Blood, Prostate, Childhood Cancer
Awareness Month (September)

Music by Marc Anthony, Vivir mi Vida,
From the Album, 3.0

THE LATINO CANCER INSTITUTE
Connect. Convene. Advocate.

Welcome to the 7th Annual National Latino Cancer Institute Forum Series

Sept 12th, Oct 3rd, Oct 24th

You Are In The Waiting Room

Hour One

Featuring Matthew "Mateo" Banegas, PhD, UCSD

"Ask the Men" – In Conversation with
Tomás Almaguer, Marty Gonzalez & Ray Suarez

Hour Two

Dr. Matthew Cooperberg, UCSF

David O. Garcia, PhD, FACSM, University of Arizona

Edgar Villavicencio, MPH, University of Arizona

Hour Three

Dr. Ana Maria Lopez
Sidney Kimmel Cancer Center, PA

Miriam Juarez-Vargas, B.A.
The Latino Cancer Institute

Blood, Prostate, Childhood Cancer Awareness Month (September)

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Addressing an Unanswered Burden – Latino Men's Health & Cancer

September 12, 2025

HEALTH IS WEALTH

Health is Wealth – Counting the Costs of Cancer

"Ask the Men"

Anatomy of a Prostate Diagnosis – One Size Does not Fit All

Why Genetics Matter – Understanding Liver Cancer Risk

Food As Medicine – We Are What We Eat!

Aims

Gain Awareness of Latino Men's Cancer Burden

- The economic harms
- The personal journey
- The science of it all
- The genetic risk
- The interventions to increase better outcomes

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Coming Up

October 3rd

Machismo – Health Barrier or Coping Mechanism? Luis Valdez, PhD, MPH, Drexel University, PA

October 24th

Building the Latino Medical Student/Physician Pipeline! Cristhian Gutierrez Huerta, Latino Medical Student Association (Chicago) & Dr. Elena Rios, National Hispanic Health Foundation (Washington, D.C.)

Housekeeping

- Keep your cameras off, and mic on mute
- Use the Chat Box for questions for our speakers
- Various documents also found in the Chat Box
- All the presentations are being recorded. Slides and recordings will be available after Nov.1st

PARA ESPAÑOL

- En los controles de su reunión/seminario web en la parte inferior de su pantalla, haga clic en "Interpretación" y elija español.
- Si no ve el ícono de Interpretación en los controles de su reunión/seminario web,
- haga clic en el ícono "Más" y seleccione Interpretación de la lista.
- Para escuchar solo español, haga clic en "Silenciar audio original."

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Interpreters


Fabiola Rivera Ramirez


Maria Esperanza Outeirino-Feijoo


Claudia Schalesky

Survey Results – Who is in the Room?

What is your role/profession? **

Public health: 6 (46%)

Research: 5 (38%)

Community outreach: 5 (38%)

Education: 3 (23%)

Administration: 1 (7%)

Other: 1 (7%)

Clinical care: 0 (0%)

Which best describes your primary connection to this topic?

Researcher/academic/other research agency: 7 (53%)

Healthcare provider: 2 (15%)

Family member/caregiver: 2 (15%)

Nonprofit/advocate, executive, staff: 2 (15%)

Community health worker: 2 (15%)

Cancer survivor: 1 (7%)

Student: 1 (7%)

Bio/Pharma: 1 (7%)

* Small sample size – 13 respondents
**Note: Respondents could select multiple options, so percentages add up to more than 100%

What You Told Us: Survey Insights

🚧 Barriers & Solutions Disconnect

- Top barrier for Latinos: "Lack of awareness/education" about cancer
  Most helpful solution: "Culturally appropriate healthcare providers" (76% ranked #1)

🤔 The Knowledge Paradox

- 46% = "somewhat familiar" with Latino cancer disparities
  → Field complexity OR need for better synthesis

🧩 You Understand Complexity

- 69% said "all factors equally" contribute to cancer risk → Today we explore intersections of economic, cultural, genetic & social factors

💪 You Recognize Cultural Impact

- 100% agree machismo influences health-seeking: 69% "strong" | 30% "moderate"
  → "Ask the Men" panel explores this lived reality

🧬 Your Knowledge Snapshot

- 69% believe prostate screening should start at 40–49 for Latino men
- 69% believe fatty liver disease can be reversed (46% partially, 23% completely)

Hispanic/Latinos are nation's second-largest racial or ethnic group after non-Hispanic whites

Hispanics make up 19.2% of the U.S. population or 65.2 Million people*

*From CENSUS 2023

Largest Subpopulations*	
Mexican	58.9%
Central American	10.3%
Puerto Rican	9.3%
South American	7.3%
Cuban	3.8%
Dominicans	3.8%

In 2023, an estimated 194,500 U.S. Hispanics were diagnosed with cancer

1 in 5 Latino deaths due to cancer. SOURCE ACS

** From CDC

In 2023

An estimated 50,000 Hispanics died from the disease

American Community Survey - Estimates 2022

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- 67% of the Hispanic/Latino population is U.S. born
- Another 13% are naturalized citizens
- In 2021, 72% of U.S. Hispanics, 5 years and older, either spoke only English at home or spoke English very well

https://www.pewresearch.org/short-reads/2023/08/16/11-facts-about-hispanic-origin-groups-in-the-us

16.8% of Hispanics/Latinos (of any race) had **no health insurance** coverage compared to 5.3% of non-Hispanic whites.

51.5% of Hispanics/Latinos (of any race) had **private health insurance coverage**, compared to 74.1% of non-Hispanic whites.

37.9% of Hispanics/Latinos had **public health insurance**, compared to 36.1% of non-Hispanic whites.

Top Five Causes of Latino Male and Pediatric Cancer

Source: 2024 American Cancer Society Hispanic Cancer Facts & Figures, Inc., Surveillance and Health Equity Science/Children Various: cancer.gov, CDC, US EPA, PMC

Adult Males Incidence	Adult Males Mortality	Youth 0-19 Incidence	Youth 0-19 Mortality
Prostate (25%)	Lung and bronchus (13%)	Leukemia (ALL) (30%)	.48 per 100,000
Colon & rectum (10%)	Colon & rectum (12%)	Brain & CNS 0-14 yrs (27%)	.59 per 100,000
Kidney/renal pelvis (8%)	Liver & intrahepatic bile duct (11%)	Lymphomas Hodgkin & Non-Hodgkin (12 -15%)	N/A
Lung & bronchus (7%)	Prostate* (9%)	Soft Cell Sarcomas	N/A
Non-Hodgkin Lymphoma (5%)	Pancreas (6%)	Non-Hodgkin Lymphoma (5%)	N/A

Health is Wealth – Cancer's Economic Toll

- 46% skip recommended treatments due to cost concerns
- Latino cancer survivors face 2 to 3x higher healthcare costs
- 71% of survivors carry medical debt
- Financial impact reverberates through families and communities
- $8.8 billion lost annually in productivity due to Latino cancer deaths

*American Cancer Society Cancer Action Network. (2022). "The Costs of Cancer in the Hispanic/Latino Community." Available at: https://www.fightcancer.org/sites/default/files/coc_hispanic_final.pdf

UC San Diego Health

Center for Health Equity
Education & Research

Counting the Costs of Cancer - The Economic Toll on Latino Men and U.S Productivity

Mateo Banegas
Associate Professor
University of California, San Diego

Raul's Story

- Armed services veteran
- Single-income household
- High-deductible health plan

Diagnosis & Treatment

- Prostate Cancer (Stage 3, Regional)
- Surgery and radiation therapy

Social/Economic Situation

- Unable to afford out-of-pocket (OOP) costs
- Stopped working soon after diagnosis
- **Needs identified**: medical bills, food, utilities, transportation

Result

- Connected with Community Navigator
- Received medical financial assistance (MFA)
- Enrollment in Medicaid

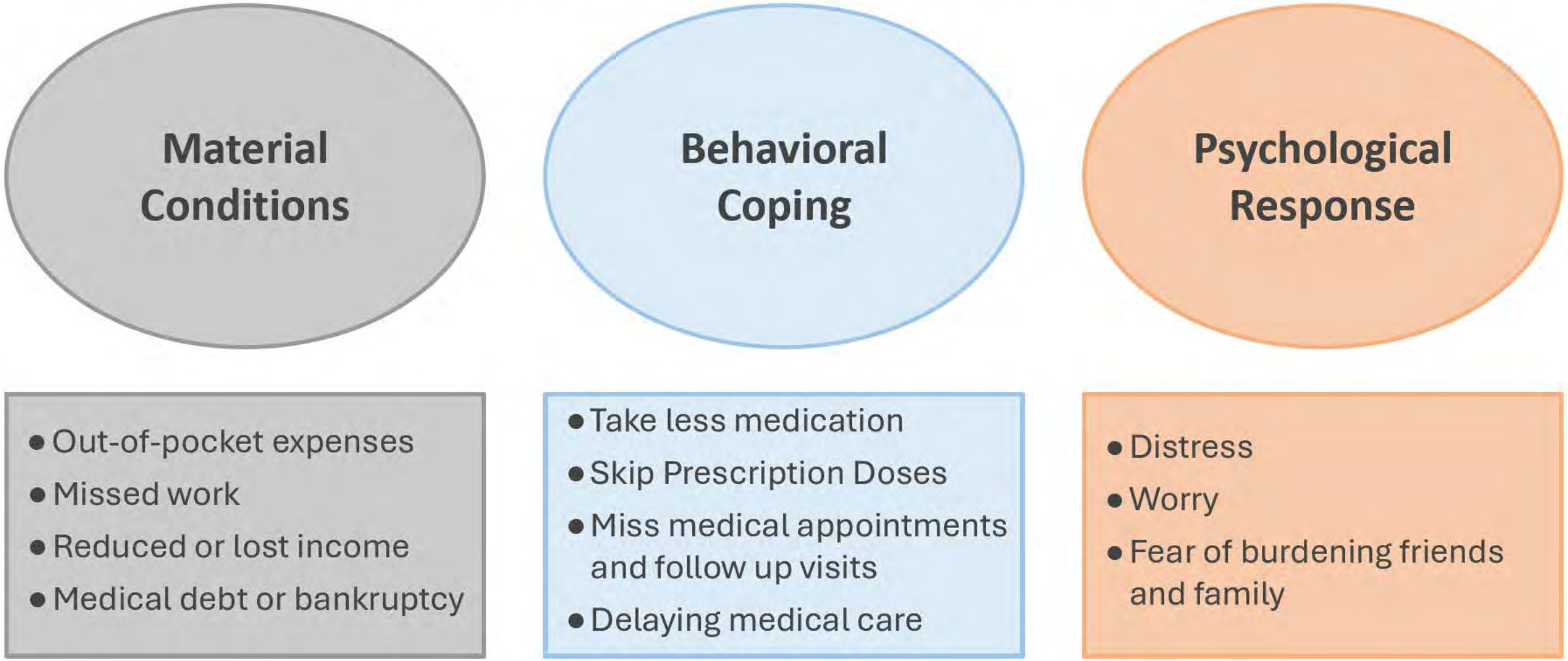
NCI R01CA237322 (Henrikson/Banegas); NCT05018000

Financial hardship

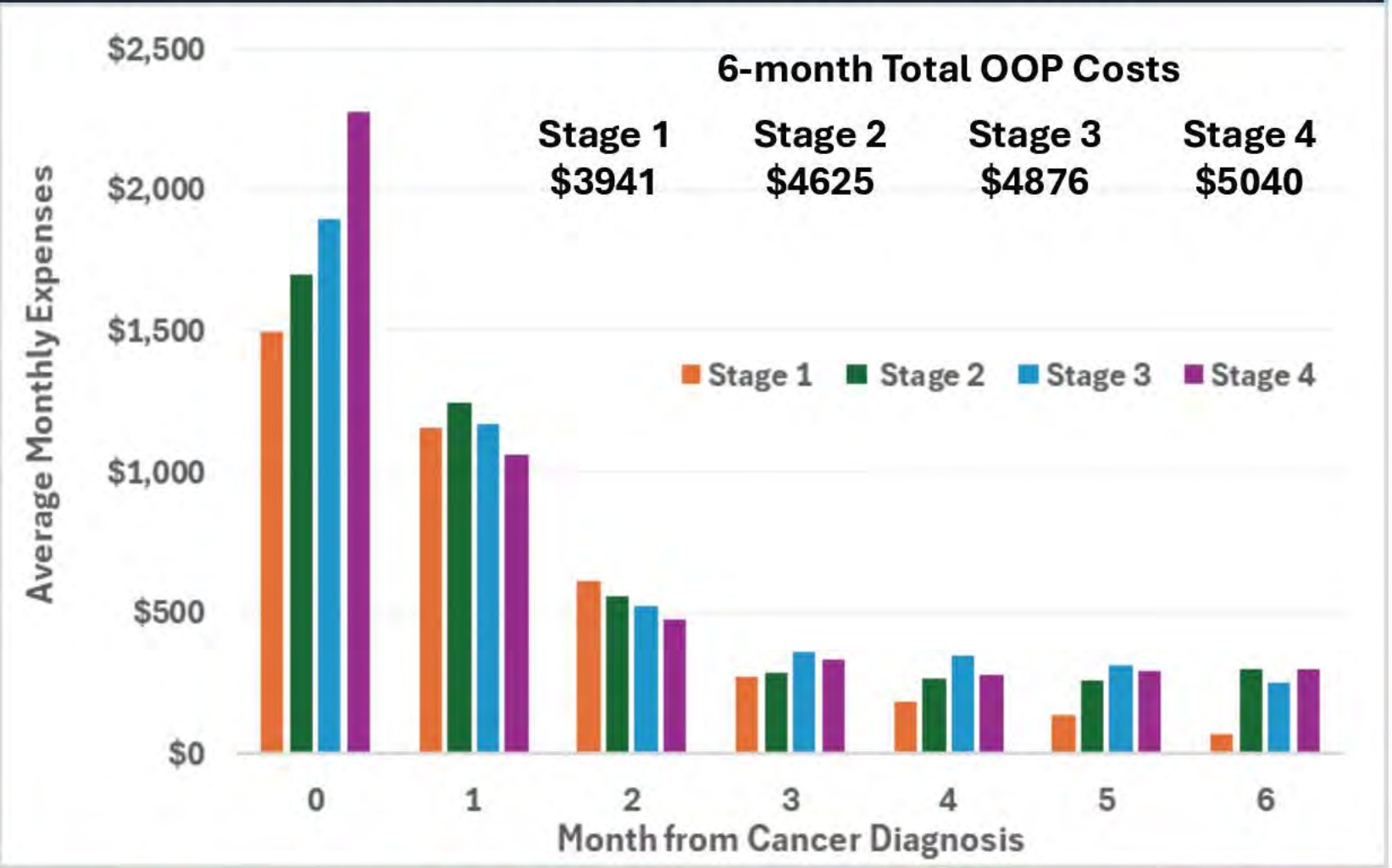
…a situation in which an individual (or family) is unable to pay for essential living expenses, including the costs to ensure the health and welfare of the individual/family.

adapted from U.S. Internal Revenue Service

Different Types of Financial Hardship from Cancer



Average Monthly Out-of-Pocket (OOP) Costs for Patient with Cancer



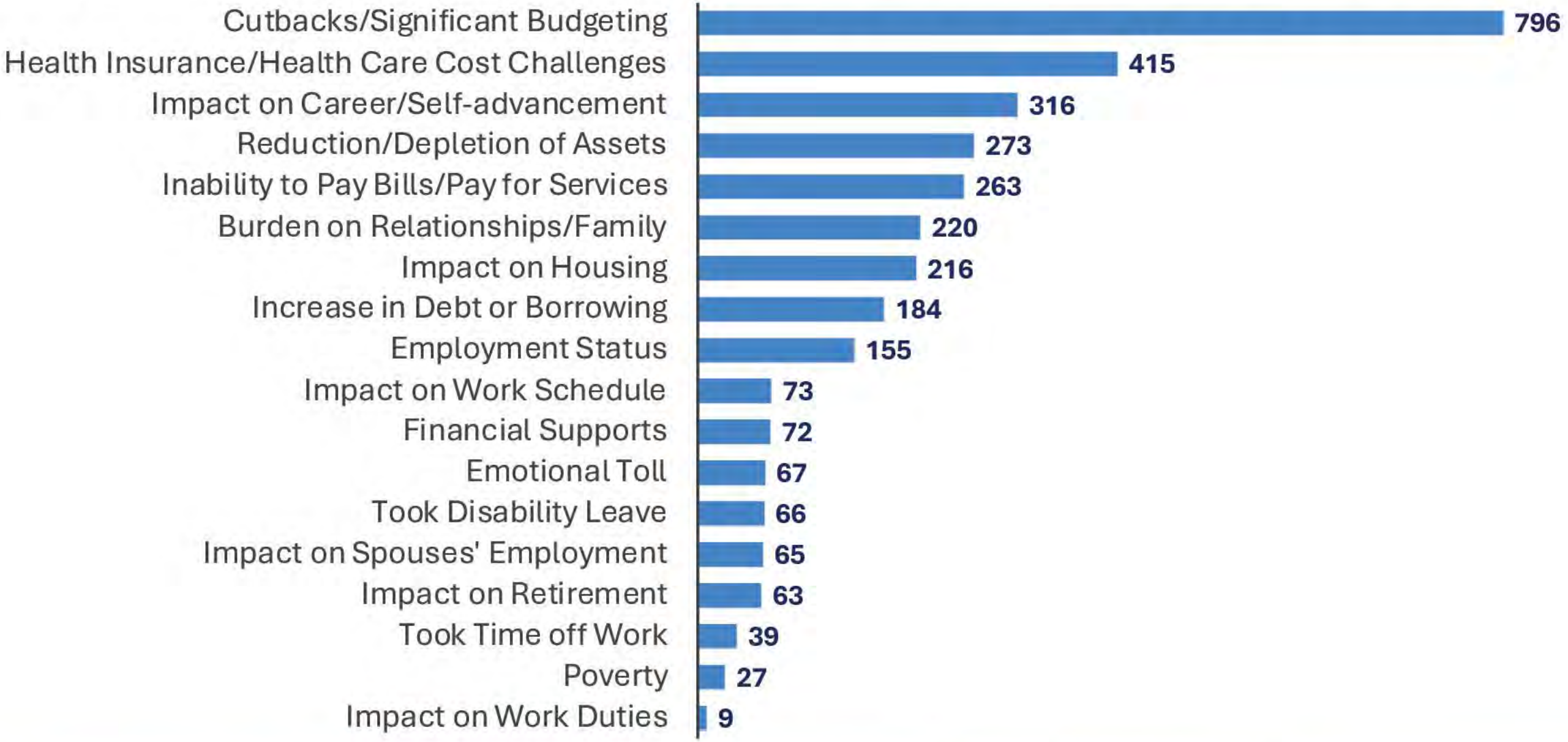
Faced with high costs, patients and families make sacrifices and tradeoffs*

