II CURSO DE RESIDENTES DE SAOM

13 y 14 DE ABRIL 2018
GRANADA

Organizado por:

SAOM
Sociedad Andaluza de Oncología Medica

17:30 · 18:30h

HÁBITOS DE VIDA Y CÁNCER. LA IMPORTANCIA DE LA PREVENCIÓN EN ONCOLOGIA

Dr.Juan Bayo

Director UGC Oncología. HJRJ. Huelva

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Pero aún…¡¡¡algo falla en la oncología….!!!

07:30h				SALA OMENDADOR
8:30-10:00h				
10:00-11:30h				
11:30-12:00h				CAFÉ CON... IERRE FABRE MELANOMA
12:00-13:00h				
13:00-14:30h	Sesión Formativa PULMÓN II (ASTRAZENECA / BMS / MSD)*	Sesión Formativa CÁNCER HEREDITARIO III	Sesión Formativa CUIDADOS CONTINUOS II	

SUPERVIVENCIA GLOBAL DE LA PREVENCION

100%

SUPERVIVENCIA GLOBAL DE LA INMUNOTERAPIA

Aproximadamente 0%

- ***BASÁNDOSE SOLO EN INVESTIGACION BÁSICA Y AVANCES TERAPÉUTICOS NUNCA SE GANARÁ LA BATALLA AL CÁNCER ..***
- ***LA PREVENCION ES EL PRINCIPAL ARMA PARA COMBATIR EL CÁNCER.***

LA ERA DELA BIOLOGIA MOLECULAR Y EL E.CLíNICO VENTAJAS

- Facilitar el desarrollo de la Oncología
- Conocimiento de la Biología Molecular del tumor
- Incorporación de muchos oncólogos a la Investigación
- Promoción científica del investigador
- Beneficio para miles de pacientes
- Ahorro económico en terapias emergentes

ES INDISCUTIBLE QUE…

“ ***EL DESARROLLO DE LA ONCOLOGIA MODERNA SE DEBE A LA INVESTIGACIÓN CLÍNICA QUE ES IMPRESCINDIBLE HOY EN DÍA EN CUALQUIER SERVICIO DE ONCOLOGIA COMO COMPLEMENTO A LA ACTIVIDAD ASISTENCIAL”.***

LA ERA DELA BIOLOGIA MOLECULAR Y EL E.CLíNICO INCONVENIENTES

- Pérdida de Independenc
- La De-Formación de los
- Falta de habilidad en onc
- Deshumanización de la a
- Sobrecarga de tareas y
- Aumento desmesurado
- Posibilidad de padecer ***"Ensayitis Aguda"***

"Trastorno obsesivo compulsivo por el cuál un oncólogo no puede reprimir su impulso persistente y recurrente de incluir a todas horas pacientes en cualquier ensayo clínico, llegándole a provocar incluso síntomas de ansiedad, angustia e insomnio" ***(J. Bayo)***

La incorporación del oncólogo a la Biología molecular

¡Esfuerzo inasumible!

ONCOLOGO
(1993)

Médico
Quimioterapeuta

ONCOMAM
(2018)

Medical
Chemotherapy
Pathology-like
Molecular Biologist
Clinical / Translational Research
Methodologist and Biostatistician
Pharmacoeconomist
Marketing and Social Communication
Psycho-oncology
Epidemiologist

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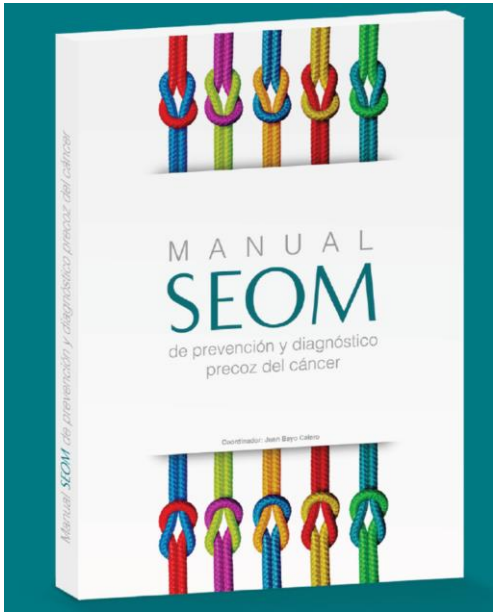
Hábitos de vida y Riesgo de cáncer



PREVENCIÓN PRIMARIA; FACTORES DE RIESGO PARA CÁNCER

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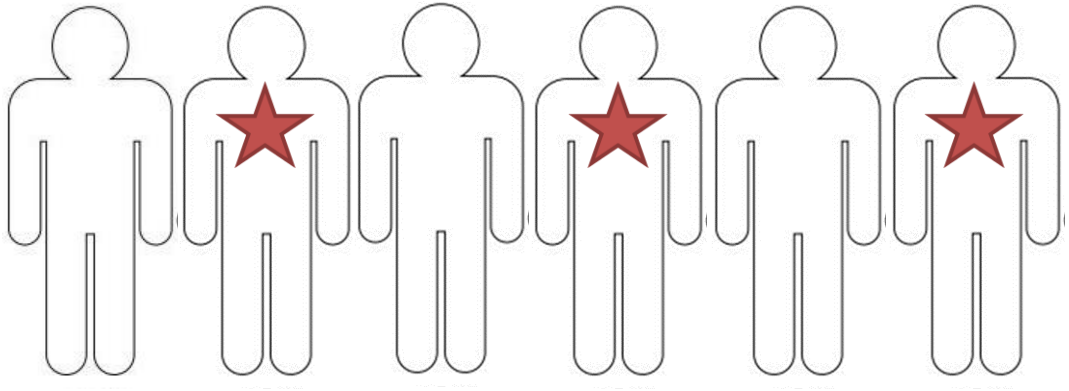
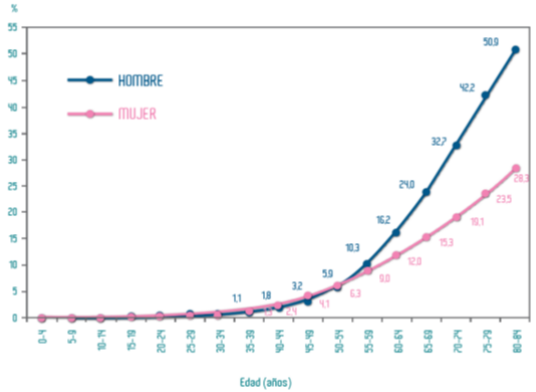
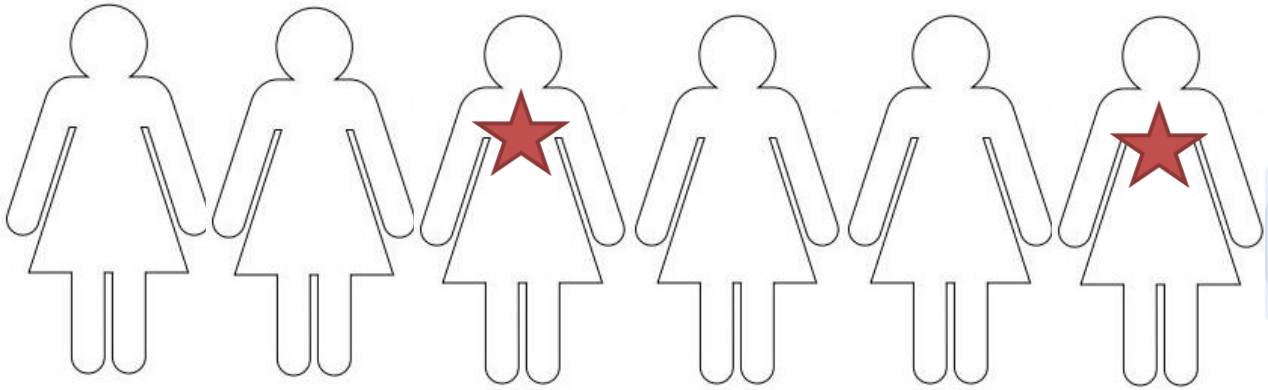
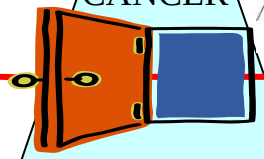






TRATAMIENTOS ONCOLÓGICOS

CANCER



POBLACION EXPUESTA

PREVENCIÓN

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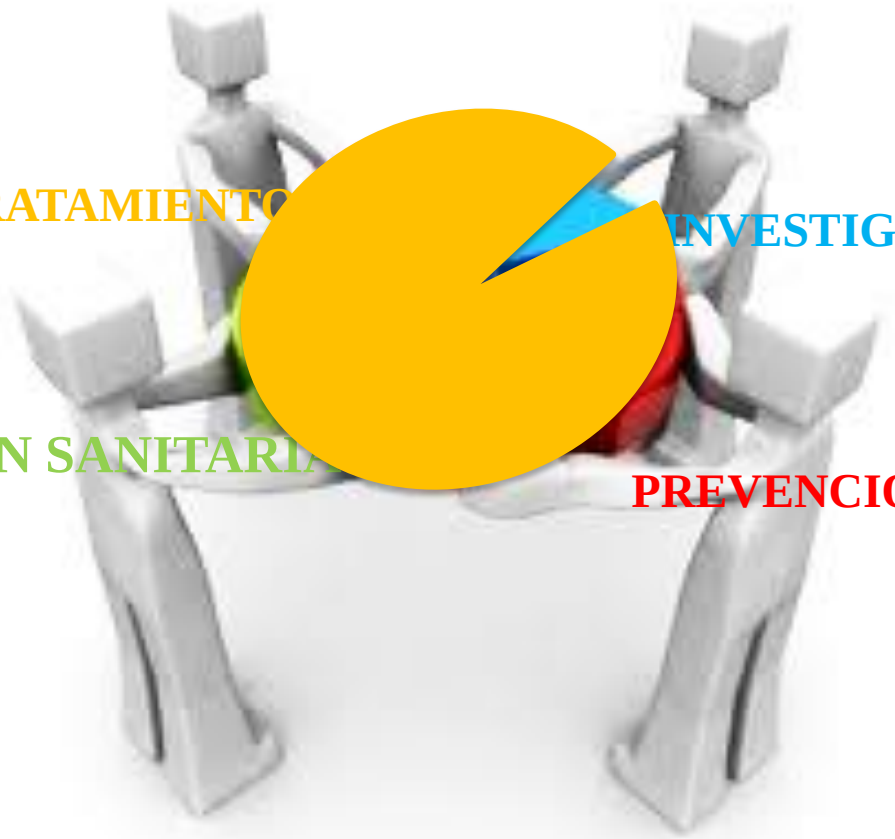
DISTRIBUCION OPTIMA DE RECURSOS SANITARIOS EN CANCER



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MADRID

Conocimiento del Código Europeo contra el Cáncer en población sensibilizada

Jiménez Ruiz FJ , Rodríguez Garcés MY, Amor Urbano M, Bolaños Naranjo M, Bayo Calero JL.
Hospital Juan Ramón Jiménez. Huelva

Introducción

En 1985 el Consejo Europeo desarrolló el Programa "Europeo contra el Cáncer" para afrontar esta enfermedad, entrando en funcionamiento en 1987. La primera versión del Código Europeo contra el Cáncer (CECC) fue aprobado en 1988. Incluye una serie de medidas sencillas para la población sobre hábitos para prevenir el cáncer hasta en un 50 %. En Octubre de 2014 aparece la cuarta edición del CECC; doce medidas de prevención primaria y
secundaria para prevenir la aparición del cáncer. A pesar de ello, consideramos que no ha tenido la divulgación y aceptación esperada

Objetivos:

- Primarios :
  - Evaluar el grado de conocimiento del código entre el personal sanitario, pacientes oncológicos y sus familiares
  - Conocer si existen diferencias entre los pertenecientes al servicio de oncología respecto del resto.
- Objetivo secundario : enumerar las medidas del CECC más conocidas en la muestra estudiada.

