularly on these cancers. The incidence of both these cancers is projected to increase in men in the next few years (incidence of lung cancer – presently the most common cancer in men – is projected to continue to fall over the same period).

Professor Weller acknowledged – as the symposium had already heard – that there is still much work to be done in understanding the epidemiology of cancer and tackling risk factors in men. His presentation however, would concentrate on the “pre-symptomatic” phase of cancer. This is the phase at which screening of men who may have cancer but who show no symptoms, is of most value. In doing so he would also explore the concept of “informed choice”. For a range of sociological, anthropological and physiological reasons cancer screening is much less established for men than for women, so this is a field of interest which is still developing.

In discussing the issue of cancer screening, it was very important to realise that the target is not simply to maximise uptake. The National Screening Committee and the General Medical Council urge that all screening programmes should ensure that people understand the process, risks and benefits. In Professor Weller's view, we should be aiming to apply the same ethical standards to health improvement programmes that we apply to treatment.

Bowel cancer screening

The National Bowel Cancer Screening Programme (NBCSP) which is in the process of being rolled out across the country, is the first mass cancer screening programme to target men as well as women. The newness of the idea will result in significant learning over the next few years. The concerns identified by the previous speakers will probably also have their impact on cancer screening in men. As a practising GP, Professor Weller's day-to-day observation was of fewer men than women attending surgery and it seems likely that normative male behaviours often militate against the best interests of men's health.

Professor Weller had been involved in the evaluation of the pilot programme for the NBCSP. That pilot was interested, among other things, in the core issues such as uptake, adverse effects, and numbers of cancers detected. The “pathway” for the rolled out national programme is essentially the same one that was used in the pilot. The process is not always straightforward; some results of the initial screening are ambiguous and patients may need to be called back. For some participants the process could take two or three months from start to finish.

The pilot showed a consistently lower uptake by men of between 5% – 10% in different age groups. This is important and will need to be addressed as the national programme develops. There has also been a falling off in participation by both men and women over the three rounds of screening in the pilot – suggesting that promotion of the programme will need constant attention. There is also a consistent social class gradient in uptake and a lower uptake by people from minority ethnic groups (both effects more marked in men).

A qualitative study of participants in the pilot programme (using focus groups and individual interviews) identified some common themes relevant to the current discussion. Important elements in encouraging people to participate in the programme included seeing the test as “non-threatening”; perceived susceptibility (e.g. knowing someone who had had colorectal cancer – especially a family member); and the influence of a spouse or partner. Fear of a positive result put people off – an attitude that was more common in men. Female interviewees often expressed the view that there should be more health screening available for men but at the same time they tended to be sceptical about whether men would take up screening even if it were available. It emerged that women may regard regular screening as “part of being a woman” – could we ever achieve this attitude in men? Some of the personal correspondence used in the cervical screening programme is quite coercive in tone (e.g. the reminder letters to people who consistently fail to attend), and it is an interesting question to ask whether that kind of approach would be more likely to provoke a negative response if it were directed at men. One conclusion of this study was that, although men consistently express a desire to receive more health information, it seems actually to be factors other than information that tipped the balance about whether they participated in the screening programme.

Prostate cancer screening

There is a continuing debate about whether the benefits of PSA testing outweigh the disadvantages both at individual and at population level. Proponents of PSA testing often point to a study in the Tyrol region of Austria where mass PSA testing

was introduced ten years ago. This study demonstrated a fall in the prostate cancer mortality rate in Tyrol over that period compared with the rest of Austria (as well as – as might be expected – a very substantial increase in the incidence rate). Two randomised trials are currently underway in Europe and the US but the results of those will not be known for some time. The results of these studies will give a clearer picture of the pros and cons of screening. Present predictors of the likelihood of an individual taking a PSA test at his own instigation include higher age, higher income and higher perceived control of health. GP consultations for urinary symptoms often result in referral for a PSA test and in the absence of other, more specific, symptoms, this is effectively a referral for screening.

GPs are known to feel under pressure to make referrals for PSA testing in the face of a request from a patient. A “decision aid” to help individual patients decide whether or not to have a PSA test is under trial in primary care in Oxford, having been piloted in eleven GP practices. It has been found to promote higher knowledge and tends to result in more negative attitudes to testing. Interestingly however, it has not affected the proportion of men intending to take a test compared with men who did not had access to the decision aid (similar interventions in the US have resulted in a drop off in men intending to take the PSA test). An Australian study involving giving detailed evidence-based information to a group of GPs about the pros and cons of PSA testing resulted in those GPs becoming less markedly likely to refer patients for PSA testing than colleagues who had not been given the information.



