Don’t Neglect Cultural Diversity in Oncology Care

Presented by Teresita Muñoz-Antonia, PhD

Abstract
The growing Hispanic population in the United States mandates the need for oncology providers to become more familiar with disease patterns and cultural belief systems that can impact cancer care. “Culturally competent care” should be the mandate of all providers. This comprises awareness of cultural differences, communication in a manner that the patient understands, and respect. (J Natl Compr Canc Netw 2014;12:836–837)

In the practice of oncology, there needs to be a better appreciation of Hispanic sub-ethnicities, according to Teresita Muñoz-Antonia, PhD, Associate Director, Molecular Oncology Program, Moffitt Cancer Center, Tampa, who spoke about “Cultural Diversity in Delivering and Receiving Oncology Care” at the NCCN 19th Annual Conference, concentrating her remarks on the Hispanic population.

“There are interethnic biological differences that affect cancer care among Hispanics, and there are cultural differences in their health-related beliefs that influence cancer care and patient management,” she said.

Hispanic (or Latino) ethnic categories include persons of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. In the United States, the largest Hispanic populations are found in the Southwest, especially New Mexico, Texas, and California.

The 4 most common cancers in whites are also the most common in Hispanics—colon, breast, lung, and prostate—however, mortality rates differ somewhat. For example, lung cancer carries a 50% lower mortality rate for Hispanics than for white non-Hispanics, despite the fact that Hispanics are less likely to receive treatment and more likely to be diagnosed at advanced stages.1

“We believe a combination of genetics and environmental exposures may be responsible for such differences,” Dr. Muñoz-Antonia said. A number of relevant single nucleotide polymorphisms have been identified among Hispanic populations. They have a fairly high rate (33%) of epidermal growth factor receptor mutations (close to the 40% seen in Asians)2 and they harbor novel mutations of unknown significance.

Acute lymphoblastic leukemia (ALL) is another area in which genetic differences are clear, based on a disease susceptibility locus (ARID5B) unique to Hispanics that increases the risk of pediatric ALL and its recurrence. Hispanic children are up to twice as likely as their white counterparts to inherit the high-risk version of ARID5B.3

Ethnicity also affects response to drugs, especially toxicity, a concept known as “pharmacoethnicity.” Differences in toxicity are because of genetic polymorphisms that affect drug metabolism and are evident for antimetabolites (5-fluorouracil in colon cancer), anthracyclines (cardiotoxicity), and alkylating agents (cytochrome P450 enzymes).

Ancestry Informative Markers
Ancestry informative markers (AIMs) are genetic markers used by researchers to determine ancestral origin. For example, studies using AIMs have shown that most Puerto Ricans carry more European and African
The receipt of care in a language the patient understands is actually a legal requirement, and it is a mistake to use a family member as an interpreter, because they may withhold frightening or embarrassing information from the patient.

Language services are necessary, including a medical interpreter for verbal communication, translation services for written communication (informed consent, discharge instructions), and consulting services and in-service education within hospital departments.

Regarding end-of-life preferences, she indicated that “fatalism” (acceptance or “God’s plan”) is a common response to a cancer diagnosis among Hispanics, who also may be uncomfortable discussing end-of-life issues with their physicians, lack advance directives, and prefer to have family members make these decisions.

In all conversations, she added, “be sure to clarify and get a positive response before you assume the patient understands.”

References