Métodos:

N = 708 encuestados (figura 1)
Analizamos si existían diferencias estadísticas entre los distintas categorías mediante X^2*pearson o test exacto de fisher*
Enumeración por orden de conocimiento de los distintos puntos del CECC

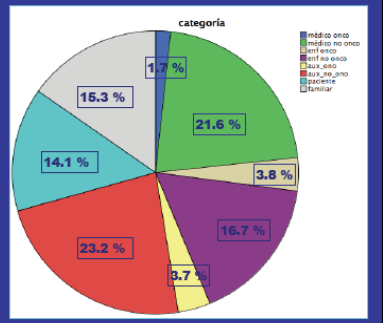


Figura 1

categoría

	N observado	N esperada	Residuo
médico onco	12	82,5	-70,5
médico no onco	153	82,5	70,5
Total	165		

conocimiento del CECC

	N observado	N esperada	Residuo
no	144	82,5	61,5
si	21	82,5	-61,5
Total	165		

Estadísticos de prueba

	categoría	conocimiento del CECC
Chi-cuadrado	120,491[a]	91,691[a]
gl	1	1
Sig. asintótica	,000	,000
Significación exacta	,000	,000
Probabilidad en el punto	,000	,000

a. 0 casillas (0,0%) han esperado frecuencias menores que 5. La frecuencia mínima de casilla esperada es 82,5.

Figura 2

Resultados:

- El 5.20% de ellos conocen el CECC.
- Encontramos diferencias significativas en el grado de conocimiento del código, únicamente en el grupo de los médicos oncológicos (66.70 %) respecto al resto de especialistas (33.30 %) con un valor p < 0.0001.

Tabla 1. Medidas del CECC según orden	de conocimiento en la muestra estudiada
1. Tabaquismo (80.60 %)	7. Control del peso (14.30 %)
2. Alimentación (76.40 %)	8. Vacunación HPV / VHB (10.50 %)
3. Alcoholismo (58.20 %)	9. Exposición de riesgo laboral (10.20%)
4. Ejercicio físico (42.20 %)	10. Leyes prevención tabaquismo (3.40 %)
5. Medidas de Cribado cáncer de mama, colorrectal y cérvix (38 %)	11. Lactancia / terapia hormonal sustitutiva (1.80 %)
6. Protección exposición solar (30.60 %)	12. Exposición al radón (0.80 %)

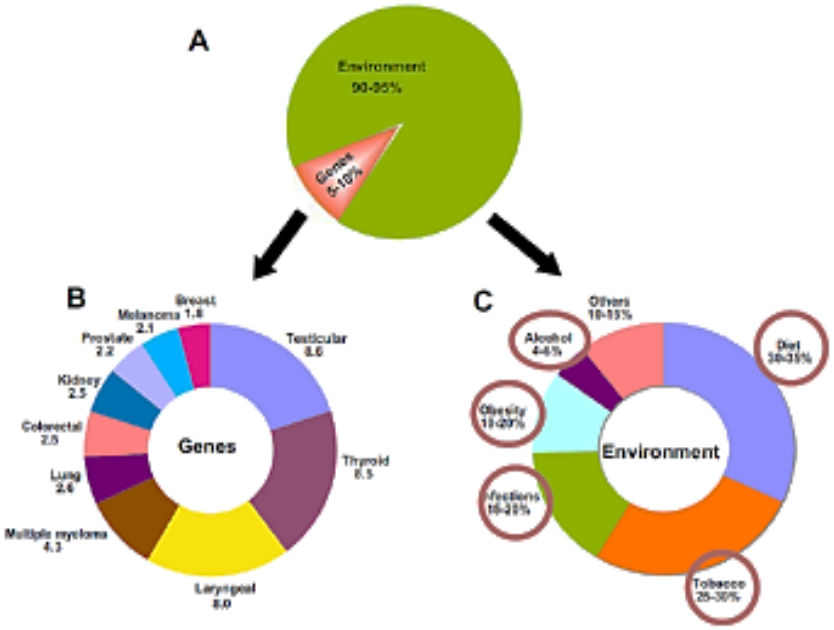
Conclusiones:

Podemos afirmar que en nuestro medio existe un gran desconocimiento del CECC. El grupo con [illegible] oncólogos (66.70 %), encontrando diferencias estadísticamente significativas respecto al resto de médicos. Concluimos que deberían emplearse medidas para aumentar la divulgación del CECC en la población.

….Muy Escasa formación de la población y de los profesionales sanitarios.

Incluso en Oncología

Factores de Riesgo



The role of genes and environment in the development of cancer. **Anand P et al. (Anderson Cancer Center, Houston)** Pharmaceutical Research 2008 25(9) 2097-2116.

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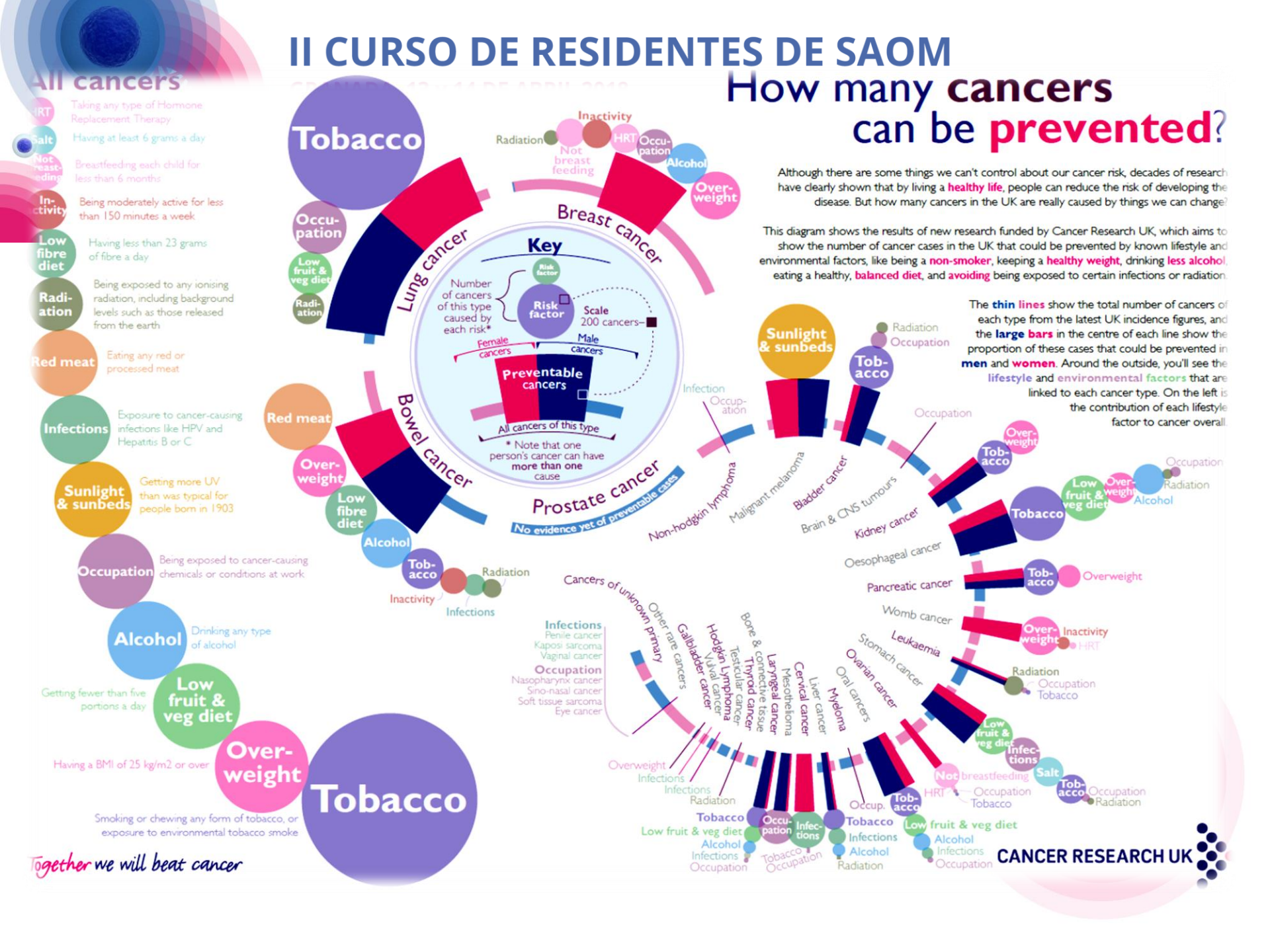

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HHS Public Access

Author manuscript

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Published in final edited form as:

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Substantial contribution of extrinsic risk factors to cancer development

Song Wu[1,2], Scott Powers[2,3], Wei Zhu[1,2], and Yusuf A Hannun[2,4]

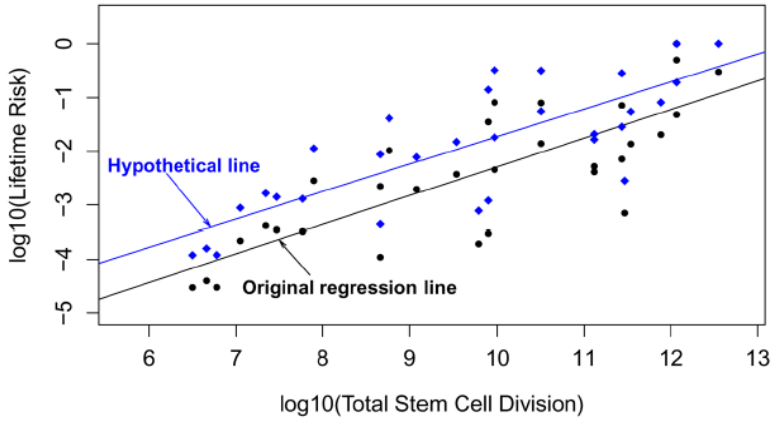
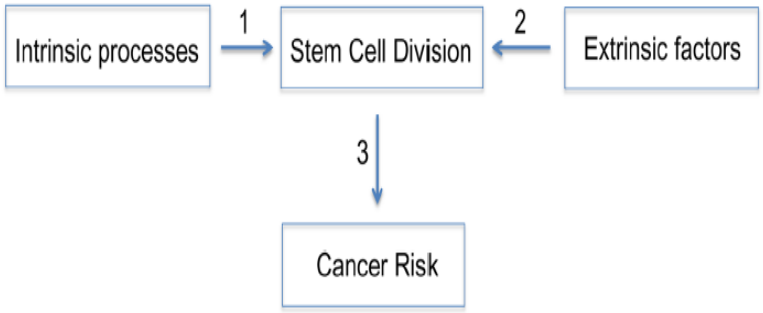
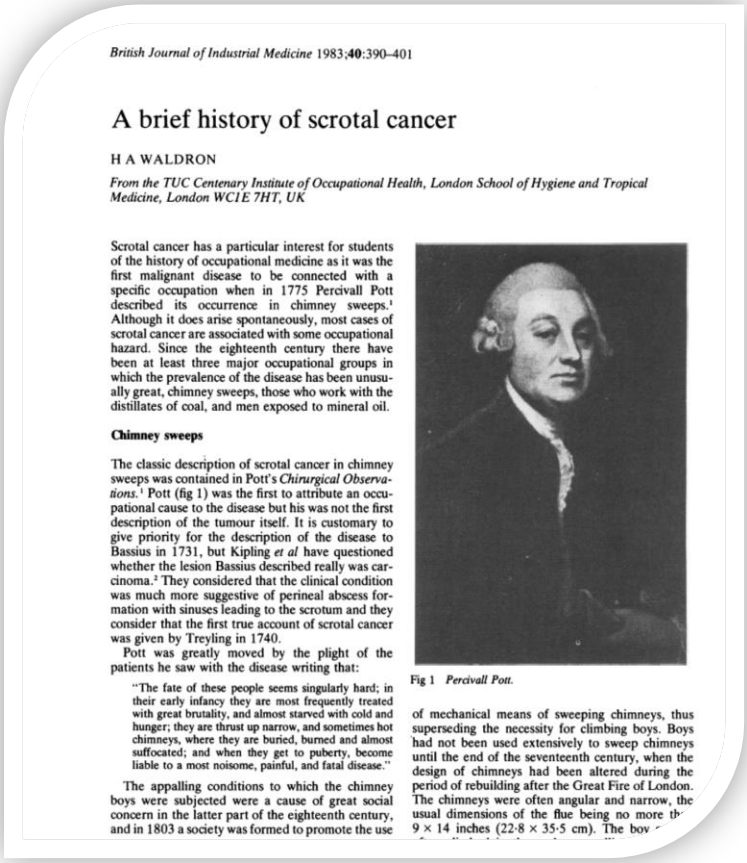


