Prostate cancer, diagnosed in one of every six men, is a major health concern and the second leading cause of cancer deaths among men in the United States. The National Cancer Institute (2006) estimates that during 2006 there will be 234,460 new cases of prostate cancer and this disease will result in 27,350 deaths. According to the National Center for Chronic Disease Prevention and Health Promotion (2006), the survival rate for prostate cancer has increased from 67% to 97% over the past 20 years. Like many other cancers, early diagnoses and treatment of prostate cancer has been associated with these increased survival statistics.

Data from the National Center for Chronic Disease Prevention and Health Promotion (2006) and the National Cancer Institute (2006) reveal that the prostate cancer death rate is higher for African-American men than for any other racial or ethnic group. Decreases in prostate cancer death rates during 1990-1999 were almost twice as great for Caucasians and Asian/Pacific Islanders than for African-Americans, American Indian/Alaska Natives, and Hispanics. Clearly, these statistics indicate that a disparity in the diagnosis and treatment of prostate cancer exists between ethnic groups.

Present activities targeted toward addressing this health care disparity include research aimed at improving communication, and developing and presenting educational programs. Many Web sites are dedicated to the diagnosis and treatment options for prostate cancer. The American Cancer Society (2006), Cancer Prevention and Control (2006), and the National Cancer Institute (2006) Web sites provide several educational resources for lay persons and access to pertinent research articles. While the availability and use of the Internet to obtain health care information is growing, its use among older adults is minimal. The ability to discriminate accurate research-based information from sites that aim to sell products requires an expanded knowledge base and critical thinking. The ability to use these concepts may be lost during a health care crisis, such as receiving a diagnosis of prostate cancer (Maliski, Heilemann, & McCorkle, 2002).

The results of research studies do not provide a blueprint for motivating those at risk to seek prostate cancer screening, but the results do highlight why current programs are not successful. These results expose educational gaps, motivation for screening differences, and a variation in treatment decisions. Reviewing the research body of knowledge outlines the specific health care concerns of this vulnerable and at-risk population. Using Ovid, CINAHL, and Medline as search engines, limiting the search words to research, prostate cancer, and different race/ethnicity groups provided few articles published in the last 10 years. After critically reviewing the ones in print, significant articles are reviewed here.

Perspective of the African-American Male

Results from the salient article, published in 1998, concluded that African-American men were significantly ($p=0.00$) less likely than Caucasian men to correctly identify early symptoms of prostate cancer and know the basic components of a prostate check-up. In addition, this study concluded that African-American men were twice as likely ($p=0.00$) to choose private appointments over mass screening when compared to Caucasian men. Radio was reported as the most preferred (25%) media forum among African-American men (Barber et al., 1998). Despite the fact that these results clearly identify appropriate interventions that would increase screening participation among African-American men, few programs were developed using the forums suggested.

In 2002, researchers Clarke-Tasker and Wade interviewed 12 African-American men after watching an educational video on the diagnosis and treatment of prostate cancer. These qualitative data revealed that older men knew more about the symptoms associated with prostate cancer, for they were experiencing symptoms (dribbling, frequency) yet they associated these symptoms with aging, rather than a cancer possibility. Knowledge of the risk fac-

Peggy Ward-Smith, PhD, RN, is an Associate Professor, School of Nursing, University of Missouri, Kansas City, MO.
tors associated with prostate cancer were unknown to all participants, these participants believed the physician placed the entire hand into the rectum to perform the digital rectum examination, and none believed they were at risk for prostate cancer. None of the participants requested prostate screening from their physician, stating that if it was a concern, the health care provider should broach the topic. These results indicate that if health care providers do not initiate the topic, screening will not occur.

These findings were again supported by subsequent research. In 2005, Clarke-Tasker and Dutta assessed prostate cancer knowledge among African-American men in an urban U.S. city. The results of this study indicated that 30% of these men would not want to know if they had prostate cancer and 53.2% did not believe they were likely to get prostate cancer in the future. Research by Meade, Calvo, Rivera, and Baer (2003) concluded a cancer diagnosis was perceived by African-American men as a death sentence.

A comparison of prostate cancer screening program participation among African-American and Caucasian males was performed by Weinrich, Weinrich, Atwood, Cobb, and Anderson (1999). The free screening participation rates were reported at 75% among Caucasians, while only 59% among African-American males. However, the results of this screening program diagnosed prostate cancer among 11.9% of the African-American males, while only 0.8% of Caucasian males tested positive for the diagnosis of prostate cancer.

African-American males are at greater risk, tend to participate in screening programs less, and do not frequently request prostate screening from their primary care provider. Health care professionals who care for these individuals must make prostate screening a routine.

Perspectives of Other Ethnic Groups

Maliski, Connor, Fink, and Litwin (2006) performed focus groups among men from varying ethnic backgrounds who had prostate cancer (African-American, Caucasian, Chinese, and Filipino). Separating the participants by ethnic background, the results indicated that each group lacked knowledge at the time of diagnosis, desired more information, and used a variety of approaches to obtain education. While some participants stated they heard of prostate cancer, the information had no meaning for them until they were diagnosed with the disease. Men in each group equated the diagnosis of cancer with death. The Filipino men received the majority of their education from their physician, and stated that they trusted this individual to give them all the information they needed. The authors concluded that ethnically relevant educational materials are needed. Pamphlets are a well-used source of information, yet they need to be language matched and easy to understand for the non-English literate. Television, churches, and work settings were mentioned as appropriate places for these brochures to be placed.