41% cancer costs affected ability to afford food

40% accumulated debt in order to buy food

*American Cancer Society Cancer Action Network. *Survivor Views: Preventive Care Coverage, Medical Debt, & Food Insecurity*. https://www.fightcancer.org/policy-resources/survivor-views-preventive-care-coverage-medical-debt-food-insecurity

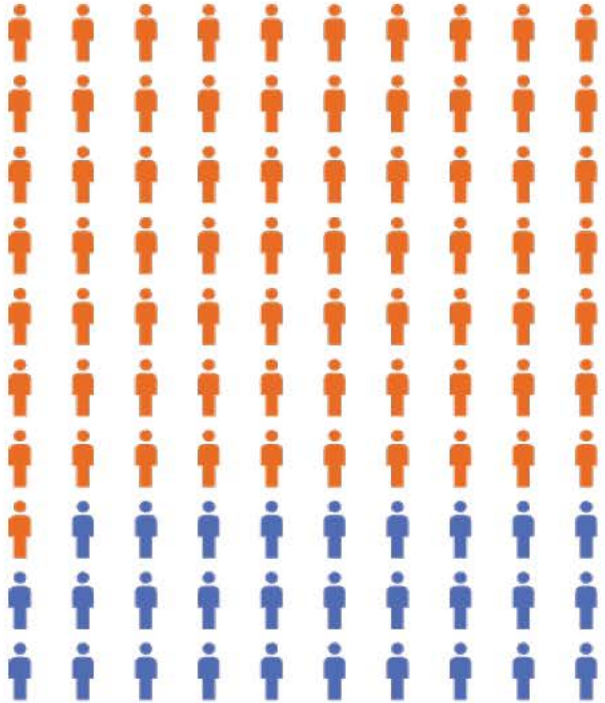
Frequency & Types of Financial and Social Sacrifices



Sources: Banegas et al. *Journal of Cancer Survivorship*. 2019 Jun;13(3):406-417. [PMID: 31123985]

Financial Hardship from Cancer is Common Among Latinos

71 in every 100 Latinos diagnosed with cancer will experience medical debt



Have Current or Past Medical Debt

Do Not Experience Medical Debt

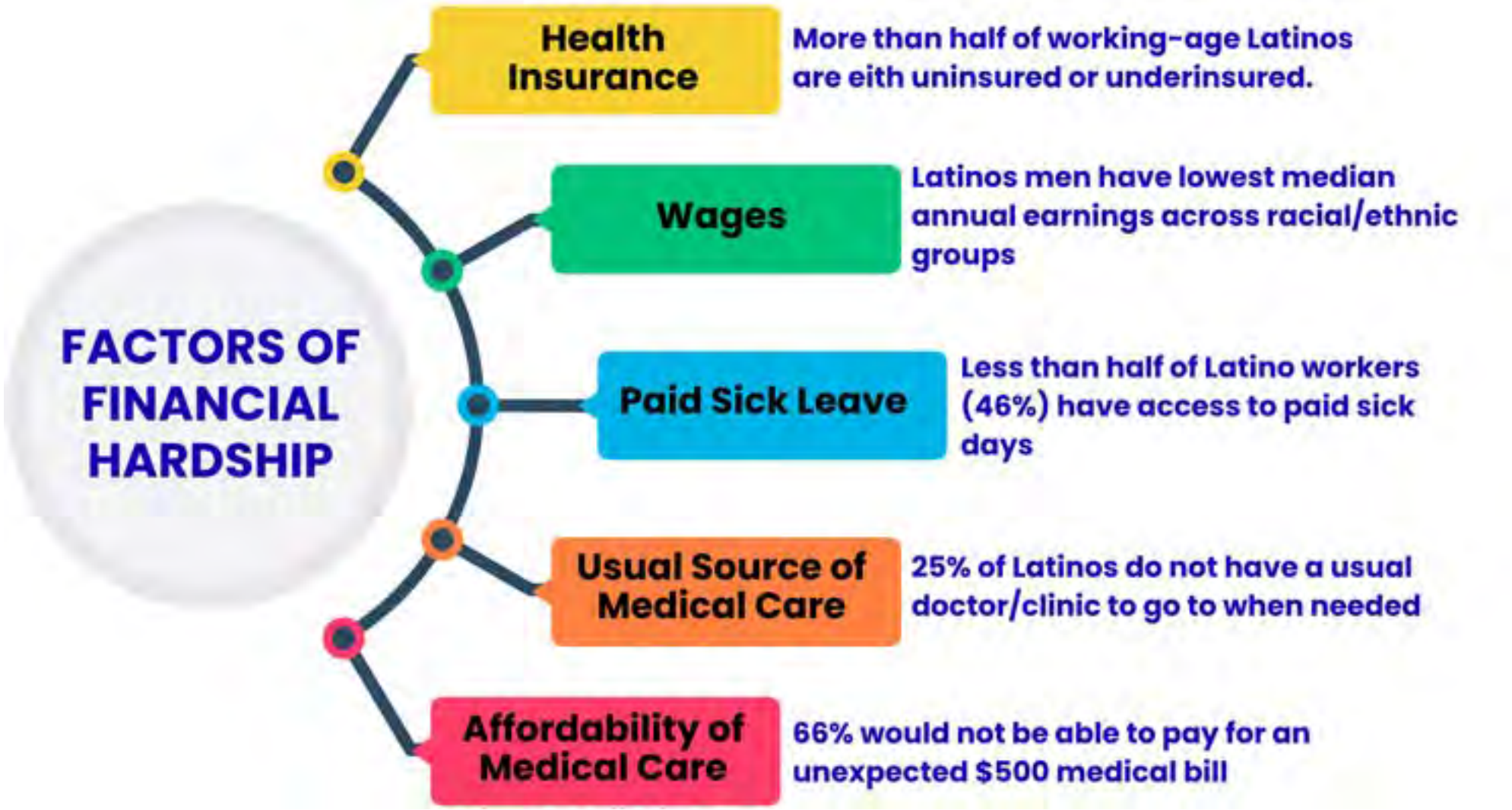
UNABLE TO AFFORD MEDICAL CARE DUE TO COST **35%**

PROBLEMS PAYING MEDICAL BILLS **61%**

WORRY ABOUT MONTHLY BILLS **61%**

ACS CAN 2022. https://www.fightcancer.org/policy-resources/costs-cancer-hispaniclatino-community-0
Swami et al 2023. J Gen Intern Med. 38(5):1334–1337. doi: 10.1007/s11606-022-08016-z

Financial Hardship Among Latinos



Source: Betancourt, 2024 Commonwealth Fund, Dec. 17, 2024. https://doi.org/10.26099/DG1R-ZH11; Artiga 2021. https://www.kff.org/covid-19/health-and-health-care-experiences-of-hispanic-adults/; UnidoUs. 2020. Latino-workers-need-paid-sick-days (nationalpartnership.org); US Dept. of Labor. https://www.dol.gov/agencies/wb/data/earnings/median-annual-sex-race-hispanic-ethnicity

The Ripple Effect on Workforce & Economic Productivity

- **Latino workers make up significant % of labor force in essential sectors:**
  - Agriculture, Forestry
  - Construction
  - Hospitality & Food Service
- **Latino business owners generated $460 billion in annual revenue and employed 2.9 million workers (2019)**
- **The U.S. Latino GDP hit $4.1 trillion in 2023**

U.S. Bureau of Labor Statistics. Labor Force Characteristics by Race and Ethnicity, 2023. BLS Reports, Report 1113, December 2024; U.S. Department of Agriculture, Economic Research Service. Farm Labor. Updated July 7, 2025. Ramos 2025. https://newsroom.ucla.edu/releases/us-latino-gdp

Costs of Early vs. Late Diagnosis of Prostate Cancer

- **A Latino man's lifetime economic contribution is ~$2.17 million**
  - Based on a $48,000 annual wage (average annual salary for a Latino male) over a 45-year career

Scenario	Treatment & Estimated Work Absence	Healthcare Cost	Lost Wages Calculation (Absence x Annual Income)	Total Loss on U.S. Economy (Lost Wages x New Prostate Cancer Cases Annually)
Early Detection and Care	3-month absence, then full return to work until retirement	$27,500	0.25 × $48,240 = **$12,060**	$12,060 x 12615 patients **= $152.1 million**
Late Detection and Care	6-month absence, then forced to retire 10 years early	$77,000	(0.5 + 10) × $48,240 = **$506,520**	$506,520 x 7699 patients **= $3.9 billion**
No Intervention/ Early Death	Death occurs with 20 years of potential work life remaining	$0	20 × $48,240 = **$964,800**	$964,800 x 2586 patients **= $2.5 billion**

U.S. Bureau of Labor Statistics. Usual Weekly Earnings of Wage and Salary Workers Second Quarter 2025. Economic News Release USDL-25-1181, released July 22, 2025; Mariotto AB, et al. Cancer Epidemiol Biomarkers Prev. 2020 Jul;29(7):1304-1312. doi: 10.1158/1055-9965.EPI-19-1534; American Cancer Society, *Cancer Facts & Figures for Hispanic/Latino People 2024-2026*

Addressing Financial Hardship Among Latino Patients with Cancer

Adapted from the Cancer Financial Experience (CAFÉ) Trial:

Aware	Ask	Adjust	Assist
• Resources not available in Spanish • Require high level of health literacy and numeracy	• Destigmatize conversations about finances • Engage family • Use validated tools (e.g., ENRICh)	• Documentation of patient's' financial circumstances • Routine and recurring assessment	• Integration of community partners • Increase number of healthcare staff fluent in Spanish

Overview

- **Be proactive** in asking and expressing cost questions and cost concerns to medical care team
- Proven solutions include **early interventions and screenings, culturally-tailored navigation, and community-based programs that reduce financial hardship**
- Develop interventions specific to Latino mens' experiences, roles, and preferences

UC San Diego Health

Center for Health Equity Education & Research

Thank you

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"ASK THE MEN"

Tomás Almaguer

Marty Gonzalez

Ray Suarez

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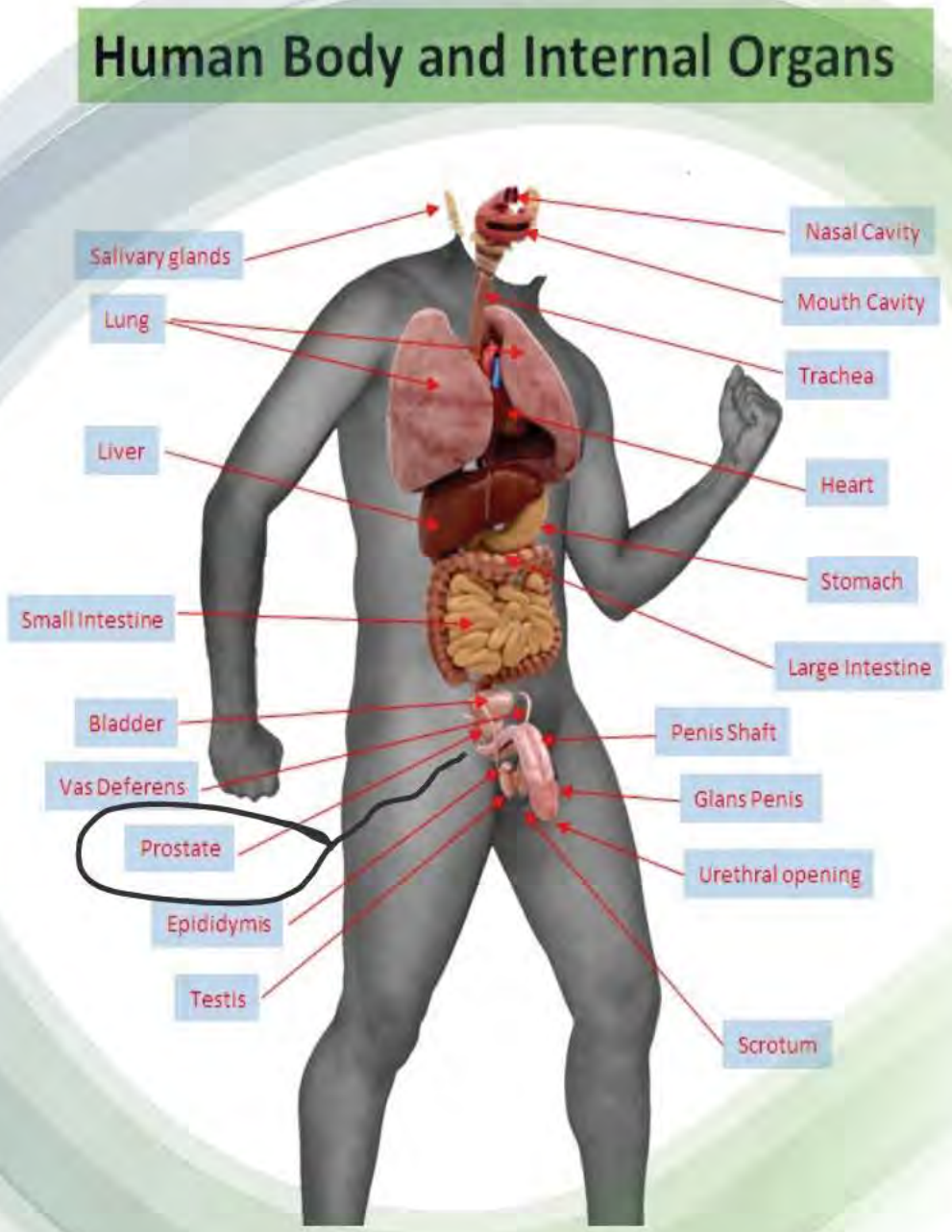
- **Prostate cancer** is a malignant growth that develops in the prostate gland, a small gland below the bladder and in front of the rectum.
- It is one of the most common cancers affecting men, with more than **19,000 Latino men diagnosed with prostate cancer** each year and increasing.
- Prostate cancer is the **4th cause** of cancer mortality in Latino men.
- **Genes** don't tell the whole story. age, identity, environment and access matter.
- **Screening** recommended **by age 50** or 45 with family history.



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University of California
San Francisco

Prostate Cancer:
Why and How to Screen *Smarter*

@dr_coops

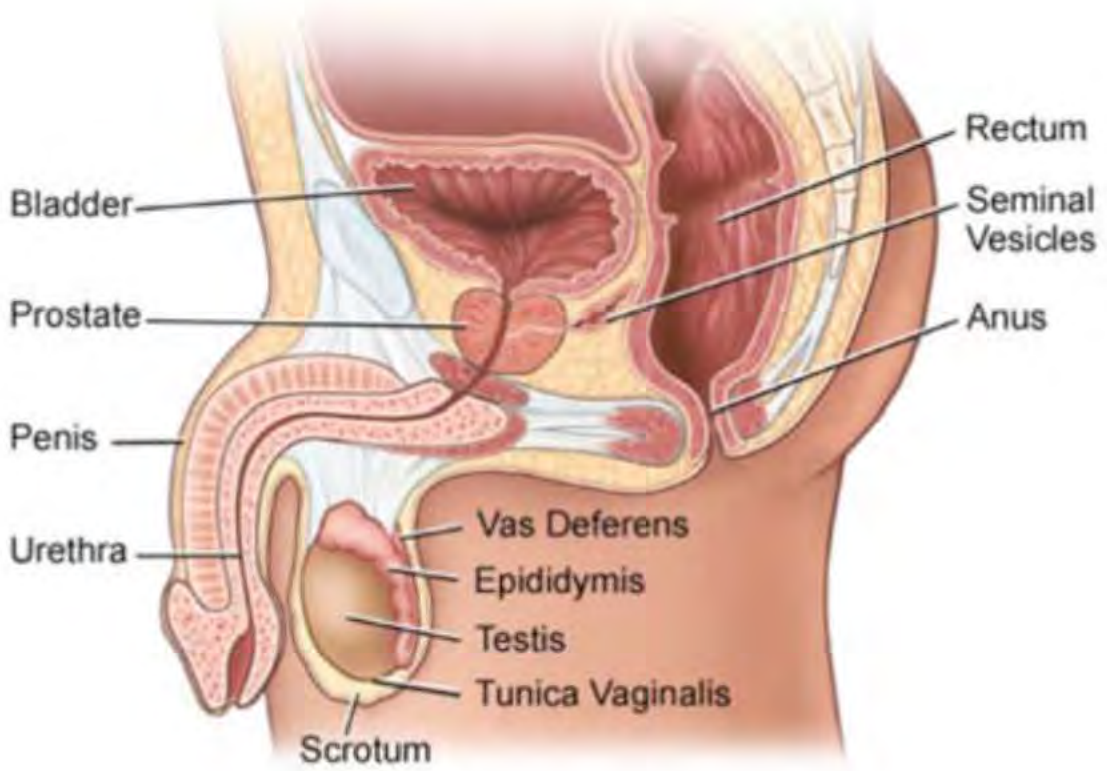
Matthew R. Cooperberg, MD, MPH
Departments of Urology and
Epidemiology & Biostatistics

Latino Men's Health - Spotlighting Cancer, An Unanswered Burden

September 12, 2025

What is prostate cancer?

- Cancer is an abnormal growth and spread of cells from one part of the body to another.
- Prostate cancer is the abnormal growth of cells in the prostate gland.
- Prostate cancer cells that spread (metastasize) to bones or other body parts are still prostate cancer



What causes prostate cancer?

Genes (what you're born with)

Environmental factors (what you're exposed to – diet and obesity, smoking, exercise, stress, etc.)

Many environmental factors are *not* under your control (e.g., pollution, cosmic rays), and are the cancers we file under "bad luck."