Figure 2. Correlation analysis of stem-cell division and cancer risk does not distinguish contribution of extrinsic vs. intrinsic factors to cancer risk



Así comenzó todo…



British Journal of Industrial Medicine 1983;**40**:390–401

A brief history of scrotal cancer

H A WALDRON

From the TUC Centenary Institute of Occupational Health, London School of Hygiene and Tropical Medicine, London WC1E 7HT, UK

Scrotal cancer has a particular interest for students of the history of occupational medicine as it was the first malignant disease to be connected with a specific occupation when in 1775 Percivall Pott described its occurrence in chimney sweeps.[1] Although it does arise spontaneously, most cases of scrotal cancer are associated with some occupational hazard. Since the eighteenth century there have been at least three major occupational groups in which the prevalence of the disease has been unusually great, chimney sweeps, those who work with the distillates of coal, and men exposed to mineral oil.

Chimney sweeps

The classic description of scrotal cancer in chimney sweeps was contained in Pott's *Chirurgical Observations*.[1] Pott (fig 1) was the first to attribute an occupational cause to the disease but his was not the first description of the tumour itself. It is customary to give priority for the description of the disease to Bassius in 1731, but Kipling *et al* have questioned whether the lesion Bassius described really was carcinoma.[2] They considered that the clinical condition was much more suggestive of perineal abscess formation with sinuses leading to the scrotum and they consider that the first true account of scrotal cancer was given by Treyling in 1740.

Pott was greatly moved by the plight of the patients he saw with the disease writing that:

> "The fate of these people seems singularly hard; in their early infancy they are most frequently treated with great brutality, and almost starved with cold and hunger; they are thrust up narrow, and sometimes hot chimneys, where they are buried, burned and almost suffocated; and when they get to puberty, become liable to a most noisome, painful, and fatal disease."

The appalling conditions to which the chimney boys were subjected were a cause of great social concern in the latter part of the eighteenth century, and in 1803 a society was formed to promote the use

Fig 1 *Percivall Pott.*

of mechanical means of sweeping chimneys, thus superseding the necessity for climbing boys. Boys had not been used extensively to sweep chimneys until the end of the seventeenth century, when the design of chimneys had been altered during the period of rebuilding after the Great Fire of London. The chimneys were often angular and narrow, the usual dimensions of the flue being no more th 9 × 14 inches (22·8 × 35·5 cm). The boy

"…característica de cierto tipo de gente; me refiero al cáncer de los deshollinadores. Esta enfermedad siempre lanza su ataque inicial contra la parte inferior del escroto, donde produce una ulcera superficial, dolorosa, irregular y de mal aspecto, con bordes duros y elevados. …Nunca la he visto antes de la pubertad, una de las razones por las cuales supongo, tanto pacientes como cirujanos la toman en general por venérea, y al ser tratada en vano con mercuriatos se irrita pronto y mucho"

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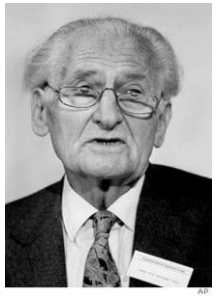

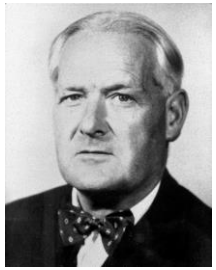

BRITISH MEDICAL JOURNAL

LONDON SATURDAY SEPTEMBER 30 1950

SMOKING AND CARCINOMA OF THE LUNG

PRELIMINARY REPORT

BY

RICHARD DOLL, M.D., M.R.C.P.

Member of the Statistical Research Unit of the Medical Research Council

AND

A. BRADFORD HILL, Ph.D., D.Sc.

Professor of Medical Statistics, London School of Hygiene and Tropical Medicine; Honorary Director of the Statistical Research Unit of the Medical Research Council

In England and Wales the phenomenal increase in the number of deaths attributed to cancer of the lung provides one of the most striking changes in the pattern of mortality recorded by the Registrar-General. For example, in the quarter of a century between 1922 and 1947 the annual number of deaths recorded increased from 612 to 9,287, or roughly fifteenfold. This remarkable increase is, of course, out of all proportion to the increase of population—both in total and, particularly, in its older age groups. Stocks (1947), using standardized death rates to allow for these population changes, shows the following trend: rate per 100,000 in 1901–20, males 1.1, females 0.7; rate per 100,000 in 1936–9, males 10.6, females 2.5. The rise seems to have been particularly rapid since the end of the first world war; between 1921–30 and 1940–4 the death rate of men at ages 45 and over increased sixfold and of women of the same ages approximately threefold. This increase is still continuing. It has occurred, too, in Switzerland, Denmark, the U.S.A., Canada, and Australia, and has been reported from Turkey and Japan.

Many writers have studied these changes, considering whether they denote a real increase in the incidence of the disease or are due merely to improved standards of diagnosis. Some believe that the latter factor can be regarded as wholly, or at least mainly, responsible—for example, Willis (1948), Clemmesen and Busk (1947), and Steiner (1944). On the other hand, Kennaway and Kennaway (1947) and Stocks (1947) have given good reasons for believing that the rise is at least partly real. The latter, for instance, has pointed out that "the increase of certified respiratory cancer mortality during the past 20 years has been as rapid in country districts as in the cities with the best diagnostic facilities, a fact which does not support the view that such increase merely reflects improved diagnosis of cases previously certified as bronchitis or other respiratory affections." He also draws attention to differences in mortality between some of the large cities of England and Wales, differences which it is difficult to explain in terms of diagnostic standards.

The large and continued increase in the recorded deaths even within the last five years, both in the national figures and in those from teaching hospitals, also makes it hard to believe that improved diagnosis is entirely responsible. In short, there is sufficient reason to reject that factor as the whole explanation, although no one would deny that it may well have been contributory. As a corollary, it is right and proper to seek for other causes.

Possible Causes of the Increase

Two main causes have from time to time been put forward: (1) a general atmospheric pollution from the exhaust fumes of cars, from the surface dust of tarred roads, and from gas-works, industrial plants, and coal fires; and (2) the smoking of tobacco. Some characteristics of the former have certainly become more prevalent in the last 50 years, and there is also no doubt that the smoking of cigarettes has greatly increased. Such associated changes in time can, however, be no more than suggestive, and until recently there has been singularly little more direct evidence. That evidence, based upon clinical experience and records, relates mainly to the use of tobacco. For instance, in Germany, Müller (1939) found that only 3 out of 86 male patients with cancer of the lung were non-smokers, while 56 were heavy smokers, and, in contrast, among 86 "healthy men of the same age groups" there were 14 non-smokers and only 31 heavy smokers. Similarly, in America, Schrek and his co-workers (1950) reported that 14.6% of 82 male patients with cancer of the lung were non-smokers, against 23.9% of 522 male patients admitted with cancer of sites other than the upper respiratory and digestive tracts. In this country, Thelwall Jones (1949—personal communication) found 8 non-smokers in 82 patients with proved carcinoma of the lung, compared with 11 in a corresponding group of patients with diseases other than cancer; this difference is slight, but it is more striking that there were 28 heavy smokers in the cancer group, against 14 in the comparative group.

Clearly none of these small-scale inquiries can be accepted as conclusive, but they all point in the same direction. Their evidence has now been borne out by the results of a large-scale inquiry undertaken in the U.S.A. by Wynder and Graham (1950).

Wynder and Graham found that of 605 men with epidermoid, undifferentiated, or histologically unclassified types of bronchial carcinoma only 1.3% were "non-smokers"—that is, had averaged less than one cigarette a day for the last 20 years—whereas 51.2% of them had smoked more than 20 cigarettes a day over the same

Landmark Article
May 27, 1950
(*JAMA* 1950;143:329-336)

Tobacco Smoking as a Possible Etiologic Factor in Bronchiogenic Carcinoma

A Study of Six Hundred and Eighty-Four Proved Cases

Ernest L. Wynder and Evarts A. Graham, M.D.
St. Louis

General Increase.—There is rather general agreement that the incidence of bronchiogenic carcinoma has greatly increased in the last half-century. Statistical studies at the Charity Hospital of New Orleans (Ochsner and DeBakey),[1] the St. Louis City Hospital (Wheeler)[2] and the Veterans Administration Hospital of Hines, Ill. (Avery)[3] have revealed that at these hospitals cancer of the lung is now the most frequent visceral cancer in men.

Autopsy statistics throughout the world show a great increase in the incidence of bronchiogenic carcinoma in relation to cancer in general. Kenneway and Kenneway,[4] in a careful statistical study of death certificates in England and Wales from 1928 to 1945, have presented undoubted evidence of a great increase in deaths from cancer of the lung. In this country statistics compiled by the American Cancer Society show a similar trend during the past two decades.[5]

Tobacco as a Possible Cause of Increase.—The suggestion that smoking, and in particular cigaret smoking, may be important in the production of bronchiogenic carcinoma has been made by many writers on the subject even though well controlled and large scale clinical studies are lacking. Adler[6] in 1912 was one of the first to think that tobacco might play some role in this regard. Tylecote,[7] Hoffman,[8] McNally,[9] Lickint,[10] Arkin and Wagner,[11] Roffo[12] and Maier[13] were just a few of the workers who thought that there was some evidence that tobacco was an important factor in the increase of cancer of the lungs. Müller[14] in 1939, from a careful but limited clinical statistical study, offered good evidence that heavy smoking is an important etiologic factor. In 1941 Ochsner and DeBakey[15] called attention to the similarity of the curve of increased sales of cigarets in this country to the greater prevalence of primary cancer of the lung. They emphasized the possible etiologic relationship of cigaret smoking to this condition. In a recent paper Schrek[16] concluded that there is strong circumstantial evidence that cigaret smoking is an etiologic factor in cancer of the respiratory tract and finds that his data are in agreement with the results of a preliminary report presented by

From the Department of Surgery, Washington University School of Medicine and Barnes Hospital.

This study has been aided by a grant from the American Cancer Society. Other phases of it will be presented in subsequent publications.

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NEWS RELEASES

Wednesday, March 14, 2012

Nearly 800,000 deaths prevented due to declines in smoking

NIH study examines the impact of tobacco control policies and programs, and the potential for further reduction in lung cancer deaths.

Twentieth-century tobacco control programs and policies were responsible for preventing more than 795,000 lung cancer deaths in the United States from 1975 through 2000, according to an analysis funded by the National Cancer Institute (NCI), part of the National Institutes of Health.

If all cigarette smoking in this country had ceased following the release of the first Surgeon General's report on smoking and health in 1964, a total of 2.5 million people would have been spared from death due to lung cancer in the 36 years following that report, according to the analysis. The results of this study were published online March 14, 2012, in the Journal of the National Cancer Institute.

U.S. Surgeon General Luther Terry addressing a press conference on release of the 1964 Report on Smoking and Health. The Advisory Committee, which compiled the report, is seated behind him.

