TSET Better Health Podcast Transcript

Episode 54: On the Road to Reducing Cancer Mortality in Oklahoma

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Summary: Oklahoma has the fourth-highest age-adjusted mortality rate for all cancers in the nation, despite ranking much lower in overall cancer incidence. Early detection is crucial for successful treatment, but lack of information and barriers to accessing cancer screening often delay detection until the cancer reaches an advanced stage. Research and innovative resources -- including a lung screening mobile unit that will travel the state -- are underway to address and narrow cancer disparities in Oklahoma. Dr. Mark Doescher of the OU Health Stephenson Cancer Center shares details on the mobile unit and how it can impact health in rural communities, Dr. Darla Kendzor of the TSET Health Promotion Research Center talks about four new research projects that aim to reduce cancer among Native and African Americans and tobacco use, and Dr. Kathryn Klump of OU Health share routine ways for everyone to reduce their cancer risks.

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[Theme music]

James Tyree: Hello everyone, I hope you are having a great day. Welcome to Episode 54 of the TSET Better Health Podcast. I am your host, James Tyree, associate director of Integrated Communications at TSET …

Sarah Carson: And I am Sarah Carson, campaign manager for TSET. Today's topic is the importance of cancer screening for early detection and of efforts to increase access to lifesaving screenings and treatment to more Oklahomans. Unfortunately, cancer affects a great many Oklahomans and their families.

J. Tyree: It certainly has effected many people I have known and loved, and I'm sure most our listeners can say the same.

S. Carson: The data bears that out. Cancer trails only heart disease as the leading cause of death in Oklahoma, and lung cancer has the highest mortality of all forms. The key to curing cancer is finding it early, followed by prompt and effective treatment or surgery. But lack of information or easy access to cancer screening and treatment prevent many Oklahomans from getting the timely care they need.

J. Tyree Fortunately, there are new efforts coming out of the OU Health Campus to address and shrink cancer care disparities. We will learn about the new research and resources in this episode, along with important actions we can take now to stop cancer early or preventing it altogether.

S. Carson: Our first two guests have been on the podcast before, but we wanted to bring them back because both are involved in new research and innovations that aim to prevent or

fight cancer in Oklahoma. We'll hear first from a leader at the TSET Health Promotion Research Center and the new multi-study research happening there.

D. Kendzor: I am Darla Kendzor. And I have multiple roles at the University of Oklahoma Health Campus. But I am the Co-Director of the TSET Health Promotion Research Center. And I am a professor in the Department of Family and Preventive Medicine. I am a professor in the Department of Family and Preventive Medicine at the University of Oklahoma Health Campus.

J. Tyree: Before we discuss the new research happening at TSET HPRC, I have to get your take on something I read recently. A National Institutes of Health article said 33 states have higher all-cause cancer rates than Oklahoma, yet only three states have a higher all-cause cancer mortality rate than ours. I'm sure there are many factors, but generally speaking, how can this be?

D. Kendzor: I think there are always complex answers to these kinds of questions, but the first thing that jumps out to me is the issue of access to care. So, when you think about Oklahoma, we've got about a third of the population that lives in rural areas. So, there can be barriers to accessing in cancer screening and then getting that initial diagnosis at an early enough stage to where it would be more treatable.

And then, if cancers are not diagnosed earlier, then you know you're not getting timely cancer care. I would also say that in Oklahoma, we have a high proportion of uninsured residents compared to the national rates. And we have more people living below the poverty threshold here in Oklahoma compared to the US overall. So, again, getting back to this access to care issue. And then just one other thing that I have to mention this, just because of my own research. We also have higher smoking rates here in Oklahoma compared to the national rates. And so, unfortunately, smoking can lead to certain cancers that may have lower survival rates than other types of cancers, such as lung cancer. So, I think that would be a contributing factor. But these are just a few things that came to mind when you asked the question.

J. Tyree: There is good news coming from your research center on closing the gap of cancer disparities in the form of a new four-year $5.6 million study. I understand there are multiple parts to it, but can you tell us more about the study and what it will entail?