Cancer Statistics 2025

Male

Estimated New Cases

Prostate	313,780	30%
Lung & bronchus	110,680	11%
Colon & rectum	82,460	8%
Urinary bladder	65,080	6%
Melanoma of the skin	60,550	6%
Kidney & renal pelvis	52,410	5%
Non-Hodgkin lymphoma	45,140	4%
Oral cavity & pharynx	42,500	4%
Leukemia	38,720	4%
Pancreas	34,950	3%
All sites	**1,053,250**	

Estimated Deaths

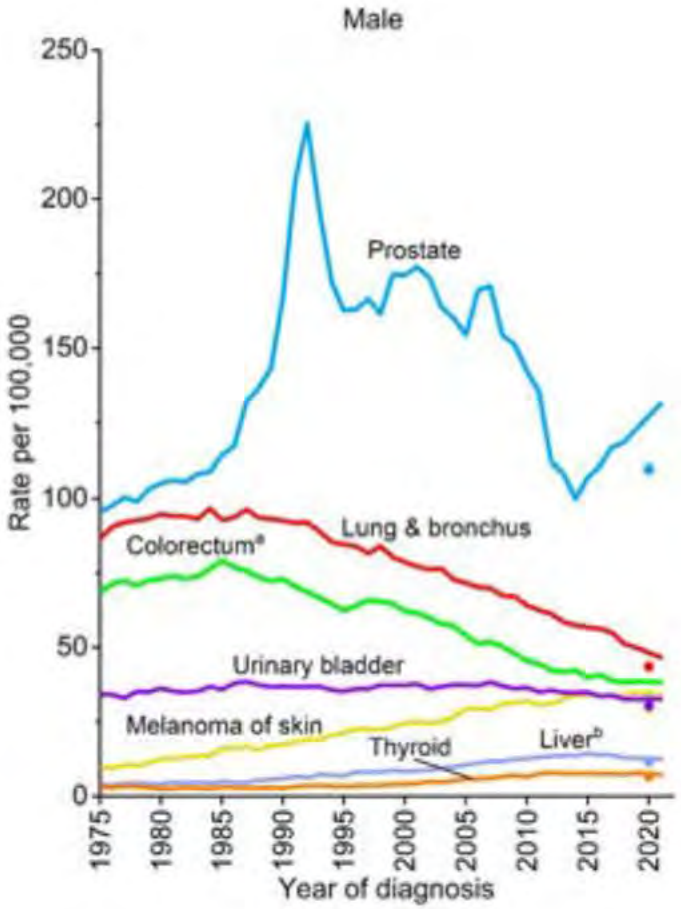
Male

Lung & bronchus	64,190	20%
Prostate	35,770	11%
Colon & rectum	28,900	9%
Pancreas	27,050	8%
Liver & intrahepatic bile duct	19,250	6%
Leukemia	13,500	4%
Esophagus	12,940	4%
Urinary bladder	12,640	4%
Non-Hodgkin lymphoma	11,060	3%
Brain & other nervous system	10,170	3%
All sites	**323,900**	

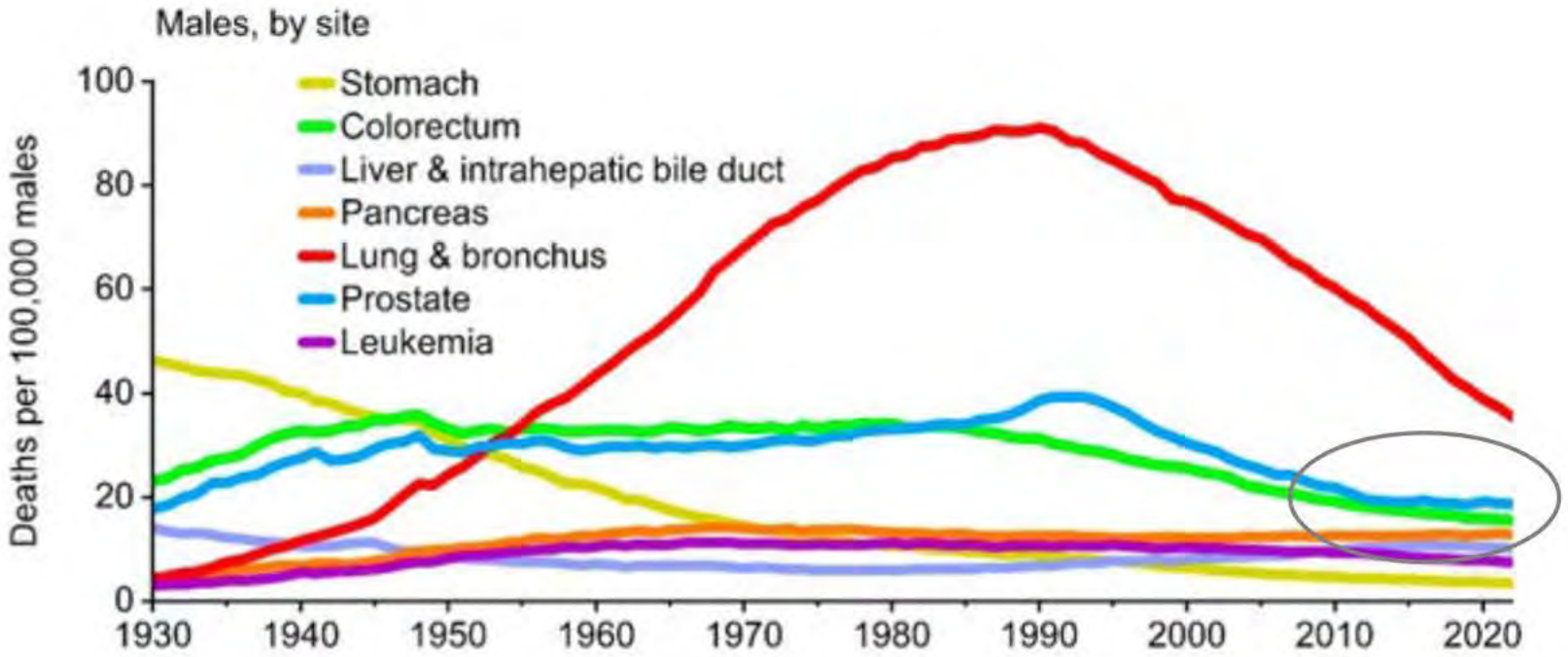
Incidence

Mortality

Cancer Statistics 2025



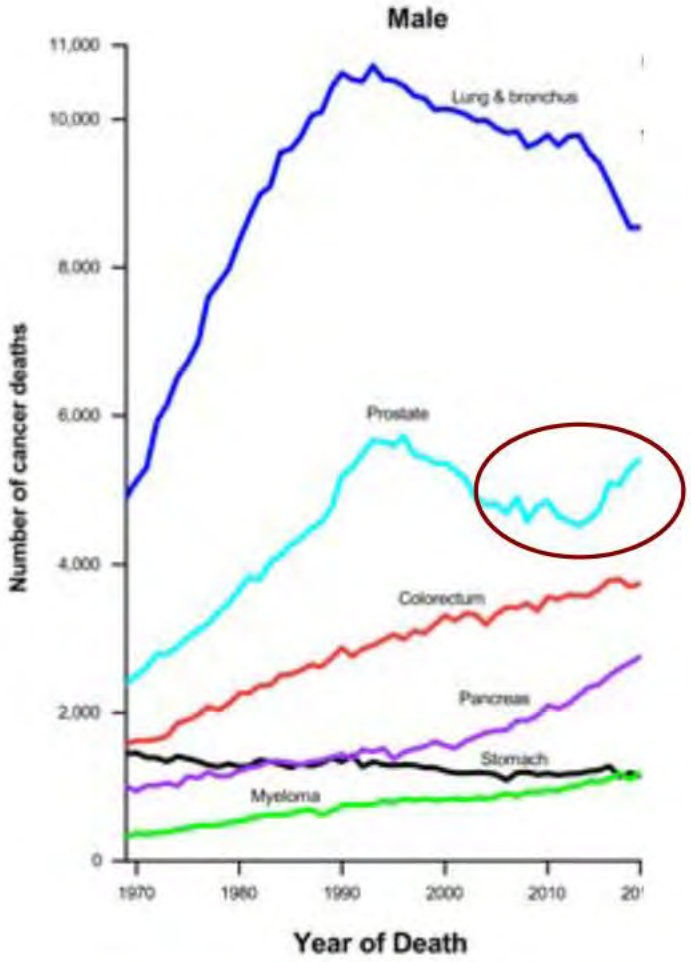
Incidence

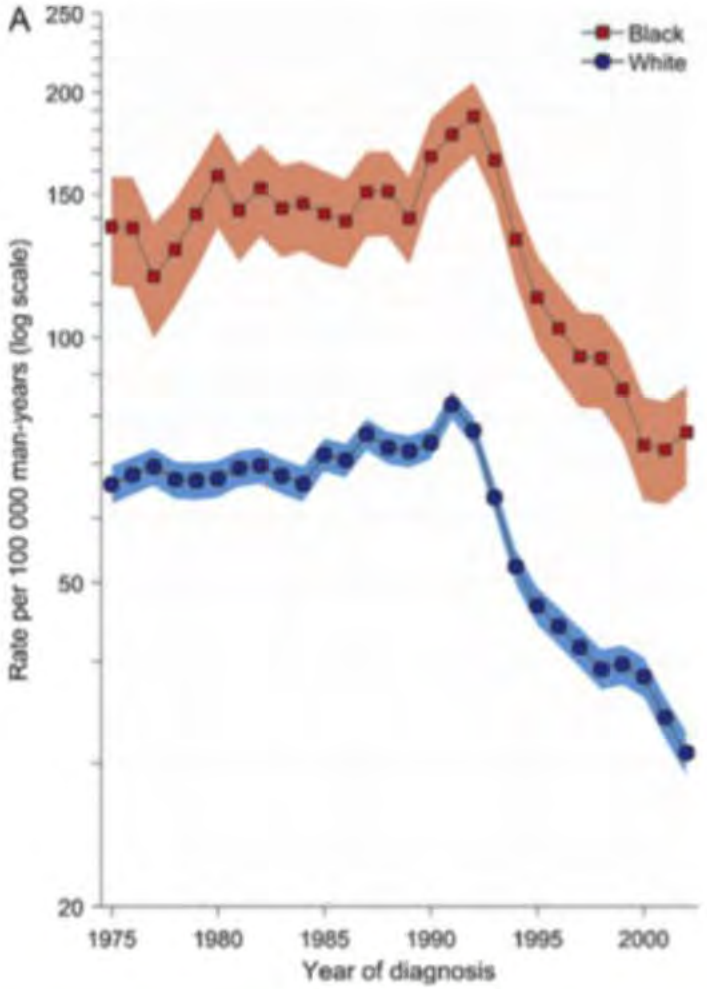


Mortality

Trends over time for Black men

Mortality

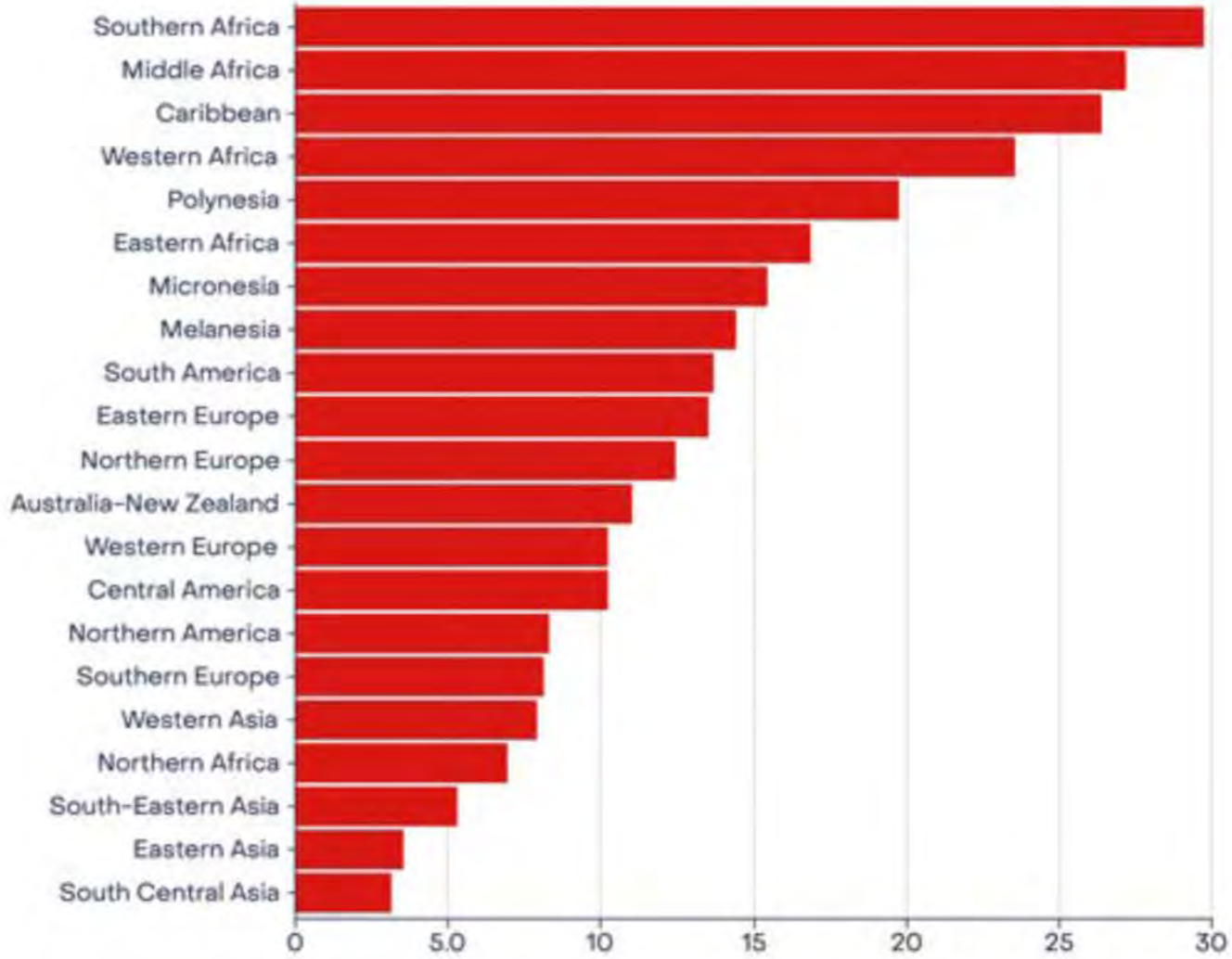




A global view

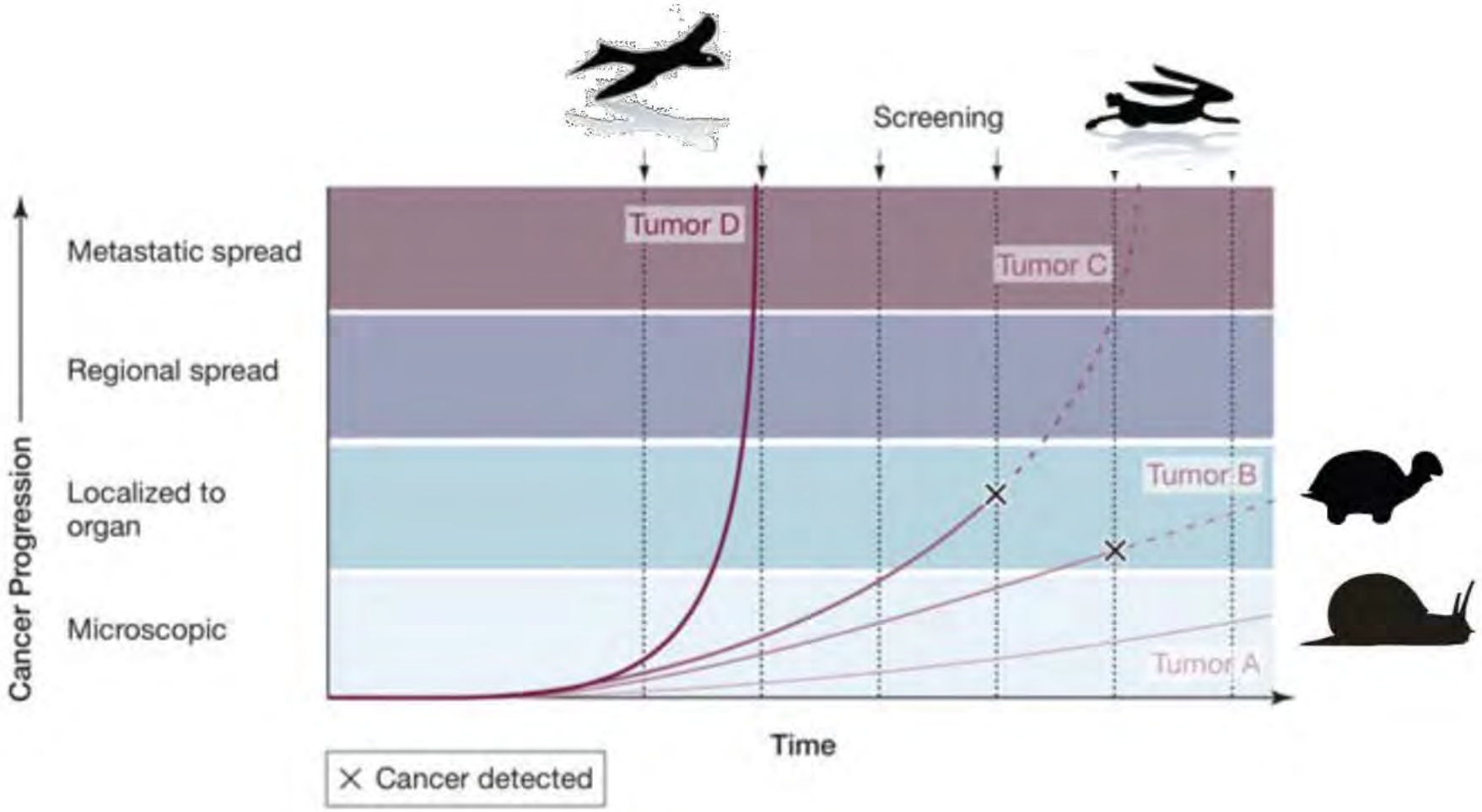
Age-standardized death rates per 100,000 men

2022 Data



https://gco.iarc.fr/

The diagnosis at the heart of the dilemma



Esserman, Shieh, Thompson. JAMA 2009; 302:1685

Which prostate cancers need treatment?

Most men diagnosed with prostate cancer would never kno e through screening

Most mer y die of other cau

Aggressiv and can be lethal, an eening and treated long before this happens.

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University of California
San Francisco

Understanding prostate cancer risk

What is PSA?

Prostate Specific Antigen (PSA) is a protein made by the prostate gland which can be detected in the blood.

"Normal" PSA historically was defined as 4.0 ng/ml, but most men should have a lower PSA than this.

Among men with prostate cancer, higher PSAs usually indicate higher risk cancers.

What is PSA?

Anything that happens to the prostate (growth with age, infection, inflammation, trauma, or cancer) can raise the PSA (not all rises in PSA mean cancer).

PSA Density (PSAD) is the PSA divided by the prostate volume (measured by ultrasound or MRI), and reflects the fact that a large prostate due to BPH (non-cancer growth) can explain at least part of a high PSA.

What is the Gleason (pattern / score / grade)?

The two key questions after a prostate biopsy are: 1) Is there cancer? and 2) If there's cancer, what is the grade, meaning how aggressive does it look under the microscope.

You may hear different numbers for the Gleason score, because you may have higher and lower grade cells within your prostate.