Institute/Center

National Cancer Institute (NCI)

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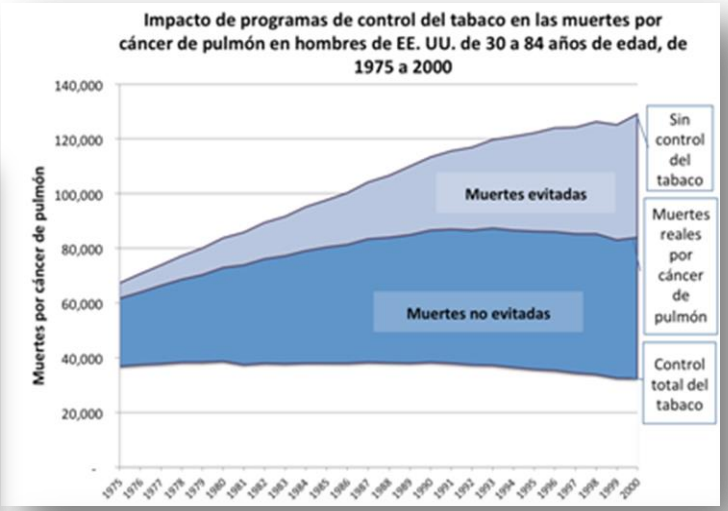

Migration Patterns and Breast Cancer Risk in Asian-American Women

*Regina G. Ziegler, Robert N. Hoover, Malcolm C. Pike, Allan Hildesheim, Abraham M. Y. Nomura, Dee W. West, Anna H. Wu-Williams, Laurence N. Kolonel, Pamela L. Horn-Ross, Jeanne F. Rosenthal, Marianne B. Hyer**

exposures, this study should provide new insights the etiology of breast cancer. [J Natl Cancer Inst 19–1827, 1993]

Table 1. Incidence rates of breast cancer for 1983-1987, in women aged 20-54 years, for Asian-Americans living in the San Francisco–Oakland MSA, the Los Angeles MSA, or Hawaii; Whites residing in the same communities; and Asians living in the countries of origin

Community, ethnicity	Incidence rate	
	Age-standardized*	Cumulative, %†
San Francisco–Oakland, Los Angeles, Hawaii		
Whites	91.8	3.45
Chinese	53.7	2.03
Japanese	69.0	2.59
Filipino	72.5	2.72
China: Shanghai	27.5	1.03
China: Tianjin	27.4	1.03
Hong Kong	37.7	1.41
Singapore Chinese	41.7	1.56
Japan: Miyagi	40.9	1.53
Japan: Osaka	28.9	1.08
Philippines: Manila	54.7	2.06
Philippines: Rizal	45.7	1.72

*Age-standardized incidence rates are per 100000 person-years.
†Cumulative incidence rates, defined in (*1*), are per 100 person-years.

Table 2 Hormone replacement therapy (HRT) use, breast cancer incidence and mammography rates in countries with an 'early' decline in breast cancer incidence after publication of the Women's Health Initiative HRT results in 2002

Country	Peak HRT	Absolute ↓HRT	↓Breast cancer	Mammography
USA[23]	35–40%	≈20–25% (2001–2003)	6.7% 2002–2003	Slight decrease 2000–2003 (2%)
Germany[28]	40%	≈20% (2000–2005)	8.8% annually 2002–2005	Increasing
Belgium[29]	33%	20% (2002–2005)	9.5% annually 2002–2004	Increasing
Canada[30]	30%	15% (2002–2005)	8% annually 2002–2004	Stable
France[31]	32%	21% (2002–2007)	12% 2003–2007	Increasing
Switzerland[32]	50%	15% (2002–2003)	6% annually 2002–2006	Stable
Australia[33]	21%	8% (2001–2003)	6.7% 2001–2003	Stable

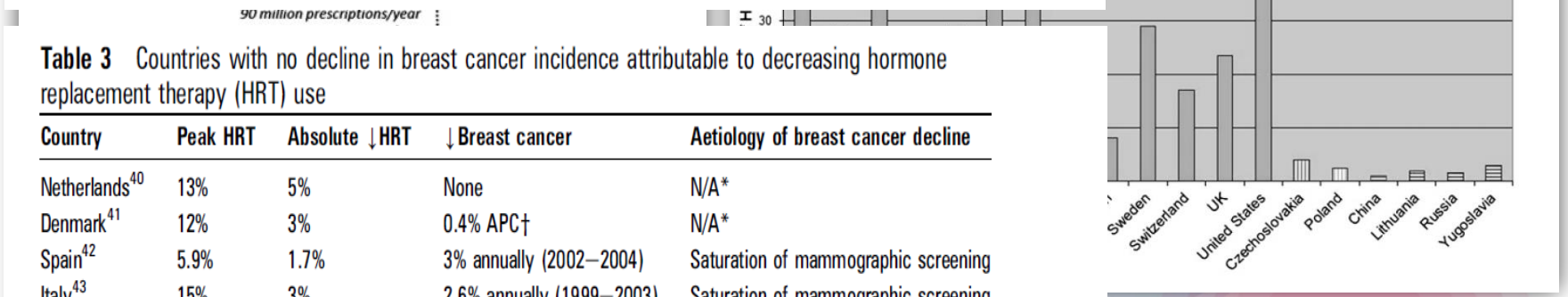

Table 3 Countries with no decline in breast cancer incidence attributable to decreasing hormone replacement therapy (HRT) use

Country	Peak HRT	Absolute ↓HRT	↓Breast cancer	Aetiology of breast cancer decline
Netherlands[40]	13%	5%	None	N/A*
Denmark[41]	12%	3%	0.4% APC†	N/A*
Spain[42]	5.9%	1.7%	3% annually (2002–2004)	Saturation of mammographic screening
Italy[43]	15%	3%	2.6% annually (1999–2003)	Saturation of mammographic screening

*N/A, not applicable.
†Not statistically significant.
APC, annual percentage change.

II CURSO DE RESIDENTES DE SAOM

GRANADA, 13 y 14 DE ABRIL 2018

Organizado por:

Thoracic Cancer
Open Access
Thoracic Cancer ISSN 1759-7706

China consume más cemento en tres años que Estados Unidos en los últimos 100

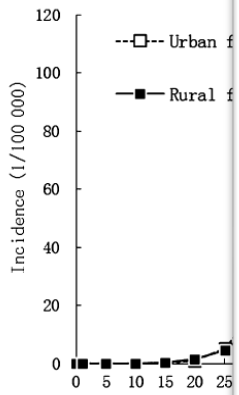

Figure 1 Breast cancer inci

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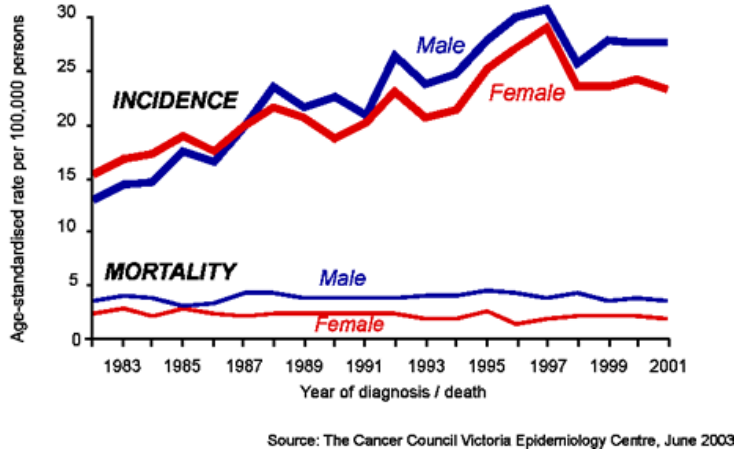
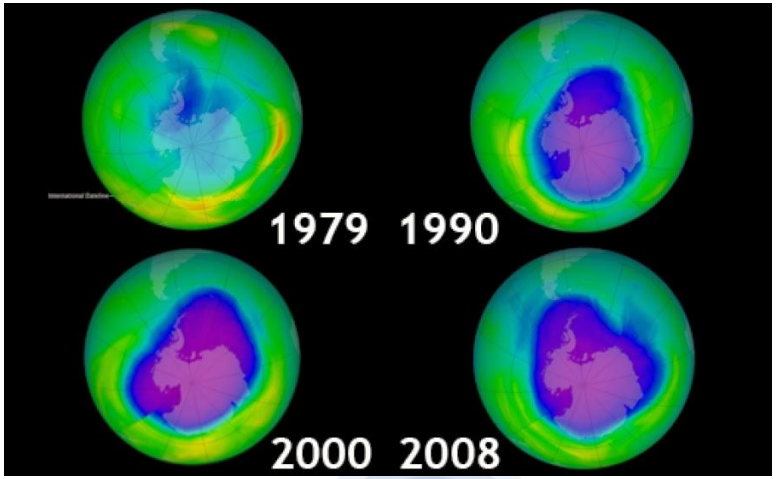

Melanoma
Trends in incidence and mortality rates 1982-2001
Age-standardised rate per 100,000 persons
30
25
20
15
10
5
0
INCIDENCE
Male
Female
MORTALITY
Male
Female
1983
1985
1987
1989
1991
1993
1995
1997
1999
2001
Year of diagnosis / death
Source: The Cancer Council Victoria Epidemiology Centre, June 2003


1979
1990
2000
2008

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GRANADA, 13 y 14 DE ABRIL 2018

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Temas de salud | Datos y estadísticas | Centro de prensa | Publicaciones | Países | Programas y proyectos | Gobernanza | Acerca de la OMS

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Calidad del aire (exterior) y salud

Nota descriptiva Nº313
Marzo de 2014

Cifras y datos

- La contaminación del aire representa un importante riesgo medioambiental para la salud. Mediante la disminución de los niveles de contaminación del aire los países pueden reducir la carga de morbilidad derivada de accidentes cerebrovasculares, cánceres de pulmón y neumopatías crónicas y agudas, entre ellas el asma.
- Cuanto más bajos sean los niveles de contaminación del aire mejor será la salud cardiovascular y respiratoria de la población, tanto a largo como a corto plazo.
- *Las Directrices de la OMS sobre la Calidad del Aire* ofrecen una evaluación de los efectos sanitarios derivados de la contaminación del aire, así como de los niveles de contaminación perjudiciales para la salud.
- Según estimaciones de 2012, la contaminación atmosférica en las ciudades y zonas rurales de todo el mundo provoca cada año 3,7 millones de defunciones prematuras.
- Un 88% de esas defunciones prematuras se producen en países de ingresos bajos y medianos, y las mayores tasas de morbilidad se registran en las regiones del Pacífico Occidental y Asia Sudoriental de la OMS.
- Las políticas y las inversiones de apoyo a medios de transporte menos contaminantes, viviendas energéticamente eficientes, generación de electricidad y mejor gestión de residuos industriales y municipales permitirían reducir importantes fuentes de contaminación del aire en las ciudades.