D. Kendzor: So, this is actually more than just a single study. It is actually a Cancer Health Research Center or a CHERC for short. So, it will support multiple studies. And it will support some training activities and some other things. So, basically, the goals of the CHERC are to address the root causes of cancer disparities in Oklahoma, through interventions that are designed to address disparities specifically in cancer preventive behavior and early detection. So, we have four research studies that focus in on these areas. And I can tell you more about those if you'd like to hear them. And then, also, we are able to support

health equity research training, so that we can increase the quantity and quality of researchers in these areas going forward. So, we're currently supporting two trainees.

J. Tyree: Yes, tell us more about each of the new studies.

D. Kendzor: So, we have four research studies. They're led by four very talented investigators. Two of the studies will focus on increasing cancer screening. So, one of them aims to increase follow-up diagnostic colonoscopy after a positive stool-based screening test. And that will be in the tribal health services units and focus specifically on American Indians. And then the other cancer screening project will aim to increase prostate cancer screening among African Americans through a social media campaign, through community health events. And then through a novel mobile app, where people can learn about prostate cancer risk, and screening, and then order prostate cancer screening tests, and be followed through that mechanism.

D. Kendzor: And then we have two other studies that are focused on tobacco. So, one will target smoking cessation through an empowerment-focused intervention, which engages people in their communities in order to increase a sense of self-control or self-advocacy. And then the fourth study will evaluate differences in the appeal and abuse liability of flavored tobaccos. So, specifically looking at concept flavors, which are flavors that don't have food labeling, like they're not mint or menthol or candy flavors, let's say. Ocean Breeze is the one that comes to mind. It's not like of food. And this kind of study can inform some of the tobacco-related policies around flavoring. So, overall, it's cancer screening, increasing cancer screening, and reducing tobacco use.

J. Tyree: Will any part of these new studies build upon earlier research that you and your colleagues have done, especially in helping people quit tobacco use?

D. Kendzor: Yes. So, all of these studies build on past work. And they're advanced in the sense that we've done a lot of pilot work already and we're kind of moving forward with it. But yes, we have a study that's based on empowerment theory. It was pilot tested at our center in our tobacco treatment research program and has shown feasibility and preliminary efficacy. And so, this new research funded by the American Cancer Society will allow us to actually do a full scale trial and to expand out into some of the surrounding states to evaluate the trial.

J. Tyree: Conversely, is there a new area of study with this grant that you're eager to delve into and explore?

D. Kendzor: These studies all kind of build on our previous work, and they all have new components. But I can say, for example, the project that will evaluate a navigation-based intervention approach to increased diagnostic colonoscopy is building on a previous study. So, colorectal cancer screening rates have been extremely low among American Indians. And so, the previous work has focused on that initial stool-based screening test. So, with

their study, they found in the past that they were able to get those screening numbers up really to a much higher rate. But then people aren't following up with that colonoscopy after they have that positive screen.

So, if you do that initial test, that's great. But you actually have to follow up with the diagnostic screening afterwards in order to move through the process of getting that diagnosis and getting the cancer care. So, I'm excited to actually see that next piece of the study build here with that project.

J. Tyree: What timetables are you and your colleagues looking at in completing each of the research areas?

D. Kendzor: Well, this American Cancer Society grant is a four-year funding period, so we are in our first year. And we are up and running, for the most part. And we hope to conclude all of these studies by the end of 2028 or December 2028. So, we have four years to do all of this work, so we will ideally be finished at that point.

J. Tyree: Finally, how do you expect and hope this new study will ultimately help shrink some cancer disparities in Oklahoma and actually save lives?

D. Kendzor: Yeah. So, each of the projects targets cancer disparities in different ways. But of course, if we can develop and disseminate effective tobacco cessation interventions, especially within groups that have high smoking rates, then we can bring down some of those tobacco-related cancers that way. In terms of policy, if we are able to show greater abuse liability or appeal from flavored tobacco, this can inform some of our tobacco policies, which ideally would lead to the restriction of the sale of these kinds of products and then reduce cancer accordingly.

