



# AMERICAN COLLEGE OF SURGEONS

## SURGERY NEWS

### Tumor Biology May Explain Incidence of Thyroid Cancer

BY MICHELE G. SULLIVAN  
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WASHINGTON — A population difference in tumor biology probably accounts for most of the 50% lower rate of thyroid cancer in blacks, compared with whites, Dr. Luc Morris said at the annual meeting of the American Academy of Otolaryngology-Head and Neck Surgery Foundation.

Lack of insurance and low income may contribute to the lower incidence among blacks by limiting early detection, but those factors don't entirely explain the difference between the groups, Dr. Morris said in an interview. "Even though we have statistically significant evidence for this and it's a real effect, it is not big enough to account for this really large disparity."

The incidence of thyroid cancer in the United States has increased dramatically over the past 30 years in both populations, probably as a result of improved screening, said Dr. Morris of the department of otolaryngology at New York University, New York. Nonetheless, whites are twice as likely to develop the disease, with an incidence of 10/100,000, compared with 5/100,000 among blacks. "With this large a disparity, the question arises, is this a true population difference with a biological explanation?"

To address this idea, Dr. Morris and his colleagues analyzed statistics from two national databases: the Healthcare Cost and Utilization Project and the National Cancer Institute's Surveillance, Epidemiology, and End Results (SEER) database. They looked for three possible trends: If underdiagnosis in blacks was the primary reason for the difference, they expected to see black patients presenting at an older age with larger, more advanced tumors and higher mortality. If less-aggressive disease was the most accurate model, Dr. Morris said, the opposite picture would emerge. "And if there were truly a lower incidence of disease in the black population, one would expect no difference in these parameters."

The authors reviewed 54,000 cases of thyroid cancer in the SEER database from 1973 to 2003. It revealed a slower annual increase in disease among blacks over the period (2% vs. 2.8%)—a difference of 1,800 cases per year.

Regions of the country with more uninsured patients showed a lower incidence of thyroid cancer, while those with more insured patients had higher rates, suggesting a

difference in early detection. A regression analysis suggested that this effect could account for up to half of the black-white difference in national disease incidence. But this should be interpreted cautiously, Dr. Morris said, because neither database contained enough socioeconomic information for a multifactorial analysis.

Clinical differences emerged as well. Blacks were 8% more likely to present at an older age (greater than 45 years), 12% more likely to have a tumor larger than 1 cm, and 13% more likely to have a tumor larger than 4 cm. But they were 11% less likely to have nodal metastases and 4% less likely to have either extrathyroidal or advanced disease—factors suggesting a less-aggressive disease course. There was no difference in mortality.



**Whites are twice as likely as blacks to develop the disease. Is there a biological explanation?**  
DR. MORRIS

Because most of these risk ratios are similar, they reflect differences that, while statistically significant, probably are clinically small, Dr. Morris said. "Taken together, the clinical and sociodemographic data are supportive of a role for socioeconomic status, a small detection bias favoring white patients, and slightly less-aggressive behavior of thyroid cancer in black patients. However, all of these effects are quite small in comparison to the substantial black-white gap in cancer incidence."

Nor can environmental factors account for the disparity, since the only two known environmental risk factors for thyroid cancer—radiation exposure and iodine deficiency—are almost unheard of in the United States, he added.

"What we're left with is that this is probably a true population difference, but unfortunately, we don't have an explanation of why this might be."

Genetic differences may be the answer, although studies have yet to confirm this hypothesis. "We are just beginning to learn about the genetics of thyroid cancer, and no one has studied whether there are racial differences in the prevalence of these mutations."

Intrinsic racial differences already have been established in the biology of breast, colon, and prostate cancer, Dr. Morris pointed out. It's not irrational to assume such a difference also exists for thyroid cancer.

"In fact, there are other interesting differences in thyroid cancer incidence. It's widely acknowledged that Southeast Asian women have the highest incidence in the world, for instance, and no one yet understands why," he said. ■

### Grants Seek to Spur Pace Of Quality Improvement

BY ALICIA AULT  
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Participants in several hospital and physician-related quality organizations are sanguine that almost \$16 million in grants from the Robert Wood Johnson Foundation will hasten development of national cost and quality measures, as well as acceptance of those measures.

In October 2007, the foundation awarded \$8.7 million to the Engelberg Center for Health Care Reform at the Washington-based Brookings Institution, \$4.2 million to the America's Health Insurance Plans (AHIP) Foundation, and another \$3 million to various other groups to identify potential cost measures.

The project will be coordinated by Dr. Mark McClellan, the former commissioner of the Food and Drug Administration and former administrator of the Centers for Medicare and Medicaid Services, who now directs the Engelberg Center.

The grants will help "fill in the gaps" of the work being done by the Quality Alliance Steering Committee (QASC), said Susan Pisano, a spokeswoman for the AHIP Foundation. The Steering Committee is an amalgam of the Hospital Quality Alliance and the AQA (formerly the Ambulatory Care Quality Alliance), bringing together hospital and physician concerns.

"By bringing all stakeholders in the health care system together, this new project is an important step in accelerating the current slow pace of improvement in health care quality," said Dr. Carolyn Clancy, director of the Agency for Healthcare Research and Quality (AHRQ), and cochair of the QASC, in a statement.

Backing from the Robert Wood Johnson Foundation also serves as recognition that the Steering Committee's efforts are worthwhile, said Dr. Frank Opelka, vice chancellor of clinical affairs at the Louisiana State University Health Sciences Center, and the American College of Surgeons' representative on the QASC.

Established in 2006, the Steering Committee's principal members include the Robert Wood Johnson Foundation, the American Medical Association, the American College of Physicians, the Association of American Medical Colleges, the Federation of American Hospitals, Blue

Cross/Blue Shield, the American Hospital Association, the Society of Thoracic Surgeons, AHIP, the AFL-CIO, the National Partnership for Women and Families, the National Business Coalition on Health, the Pacific Business Group on Health, General Motors, Honeywell, Boeing, Exxon Mobil, the Joint Commission, the AHRQ, the Centers for Medicare and Medicaid Services, the National Quality Forum (NQF), and the National Committee for Quality Assurance.

The group will use performance measures that have been developed and endorsed by the NQF and AQA, but will use them in conjunction with a new database being developed by AHIP. The data will be collected from private plans and Medicare—all from claims—and aggregated into a practice-wide and a nationwide picture, said Ms. Pisano.

The database means that reports back to physicians will "provide a more comprehensive view of their practices," she said. Instead of getting a report from one plan on all that plan's patients, and another from another plan, it will be a report that cuts across all insurers.

The bigger picture is important because it will give physicians the information they need to evaluate their performance across an entire practice, not just a single encounter, said Dr. John Tooker, executive vice president and CEO of the American College of Physicians. It also will make for more accurate reporting, he said, noting that with a larger sample, there should be fewer outlier patients to skew a physician's rating.

Grants from the Robert Wood Johnson Foundation will also support the development of cost measures that will look at how physicians and hospitals use resources and compare them with national data. Initially, measures will be developed for 20 common conditions.

Both the quality and cost data will also eventually be shared with consumers.

"Tracking performance by adherence to quality standards tells patients only part of what they need to know in order to make informed decisions about health care services," said Dr. McClellan, in a statement. "They also need to know how the cost for these services compares." ■