Professor David Weller

Professor David Weller: Conclusions

- ▶ **There is a range of mediating factors on men's behaviour in relation to preventing cancer. These include their awareness and knowledge; their self confidence and motivation; and their social status.**
- ▶ **Men are more likely than women to exhibit negative attitudes towards disease prevention interventions. These attitudes run counter to societal and familial expectations that people will want to take care of their health.**
- ▶ **Male uptake in the pilot programme for the The National Bowel Cancer Screening Programme (NBCSP) was disappointingly low in comparison to uptake by women. Specific strategies will be needed to counter this as the programme is rolled out nationally.**
- ▶ **A great deal more work is needed in understanding and promoting informed choice in relation to PSA testing – and indeed, in relation to choices associated with the prevention and treatment of other cancers.**

Men's knowledge, behaviour and attitudes

Dr Una Macleod

Dept. of General Practice and Primary Care, University of Glasgow

Dr Macleod explained that although not an expert on gender per se, she had done considerable work on the management of cancer in primary care and had always recognised that gender was relevant to that. Her presentation would take the audience through some of the published literature that had considered gender as a factor in people's knowledge of symptoms; people's attitudes to cancer; and people's help-seeking behaviour. She would also look at the issue of "delay". Her presentation would also highlight the limitations in what is currently known.

Some years ago there was an influential study of the relationship between delay in help-seeking and breast cancer survival. Dr Macleod's department subsequently undertook, on behalf of the Department of Health, a systematic review of the literature about help-seeking and delay in relation to all other cancers in adults. The review gave particular consideration to the role of both patients and primary care practitioners. Much of Dr Macleod's presentation would be drawn from that review. A separate review of the qualitative literature in relation to help-seeking and delay had subsequently been undertaken by the University of Leicester and her presentation would also look at that. Dr Macleod briefly outlined the methodology and process of the review, which eventually included a total of 229 papers that were judged to have met the validation criteria.

Knowledge and awareness of cancer

20 papers qualified to be included under this broad heading. Some had looked at primary care populations but most had targeted the general public. Eight of the papers allowed comparison of men and women. It was worth looking at some of these in more detail:

- ❶ A US study of 1,210 randomly selected individuals from the Los Angeles Health Survey, of whom 1,092 had reported potential cancer symptoms, found that men and older people were less likely to report symptoms and that men, married people, younger people and those on higher incomes were less likely to seek care for their symptoms

- ❷ A Canadian study looked at 512 people of whom 18% were men (consistently a minority of participants in these studies are men) and reported that two-thirds of the male participants were able correctly to identify the location of the prostate gland in the body – but only 38% knew that difficulty when urinating could be a sign of prostate cancer (by broad comparison 81% of women knew how to examine their breasts for lumps).

- ❸ A study in the Netherlands invited people (20% of participants were men) to consider a list of real and "dummy" cancer symptoms to establish whether they were able accurately to identify cancer risk. Women were consistently both more likely to dismiss the dummy symptoms and more likely than men to recognise actual symptoms of cancer with only one exception (urinary symptoms, which were correctly identified by more men).

④ Another study in the Netherlands used self-completion questionnaires to look at the relationship between simply knowing about symptoms and preparedness to seek help. 23% of participants in this study were male. The study found greater preparedness to seek help among women and people (male and female) of higher educational status. These two factors were found to account for 16% of the variation in behaviours.

⑤ A study of 406 adults in two primary care centres in Leeds using self-completion questionnaires found that women were more aware than men that weight loss and loss of appetite were potential symptoms of cancer. Again men were more likely to recognise urinary problems as a potential symptom but this was still less than half of men (48% compared with 14% of women)

Delay

Dr Macleod stressed the great importance of understanding what is properly meant by “delay”. There are three measurable forms of delay:

- ▶ **Patient delay** is the time between first noticing a symptom and initial presentation to practitioner.
- ▶ **Practitioner delay** is the time between initial consultation and referral to secondary care.
- ▶ **Hospital delay** is the time between referral and eventual diagnosis.

Delay is not synonymous with “late presentation” by patients, although it is often assumed to be so – even sometimes in the academic literature. Late presentation may of course, be explained by patient delay but it might also be the case, for example, that a cancer has reached a “late” stage without the patient ever becoming aware of any symptoms.