In terms of cancer screening, if we can get African-American men to increase prostate cancer screening at an earlier age, we may be able to identify those cancers at an earlier stage when it is more treatable. So, again, just increasing survival by identifying cancers at an early stage. And then finally, once you have a positive stool-based screening test for colorectal cancer, you really need to follow up with that diagnostic colonoscopy in order to find out whether you actually have the diagnosis and will need to initiate treatment.

So, I think it's really about preventing cancer through tobacco control and then identifying cancers early when they are more treatable, so you can actually have a better outcome. Thank you.

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S. Carson: Dr. Kendzor said there are four parts to the American Cancer Society Cancer Health Research Center grant, to the TSET Health Promotion Research Center, and after her interview she sent us a brief description of each sub-project and their lead researcher.

Dr. Amy Cohn will lead the study on differences in appeal and preferences for flavored little cigars and cigarillos, Dr. Julia McQuoid is the lead on empowering smoking cessation for communities with high stress and low social support in Oklahoma and surrounding region, Dr. Jordan Neil is leading the multilevel intervention to increase prostate cancer screening rates for men in Oklahoma, especially for African American men, and our next guest is studying a tribally engaged approach to increasing diagnostic colonoscopies.

He spoke a bit more on that with James, but the primary topic of their conversation was a new resource for bringing lung cancer screenings to more Oklahomans. Let's meet him now and hear their conversation.

M. Doescher: Hi, I'm Mark Doescher. I'm Professor of Family and Preventive Medicine, an active family physician. My main role within OU Health, however, is serving as Associate Director of Community Outreach and Engagement.

J. Tyree: Thank you for joining the podcast today. So what can you tell us about the TSET OU Health Lung Screening Mobile Unit? What's it like for someone to go inside the vehicle?

M. Doescher: Sure. So this is one of just a handful of mobile units for lung cancer screening in the United States. It has a CT scanner on the unit. So as they step into the vehicle, there's an area for intake in terms of meeting with the patient or participant who will undergo lung cancer screening. And then it's a donut-shaped CT scanner, just like if you went to the hospital to get a CT scan that the person can get the screening from. So it's a pretty simple layout, but it's all designed to be able to enable the CT scan to be taken.

J. Tyree: About when will it be up and running for lung screening?

M. Doescher: Yeah. So it should be increasing in volume over the coming months and should be up to full volume by mid to late 2026. So we've already done some screenings with the unit. We've pilot tested it here within OU Health over at Family Medicine and run patients through in the scans. I'm happy to report our coming into our radiologist at very high quality images. And we've started scheduling events with community partners.

At this point, some of it is going out to community events and introducing the units, so stakeholders in the community can get an idea of what it looks like if it were to visit their location. And some of it is now going into the fall, doing our initial outreach to communities with doing the lung cancer screening. So we're at the point where we're ready to roll and schedule with community partners.

J. Tyree: So the mobile unit will go out to communities throughout Oklahoma?

M. Doescher: Correct. So our goal ultimately is to be going up throughout the state. But in particular, concentrating on areas where the lung cancer rates tend to be highest. And if you could envision a map of Oklahoma, if you're to look at the eastern half, particularly the southeastern corner into the southwest and southwest parts of Oklahoma, that's where the rates are highest, particularly in rural areas. It's also the locations where access to CT scanning for lung cancer screening is most challenging. We've mapped out and we're doing more sophisticated gap analysis to look where travel times to current standing CT imaging centers is more than a 30 minutes' drive. We're really trying to concentrate on areas where that access to the standing facilities is least.

We're also wanting to concentrate in populations that have the highest rates of lung cancer screening in Oklahoma, the highest risk group is the Native American population. So we've done a lot of outreach already to tribal nations and their healthcare delivery systems about potentially working with them for lung cancer screening. We're also meeting with smaller rural hospitals, federally qualified health centers and other health care providers that see populations that are especially at high risk. Rural areas, the risk from lung cancer is about 25% higher than the general population. In our Native American populations, the risk goes up to 60 to 70% higher. So we're really trying to use this unit in a way that meets the need for screening in the highest risk populations in the state.