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SAOM
Sociedad Andaluza de Oncología Medica

Table 2. Adjusted odds ratios for the association between breast cancer i
menopausal status

	All women, $n=1946$	
	Co/Ca	OR[a] (95% CI)
'A posteriori'		
Western pattern		
Q1	244/195	1
Q2	243/224	1.20 (0.90–1.60)
Q3	242/258	1.30 (0.97–1.75)
Q4	244/296	1.46 (1.06–2.01)
P-trend		0.02
Per s.d. increase		1.17 (1.04–1.31)
Prudent pattern		
Q1	244/219	1
Q2	242/252	1.19 (0.91–1.56)
Q3	244/227	1.04 (0.78–1.40)
Q4	243/275	1.09 (0.79–1.50)
P-trend		0.82
Per s.d. increase		1.00 (0.89–1.13)
Mediterranean pattern		
Q1	244/246	1
Q2	243/260	0.98 (0.74–1.28)
Q3	242/264	0.88 (0.65–1.19)
Q4	244/203	0.56 (0.40–0.79)
P-trend		<0.01
Per s.d. increase		0.78 (0.69–0.89)

BJC

FULL PAPER

British Journal of Cancer (2014) 111, 1454–1462 | doi: 10.1038/bjc.2014.434

Keywords: breast neoplasms; dietary patterns; aMED; AHEI; principal component analysis; Mediterranean pattern

Spanish Mediterranean diet and other dietary patterns and breast cancer risk: case–control EpiGEICAM study

A Castelló[1,2,3,17], M Pollán*[,1,2,17], B Buijsse[3], A Ruiz[4], A M Casas[5], J M Baena-Cañada[6], V Lope[1,2], S Antolín[7], M Ramos[8], M Muñoz[9], A Lluch[10], A de Juan-Ferré[11], C Jara[12], M A Jimeno[13], P Rosado[6], E Díaz[5], V Guillem[4], E Carrasco[13], B Pérez-Gómez[1,2], J Vioque[2,14], H Boeing[3] and M Martín[15,16] on behalf of GEICAM researchers

Conclusions: Our results confirm the harmful effect of a Western diet on BC risk, and add new evidence on the benefits of a diet rich in fruits, vegetables, legumes, oily fish and vegetable oils for preventing all BC subtypes, and particularly triple-negative tumours.

II CURSO DE RESIDENTES DE SAOM

GRANADA, 13 y 14 DE ABRIL 2018

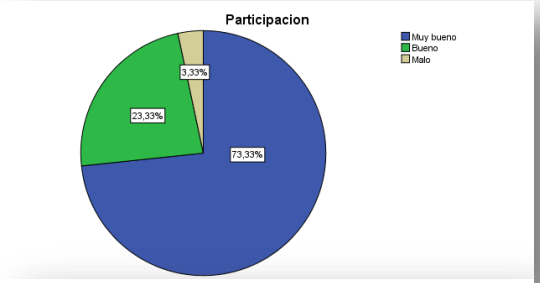
Organizado por:

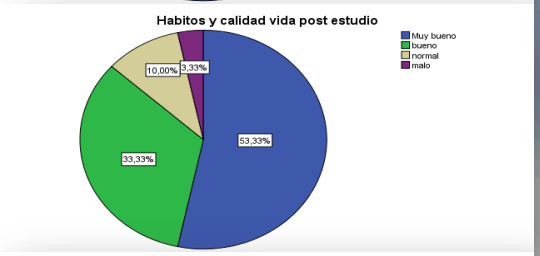
Sociedad Andaluza de Oncología Medica

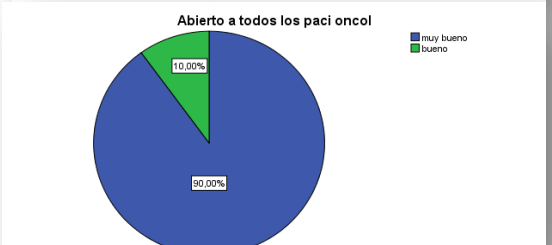
"PROGRAMA DE ALIMENTACIÓN Y VIDA SALUDABLE EN LA PACIENTE CON CÁNCER DE MAMA"

Servicio de Oncología (HJRJ.Huelva)

	Median Before Intervention	Median After Intervention	p
IMC	27,32	27,35	0,008
Autoevaluacion dieta	Equilibrada (n = 19)	Equilibrada (n = 24)	0,004*
Adherencia DM	Alta (n = 19)	Alta (n = 26)	0,003*
Numero de comidas al dia	4 Comidas (n = 12)	5 Comidas (n = 21)	0,014*
Consumo de Vitaminas/ minerales	Si (n = 17)	Si (n = 16)	0,705
Lugar donde desayuno	Casa (n = 29)	Casa (n = 26)	0,317
Lugar donde almuerza	Casa (n = 34)	Casa (n = 29)	1
Lugar donde cena	Casa (n = 35)	Casa (n = 29)	1
Frecuencia consumo Alcohol	Ocasional (n = 24)	Ocasional (n = 19)	1
Tabaco	No (n = 16)	No (n = 16)	0,157
Actividad fisica	Ocasional (n = 9)	Habitual (n = 17)	0,18
Cocina aceite oliva	Si (n = 35)	Si (n = 29)	1
Cucharadas aceite oliva dia	>2 (n = 32)	>2 (n = 29)	0,317
Raciones verduras, hortalizas dia	>2 (n = 19)	>2 (n = 23)	0,034*
Piezas fruta al dia	>3 (n = 23)	>3 (n = 26)	0,005*
Carnes rojas, embutidos, etc día	<1 (n = 31)	<1 (n = 26)	0,705
Ración de mantequilla, nata día	<1 (n = 27)	<1 (n = 27)	0,025
Bebidas carbonatadas día	<1 (n = 27)	<1 (n = 27)	0,317
Consumo copas vino sm	<3 Copas (n = 29)	<3 Copas (n = 24)	1
Consumo legumbres sm	<3 (n = 24)	>3 (n = 21)	0,005*
Consumo Pescado y marisco sm	>3 (n = 20)	>3 (n = 24)	0,008
Reposteria comercial sm	<3 (n = 29)	<3 (n = 27)	0,414
Consumo frutos secos sm	<1 (n = 19)	>1 (n = 20)	0,083
Consumo carnes blancas	Si (n = 28)	Si (n = 26)	0,414
Consumo vegetales, pasta, arroz sm.	>2 (n = 24)	>2 (n = 28)	0,002*







Pero, ¿cuánto podemos evitar?

عربي 中文 Eng

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Cáncer

Prevención del cáncer

Al menos un tercio de todos los casos de cáncer pueden prevenirse. La prevención constituye la estrategia a largo plazo más costoeficaz para el control del cáncer.

The cancer wars 1

Global cancer patterns: causes and prevention

Paolo Vineis, Christopher P Wild

Cancer is a global and growing, but not uniform, problem. An increasing proportion of the burden is falling on low-income and middle-income countries because of not only demographic change but also a transition in risk factors, whereby the consequences of the globalisation of economies and behaviours are adding to an existing burden of cancers of infectious origin. We argue that primary prevention is a particularly effective way to fight cancer, with between a third and a half of cancers being preventable on the basis of present knowledge of risk factors. Primary prevention has several advantages: the effective actions could have benefits for people other than those directly targeted, avoidance of exposure to carcinogenic agents is likely to prevent other non-communicable diseases, and the cause could be removed or reduced in the long term—eg, through regulatory measures against occupational or , the preventive effort does not need to be renewed with every generation, which is esources are in short supply). Primary prevention must therefore be prioritised as an control.

Lancet 2014; 383: 549–57
Published Online December 16, 2014 http://dx.doi.org/10.1016/S0140-6736(13)62224-2
This is the first in a Series of three papers about the cancer wars

MRC-PHE Centre for Environment and Health, School of Public Health, Imperial College, London (Prof P Vineis PhD); HuGeF Foundation, Torino, Italy

The fraction of cancer attributable to lifestyle and environmental factors in the UK in 2010

Summary and conclusions

British Journal of Cancer (2011) 105, S77 – S81

DM Parkin*[,1], L Boyd[2] and LC Walker[2]
[1]*Centre for Cancer Prevention, Wolfson Institute of Preventive Medicine, Queen Mary University of London, Charterhouse Square, London EC1M 6BQ, UK;* [2]*Cancer Research UK, Angel Building, 407 St John Street, London EC1V 4AD, UK*

This chapter summarises the results of the preceding sections, which estimate the fraction of cancers occurring in the UK in 2010 that can be attributed to sub-optimal, past exposures of 14 lifestyle and environmental risk factors. For each of 18 cancer types, we present the percentage of cases attributable to one or all of the risk factors considered (tobacco, alcohol, four elements of diet (consumption of meat, fruit and vegetables, fibre, and salt), overweight, lack of physical exercise, occupation, infections, radiation (ionising and solar), use of hormones, and reproductive history (breast feeding)).
Exposure to less than optimum levels of the 14 factors was responsible for 42.7% of cancers in the UK in 2010 (45.3% in men, 40.1% in women) – a total of about 134 000 cases.

Published in final edited form as:

JAMA Oncol. 2016 September 1; 2(9): 1154–1161. doi:10.1001/jamaoncol.2016.0843.

Preventable incidence and mortality of carcinoma associated with lifestyle factors among whites in the United States

Mingyang Song, MD, ScD[1,2] and **Edward Giovannucci, MD, ScD**[2,3]

Comparison of lifestyle factors in the low- and high-risk groups and in the US population in 2010 *

Variable	Women			Men		
	Low-risk group	High-risk group	US population	Low-risk group	High-risk group	US population
Smoking †						
Never, %	78	31	66	83	26	54
Past, %	22	61	18	17	69	25
Current, %	0	8	16	0	5	21
Met 2008 federal physical activity guideline, % †‡	100	63	47	100	83	54
Body mass index, kg/m² §	23.4	26.7	26.9	24.4	27.3	26.4
Alcohol, drink/day ‖	0.1	0.1	0.5	0.4	0.7	1.4
AHEI score §	48.1	46.4	39.0	43.8	40.5	35.7

Abbreviations: AHEI, Alternative Healthy Eating Index.

Incidence and mortality rates of total carcinomas in the low- and high-risk groups and in the general US population, and the corresponding estimates of population attributable risk *

	Rate in the low-risk group (per 100 000)	Rate in the high-risk group (per 100 000)	Rate in the US population (per 100 000)†	PAR (Low-risk vs. high-risk groups) (95% CI)‡	PAR (Low-risk vs. national population) (95% CI)§
Women					
Incidence	463	618	789	25% (21–29%)	41% (39–44%)
Mortality	132	256	320	48% (44–53%)	59% (55–62%)
Men					
Incidence	283	425	759	33% (28–38%)	63% (60–65%)
Mortality	156	277	470	44% (39–48%)	67% (64–69%)

In conclusion, we found that a substantial proportion of cancer cases and even more deaths in the US whites may be prevented if all individuals quit smoking, avoided heavy alcohol drinking, maintained a BMI of 18.5–27.5 kg/m^2, and exercised in a moderate intensity for at least 150 minutes or in a vigorous intensity for at least 75 minutes every week. These findings reinforce the predominant importance of lifestyle factors in determining cancer risk. Therefore, primary prevention should remain a priority for cancer control.

Song and Giovannucci, JAMA Oncol 2016 September 1; 2 (9) 1154-1161

¿Se acerca la solución?