Delay is a particularly important issue because it is widely believed to be one of the key explanations for higher cancer mortality specifically among men.

The review assessed the relative importance of a variety of factors potentially associated with patient delay. The patient’s sex was among these factors. In upper gastro-intestinal and lower gastro-intestinal cancers, and cancers of the head and neck, the sex of the patient was not associated with the likelihood of him or her delaying seeking help. In the cases of melanoma and urological cancers, the evidence was not clear enough to form a judgement either way. By comparison, some of the other factors considered – such as whether the patient mistakenly considered the symptoms not to be serious – did show a very clear association with the likelihood of patient delay.

Interestingly, when the evidence was considered in relation to practitioner delay, it emerged that in some cases (upper GI and melanoma) men were actually *less* likely to experience delay (i.e. men were referred by their GP more speedily than women). In lung cancer however, male patients were more likely to experience practitioner delay. The most common cause of practitioner delay across all cancers studies was misdiagnosis.

Dr Macleod drew attention to a Norwegian paper considered in the review which had specifically measured the degree of psychological distress experienced by patients in the period between referral by a GP and examination and treatment by a specialist. This is of some interest because another commonly held belief is that men are more fearful of serious illness than women, and it is often speculated that this may be an underlying explanation for their poorer help-seeking behaviour. This study found that levels of distress were measurably higher in women. Dr Macleod cautioned against placing undue emphasis on the findings of this one study however, not least because more than half of the female patients in the study had breast cancer, and it was possible that the widespread public knowledge about breast cancer and its treatment may have contributed to the severity of distress suffered by patients. It would have been interesting to have made the comparison between men and women again after having excluded those patients with breast cancer from the data.

In respect of intervention studies, the review found, broadly, that a combination of practitioner awareness training and health promotion campaigns had been useful in changing people's help-seeking behaviour, although the bulk of this work had so far been in relation to one particular cancer (melanoma). Male-specific intervention studies on prostate and testicular cancer have shown a small amount of benefit but the effect tends to be short term.

A Swedish study was of particular interest. 32,000 people were sent information about cancer symptoms and invited to seek further

advice if they had any concerns. Some respondents needed only reassurance by telephone, but 234 patients were visited as a result of the concerns they expressed. More men than women received visits (139 men, 95 women) and, once basal cell carcinomas were excluded, no women ended up by having cancers diagnosed but 11 men were found to have a previously undiagnosed cancer.

Finally Dr Macleod looked at the synthesis of qualitative studies of help-seeking behaviour undertaken in Leicester that she had mentioned at the outset. 32 papers were considered in this review, covering 20 types of cancer. Half of the papers looked at breast cancer and one at ovarian cancer, so many of the studies were female-specific. It was found that factors associated with delay by patients could be grouped under two headings: "recognition and interpretation of symptoms" and "fear". Both these factors might usefully be further split into two sub-categories; the first into issues associated with the symptoms themselves (for example, symptoms being vague, minor or intermittent) and issues associated with seeking help (knowledge of cancer symptoms, recognition that symptoms have become severe, advice and encouragement sought from friends and family). "Fear" might be separated into "fear of cancer" and "fear of embarrassment" (i.e. embarrassment associated with seeking help or receiving treatment). In practice though the conclusions tended to be vague in terms of the sex of the participants, so the scope for exploring gender differences was limited. One clear conclusion was that the role of social networks in supporting help-seeking behaviour are poorly understood and may reveal significant gender differences.



Dr Una Macleod

Dr Una Macleod: Conclusions

- ▶ **Few studies into help-seeking behaviour and delay have studied gender as a primary issue, and few have included sufficient men.**
- ▶ **Awareness of symptoms is important for both men and women. Failure to act on symptoms is the most common cause of delay in seeking medical help.**
- ▶ **Men appear to be most well informed about urinary symptoms and it might be worth understanding more about why this is so, and considering its implications for practice.**
- ▶ **There is no evidence that men are more likely to delay seeking help than women.**
- ▶ **There is no clear evidence that men are more likely to delay in respect of some cancers and/or symptoms more than others.**
- ▶ **Understanding of the context (psychological and sociological) of help seeking is very important.**

Do men and women with similar cancers receive similar treatment?