- Gleason pattern indicates the grade of a given area of the biopsy. Usually pattern 3 means low-grade, 4 is intermediate, and 5 means high grade.
- Gleason score reflects the different patterns in a given cancer (e.g., 3+4)
- Gleason grade group converts the score to a simpler 1-5 scale

What is the Gleason (pattern / score / grade)?

Gleason 3+3 = Grade group 1

Gleason 3+4 = Grade group 2

Gleason 4+3 = Grade group 3

Gleason 4+4 = Grade group 4

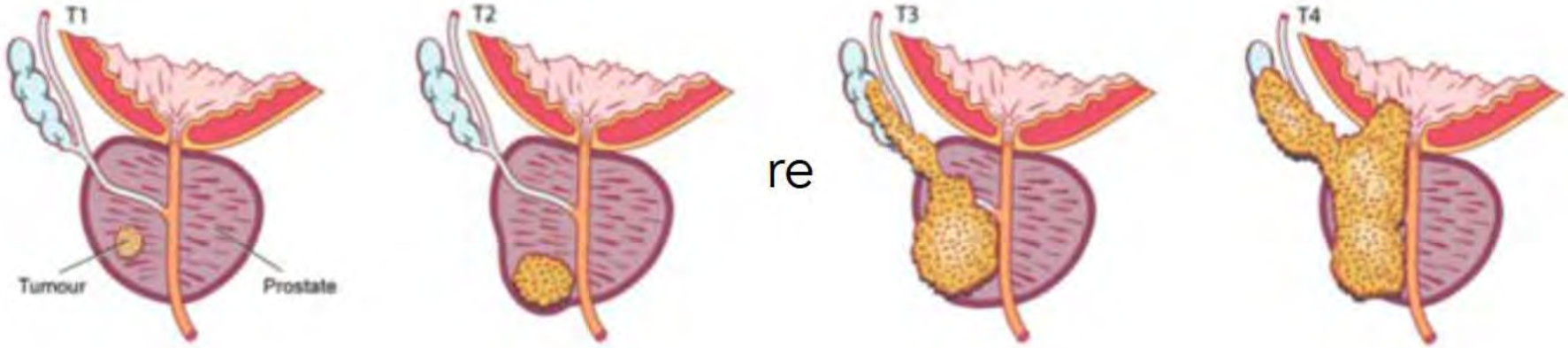
Gleason 4+5 / 5+4 = Grade group 5

What is clinical stage?

The stage of any cancer is described by its growth within the organ of origin, and then whether it has involved lymph nodes or other parts of the body.

T (tumor) stage: whether a prostate cancer can be felt on a finger exam, and whether we suspect growth outside the edge

N (re ph nodes an



Putting it all together

Risk stratification considers all the risk factors (PSA, grade, stage, biopsy extent, and other factors) to assess the likelihood that the cancer might grow or spread to other parts of the body.

Risk groups

Low
PSA <10, GG1, *and* stage T1-2a

Favorable Intermediate
PSA 10-20, GG2, *or* stage T2b-c, <50% cores

Unfavorable Intermediate
PSA 10-20, GG2-3, stage T2b-c, or >50% cores

High
PSA >20, GG4, *or* stage T3a

Very High
T3b-4, GG5 or >4 cores with GS 8-10

The UCSF-CAPRA score

Variable	Level	Points
PSA	2.0-6	0
	6.1-10	1
	10.1-20	2
	20.1-30	3
	Above 30	4
Gleason	1-3/1-3	0
	1-3/4-5	1
	4-5/1-5	3

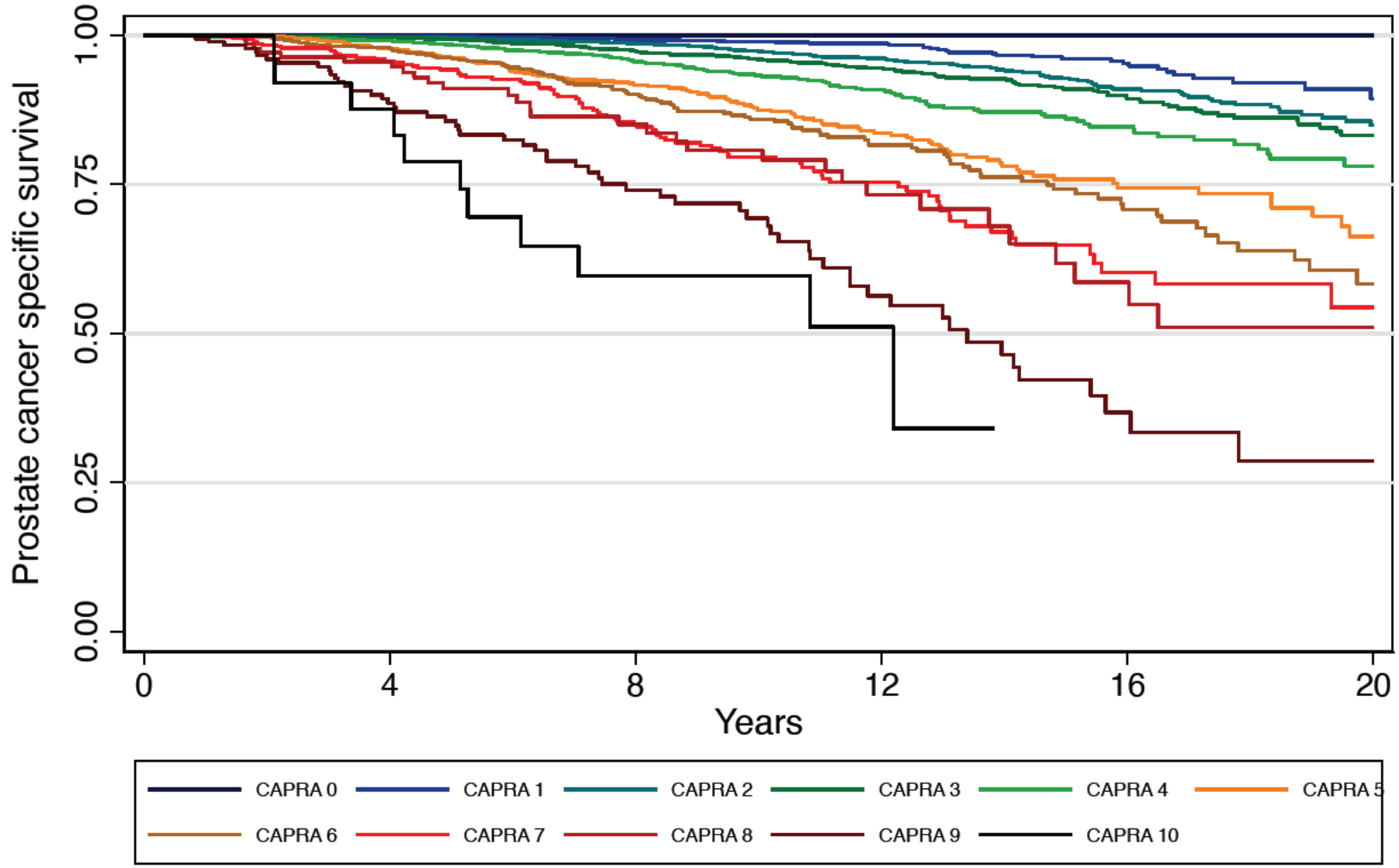
Variable	Level	Points
T-stage	T1/T2	0
	T3a	1
% pos biopsies	Under 34%	0
	34% or more	1
Age	Under 50	0
	50 or more	1

Sum of points from each variable for 0-10 score

http://urology.ucsf.edu/capra.html

Cooperberg et al. J Urol 173:1938, 2005

Risk stratification is critical



Depending on these risk factors, likelihood of dying of prostate cancer within 20 years of diagnosis ranges from virtually 0% to more than 70%

Herlemann et al. Eur Urol 2023; 85:565

UCSF
University of California
San Francisco

Smarter screening

PSA is one of the best cancer tests ever studied!

We just haven't used it *properly.*

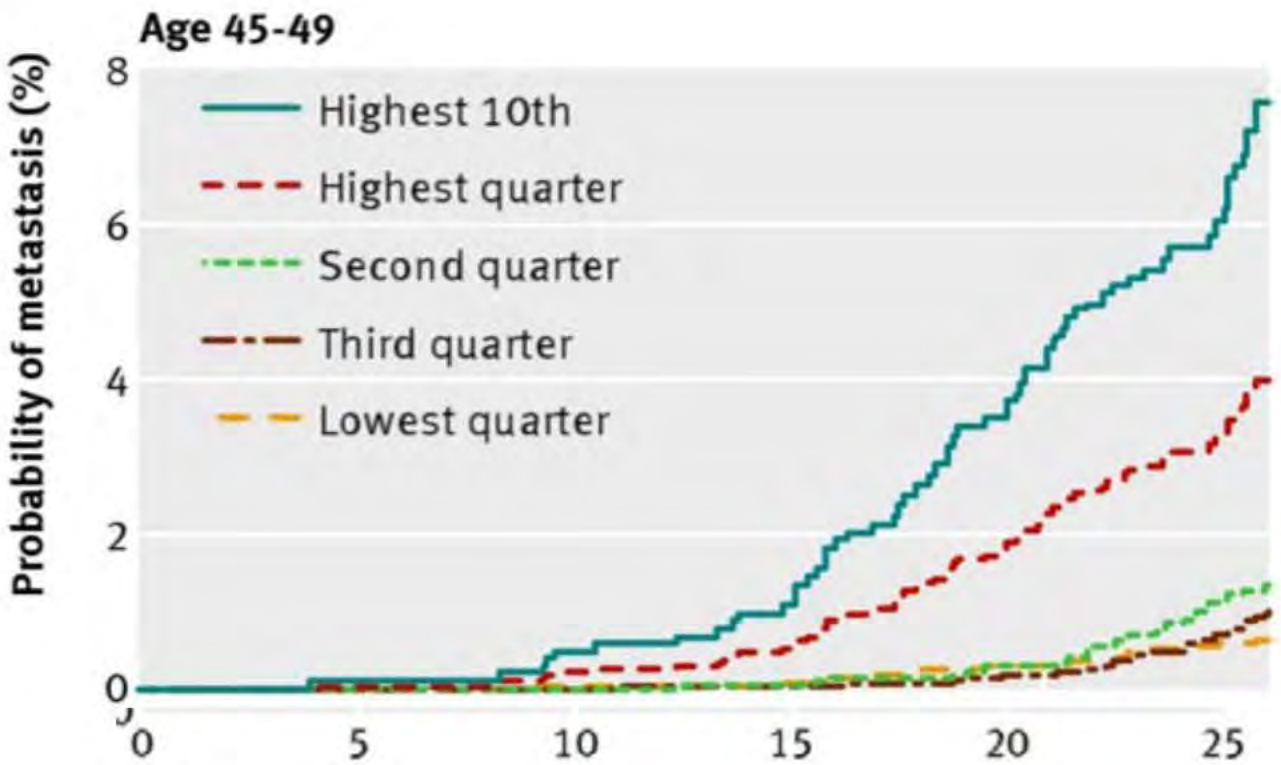
- We have over-screened older men, under-screened young men, over-treated low-risk prostate cancer and under-treated high-risk prostate cancer.
- And *4.0 ng/ml is the wrong threshold*

Yet we have *still* driven down prostate cancer mortality by >50%.

Imagine if we used PSA itself more intelligently…

Checking a PSA in mid-life

- If PSA <1.0 at age 60, likelihood of prostate cancer death <0.3%
- 90% of prostate cancer deaths occurred in men with PSA >2.0 (top quartile)



Tests to consider before a biopsy

PRS

PCA3

MPS v2

4K

phi

SelectMDx

ExoDx

mpMRI

We are trying really hard *not* to diagnose GG1!

Guidelines 2025: toward consensus

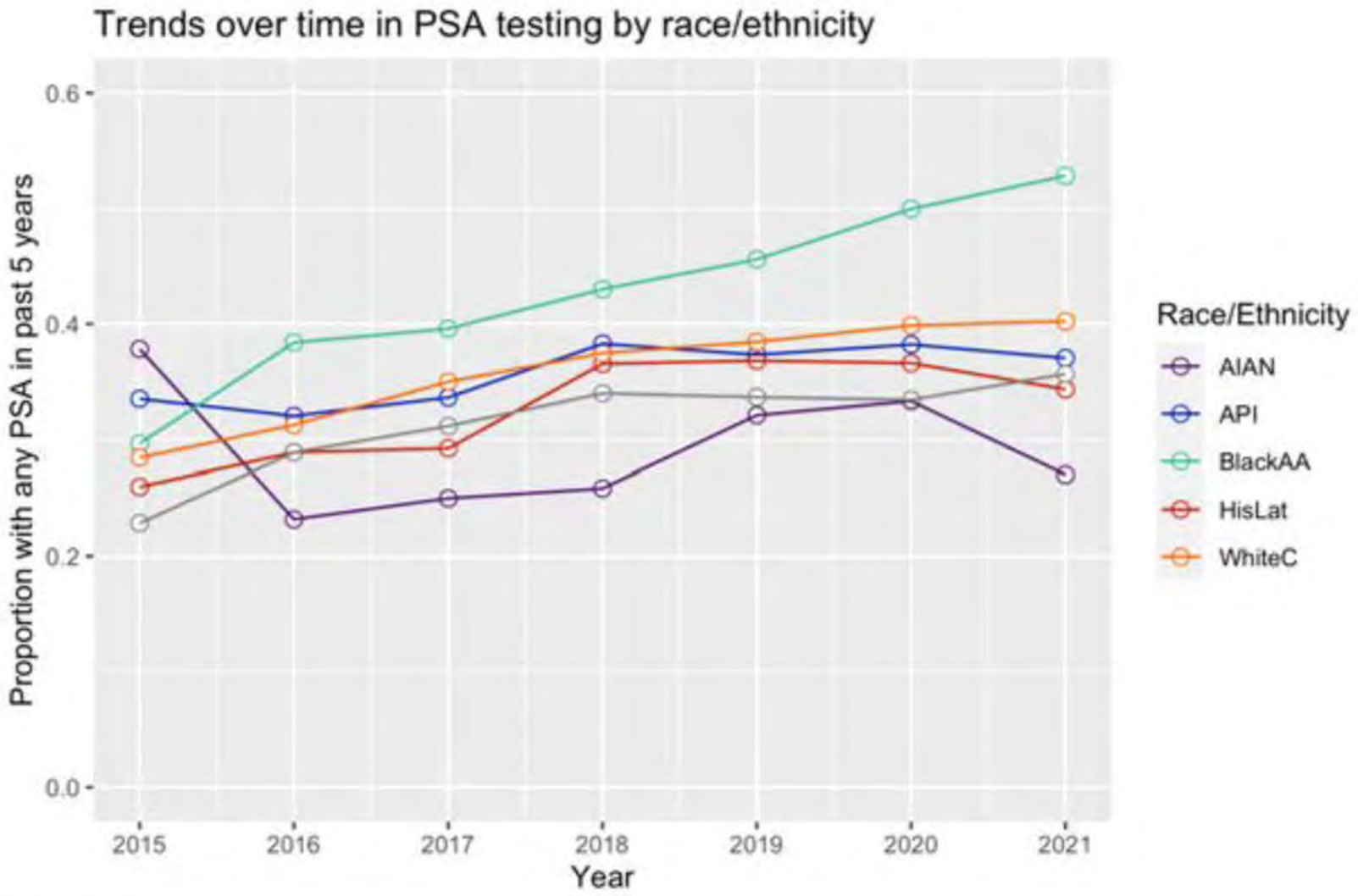
- AUA: shared decision making (SDM) with baseline test age 45-50; 40-45 if Black, family history, or genetic risk
- NCCN: SDM for men 45-75, start "several years earlier" for Black men
- ACS and EAU: SDM for most men starting age 50; earlier baseline (40 or 45) if risk factors including race
- USPSTF and AAFP: SDM for men 55-69; recommend against for >70. No recs for Black men.

Smarter Screening and Treatment: Live now at UCSF!

- Offer screening to healthy men with good life expectancy.
- Tailor intensity based on race/family history and baseline PSA.
- Nearly all low risk disease should be managed by surveillance.
- Emerging markers and imaging tests can help but should be used selectively.
- Treatment must be high quality, and quality must be measured.