J. Tyree: It's important to detect and treat all kinds of cancers early, so why the emphasis on lung cancer?

M. Doescher: So lung cancer remains the leading cause of cancer death in the United States. If you were to look at the total number of lung cancer deaths in any year, it's about the same as the next three cancers combined. So lung cancer really is the major cancer in the United States. And then if you look at all of the states across the nation, Oklahoma has the fourth-highest lung cancer mortality rate. So the need in Oklahoma is great. We have very, very high burden of lung cancer mortality in Oklahoma. And at the same time, we've had lung cancer screening with low dose CT as an available screening tests since 2013 in the United States. So we're going on 12 plus years now, where there's been an effective modality that can reduce lung cancer mortality by up to 25%. Which is on the same level of risk benefit as mammography for breast cancer.

But in the United States, only about 15% or so of people are up-to-date with this guideline. And in Oklahoma, the percentage is much lower, it's well under 10% of people who are eligible have been screened. We are the worst state to second-worst state in the nation for lung cancer screening right now. So we have the fourth-highest mortality rate. We have the worst five-year survival for lung cancer in the nation. But we are also unfortunately the worst or next to worst depending on which measure you use for lung cancer screening. So we have a lot of work to do in this space.

J. Tyree: So the hope and expectation is for the mobile unit to raise that percentage of people getting screened for lung cancer and to do it earlier.

M. Doescher: I think it'll help in terms of volume of people that we're ultimately able to screen and get into healthcare. We're also being very intentional about making sure that those who are currently smoking cigarettes, because that is the biggest risk factor for lung cancer, are connected with tobacco cessation services, including the state quit line if they do get screened. But it also increases visibility about lung cancer screening and the benefit of getting screened. And I think that will help people and clinics understand that they can go to this unit. They can also go to their local providers and local hospitals to get screened as well. We just need to increase visibility, and I think that's another advantage of having a mobile unit. It brings visibility to the issue.

J. Tyree: So who are actually eligible to get screened for lung cancer?

M. Doescher: I think this is really important for folks to know. It's probably the most complicated cancer screening, evidence-based cancer screening guideline that we have. So I will just try to put it here succinctly. It's adults aged 50 to 80 years who have at least a twenty-pack year history of smoking cigarettes that are either currently smoking or have quit within the past 15 years. That's a bit of a mouthful, and that's been one of the challenges for healthcare systems and I think the population to handle. But again, it's 50- to 80-year olds who currently smoke or who have quit within the past 15 years that have at least a twenty-pack year history of tobacco use, namely cigarette smoking.

J. Tyree: What is a 20-pack year history?

M. Doescher: Yeah, so that's a pack per day on average for at least 20 years in their life. So if you smoked a half a pack a day for 40 years, that would be a twenty-pack year history. If you smoked two packs a day for 10 years, that would be a twenty-pack year history. So you have to calculate it out. And that is how the guideline was set up. It will continue to be how the guideline is calculated. It's not something that the healthcare system has historically done routinely. Most primary care clinics or other hospital systems will ask if a person has a history of smoking or currently smokes, but they don't tabulate the pack years. I think with this guideline, systems need to be more, if you will, systematic about tabulating pack year history as well.

J. Tyree: That is important to know, thanks for that clarification. This episode is about narrowing disparities in cancer screening and treatment and lung cancer, as you pointed out warrants its large focus. But I understand you and other researchers are involved in projects that aim to lower other forms of cancer. Can you tell us more about that?

M. Doescher: Colorectal cancer has the second-highest number of deaths after lung cancer each year in the United States. And Oklahoma once again is in the bottom four states for colorectal cancer mortality. So just like lung cancer, we have major disparities in Oklahoma around colorectal cancer. And the rates are particularly high in the Native American population, as well as our rural communities. They're also high in our African American communities and some other high risk communities.