Professor Henrik Møller

London School of Hygiene & Tropical Medicine

Professor Møller explained that he had been asked to look at the role of clinicians and other health professionals in relation to the central question being addressed by the symposium. In particular, he intended to address the specific matter of whether male and female patients are offered the same treatment regimes for the same cancers. All the information that he would present was drawn from the databank of the Thames Cancer Registry. The Registry covers an area that has a population of 12 million people.

Professor Møller had settled upon two particular questions as the basis for his presentation. The second question is effectively a more sophisticated way of looking at the first but was an important matter to consider in the light of the symposium's main objective:

- ▶ For any given type of cancer, are there systematic differences in the treatments given to men and women?

- ▶ All other things being equal, is male sex an independent predictor of the likelihood of a particular treatment being offered ?

Professor Møller had chosen six common types of cancer and, using recent data, would compare the treatment of male and female patients. He would introduce the six cancers by looking briefly at their incidence and survival rates and then concentrate on a comparison of three forms of treatment: **surgery, radiotherapy and chemotherapy**. He would be concentrating on treatment during the first six months post-diagnosis because that is the period for which the Registry has the best data.

The six chosen cancers were:

- ▶ Oesophageal cancer

- ▶ Stomach cancer

- ▶ Cancer of the colon

- ▶ Rectal cancer

- ▶ Lung cancer

- ▶ Melanoma

The numbers of people diagnosed with these cancers each year in the Thames Cancer Registry area range from 2,500 to 20,000. These numbers are comfortably high enough to give reliable data.

As the audience had already heard, incidence is greater in men for five of these six cancers, the exception being melanoma. An important difference between men and women not yet addressed is in age of onset. Men develop all but one of these cancers between 3 and 6 years earlier than women. The exception is melanoma where the mean age of onset is two years earlier in women. Five year survival rates for these cancers tended to be pretty much equal – another point already emphasised by other speakers (again, with the exception of melanoma which has an 83% five year survival in women compared with a 72% five year survival in men).

The central part of Professor Møller's presentation was concerned with treatment for these cancers. At first sight, a very obvious pattern appears to emerge. With only a couple of exceptions, men are significantly more likely than women to receive all three



Professor Henrik Møller

forms of treatment that Professor Møller had looked at – suggesting that men are much more likely than women to receive aggressive forms of treatment for cancer.

First impressions are however, misleading. There is a clear explanation for a large part of this ostensible discrepancy. The key is to understand the issue to which Professor Møller had already drawn attention, namely the typical age differential between male and female patients. Men develop five of these six cancers at an earlier age than women and, for clinical reasons, aggressive treatments may be seen as more appropriate in younger patients.

Professor Møller explained that if we control for age, the pattern of sex differences becomes rather more complicated and much more difficult to explain. In many cases, the patterns of treatment offered are broadly similar between men and women but there are some clear exceptions:

- ▶ Oesophageal cancer: More women than men are treated by radiotherapy; more men than women by chemotherapy

- ▶ Stomach cancer: More men than women are treated by both radiotherapy and chemotherapy

- ▶ Cancer of the colon: More women than men are treated surgically

- ▶ Rectal cancer: More men than women are treated surgically

- ▶ Lung cancer: In younger patients, women are more likely to be treated surgically; in older patients men are more likely to be treated surgically. This same age/sex difference is repeated in the use of

chemotherapy. Men are more likely to receive radiotherapy at all ages.

Of those differences highlighted above, the ones that are most marked – and therefore less susceptible of easy explanation – are that:

- ▶ radiotherapy is favoured as a treatment for oesophageal cancer in women but chemotherapy is favoured in men;

- ▶ women are more likely than men to have surgery for cancer of the colon but men are more likely than women to have surgery for cancer of the rectum;

- ▶ the differences in treatment offered for lung cancer vary significantly between men and women on the basis of age.

It is possible that there are similar differences in the patterns of treatment for other cancers.

Professor Henrik Møller: Conclusions

- ▶ There are some clear differences in the treatments offered to men and women for the same cancer.

- ▶ Once age of presentation is accounted for, these differences do not conform to an obvious pattern.

- ▶ Some of these differences are significant enough that they merit further exploration. In particular it would be interesting to look at these differences in relation to: stage of presentation; histological subtype; and sex-specific indications and contra-indications for particular treatments.