Age	PSA	Protocol
45-60	<1	Recheck in 5+ years
	1-2	Recheck in 6-12 mos vs. early referral based on family history, anxiety, etc + SDM
	>2	Referral
61-75	<1	Recheck in 5+ years
	1-3	Recheck in 6-12 months vs. early referral based on family history, anxiety, etc + SDM
	>3	Referral

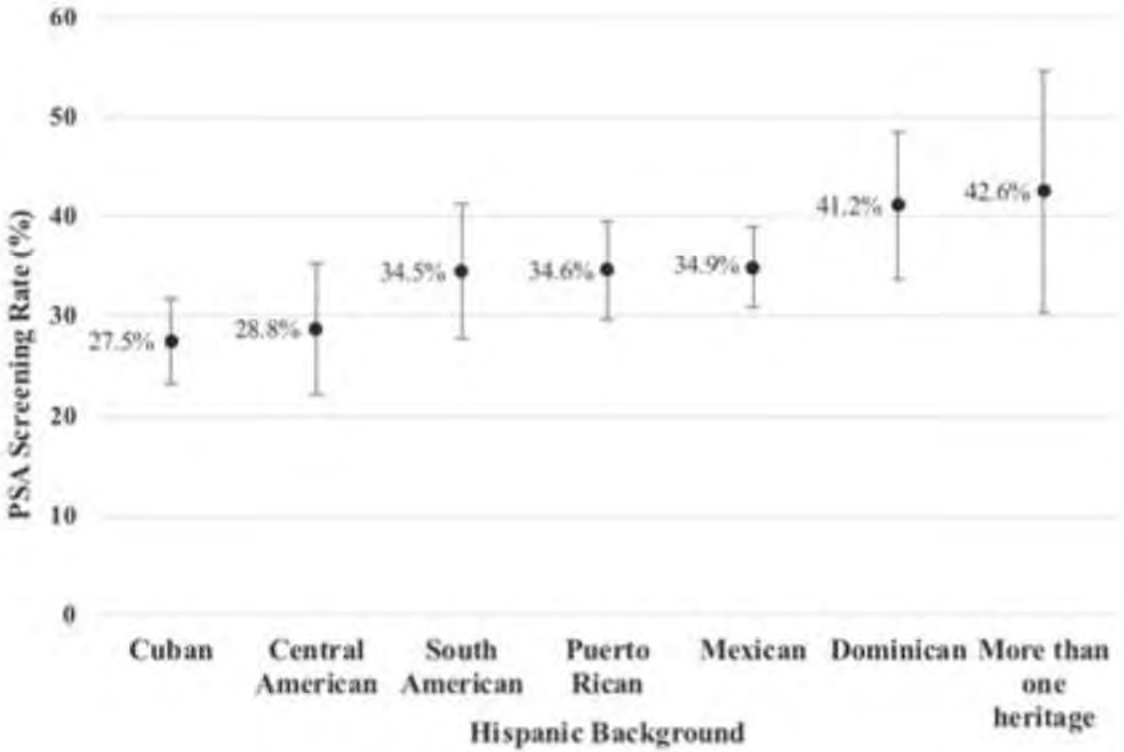
(Slow) progress in screening: UCSF trends

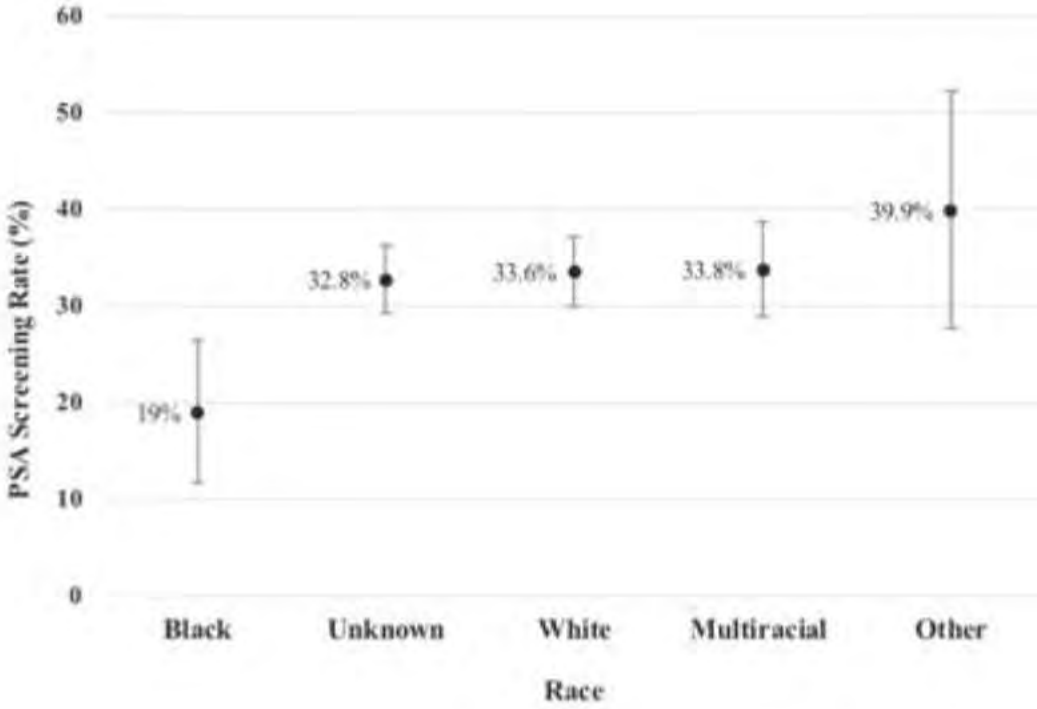


Nie et al. J Gen Intern Med 2025, epub

Screening among Hispanic/Latino men

16,415 men in the Bronx, Chicago, Miami, and San Diego 2008-2017





Stay positive!

It is important to remember that prostate cancer is usually slow-growing. 5-year survival is nearly 100% for localized cancers, even high risk ones, and even men with advanced disease usually live for years with modern treatment.

The best way to avoid lethal disease is early detection of high-risk disease.

Get screened!

UCSF
University of California
San Francisco

Questions?

@dr_coops

Why Genetics Matter: Understanding Liver Cancer Risk in Mexican Men

David O. Garcia, PhD, FACSM; Associate Professor
Director, Nosotros Comprometidos a Su Salud
Director, Zuckerman Family Center for Prevention and Health Promotion
Mel & Enid Zuckerman College of Public Health
Department of Health Promotion Sciences

Edgar A. Villavicencio, MPH
Research Director, Nosotros Comprometidos a Su Salud

Presentation Outline

- Brief review of cancer incidence and mortality for Hispanic Men
- Review of MASLD as a risk factor for liver cancer, particularly among Mexican-origin communities
- Discuss efforts to engage Mexican men in risk reduction research
- Calls to Action

Leading Sites of New Cancer Cases and Death in Hispanic Men

Male

Estimated New Cases*

Prostate	22,900	25%
Colon & rectum	9,300	10%
Kidney & renal pelvis	6,900	8%
Lung & bronchus	6,300	7%
Non-Hodgkin lymphoma	4,900	5%
Liver & intrahepatic bile duct	4,800	5%
Leukemia	3,900	4%
Urinary bladder	3,900	4%
Pancreas	3,300	4%
Oral cavity & pharynx	2,900	3%
All sites	**91,700**	**100%**

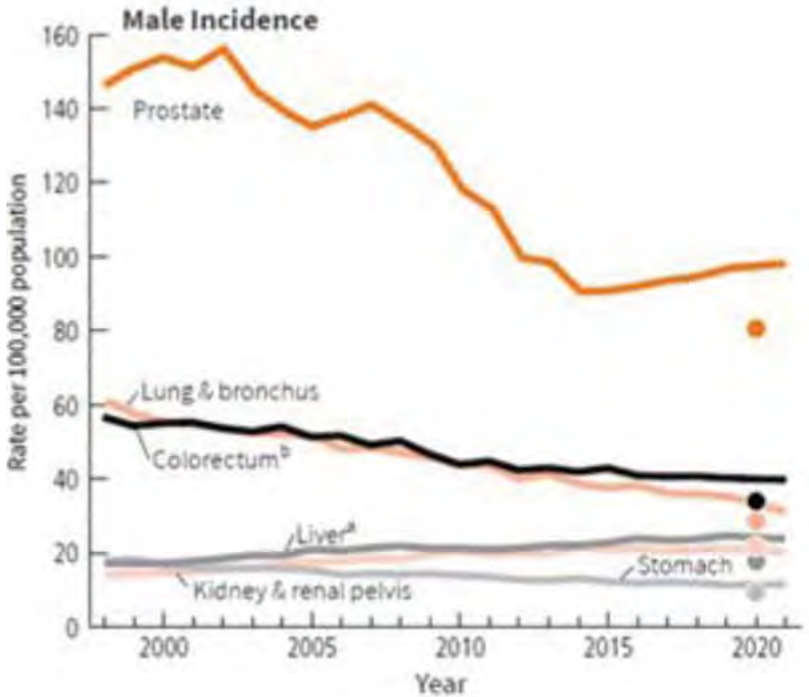
Male

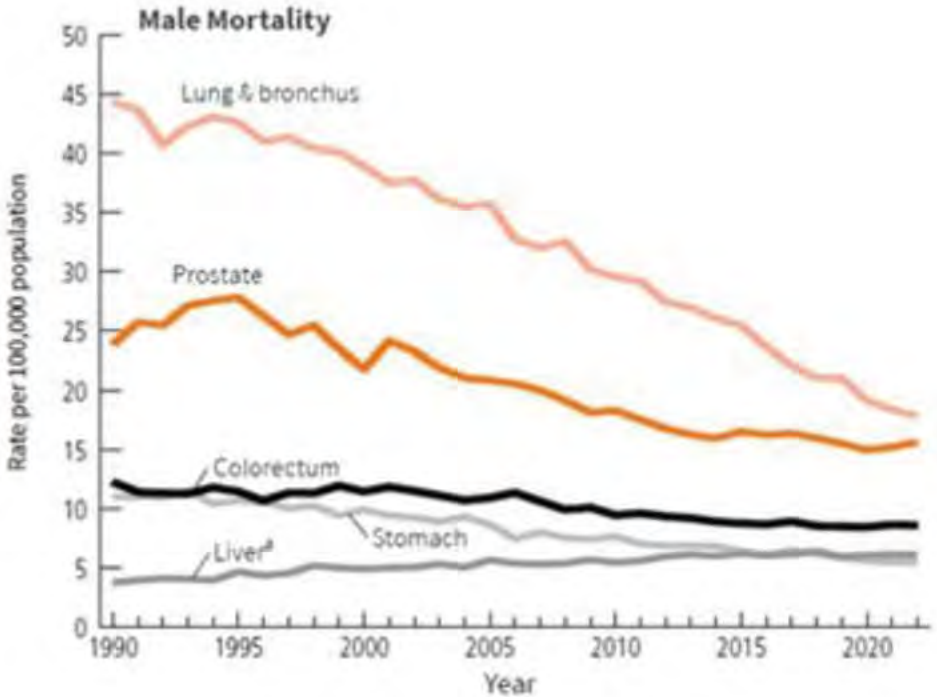
Estimated Deaths

Lung & bronchus	3,200	13%
Colon & rectum	3,000	12%
Liver & intrahepatic bile duct	2,700	11%
Prostate	2,600	10%
Pancreas	2,200	9%
Stomach	1,200	5%
Leukemia	1,100	4%
Non-Hodgkin lymphoma	1,000	4%
Kidney & renal pelvis	1,000	4%
Brain & other nervous system	1,000	4%
All sites	**25,600**	**100%**

American Cancer Society. Cancer Facts & Figures for Hispanic/Latino People 2024-2026 Atlanta: American Cancer Society, Inc. 2024.

Trends in Incidence (1998-2021) and Mortality (1990-2022) in Hispanic Males for Selected Cancers





American Cancer Society. Cancer Facts & Figures for Hispanic/Latino People 2024-2026
Atlanta: American Cancer Society, Inc. 2024.

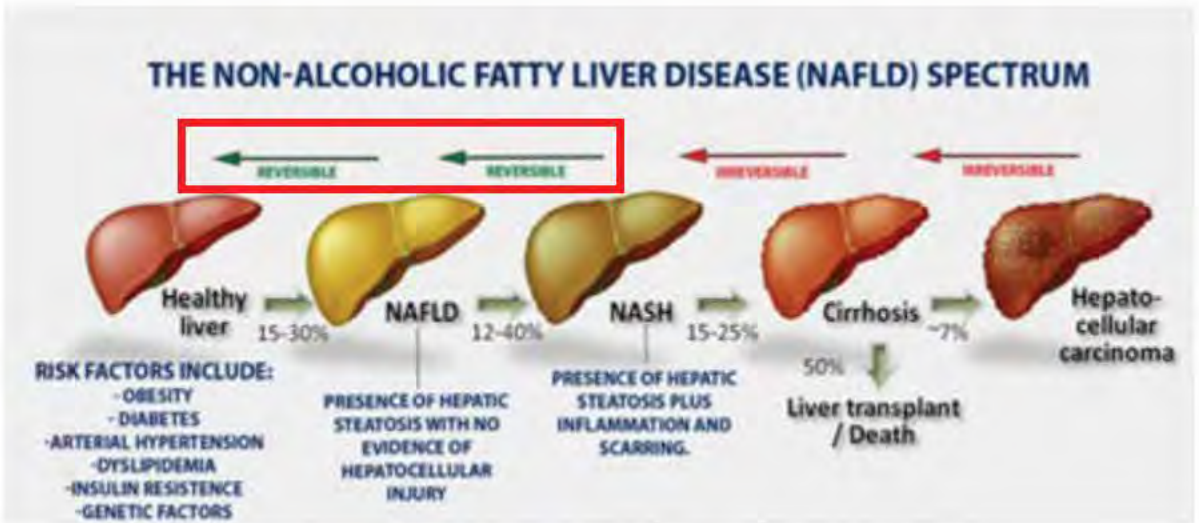
Leading Sites of Death in Hispanic People

	Hispanic				White			
	Rank	Number of deaths[a]	Percent of total deaths	Death rate[b]	Rank	Number of deaths[a]	Percent of total deaths	Death rate[b]
Heart diseases	1	47,712	17	115.4	1	539,198	22	172.3
Cancer	2	47,020	17	105.0	2	464,045	19	147.7
Accidents (unintentional injuries)	3	28,699	10	48.8	3	153,663	6	67.6
COVID-19	4	20,498	7	47.6	4	135,836	6	43.7
Cerebrovascular diseases	5	14,224	5	35.6	6	120,205	5	38.2
Diabetes mellitus	6	12,508	5	28.5	8	64,902	3	21.2
Alzheimer's disease	7	9,552	3	27.2	7	97,044	4	30.5
Chronic liver disease and cirrhosis	8	8,933	3	17.0	9	38,942	2	14.5
Chronic lower respiratory disease	9	5,615	2	14.4	5	127,319	5	39.4
Nephritis, nephrotic syndrome, & nephrosis	10	5,299	2	12.5	10	38,885	2	12.4
All causes		**275,674**	**100**	**618.4**		**2,455,321**	**100**	**818.0**

American Cancer Society. Cancer Facts & Figures for Hispanic/Latino People 2024-2026
Atlanta: American Cancer Society, Inc. 2024.

NAFLD is categorized into NAFL or NASH

- **Non-alcoholic fatty liver (NAFL)**
  - **≥ 5% liver fat without any evidence of liver cell injury or inflammation**
- **Non-alcoholic steatohepatitis (NASH)**
  - **≥ 5% liver fat with evidence of liver cell injury and inflammation**



Chalasani et al., 2018

No More NAFLD

The NAFLD nomenclature is changing.

AASLD
AMERICAN ASSOCIATION FOR THE STUDY OF LIVER DISEASES

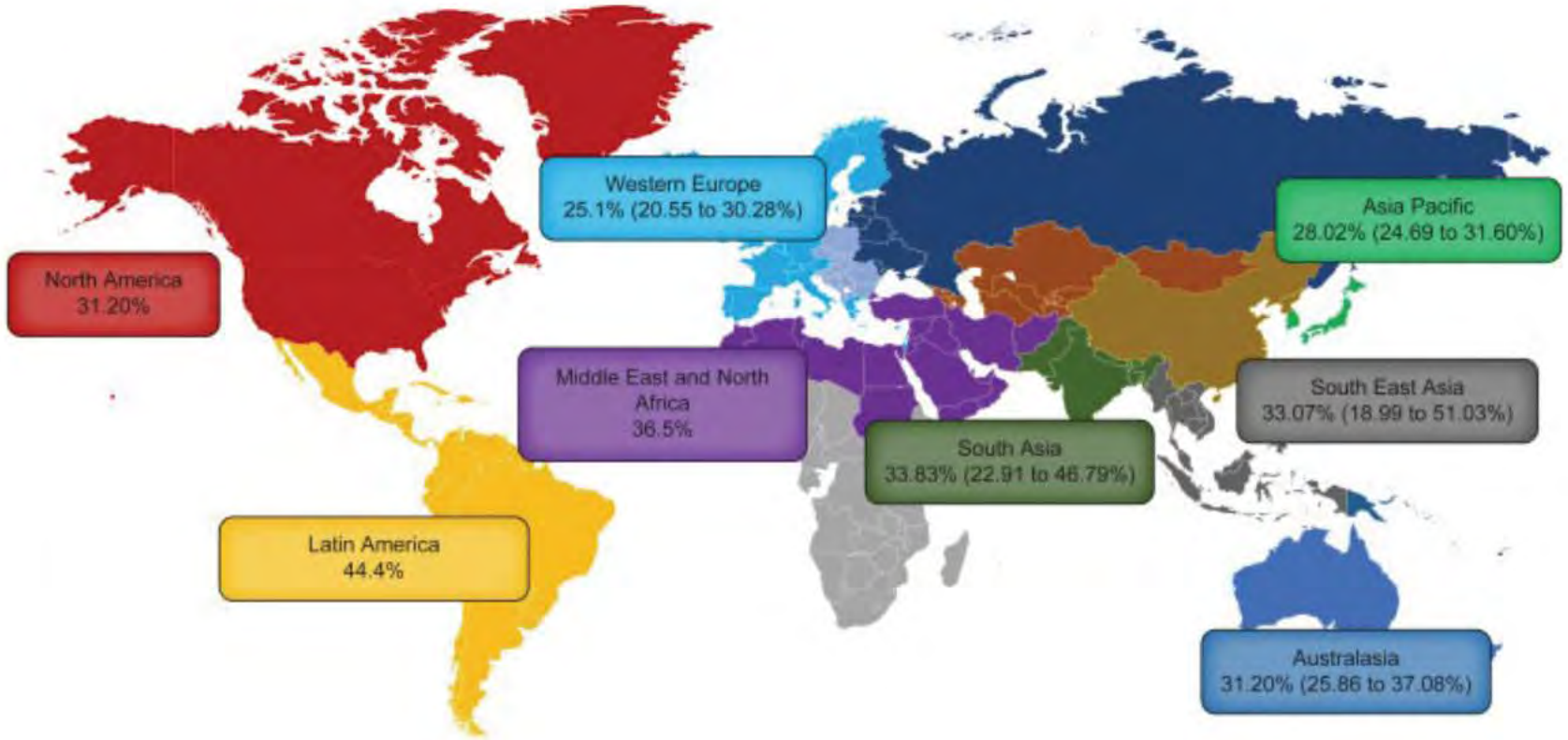
ELSEVIER

Annals of Hepatology
Available online 24 June 2023, 101133
In Press, Journal Pre-proof What's this?