Just like for lung cancer screening, for colorectal cancer screening, we're in the bottom, in this case, five states in the nation for colorectal cancer screening. So we have high rates of mortality, low rates of screening. This is a consistent pattern for most evidence-based cancer screens. But for colorectal cancer screens, we have a lot of improvement that could be done. We've already done work with several tribal clinics, urban Native American clinics, Indian health service sites on navigation to improve colorectal cancer screening, the first stage of it. With what's called stool-based tests, so FIT is one of them. People have heard of Cologuard, that's another one that gets done. But what we are finding is a drop-off, if you have a positive stool-based test result, a positive FIT kit result. About half of people are not getting the diagnostic colonoscopy that is essential if you're going to complete the screening process. You need to know with a positive stool-based test if there are polyps or cancer in the colon.

J. Tyree: So how will the study you're involved in address this important health matter?

M. Doescher: So what we're doing in this current study that is funded by the American Cancer Society is to really work hard on getting that front-end screening with stool-based tests completed. But then making sure that the diagnostic follow-up testing occurs as well. Because that's vitally important. I think people forget this, with screening tests, it's not just the initial screening, it's not just the Cologuard or the FIT test. It's not just the low-dose lung CT for lung cancer screening, it's not just the mammogram. It's also the follow-up if you have a positive result. So we're doing work to work on that under the equation as well, so that people can get in for timely cancer treatment if they do have cancer.

Can I just mention a couple other things that we've done in this realm? So we also have done a lung cancer screening implementation at a large tribe in Oklahoma, in Southeast Oklahoma, the Choctaw Nation, we've published with them. They had zero lung cancer screens before our implementation, and now I think they've screened over 6000 individuals. And we just got funding through the National Institutes of Health Center grant that one of the projects is to do lung cancer screening at Cherokee Nation, the largest tribal nation ... delivery system in the nation. So we're doing a lot of work beyond the mobile unit in lung cancer screening. We've also had NIH funded work on colorectal cancer screening with tribal nations.

And then I just finally wanted to mention, we have an exciting grant where one of the accrual hubs for NCI, National Cancer Institute Cancer Screening Research Network, where we just launched what's called the Vanguard Study. Which is a randomized

controlled trial to look at new blood tests called multi-cancer early detection tests, or MCEDs. We don't know if those yet avert deaths from the types of cancers they screen. But a single blood test can pick up multiple types of cancer, including cancers for which we can't currently screen, like pancreatic cancer and liver cancer, and some other major ones.

So we're just launching a statewide trial in many locations throughout the state, including rural clinics. And hopefully with at least one tribal nation clinic to do assessment of these new cancer detection tests, which are blood tests. Which may over the next 10 or 20 years supplant a lot of the screening that we're currently doing. So it's an exciting time for improving cancer screening. I just wanted to put a plug in for those studies too because I think they're very important.

J. Tyree: Yes, by all means, thanks for telling us about all these different studies that ultimately could help save lives soon and for years to come.

M. Doescher: Well, that's a really interesting question you're raising because to get to mortality endpoints does take ten-plus years. And we're now in an era of rapidly advancing technology in terms of what we can do with blood tests, and learn about cancer at an early stage. So this national network is trying to come up with strategies for getting answers to whether screening at the mass population level might be effective or not. Looking at mortality endpoints, but also looking at some intermediate endpoints before that to help guide that decision process. Because if we wait 10 years, the technology will be different yet again. It's a good time, but it's a challenging time for evaluating these technologies.

J. Tyree: Dr. Doescher, thank you for joining us today to share some of what's new in the fight against cancer here in Oklahoma.

M. Doescher: Yep. One more plug. TSET was a primary funder for the lung bus and we're very grateful to the support they've been providing toward this program. I think it's time to make lung cancer screening widely available in Oklahoma. People need to know about it. And so there's a lot of energy right now around lung cancer screening and TSET's been instrumental in moving that forward, so I just want to make sure that that gets noted. Thanks.

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J. Tyree: The high mortality rate for lung cancer in Oklahoma coupled with our very low rate of cancer screenings. The lung screening mobile unit, once fully utilized, will help improve both of those sobering statistics, which means more lives saved and extended to enjoy with loved ones.

S. Carson: Our final guest, Dr. Kathryn Klump, is also quite familiar with the lung screening mobile unit. And as a family physician, she also helps people of all ages live as healthily as

possible to prevent cancer and other serious illnesses. Let’s welcome Dr. Klump to the podcast and learn more about her.