Speaking from personal experience

David Howe

Neil Walsh

At two points during the day, the symposium also heard from male cancer patients who had agreed to come along and share their personal experiences, particularly reflecting on their experiences "as men". David Howe, from West Yorkshire, and Neil Walsh, originally from Belfast but living near London, both spoke about having bowel cancer.

David Howe

David worked for 30 years as representative in the pharmaceutical industry. He regularly worked 70 – 80 hours a week. He enjoyed his work but it made for a very unhealthy lifestyle with irregular eating hours and limited opportunity for exercise. He often experienced extreme tiredness but he ignored this symptom for as long as he could – he regarded himself as "a typical man, doing his bit". By 2000 however, he was suffering from stress and depression was signed off from work by his GP. During this period, when he had some enforced time to himself, his wife encouraged David to see his GP about his rectal bleeding, which David had been dismissing up to that point as probably caused only by haemorrhoids.

The bleeding turned out to indicate a large rectal tumour. Despite spending long periods in hospital departments over many years as part of his job, and having a much better than average knowledge about cancer, David realised at this point that he had somehow been perfectly willing to deny fairly obvious symptoms in himself. It was his wife who had been prepared to take the matter seriously. After surgery, David declined chemotherapy, only to find himself subsequently with a secondary tumour in his lung. Now he wonders if again he had been practising some form of "denial". After surgery to remove

this tumour "common sense" prevailed and he had chemotherapy. He is now retired from work and often speaks publicly about his experience of cancer – wondering, even as he does so, whether this is another manifestation of his male drive to keep on working hard.

David has also observed male friends' willingness to ignore symptoms of poor health. He puts this down to men's belief that they are somehow "superhuman". He also feels that men often find it easier to do nothing when faced with a potentially serious problem – especially one that may be embarrassing to discuss. Women, by and large, are used to physical examination and to discussing symptoms "below the belt".

Neil Walsh

Neil had also had rectal bleeding of increasing seriousness for a long time (over two years) before he was finally diagnosed with cancer. In his case he had actually attended his own GP surgery on one occasion early on but having "plucked up courage" to go, he was dismissed by a locum GP as not having anything to worry about at all. This was probably because his age at the time – 25 – made it unlikely that either Neil or his GP would consider a possible diagnosis of bowel cancer. When he eventually did get around to seeing his GP again, simply because he happened to have a couple of days off work, he was prescribed suppositories for haemorrhoids. By this time however, his symptoms were extremely serious, with very significant blood loss, and a return visit to the GP resulted in a referral to his local hospital where cancer was diagnosed.

Neil had had a series of operations and at the time of addressing the symposium still had an



David Howe



Neil Walsh

ileostomy, although he hoped that this might be reversed in the next couple of months. In thinking about his experience in terms of his masculinity however, Neil stressed that he was not exaggerating when he said that the possibility of impotence as a result of damage to the nerve endings during surgery was a more frightening prospect to a 26 year-old man, than any other single aspect of the cancer.

Like David, Neil acknowledged that despite, in his case, having a degree in psychology, he had still been able to deny to himself – for apparently rational reasons to do with his youth and the lack of a family history of cancer – that he might have developed bowel cancer. He urged delegates at both a personal and professional level to stress to patients, friends and relatives that to ignore symptoms in the way that he had, was literally to put life at risk.

Summary of speakers' conclusions

The conclusions of the speakers can be summarised as follows:

▶ Men are very much more likely than women both to develop and to die from virtually all cancers that are not specific to one sex or the other.

▶ There are some potential biological explanations for this gap between the sexes in relation to some cancers but most of the explanations that are well understood at present are to do with lifestyle differences between men and women.

▶ For most cancers the explanation of the gap between the sexes is partial at best. In some cases there is no explanation at all.

▶ The evidence at present suggests that the most widely-believed explanation for the difference in mortality rates – that men are more likely than women to delay seeking help once they have developed potential cancer symptoms – is incorrect.

▶ It is probable that cancer prevention programmes and campaigns are less effective with men than women, although the reasons why this is so are not fully understood.

▶ Cancer prevention campaigns and treatment programmes are undoubtedly being hampered by misconceptions and lack of knowledge.

▶ There is some sketchy evidence that men and women with the same cancer may sometimes be offered (or may choose) different treatment options. It is not known why this happens but it may

potentially contribute to differences in outcomes.

▶ The existing evidence suggests that the currently unknown explanations are likely to depend upon a complex mix of biological, social and environmental factors, and may vary from one type of cancer to another.