A multi-society Delphi consensus statement on new fatty liver disease nomenclature

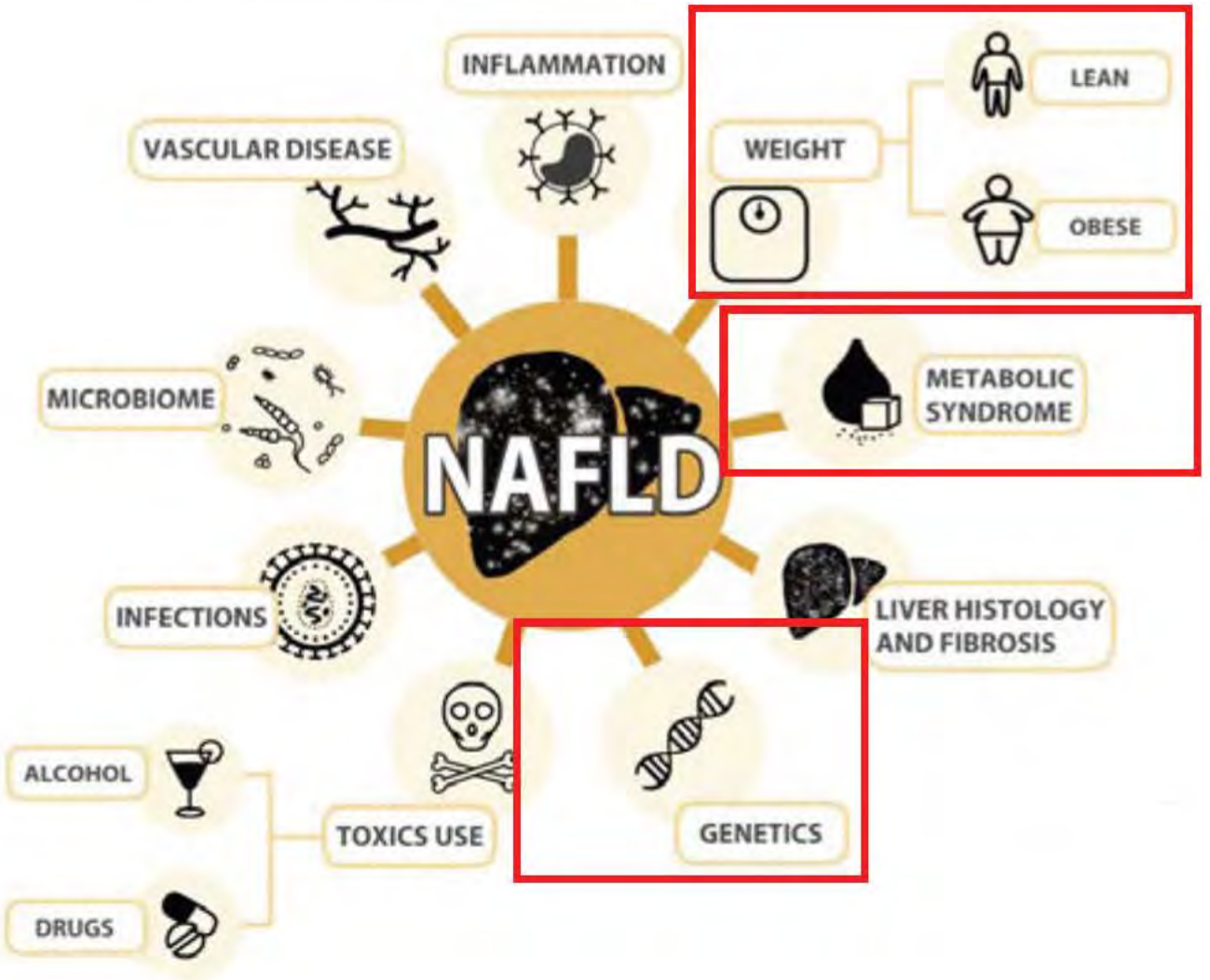
Mary E. Rinella[1], Jeffrey V. Lazarus[2,3], Vlad Ratziu[4], Sven M. Francque[5,6], Arun J. Sanyal[7], Fasiha Kanwal[8,9], Diana Romero[2], Manal F. Abdelmalek[10], Quentin M. Anstee[11,12], Juan Pablo Arab[13,14,15], Marco Arrese[15,16], Ramon Bataller[17], Ulrich Beuers[18], Jerome Boursier[19], Elisabetta Bugianesi[20], Christopher D. Byrne[21,22], Graciela E. Castro Narro[16,23,24], Abhijit Chowdhury[25], Helena Cortez-Pinto[26], Donna Cryer[27]...Philip N. Newsome (senior)[66,67]

Global Prevalence of MASLD



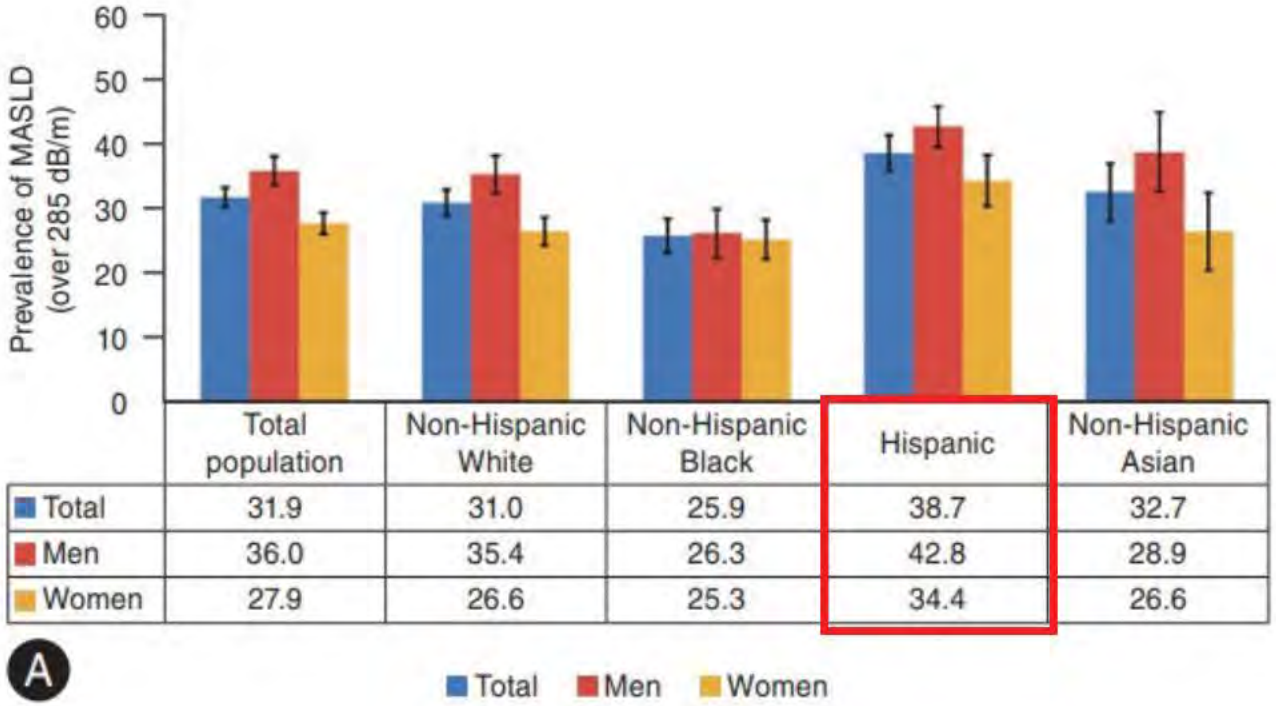
Allen et al., 2023

Causes of MASLD



Pena et al., 2023

Hispanic adults among highest risk group



	Total population	Non-Hispanic White	Non-Hispanic Black	Hispanic	Non-Hispanic Asian
Total	31.9	31.0	25.9	38.7	32.7
Men	36.0	35.4	26.3	42.8	28.9
Women	27.9	26.6	25.3	34.4	26.6

Kim et al., 2025

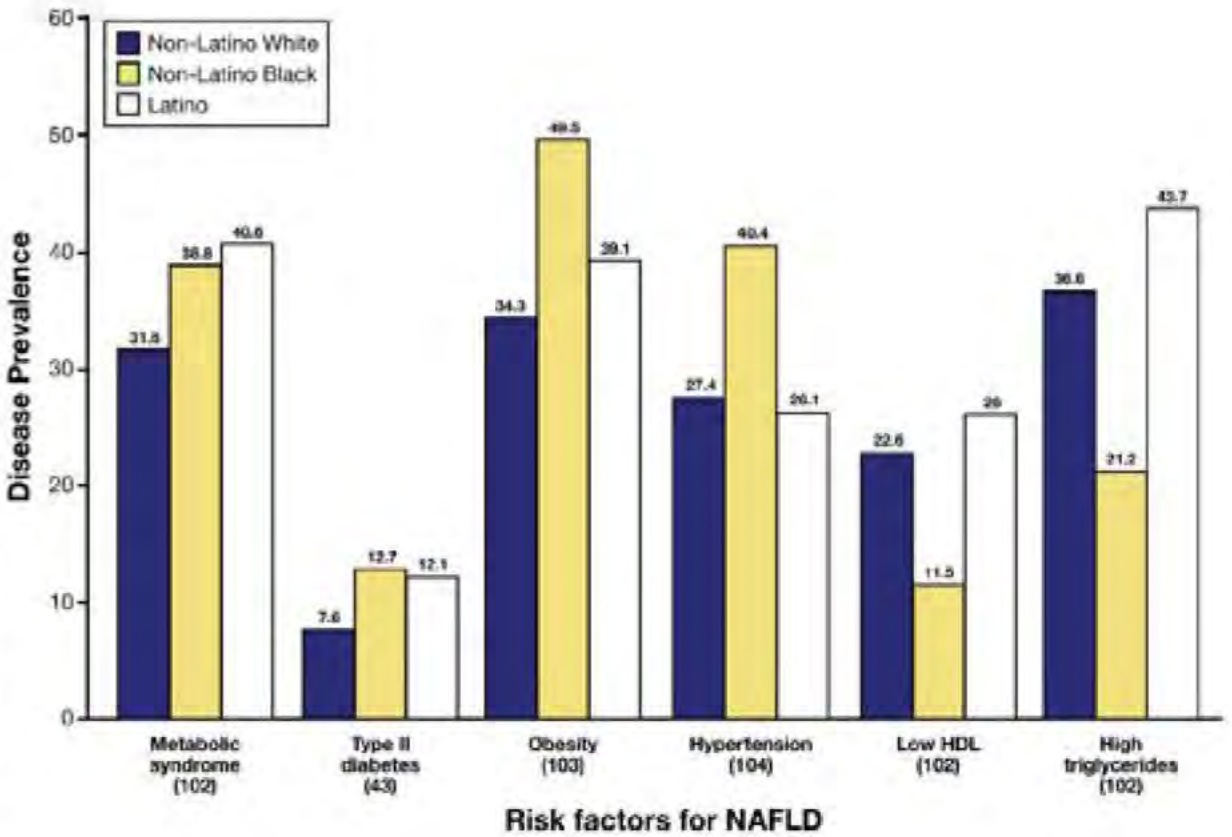


Figure 1. Estimated prevalence of selected risk factors of NAFLD by ethnicity. The prevalence of risk factors of NAFLD based on ethnic differences in the adult US population. LDL, low-density lipoprotein. These data sets reported prevalence as a function of Mexican Americans as opposed to Latino/Latino.

Saab et al., 2016

Additional Risk Factors…

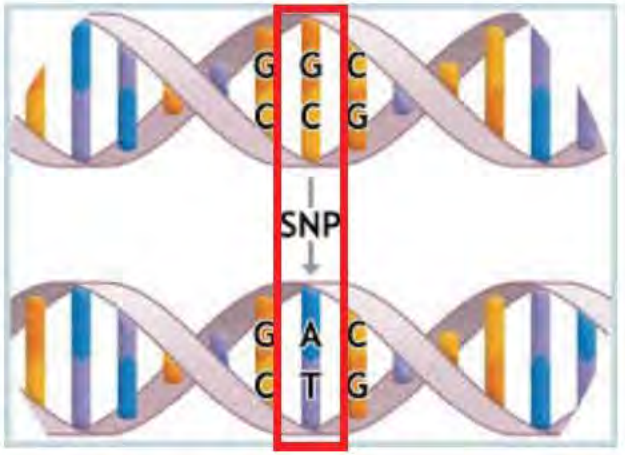
- **Genetic Predisposition**
  - **SNPs**
- **Dietary habits**
  - **Consumption of processed foods and/or foods with high content of fat, salt, and sugar or corn syrup**
  - **Fructose**
- **Physical inactivity**
  - **Low levels of physical activity and high levels of sitting time**

Saab et al., 2016


THE CELEBRATION OF A LIFETIME
Disney · PIXAR
COCO
NOVEMBER 22
IN 3D AND REAL D 3D

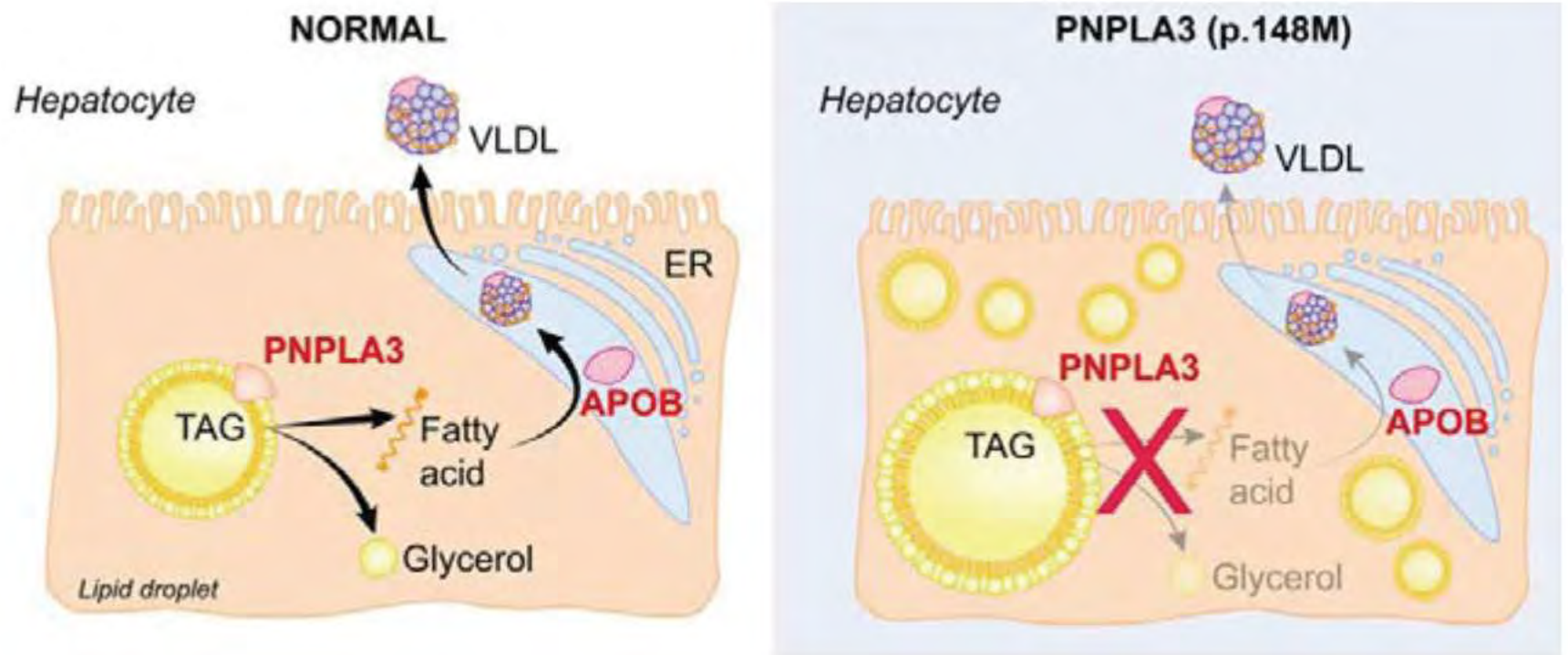
SNPs (genetic variants) linked to the development and/or severity of NAFLD

- GWAS have identified loci associated with disease severity phenotypes
  - PNPLA3
  - TM6S2
  - GCKR
  - MBOAT7



- *PNPLA3* rs738409 (C>G) variant's role in the development and progression of NAFLD
  - *PNPLA3* risk allele carrier status in men and women is 55% compared to 25% for NHW and 13.8% for NHB men and women
  - Variant associated with a >2-fold higher liver fat content in adults, strongest effect size in Hispanics

Pei et al., 2025



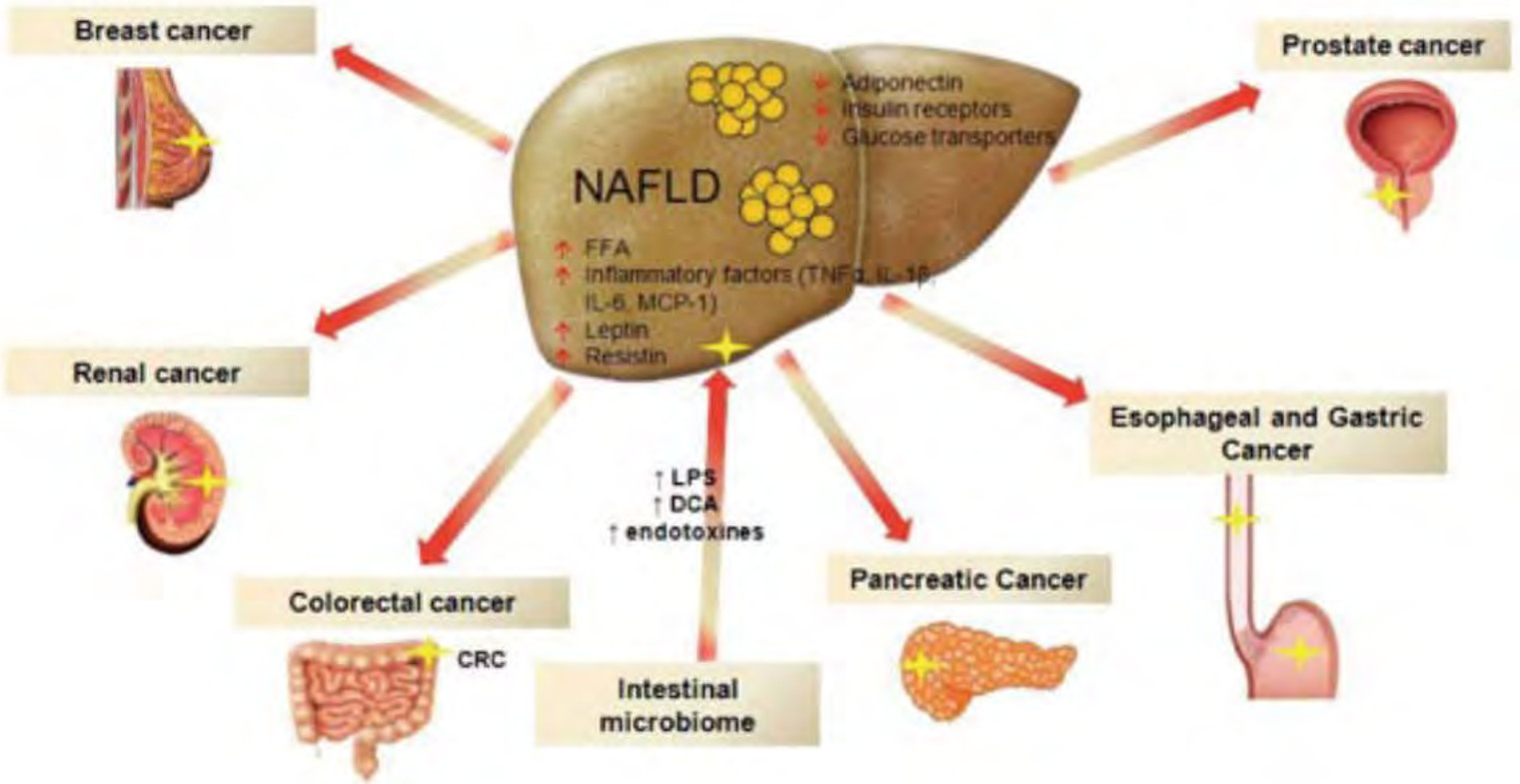
Trepo et al., 2016

The LUNA Study (Liver Ultrasound & Nutrigenetic Assessment)