K. Klump It's a pleasure to be here. I am a family medicine physician at the OU Health Physicians Family Medicine Center in Oklahoma City, where I serve as the Medical Director, and I also work with the OU Health Stephenson Cancer Center as the physician champion for lung cancer screening and primary care.

J. Tyree: How and why are routine visits with one's personal or family physician play a critical role in cancer detection and treatment?

K. Klump: Oh, goodness. I would say there are so many reasons why those routine visits are important. In family medicine and as a primary care physician, I love the opportunity to get to know my patients, to build long-term relationships with them and to provide longitudinal care that really focuses on the whole person, but also focuses on their health and wellness.

And in those routine visits, annual visits, even when you're feeling well, that is the time that we can set aside to really learn about you and your healthcare goals, to learn about a patient's risk factors, whether that is something that is environmental or something as a behavior that they engage in, or if it's something that is history, family history, or other risk factors that we need to know about. It's the time where we are able to really dive deep into what preventive care that's evidence based, but also individually tailored to your risk factors and your needs, and talk about ways in which we can not only screen for different types of cancers, different other types of illnesses, but also how we can work together to prevent those from happening.

J. Tyree: Can you recall a specific example or two of a surprising early cancer detection and diagnosis that may have saved the person's life?

K. Klump: Yes, actually, that is something that does come up in our routine screening. And really recently, actually, somebody that I had spent a lot of time with talking through the importance of specific routine cancer screening tests. And after a lot of discussion and some reluctance, because not all of the screening tests are always the most fun to go through. Most of them are also very accessible and are not too uncomfortable. But everyone has had a discussion about a colonoscopy or the different types of less invasive colon cancer screening. And one of the individuals that I have had the privilege to take care of, recently made the decision to go for their first colonoscopy. And in that procedure, a early cancerous polyp was found that was able to be removed, and now we don't have to worry about that particular lesion becoming a problem. It was both prevention and it was screening.

J. Tyree: I would imagine it’s common for someone to suspect something may be wrong physically, but they just don't want to get it checked out. What would you say to someone who may be apprehensive about potentially learning something scary?

K. Klump: Yeah, there are lots of reasons why it can be scary to think about finding out information that might be considered unpleasant or bad news and lots of things that go along with the process of finding out about a diagnosis. Part of the just kind of beauty of being a family physician is that I get to see my patients and really explore their values, their beliefs surrounding, and their concerns.

And so from there, we're able to really go through and partner in, what is something that would make this important for your health? But also, to really talk about, what are those worries? And sometimes those worries are based on an experience with a family member, a colleague, and everyone's kind of health journey is different. Sometimes those fears are based on maybe the types of technology and things that were available at one time that we have now in medicine learned a lot about mitigating side effects with treatment for cancers when treatments are needed, with technologies and medications that are able to treat things. And finding things at an earlier stage is often going to result in a very positive outcome and with a lot more ability to be able to identify and treat something that is found. So, exploring those fears, finding out how we can partner together with the right amount of knowledge and information that can give those individuals the best information to make the most informed decisions about their health, and then being there throughout the whole process.

J. Tyree: What are some other reasons or factors that keep some Oklahomans from getting prompt cancer screenings?

K. Klump: Yeah, so there can be a lot of reasons why it can be difficult to get to cancer screenings. One, this may be, it's something that falls down further on our list. Time and recognizing the importance of cancer screening and prevention and early detection. Accessibility can be a challenge. Some of these cancer screenings can be done really easily in the primary care office, but others may need a little bit more a facility, a hospital-based screening.

For example, with lung cancer screening, you need a CT scanner, in addition to a visit with a primary care provider to talk about the risks and benefits of that screening. And so, sometimes it's difficulty with access, other times it can be difficulty with many other factors. And again, having that knowledge of knowing where you stand as an individual and your risk, and the importance for those evidence-based screenings, and then working together to mitigate the barriers, whether those are financial, distance, and other accessibility issues.

J. Tyree: With that in mind, how happy are you about the upcoming launch of OU Health's lung cancer screening bus? How can this become a huge wellness resource for Oklahomans?