Mexican-American men are believed to receive fewer prostate cancer screening services than other populations. The result of interviews, conducted by Coronado and Thompson (2000), revealed that these individuals had little knowledge about the causes of cancer and the need for cancer prevention practices. The participants in this study were low-income, marginally educated, and primarily agricultural workers. These individuals also reported avoidance and fatalistic attitudes about cancer. This finding is supported by subsequent work of Meade et al. (2003). Specifically developed educational programs for these individuals should be presented in their native language, use simple language, not include or rely on the Internet, and be available at their work sites.

Treatment Differences

Watchful waiting is a more frequent treatment choice for prostate cancer among the racial/ethnic minority patient. Using the Surveillance Epidemiology and End Results-Medicare data from 1994-1996, Shavers and associates (2004) determined that 5% Hispanic, 6% of African-American, and 1% of Caucasian men failed to receive any followup for 60 months after receiving the diagnosis of prostate cancer ($p=0.001$). Differences in socio-economic status did explain these results.

In a systematic review of the literature, Zeliadt and colleagues (2006) identified variations in treatment decision making. Data on the importance of eradication of the cancer is conflicting, and the number of physicians seen and the importance of these recommendations also varied. After reviewing 70 articles, the authors concluded that the variance in treatment choice occurs due to differences in information patients receive rather than being truly reflective of patient preference. Thus, these authors recommend that education focus on helping patients understand the complex issues (side effects, treatment limitations, and associated morbidity) associated with each treatment modality.

Socio-Economic Status

Research by Weinrich and associates (2000) evaluated the prostate cancer screening participation rate among men of various socio-economic status. The participation rate was lowest ($p=0.001$) among those with lower incomes. However, the detection rate was greater ($p=0.01$) among this group. Since the participation rate among this population is so low, the program cost to detect prostate cancer was 3 to 4.5 times greater.

Krupski and colleagues (2005) obtained telephone and mailed survey data from individuals enrolled in a public assistance prostate cancer program. Participants were 51% Hispanic, 23% non-Hispanic whites, and 17% African-Americans. After age matching these participants to individuals without cancer, low-income individuals with cancer had worse scores in every quality of life domain. Being Hispanic and having a low-income were the greatest
predictors for poor physical functioning, although all men with prostate cancer obtained scores that were meaningfully worse than the age-matched participants without cancer.

Gorin and Heck (2005) used data from the 2000 National Health Interview Survey to determine the use of cancer screening activities among Latino and Cuban males. Cuban males, when compared to Latino males, were five times more likely to participate in prostate screening activities. Latino males were more likely to participate in prostate screening activities if they were older (between 50 and 69 years of age), visited their primary care provider annually, and also participated in other health screening activities.

Outcome Differences

Using data from the Prostate Cancer Outcomes Study, Johnson and associates (2004) separately analyzed data based upon treatment modality and racial/ethnic differences. These analyses determined that 60 months after prostatectomy, African-Americans had significantly higher sexual function (p=0.02) and urinary function (p=0.04) scores than non-Hispanic whites. No racial/ethnicity differences were found after radiotherapy treatment.

Additional analyses by Hoffman and colleagues (2001) of the Prostate Cancer Outcomes Study determined that African Americans have twice the risk of non-Hispanic whites for presenting with advanced-stage prostate cancer. Breaking down the statistics, 12.3% of African Americans, 10.5% of Hispanics, and 6.3% of Caucasians presented with advanced-stage prostate cancer. While socioeconomic factors could account for some of the statistical difference in Hispanic males, the risk remained statistically significantly increased for the African-American male.

The Challenge

Analyzing cancer screening, Baker, Phillips, Haas, Liang, and Sonneborn (2004) determined that participation in a health maintenance organization had no effect on prostate cancer screening rates. Relying on these institutions to impact this disease is inappropriate.

If the disease has no relevance until the diagnosis is made, how can screening messages be more effective? A review of the literature provides evidence-based data that can be used to develop ethnic-specific educational forums which will increase the knowledge base of men at risk. Ethnically diverse men do not know, do not ask, will not volunteer to participate, and believe that prostate cancer is a death sentence.

Providing education so that individuals do not have to request it allows one’s pride to remain intact, provides privacy to the individual, and allows him to read the information without risk of having to reveal his prostate-related concerns to others. Including this material in packets increases the chances that it may get read.

Using focus group data, culturally sensitive educational brochures were developed by Chan, Haynes, O’Donnell, Bachino, and Vernon (2003). These data allowed the brochures to be content and graphically specific to the needs of each ethnic group. Brochures for Caucasians described the prostate as the size of a walnut and explained how early prostate cancer can be asymptomatic. Hispanic brochures described the prostate gland as the size of a small lime, focused on the fact that advanced prostate cancer can be asymptomatic, and did not mention the pros or cons of prostate cancer screening tests. African-American brochures focused on the specific risk information for this population and the advantages of screening activities.

Education should be cultural sensitivity, presented as factual data, using a forum in which the individual does not have to request information. Just suggesting that men participate in prostate cancer screening activities, either during health fairs or when they see their primary care providers, may influence health promotional behaviors. Proactive behavior from health care professionals will impact the early diagnosis and successful treatment of this disease.

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