▶ Given that the higher rates in men are so fundamental a feature of cancer incidence and mortality, it is unsatisfactory and extremely surprising that the knowledge base is so poor.

Summary of debate; and recommendations arising



Dr Ian Banks

The presentations were followed by an open forum for symposium attendees led by Dr Ian Banks, President of the MHF. For reasons of space, the debate itself (which lasted for two hours) is not described here but there was clear agreement that this issue had been inexplicably neglected in the past, and a strong desire that the day's event should mark a turning point. Several contributors acknowledged that they had not previously realised the full extent of the sex differences in cancer incidence and mortality, nor had they understood the complexity of the factors interacting to create them. A number of attendees who represented national cancer support organisations confirmed that their members and/or users are much more likely to be women than men – even sometimes, in relation to male-specific cancers. It was recognised that finding solutions to some of these problems will not be easy, at the same time there was agreement that there are some relatively simple steps that could be taken quickly and which have the potential to “kick-start” progress. Particularly it was felt that the knowledge base could be greatly improved within a relatively short time.

Consensus emerged from the debate for the following recommendations:

- ❶ **There should be a systematic review of the existing evidence in relation to men and cancer. The review – which is needed urgently – should consider both qualitative and quantitative data and include at least:**
 - ▶ Incidence and mortality rates
 - ▶ The inter-relationship between gender and social class, ethnicity, and other markers of inequality

- ▶ Attitudinal and behavioural differences between men and women
- ▶ Age differences between men and women in relation to diagnosis of particular cancers
- ▶ Gender differences in symptom awareness
- ▶ Gender differences in help-seeking behaviour

❷ **There is a particular need for a study to examine why some patients delay presenting with cancer symptoms, and how and why this varies according to gender. Such a study should also examine the inter-relationship between gender and other demographic factors such as social class, ethnicity, geographical location and age. Delay should be measured in terms of time from beginning of symptom recognition to presentation in primary care (“patient delay”). The study also should seek to understand the relationship between patient delay and other reasons why patients present at a later stage in the development of their disease.**

❸ **Work should be undertaken to examine how men respond to the vocabulary of cancer both when they do not have the disease and post-diagnosis. One excellent immediate opportunity to begin this work is the roll-out of the National Bowel Cancer Screening Programme. A “gender-specific” information package should be developed and tested against the standard information package used elsewhere in the National Programme to ascertain whether an improved take-up by men (and women) can be achieved.**

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- ④ There is good existing evidence that symptom recognition is a crucial factor for both sexes in ensuring timely diagnosis and treatment. It is probable that levels of symptom recognition vary between men and women, with men tending perhaps to have better knowledge of symptoms of male-specific cancers. Greater emphasis should be placed on symptom recognition as a component of health improvement campaigns, with particular attention being paid to the need for “male-sensitive” communication strategies.
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- ⑤ It might be useful to examine the extent to which cancer patients are offered choices and asked to make decisions during the course of their treatment. It might be that men and women are offered different kinds of choices and/or that they deal with choices and decisions differently. This may make a difference to outcomes.
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- ⑥ The psycho-social aspects of cancer diagnosis and treatment may affect men and women differently. Psychological responses and social factors may in turn impact on the patient’s progress post-diagnosis. Again, differences here between men and women are currently little understood. Evidence from other fields suggests that women probably have access to wider social networks and to higher levels of emotional support. It might be important to understand whether interventions aimed at providing greater support for men would be useful, and/or whether there are potentially “male-sensitive” forms of support that may be particularly effective.
-
- ⑦ There is significant scope to extend the range of settings in which men are offered advice, information, routine health checks and even, potentially, basic treatment. It is well-recognised that for a variety of structural and cultural reasons men tend to use both primary and secondary care services less effectively than women. Cancer prevention programmes should be instituted that take an outreach approach to engaging with men – with the workplace potentially a crucially important setting. At the same time, it must be acknowledged that, sooner or later, individual men who need treatment will need to attend traditional health care settings. Outreach programmes must therefore also have a central function of encouraging and enabling men to make better use of mainstream services.
-
- ⑧ The National Curriculum should include education – particularly targeted at boys – about how to take maintain good health and how to use health services effectively. The approach should be to place health and health-seeking behaviour within the context of a “masculine” world view – for example it should stress that being prepared to take responsibility, showing respect for oneself and others, facing up to difficult choices and so on, are part of “being a man”.
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Appendix 1