"…afirmo que en ocho años el cambio de hábitos, las campañas de prevención y la detección precoz marcarán un punto de inflexión en el cáncer, ya que comenzará a disminuir, recordando que el 40% de los cánceres podrían evitarse con prevención"…

ESPAÑA | AMÉRICA | BRASIL | CATALUÑA NEWSLETTER SUSCRÍBETE

EL PAÍS Materia

España cae del 'top ten' global de salud

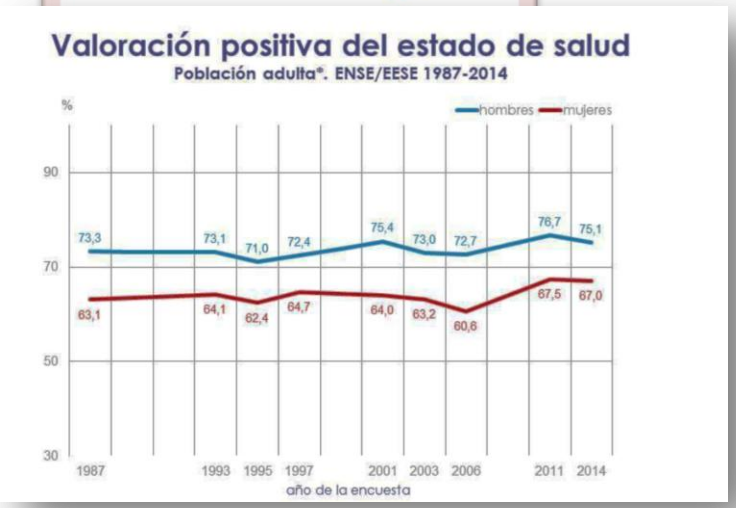
Un estudio para Naciones Unidas pone suspenso en consumo de alcohol, tabaquismo y sobrepeso infantil

JAVIER SALAS

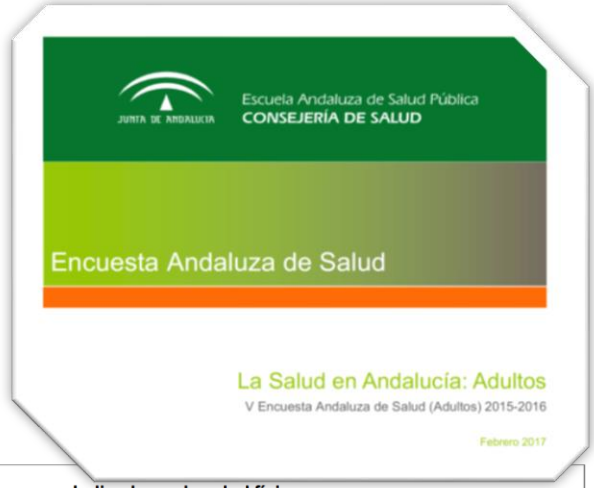
13 SEP 2017 - 16:48 CEST

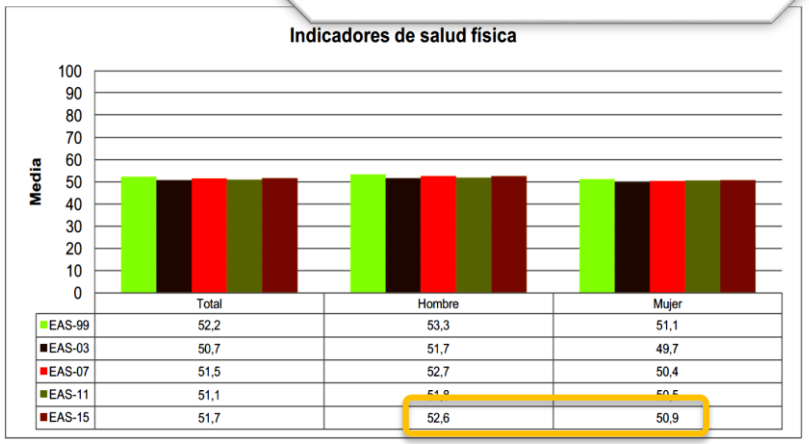
Una trabajadora sanitaria en un hospital de Madrid. LUIS SEVILLANO VÍDEO: ATLAS

Encuesta Europea de Salud en España-2014
vs
Encuesta Andaluza de Salud 2015-2016



Fuentes: EESE 2014 (INE), ENSE 2003-2011 (MSSSI/INE), EES 2009 (INE/MSSSI) y ENS 1987-2001 (MSSSI)





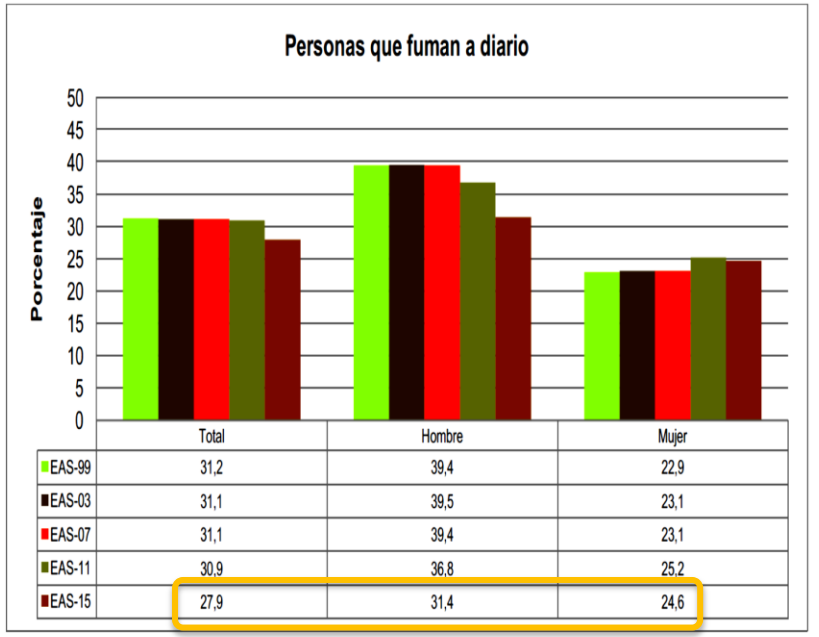
	Total	Hombre	Mujer
EAS-99	52,2	53,3	51,1
EAS-03	50,7	51,7	49,7
EAS-07	51,5	52,7	50,4
EAS-11	51,1	51,8	50,5
EAS-15	51,7	52,6	50,9

Ilustración 7. Valores medios en la puntuación física para la escala SF-12 por sexo. Andalucía. Años 1999, 2003, 2007, 2011 y 2015.

MINISTERIO DE SANIDAD, SERVICIOS SOCIALES E IGUALDAD

La Salud en Andalucía: Adultos
V Encuesta Andaluza de Salud (Adultos) 2015-2016

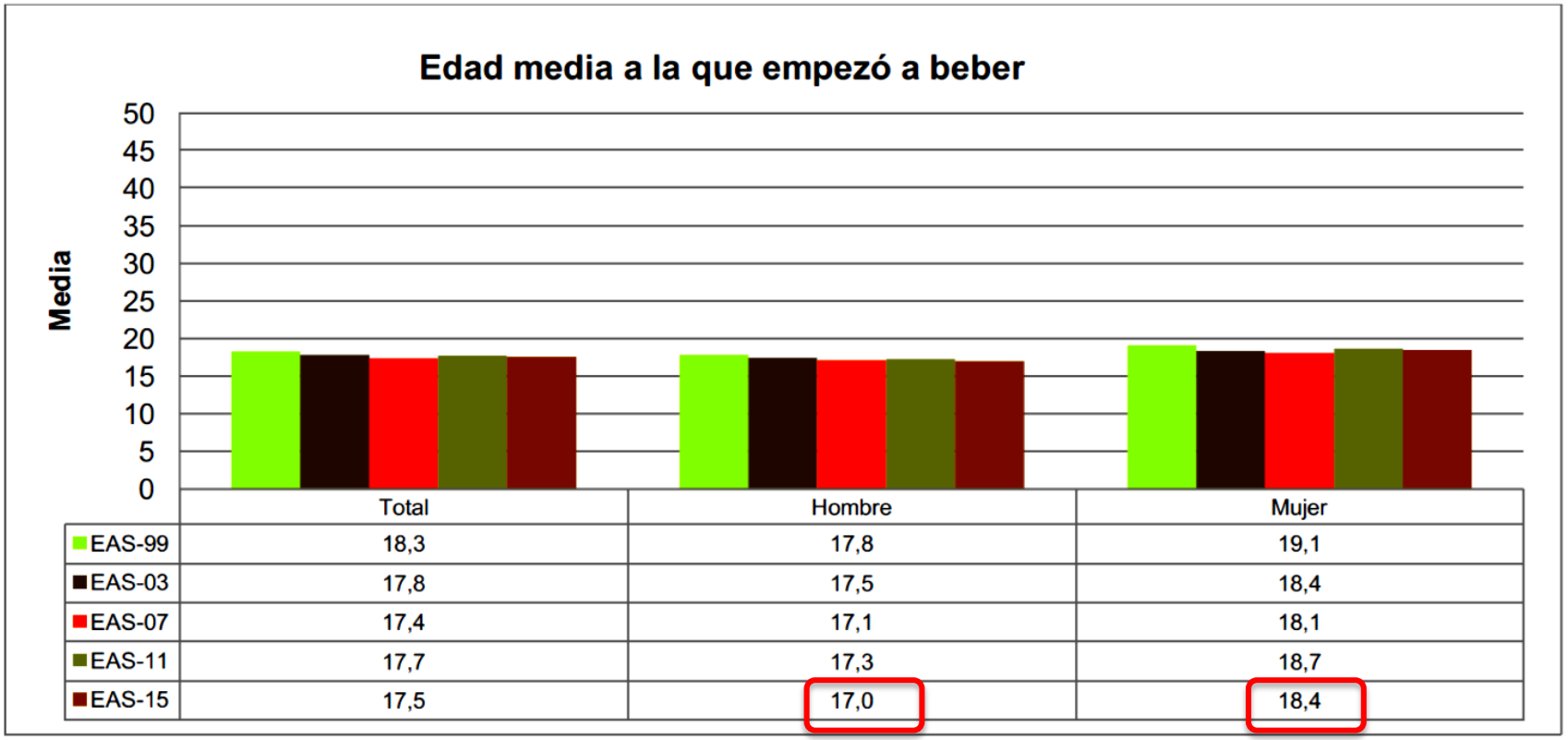
Tabaquismo



	Total	Hombre	Mujer
EAS-99	31,2	39,4	22,9
EAS-03	31,1	39,5	23,1
EAS-07	31,1	39,4	23,1
EAS-11	30,9	36,8	25,2
EAS-15	27,9	31,4	24,6

Ilustración 135. Prevalencia de personas que fuman a diario por sexo. Andalucía. Años 1999, 2003, 2007, 2011 y 2015.