- From May 2019-March 2020
  - 778 people were interested in participating
  - 307 people completed the study
  - Around 50% were found to have NAFLD and 77% identified as PNPLA3 carriers

Garcia et al., 2022

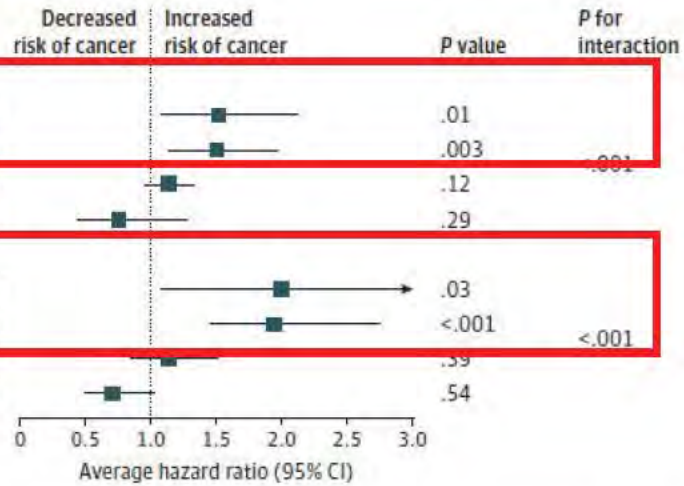
MASLD and Related Cancers



Sanna et al., 2016

Figure 2. Risk of Cancer by Age Group

Age of NAFLD onset, y	Patients with cancer, No./total No.		Average hazard ratio (95% CI)	P value	P for interaction
	Control group	New-onset group			
All cancer types					
<45	91/8952	131/8984	1.52 (1.09-2.12)	.01	
45-54	351/10273	432/10271	1.50 (1.15-1.97)	.003	<.001
55-64	417/8572	467/8585	1.13 (0.97-1.33)	.12	
≥65	275/4051	251/4008	0.75 (0.45-1.27)	.29	
Digestive system cancers					
<45	29/8952	57/8984	2.00 (1.08-3.47)	.03	
45-54	101/10273	140/10271	1.94 (1.46-2.74)	<.001	<.001
55-64	138/8572	160/8585	1.15 (0.85-1.51)	.39	
≥65	77/4051	82/4008	0.71 (0.50-1.02)	.54	



Average hazard ratios with 95% CIs of all cancer types and digestive system cancers are presented among participants with new-onset NAFLD vs controls across age groups. The model was adjusted for age (continuous), sex (categorical), body mass index (continuous; calculated as weight in kilograms divided by height in meters squared), waist circumference (continuous), total cholesterol level (continuous), triglyceride level (continuous), total bilirubin level (continuous), hypersensitive C-reactive protein level (continuous), alanine aminotransferase level (continuous), smoking status (categorical), physical activity (categorical), hypertension (categorical), diabetes (categorical), gallbladder polyps (categorical), and gallstone disease (categorical). NAFLD indicates nonalcoholic fatty liver disease.

Liu et al., 2023

Early Detection and Screening

- **Imaging**
  - **Ultrasound**
  - **CT**
  - **MRI**

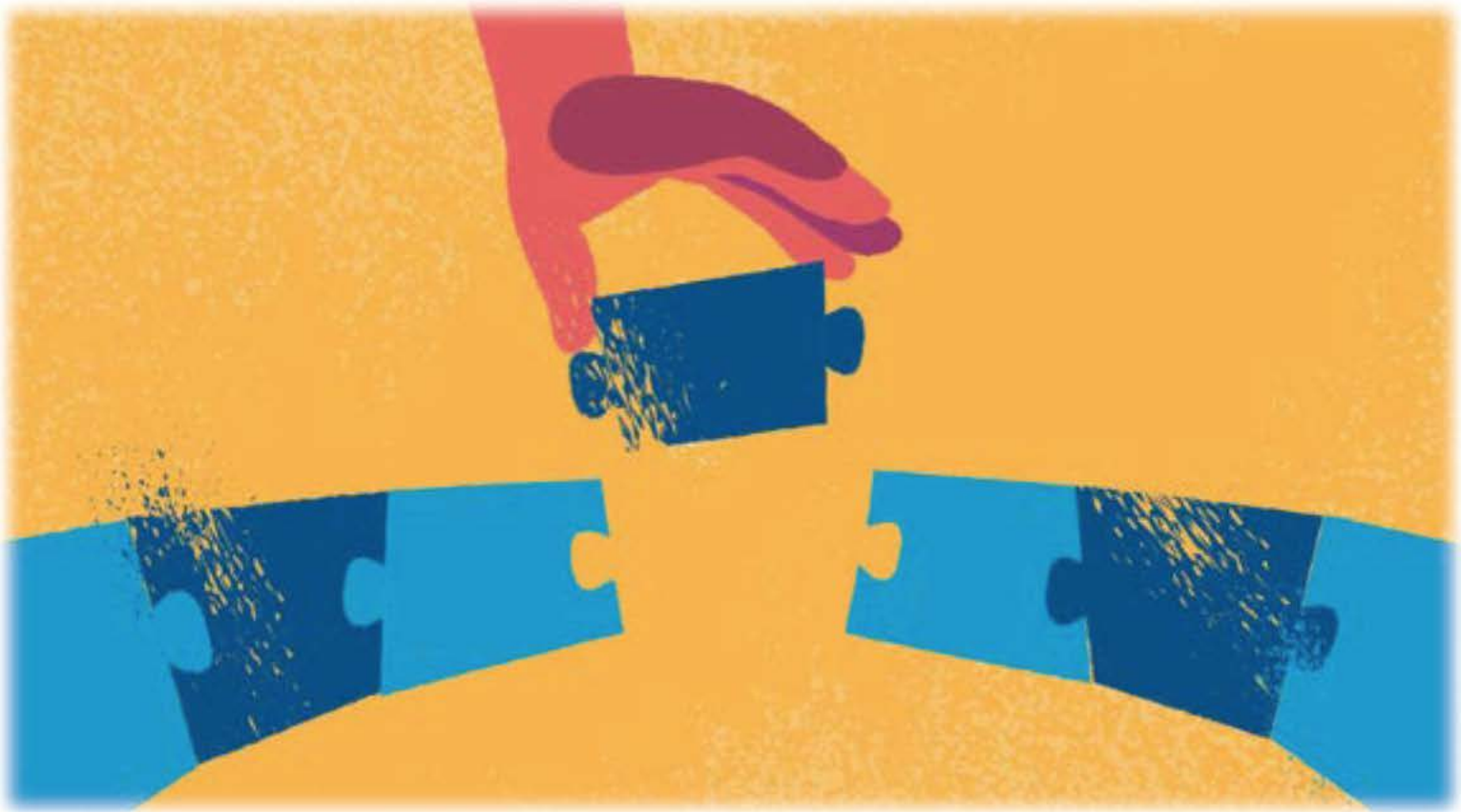
- **Non-Invasive Tests**
  - **Transient elastography (FibroScan®)**
  - **Fibrosis-4 (FIB-4) Score**
  - **Enhanced Liver Fibrosis (ELF) Test**

Prevention and Treatment for NAFLD

- Currently no FDA-approved pharmacological treatments exist – lifestyle modification (diet, physical activity) is the recommended therapy for MASLD

- However, in conjunction with diet and exercise, the first and only FDA-approved treatment for adults with noncirrhotic MASH with moderate to advanced fibrosis

Chalasani et al., 2018



A Gender and Culturally Specific Approach to Reduce MASLD in Mexican American Men (Garcia K01)

The goal of this project was to create a gender- and culturally-targeted weight loss intervention that focuses on relevant genetic and lifestyle risk factors of MASLD (e.g., dietary sugar consumption) to improve participant engagement and result in a successful targeted weight loss intervention.

Ricky's Journey

Who is Ricky?

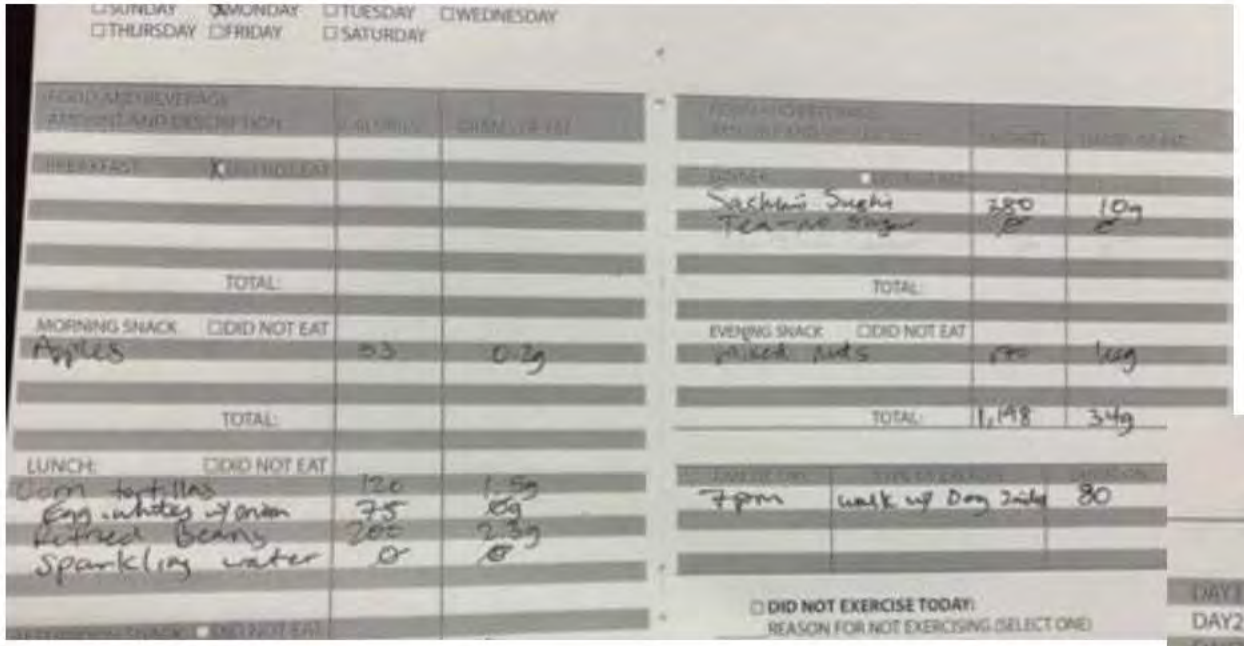
- 27 years old
- Full time job
- Struggles with weight for 10+ years

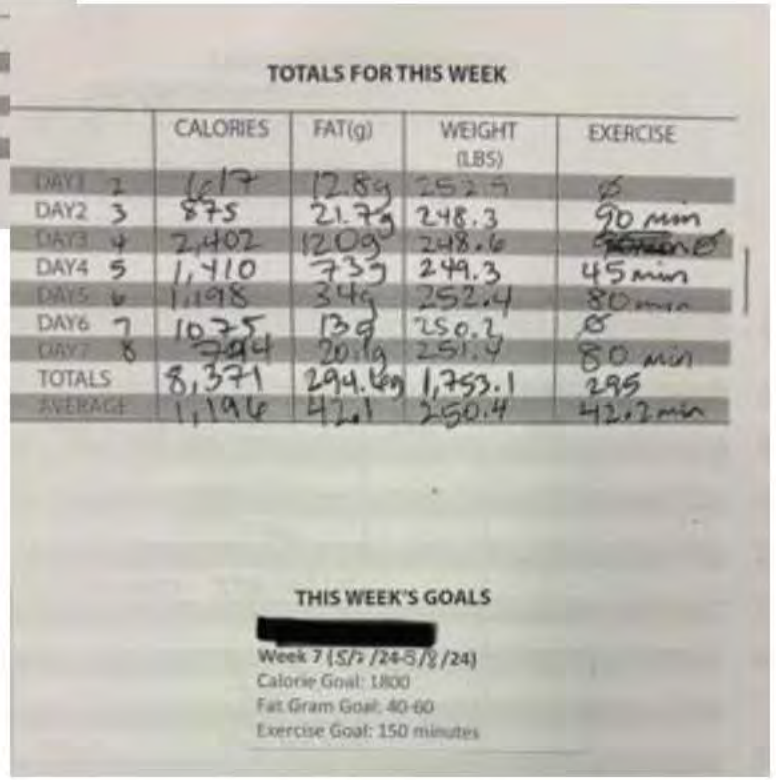
- Hypertension diagnosis at 26
- Family history of: Obesity, diabetes, hypertension, and chronic liver disease

Ricky's Baseline Status

- Baseline weight: 265.8 lbs
- BMI: 39.1 kg/m² (obesity class 2)
- Steatosis (CAP) Score: 336 dB/m (severe MASLD)
- PNPLA3 GG variant
- No leisure PA, sedentary job
- More context: Frustrated and unmotivated, previous weight loss attempts with no success

Ricky's Engagement with Intervention





TOTALS FOR THIS WEEK

	CALORIES	FAT(g)	WEIGHT (LBS)	EXERCISE
DAY1 2	1617	12.8g	252.5	0
DAY2 3	875	21.7g	248.3	90 min
DAY3 4	2,402	120g	248.6	0
DAY4 5	1,410	73g	249.3	45 min
DAY5 6	1,198	34g	252.4	80 min
DAY6 7	1075	13g	250.2	0
DAY7 8	794	20.1g	251.4	80 min
TOTALS	8,371	294.6g	1,753.1	295
AVERAGE	1,196	42.1	250.4	42.2 min

THIS WEEK'S GOALS

[redacted]

Week 7 (5/5 /24-5/11/24)
Calorie Goal: 1800
Fat Gram Goal: 40-60
Exercise Goal: 150 minutes

Accountability and peer support

After 6 months…

Ricky	
Weight change	-32.4 lbs
BMI	-5.1 kg/m²
Steatosis Score (CAP)	-105 dB/m
Physical Activity	
Vigorous Intensity	5 days/week, avg: 60 min
Moderate Intensity	5 days/week, avg: 30 min

Turning Point

- What we do not see….
  - Lost his job
  - Went through divorce
  - Moved back with his mom

- Remained motivated adhering to skills learned throughout intervention
- **Did not want genetics to define his destiny**

At 12 months…

Ricky	
Weight change	-41.2 lbs
BMI	-6.4 kg/m²
Steatosis Score (CAP)	-110 dB/m
Physical Activity	
Vigorous Intensity	3 days/week, avg: 60 min
Moderate Intensity	3 days/week, avg: 30 min

Ricky's Reflection

"Even after losing my job and going through a divorce, I stuck with what I learned in the program. Walking became my therapy; just getting outside and moving gave me peace when everything else felt chaotic. Tracking my meals and workouts gave me structure and reminded me that I still had control over something. I didn't let the setbacks or my family history and genetic risk become excuses. This wasn't just about weight loss, it was about showing up for myself."

Why Ricky's Story Matters?

- Ricky's story reflects a common

  trajectory: **motivation → support → self-efficacy**
- Personal connection is a critical catalyst for change
- Accountability and coaching helped sustain engagement, even during major life events
- Small wins build momentum and confidence

Calls to Action

- **Early detection and screening for MASLD must be prioritized**
- **Efforts to integrate genetic testing for PNPLA3 within intervention strategies are important**
- **Shift the paradigm…**
  - **Family-based approach vs. individual**

Acknowledgements

HRSA Health Resources & Services Administration
NIH National Institute on Minority Health and Health Disparities
CPCRN
American Cancer Society
EL RIO HEALTH
NIH NATIONAL CANCER INSTITUTE
ARIZONA LIVER HEALTH™

Questions?

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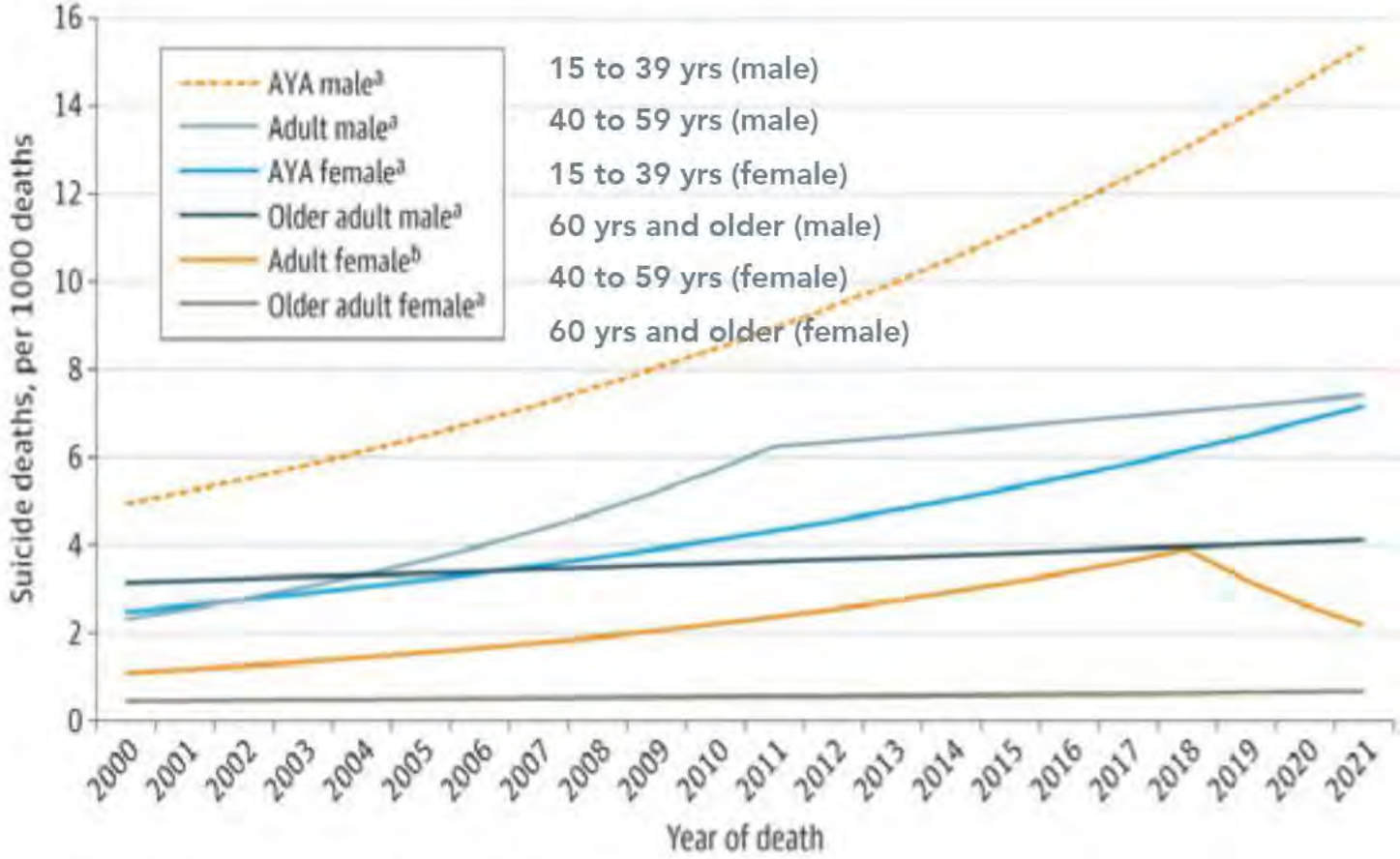
evillavicencio@arizona.edu

- Coping with cancer is rarely easy for anyone, but men tend to fare worse – emotionally and physically – than women.
- Evidence shows male survivors isolate more, seek less peer and other support and, alarmingly, die earlier.
- This slide shows the differences in suicide rates particularly among the younger, male population 15 to 39 yrs old with cancer.
- There are also indicators in this study published last year that males 40 and up have a higher propensity for suicide than most females.

www.npr.org/2025/08/13/nx-s1-5500147/cancer-young-survivorship-men-support



Suicide Deaths Among Adolescent and Young Adult Patients With Cancer. JAMA Network Open. Published November 4, 2024. doi:10.1001/jamanetworkopen.2024.42964 Koji Matsuo, MD, PhD,[1,2,3], Christina J. Duval, BA[4], Briana A. Nanton, BS[1,5]

Learn more at our October 24th Forum

THE LATINO CANCER INSTITUTE
Connect. Convene. Advocate.