Programme for the expert symposium

Tackling the excess incidence of cancer in men
Leeds Metropolitan University on November 16th 2006

Morning programme

10:00 – 10:30	Registration and coffee Welcome Simon Lee, Vice-Chancellor of Leeds Metropolitan University
10:30 – 10:35	Introduction from the Chair Professor Mike Richards, National Cancer Director
10:35 – 11:00	The epidemiology: what is known and what is not known? Professor David Forman Centre for Epidemiology and Bio statistics Leeds University
11:00 – 11:05	A personal experience David Howe
11:05 – 11:30	Risk of developing cancer Professor Alan White Centre for Men's Health Leeds Metropolitan University
11:30 – 11:45	Break
11:45 – 12:10	Choosing health: men's behaviour in relation to cancer services Professor David Weller General Practice Section, Division of Community Health Sciences University of Edinburgh
12:10 – 12:35	Men's knowledge, behaviour and attitudes Dr Una Macleod Dept. of General Practice and Primary Care University of Glasgow
12:35 – 1:00	Do men and women with similar cancers receive similar treatment? Professor Henrik Møller London School of Hygiene & Tropical Medicine
1:00 – 1:45	Lunch

Tackling the excess incidence of cancer in men
Leeds Metropolitan University on November 16th 2006

Afternoon programme

1:00 – 1:45	Lunch
1:45 – 1:50	A personal experience Neil Walsh
1:50 – 3:00	Discussion of issues raised in morning session Led by Dr Ian Banks President, Men's Health Forum
3:00 – 3:20	Break
3:20 – 4:30	Addressing the problems and finding solutions Led by Dr Ian Banks President, Men's Health Forum
4:30 – 5:00	Summary and conclusions from the Chair

Appendix 2

Text of the letter of support from The Rt. Hon. Patricia Hewitt MP, Secretary of State for Health

Text of the letter dated November 13th 2006 from the Secretary of State for Health, Patricia Hewitt MP to Peter Baker, Chief Executive of the Men's Health Forum:

Dear Peter,

Tackling the excess incidence of cancer in men Leeds Metropolitan University, 16 November 2006

I would like to congratulate the Men's Health Forum, Macmillan Cancer Support, Cancerbackup and the Centre for Men's Health at Leeds Metropolitan University for setting up this unique symposium to answer the question of why cancer incidence and mortality is so much higher in men than women.

Their symposium is timely as the Gender Equality Public Sector Duty goes live in April 2007. May I assure you that gender is not a factor in any of the Government's decisions on cancer funding and these decisions are made using the best possible clinical evidence available.

Tackling cancer is a key priority for this Government and since the NHS Cancer Plan was published in 2000, we are now delivering better treatment more quickly to more people than ever before. On the male specific cancers, good progress has been made since we published the NHS Prostate Cancer Programme in 2000, and testicular cancer is nearly always treatable.

However, we acknowledge that there is more to be done. Men need to adopt a healthier lifestyle that would prevent some forms of cancer (eg by not smoking, by eating a better diet and taking more exercise, by avoiding excess exposure to the sun) and to present at an earlier stage with symptoms that might suggest any cancer. But we accept that this is easier said than done and that the Government also has a role to play.

The Men's Health Forum paper on men and cancer published in 2004 clearly showed that men are more likely than women to suffer from nine of the ten most common forms of cancer. Your discussions today will hopefully help us to understand why this is, and help identify practical ways forward that will make a real difference to men's lives.

I wish you well with your discussions and look forward to seeing the outputs of this important event.

Best wishes,

Patricia Hewitt

Tackling the excess incidence of cancer in men

Proceedings of the expert symposium held at
Leeds Metropolitan University on November 16th 2006

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The mission of the Men's Health Forum (MHF) 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.

We aim to achieve this through:

- ▶ **Policy development**
- ▶ **Research**
- ▶ **Providing information services**
- ▶ **Stimulating professional and public debate**
- ▶ **Working with MPs and Government**
- ▶ **Developing innovative and imaginative projects**
- ▶ **Professional training**
- ▶ **Collaborating with the widest possible range of interested organisations and individuals**
- ▶ **Organising the annual National Men's Health Week**

The Men's Health Forum (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 a "gold standard" for men's health – the MHF is committed to improved health for both men and women.

The Forum's mission, vision, values and beliefs statement can be read in full at: www.menshealthforum.org.uk.

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