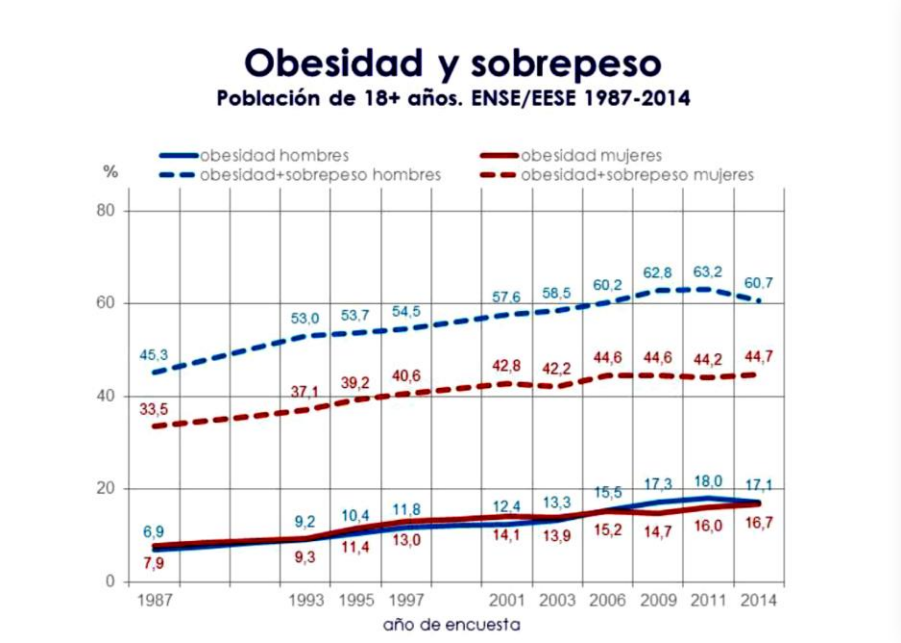
Edad de comienzo Alcohol

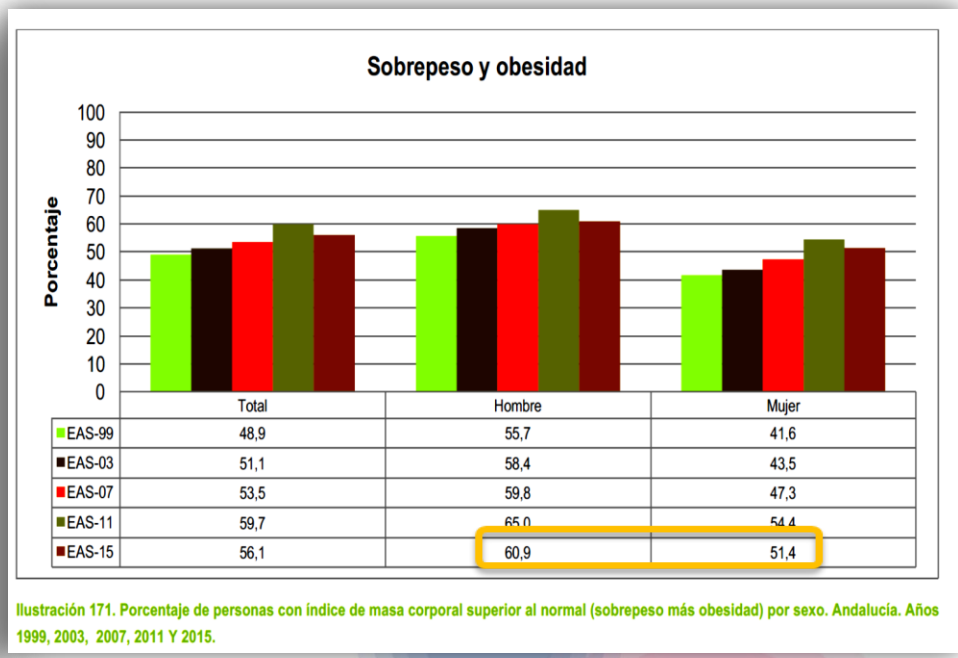


	Total	Hombre	Mujer
EAS-99	18,3	17,8	19,1
EAS-03	17,8	17,5	18,4
EAS-07	17,4	17,1	18,1
EAS-11	17,7	17,3	18,7
EAS-15	17,5	17,0	18,4

Ilustración 123. Edad media de inicio al consumo de bebidas alcohólicas por sexo. Andalucía. Años 1999, 2003, 2007, 2011 y 2015.

Obesidad y Sobrepeso

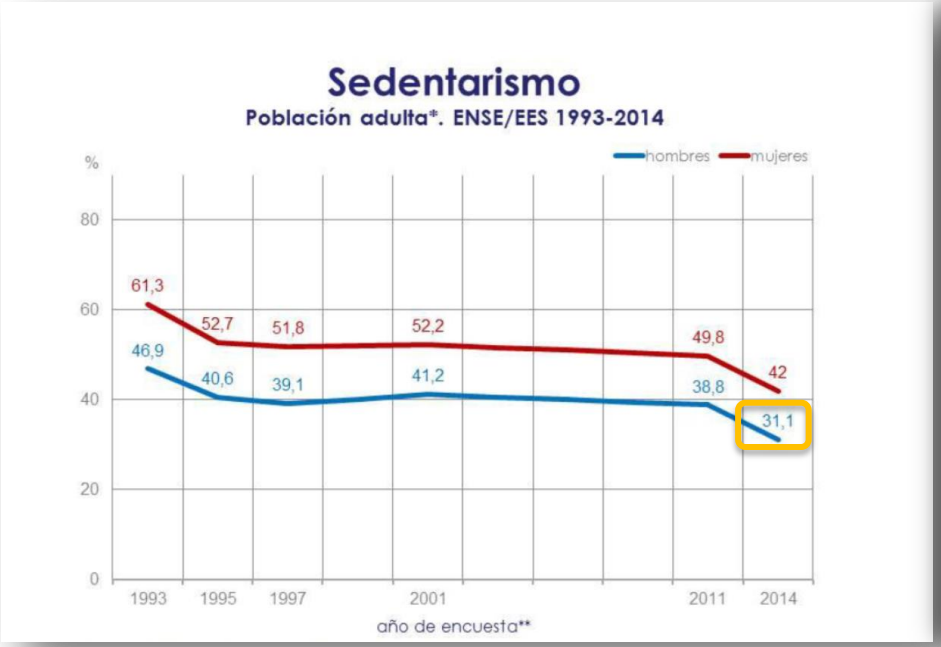


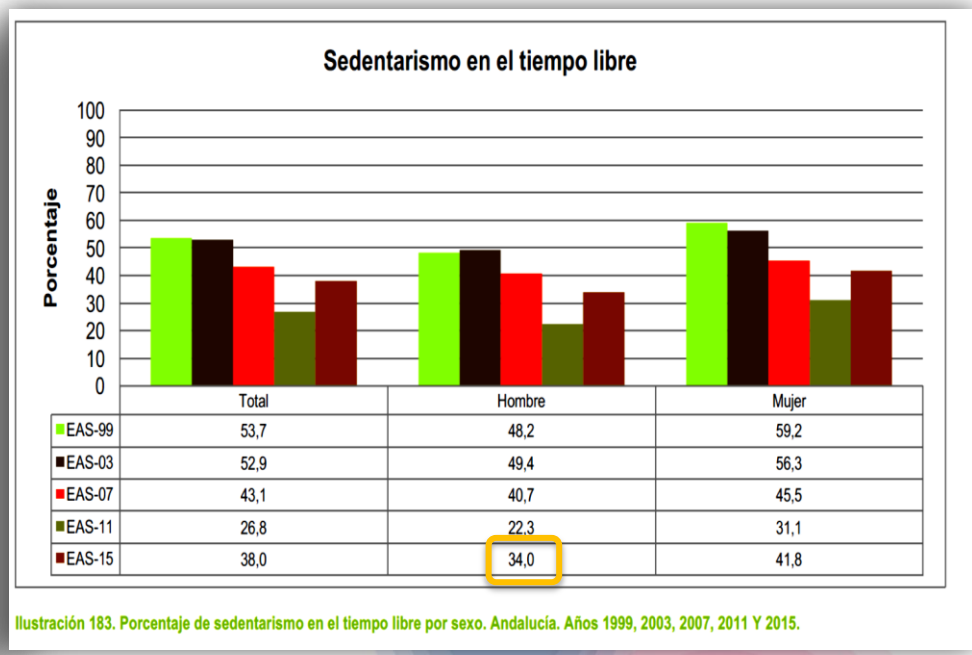


	Total	Hombre	Mujer
EAS-99	48,9	55,7	41,6
EAS-03	51,1	58,4	43,5
EAS-07	53,5	59,8	47,3
EAS-11	59,7	65,0	54,4
EAS-15	56,1	60,9	51,4

Ilustración 171. Porcentaje de personas con índice de masa corporal superior al normal (sobrepeso más obesidad) por sexo. Andalucía. Años 1999, 2003, 2007, 2011 Y 2015.

Sedentarismo

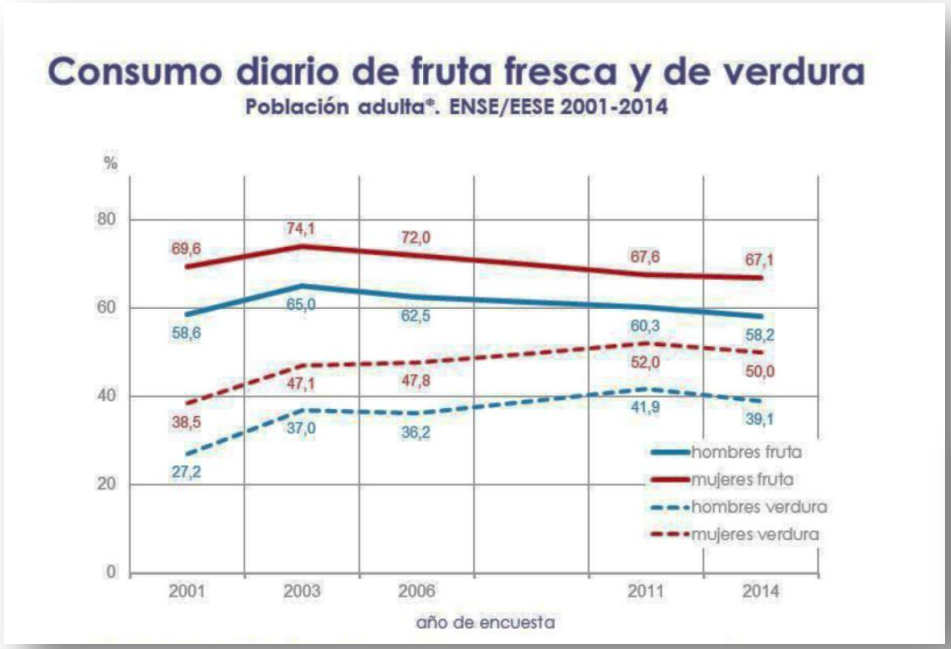


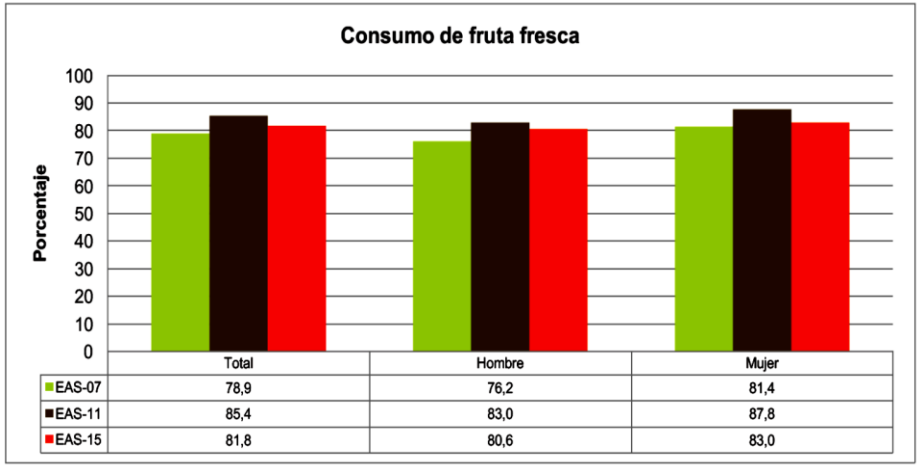


	Total	Hombre	Mujer
EAS-99	53,7	48,2	59,2
EAS-03	52,9	49,4	56,3
EAS-07	43,1	40,7	45,5
EAS-11	26,8	22,3	31,1
EAS-15	38,0	34,0	41,8

Ilustración 183. Porcentaje de sedentarismo en el tiempo libre por sexo. Andalucía. Años 1999, 2003, 2007, 2011 Y 2015.