K. Klump: So, I am thrilled about the launch of the OU Health Lung Cancer Screening Mobile Unit. It has been a really neat thing to be a part of the development and planning for this state resource that is going to be able to travel out into areas in and around Oklahoma

where there's some of the highest incidence of lung cancer, but also, again, one of those barriers, lots of distance potentially to get to a center that has a CT-equipped facility. And so, it has been really neat.

K. Klump: Just this last week, I was actually able to talk to the Oklahoma Primary Care Association with a really wonderful group of physicians, nurse practitioners, physician associates, and clinic administrators about the availability of this unit and the ways in which we can partner together with multiple clinics and health centers throughout Oklahoma to make sure that patients are able to access this type of screening, and that they can access it near where they're located and remove some of those difficulties of getting to a place with a CT scanner. So, it's been really exciting and I think it will be an amazing resource for Oklahomans, again, to break down barriers to accessing the lung cancer screening, but also to bring awareness to it. And this weekend coming up, the Lung Bus will be going out into the community where individuals can actually interact with it, and we are looking forward to continuing that and being able to screen patients.

J. Tyree: Let's finish with prevention: What are the most important things people can do — and not do — to lower their risk of cancer, and can you think of at least one cancer prevention tip that may get overlooked or doesn't get mentioned as often?

K. Klump: It's a really good question. So, so many things that we can do to decrease our risk for developing cancer. One of those and one of the most important, is actually avoiding tobacco. So, not using tobacco and if you're currently using tobacco, working with your primary care physician or our state quit line to be able to get the resources to cut back on tobacco use. Eating healthy foods, getting enough exercise, protecting yourself from the sun, and then decreasing alcohol consumption are all ways that we can lower cancer risk.

And one of the things I love to share with patients who are really working towards making those changes is that we really do see decreases in the incidence of cancers, as well as lowering your risk with something like stopping tobacco use, stopping cigarette smoking, you reduce your risk after a year of things like coronary artery disease. And by the time you reach the seven to 10 year mark of no longer using cigarettes and stopping that tobacco use, that risk of lung cancer actually drops by 50%.

One of the things that I think may get overlooked, that's a great cancer prevention tip, is actually that we now have vaccines for some types of cancer, one of those being the HPV vaccine. And that is able to prevent cancers that are caused by the human papillomavirus, that includes cervical cancers, as well as multiple types of head and neck cancers and other cancers that we see increasing, and it is an effective prevention tip.

J. Tyree: Thank you for joining us and sharing your insights, Dr. Klump.

K. Klump: Thank you again for having me. I look forward to hopefully being able to talk again, and especially as we get further and further out on the road with the lung cancer screening bus, to be able to share more stories with you. Thank you so much.

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S. Carson: The extensive research and latest technology to fight cancer are really impressive. But as Dr. Klump pointed out, there's no substitute for the important role that routine checkups with your doctor plays in detecting and beating cancer.

J. Tyree: Taking it a step further, there's nothing better in the fight against cancer than preventing it altogether.

S. Carson: Dr. Klump said the biggest thing a person can do to reduce one's risk of cancer is to quit tobacco use. She also mentioned how helpful state quit lines can be.

The Oklahoma Tobacco Helpline ranks among the most successful in helping people stay quit.. And some exciting news - anyone registering during the month of October can receive a minimum of eight weeks of nicotine patches, lozenges or gum – double the usual amount – and that's in addition to free coaching and online support. Anyone in Oklahoma can access the Helpline by visiting https://okhelpine.com or calling 1-800-QUIT-NOW.

J. Tyree: We at the TSET Better Health Podcast want to thank Drs. Darla Kendzor, Mark Doescher and Kathryn Klump for joining us for this episode. And we always thank you, our wonderful listeners, for your time, interest and support.

S. Carson: Remember, you can listen to this or any episode of the TSET Better Health Podcast at oklahoma.gov/tset/podcast or anywhere you listen to podcasts. Thanks again for joining us today, and until next time, this is Sarah Carson …

J. Tyree: And James Tyree wishing you peace …

S. Carson: And better health!