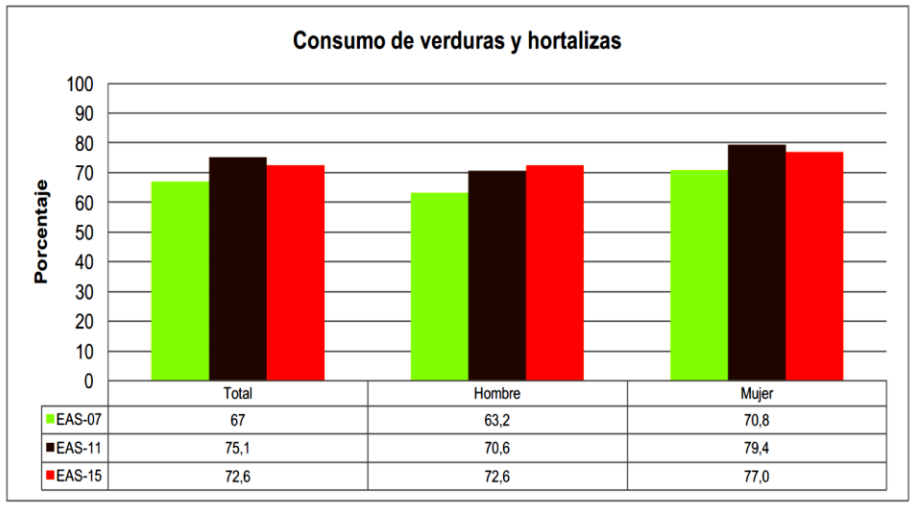
Consumo Fruta y Verduras





	Total	Hombre	Mujer
EAS-07	78,9	76,2	81,4
EAS-11	85,4	83,0	87,8
EAS-15	81,8	80,6	83,0

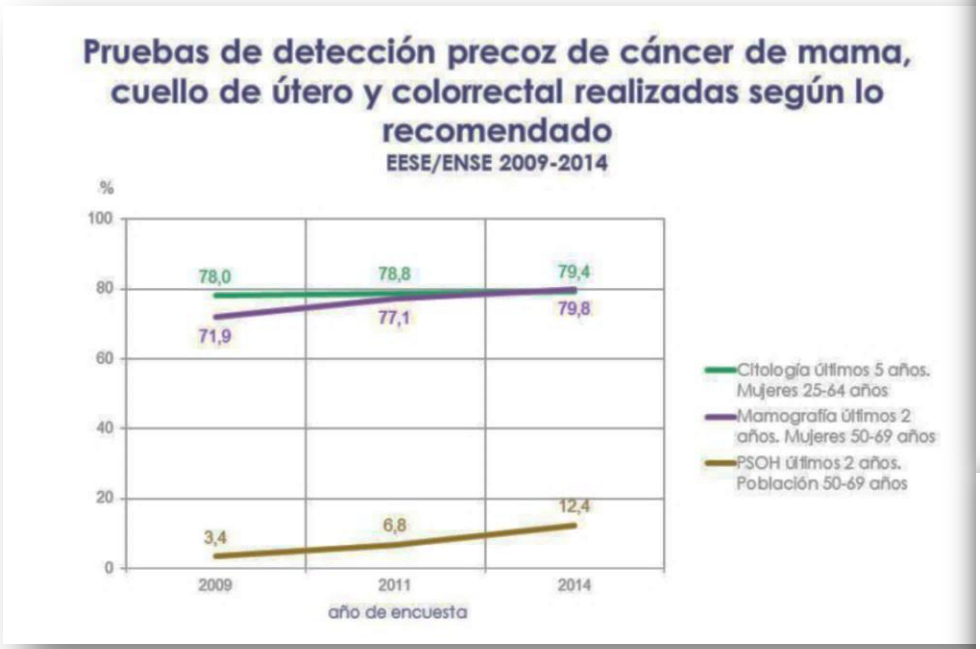
Ilustración 159. Porcentaje de personas que consumen fruta fresca al menos tres veces por semana por sexo. Andalucía. Años 2007, 2011 Y 2015.

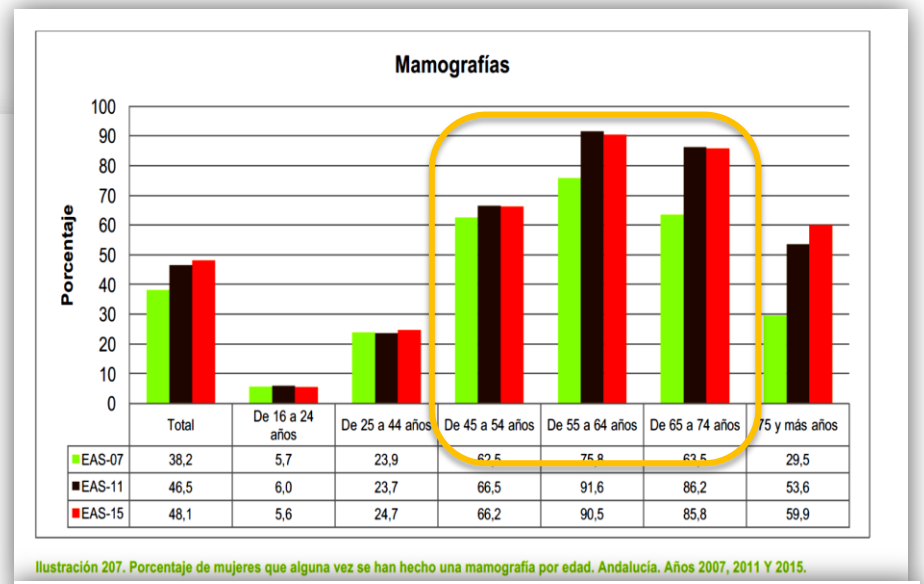


	Total	Hombre	Mujer
EAS-07	67	63,2	70,8
EAS-11	75,1	70,6	79,4
EAS-15	72,6	72,6	77,0

Ilustración 165. Porcentaje de personas que consumen verdura al menos tres veces por semana por sexo. Andalucía. Años 2007, 2011 y 2015.

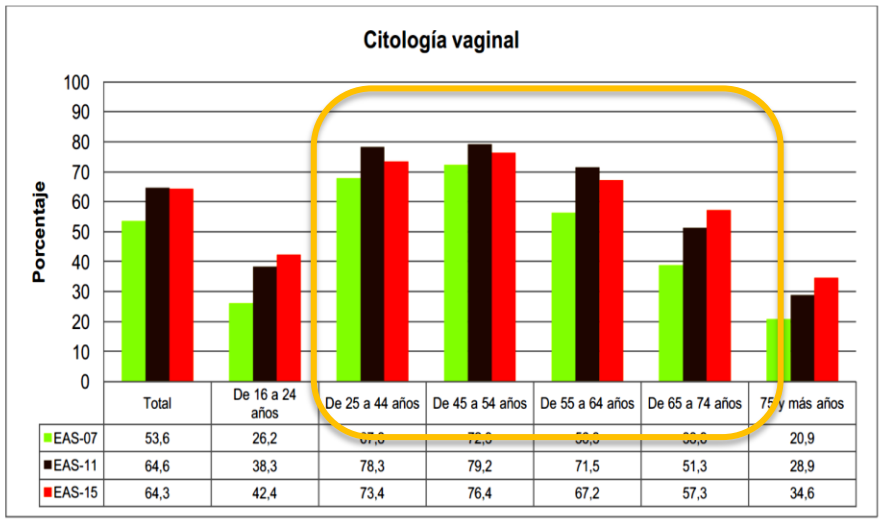
Participación en PDP





	Total	De 16 a 24 años	De 25 a 44 años	De 45 a 54 años	De 55 a 64 años	De 65 a 74 años	75 y más años
EAS-07	38,2	5,7	23,9	62,5	75,8	63,5	29,5
EAS-11	46,5	6,0	23,7	66,5	91,6	86,2	53,6
EAS-15	48,1	5,6	24,7	66,2	90,5	85,8	59,9

Ilustración 207. Porcentaje de mujeres que alguna vez se han hecho una mamografía por edad. Andalucía. Años 2007, 2011 Y 2015.



	Total	De 16 a 24 años	De 25 a 44 años	De 45 a 54 años	De 55 a 64 años	De 65 a 74 años	75 y más años
EAS-07	53,6	26,2	67,8	72,5	56,8	38,8	20,9
EAS-11	64,6	38,3	78,3	79,2	71,5	51,3	28,9
EAS-15	64,3	42,4	73,4	76,4	67,2	57,3	34,6

Ilustración 212. Porcentaje de mujeres que alguna vez se han hecho una citología por edad. Andalucía. Años 2007, 2011 Y 2015.

II CURSO DE RESIDENTES DE SAOM

GRANADA, 13 y 14 DE ABRIL 2018

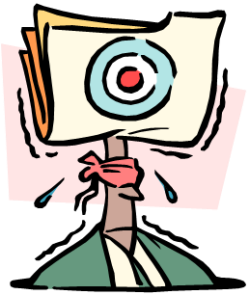
Organizado por:

SAOM
Sociedad Andaluza de Oncología Médica

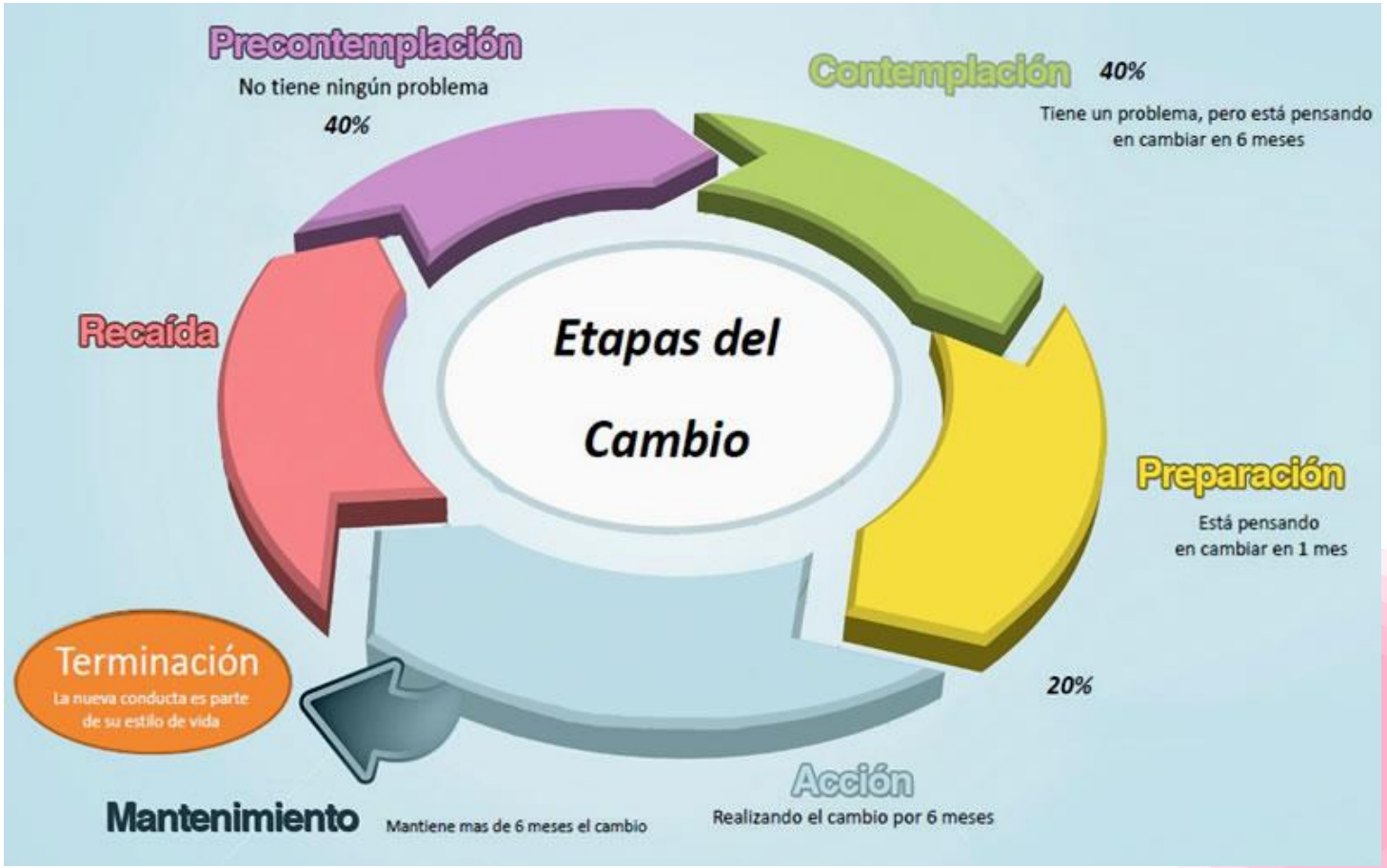
Barreras en la prevención del cáncer

BARRERAS PSICOLÓGICAS EN LA PREVENCIÓN DEL CANCER

- Resisten stilo de Vida
- Reforzan a consecue
- Tiempo e
- Aparició eatorio e inevitabl
- No quere “global” e indefinid



La clave es “la entrevista motivacional”



"El único paciente oncológico que se cura totalmente sin ni siquiera necesidad de tratamiento, es el que en realidad nunca llega a serlo" (J.Bayo)