Poverty is a Carcinogen

From a statement by Dr. Samuel A. Broder, 1989

In its report quoting Dr. Broder, the American Cancer Society determined that the lower a person's socioeconomic status, the greater the risk of cancer.

Dr. Samuel A. Broder

Director, National Cancer Institute, 1989-1995

Appointed by Ronald Reagan

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Factors Driving the Cancer Dynamic

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Social Determinants of Health (SDOH).....

the conditions in which people are born, grow, live, work and age that affect a wide range of health outcomes, risks and quality of life.

Besides biology and genetics, SDOH are considered 70% of the significant risk factors for cancer.

Food as Medicine

Lead a healthy lifestyle. Taking care of yourself with regular check-ups, exercise, good nutrition and plenty of sleep is good for your lungs, your mood and your overall health

On Food, Health, and Cancer Risk Reduction

Ana Maria Lopez, MD, MPH, MACP, FRCP (London), FASCO
Professor, Medical Oncology and Integrative Medicine (ABOIM) & Nutritional Sciences, Sidney Kimmel Medical College
Director, Integrative Oncology, Sidney Kimmel Comprehensive Cancer Center
Thomas Jefferson University, Philadelphia, PA

Thomas Jefferson University | Drexel University

Thank you!

Medical Oncologist

- Breast Cancer Oncologist
- Focus on Cancer Risk Reduction

- Integrative Oncologist
  - Focus on whole person care
  - Focus on lifestyle and cancer care
  - Focus on empowering people and communities towards self-care

Why think about men and cancer?

- Cancer risk:
  - Women 1/3 lifetime risk
  - Men 1/2 lifetime risk
- Why?
  - Biological factors: only one X chromosome (lack copy of tumor-suppressor genes)
  - Seek less medical care: less frequent medical visits for prevention and screening
  - Lifestyle factors: smoking, alcohol consumption, and obesity

It's Never Too Late to Quit!

- Quitting at any age provides significant health benefits and reduces cancer risk.
- The earlier you quit, the greater the health benefit.
  - If you quit before age 40, reduce your risk of dying from smoking-related diseases by as much as 90%

- **Within a few days:** start to smell again
- **Within a few years:** risk of mouth and esophageal cancer-cut in half.
- **Within 10 years:** risk of death from lung cancer-drops by half and risk of other cancers (stomach and colon) drops significantly.
- **Long-term:** After quitting, your risk of most smoking-related cancers decreases over time compared to continued smoking.

Why think about Latinos and cancer in the US?

- Young population overall-less cancer risk but GROWING
- When detected, cancer is more advanced, more aggressive, and in younger people
  - lung, colorectal, melanoma, prostate, and female breast cancers
- Less insured population-less access to care
- Less trust and GROWING

Haile RW, John EM, Levine AJ, Cortessis VK, Unger JB, Gonzales M, et al. A review of cancer in U.S. Hispanic populations. Cancer Prev Res. 2012;5(2):150–63.

Risk differences exist across Latino subgroups

- Colorectal cancer mortality is higher among Puerto Ricans than Mexican Americans
- Stomach cancer mortality is higher among Mexican Americans than Puerto Ricans
- Mexican Americans have higher mortality from cancer (colorectal, pancreatic, kidney, liver, and esophageal) than do Mexicans living in Mexico

Haile RW, John EM, Levine AJ, Cortessis VK, Unger JB, Gonzales M, et al. A review of cancer in U.S. Hispanic populations. Cancer Prev Res. 2012;5(2):150–63.

Are risk differences genetic?

- Consider migration-In a comparison of age-standardized rate ratios for Puerto Ricans living on the island of Puerto Rico with Puerto Ricans living on US mainland
  - Puerto Ricans (living on US mainland): significantly higher cancer risk than island PR
  - Among island Puerto Ricans, lower risk for liver, prostate, and colorectal cancer
- Immigrants acculturate-adopt US behaviors the longer that they are in uS
  - An unhealthy behavior/exposure-decline in dietary quality.

Pinheiro PS, Callahan KE, Stern MC, de Vries E. Migration from Mexico to the United States: a high-speed cancer transition. Int J Cancer. 2018;142(3):477–88

Why think about food and cancer?

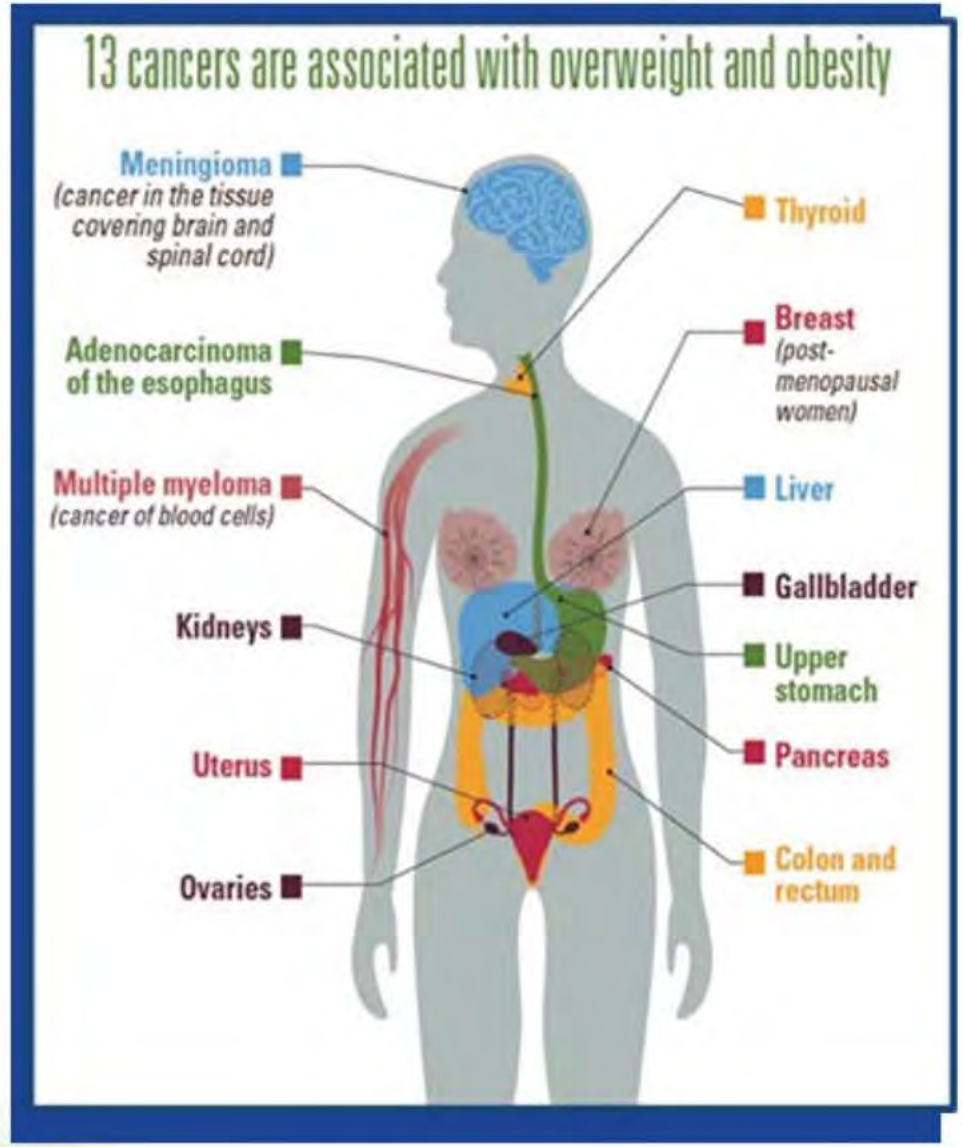
- We are what we eat!

- 20-42% of all cancers may be prevented by addressing preventable risk factors, including dietary intake behaviors

- 45% of all cancer deaths may be prevented by addressing preventable risk factors, including dietary intake behaviors

Why think about food and cancer?

- ~20% cancer cases attributable to specific nutrition-related risk factors:
  - obesity (8%)
  - excess alcohol (6%)
  - low fruit, vegetable, fiber intake (3%)
  - processed meat intake (1%)
  - lower contributions from red meat and low calcium


13 cancers are associated with overweight and obesity
Meningioma
(cancer in the tissue covering brain and spinal cord)
Adenocarcinoma of the esophagus
Multiple myeloma
(cancer of blood cells)
Kidneys
Uterus
Ovaries
Thyroid
Breast
(post-menopausal women)
Liver
Gallbladder
Upper stomach
Pancreas
Colon and rectum

Alcohol and cancer risk

- Alcoholic beverage: 12 oz of beer, 5 oz of wine, or 1.5 oz of distilled spirits
- People who drink +1 drink/day (women); +2 drinks/day (men) have significantly increased risk for mouth, larynx, esophagus, liver, and breast cancers.
  - 15% increase of lung cancer risk
- 2/3 adults (US) exceed amount at least once per month

Bagnardi V, Rota M, Botteri E, Tramacere I, Islami F, Fedirko V, et al. Alcohol consumption and site-specific cancer risk: a comprehensive dose-response meta-analysis. Br J Cancer. 2015;112(3):580–93.

Fruits and Vegetables

- High fruit and vegetable intake: lower risk of lung, colorectal, breast, esophageal, stomach, pancreatic, uterine, cervical, and ovarian cancers.
- Cruciferous vegetables: phytochemicals-thought to reduce colorectal cancer risk
- Fiber: mixed data
- Antioxidant nutrients in fruits and vegetables (vitamin C, vitamin E, selenium, carotenoids, and other phytochemicals) protect against tissue damage from oxidative stress.
  - Several trials of antioxidant supplements did not show protection-important to obtain nutrients from food

Red and Processed Meat

- Red and processed meats contribute to carcinogenic processes.
- Nitrites in processed meats may be converted in the stomach to carcinogenic nitrosamines
  - Diets high in fruits and vegetables, with vitamin C and phytochemicals, may slow this conversion.
- The way in which one cooks meat: frying, broiling, or grilling meats at high temperature creates chemicals that increase cancer risk-stewing better
- High consumption of red and processed meats may increase serum obesity-related inflammatory markers

Joshi AD, Kim A, Lewinger JP, Ulrich CM, Potter JD, Cotterchio M, et al. Meat intake, cooking methods, dietary carcinogens, and colorectal cancer risk: findings from the Colorectal Cancer Family Registry. Cancer Med. 2015;4(6):936–52

Nutrition-Inflammation-and Cancer

- Diets high in processed foods, refined sugars, and unhealthy fats promote inflammation
- Inflammation fuels carcinogenesis
  - **DNA Damage:** Inflammation produces free radicals that can damage DNA and lead to mutations, a crucial step in cancer formation.
  - **Cellular Signaling:** Inflammatory signals and cytokines can turn on genes that promote cancer growth.
  - **Gut Microbiome:** Western diets rich in processed foods can promote gut dysbiosis (imbalance) and inflammation, which can contribute to cancer risk.

Nutrition-Inflammation-and Cancer

- Anti-inflammatory diets: rich in fruits, vegetables, whole grains, legumes, healthy fats, whole unprocessed foods

Latinos in the US

- Boston Puerto Rican Health Study: low intakes of fruits and vegetables, whole grains, dietary fiber, folate, vitamin B6, vitamin C, and calcium, relative to recommendations, with high intakes of refined carbohydrates
- Food acculturation: dietary habits acculturated to US diet
  - Mexican Americans born in Mexico had higher intakes of fruits, vegetables, and fruit juices related to all other subpopulations
  - Declining food quality with years in the US, and with the subsequent generations

Batis C, Hernandez-Barrera L, Barquera S, Rivera JA, Popkin BM. Food acculturation drives dietary differences among Mexicans, Mexican Americans, and Non-Hispanic Whites. J Nutr. 2011;141(10):1898–906

Healthy Eating

- A healthy eating pattern **includes:**
  - Foods high in nutrients in amounts that help you get to and stay at a healthy body weight
  - A **variety** of vegetables - dark green, red and orange, fiber-rich legumes (beans and peas)
  - Fruits, especially whole fruits in a variety of colors
  - Whole grains
  - Explore your traditional foods
- A healthy eating pattern **limits or does not include:**
  - Red and processed meats
  - Sugar-sweetened beverages
  - Highly processed foods and refined grain products
  - Alcohol

Maintain a Healthy Weight

- Avoid weight gain in adulthood
  - Usual weight gain: 0.5 to 2#/year from 20s to 60s (~40#!)

- Avoid sugar-sweetened beverages, fast foods, and "Western type" diets (diets high in added sugars, meat, and fat); foods containing fiber and "Mediterranean" diet patterns may reduce risk.
- Move!
  - Aerobic physical activity, walking -> lower risk of excess body weight
  - Sedentary behaviors-sitting, lying down, screen time (phone, computer, TV)-higher risk

ACS Guideline at https://acsjournals.onlinelibrary.wiley.com/doi/full/10.3322/caac.21591.

Take home message!

- Eat a wide variety of nutritious foods-mostly plants
  - If your grandparents wouldn't recognize it as food, don't eat it!

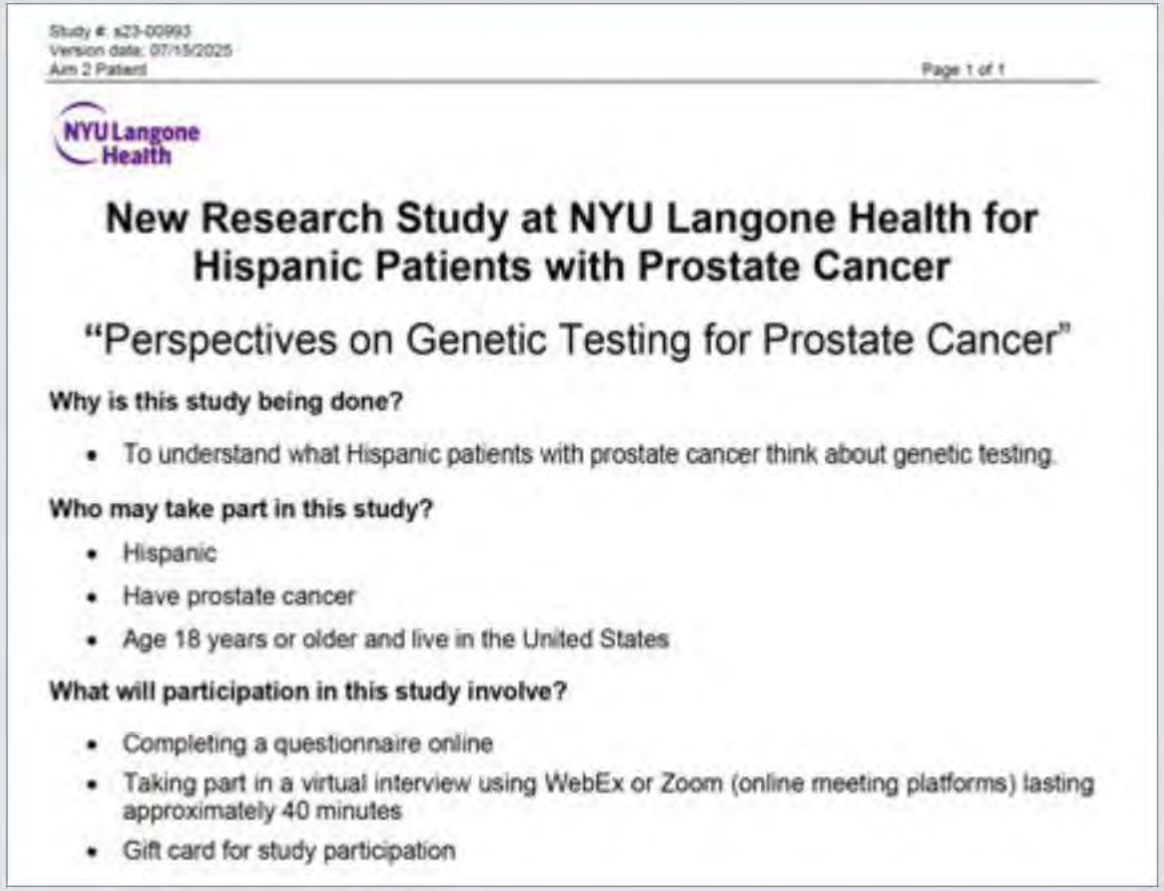
- Maintain a healthy weight: move your body
- Limit alcohol
- Don't smoke

ACS Guideline at https://acsjournals.onlinelibrary.wiley.com/doi/full/10.3322/caac.21591.

Thank you!

anamaria.lopez@jefferson.edu

*Latino Prostate Cancer Patients/Survivors Wanted



Study #: s23-00993
Version date: 07/15/2025
Aim 2 Patient
Page 1 of 1

NYU Langone Health

New Research Study at NYU Langone Health for Hispanic Patients with Prostate Cancer

"Perspectives on Genetic Testing for Prostate Cancer"

Why is this study being done?

- To understand what Hispanic patients with prostate cancer think about genetic testing.

Who may take part in this study?

- Hispanic
- Have prostate cancer
- Age 18 years or older and live in the United States

What will participation in this study involve?

- Completing a questionnaire online
- Taking part in a virtual interview using WebEx or Zoom (online meeting platforms) lasting approximately 40 minutes
- Gift card for study participation

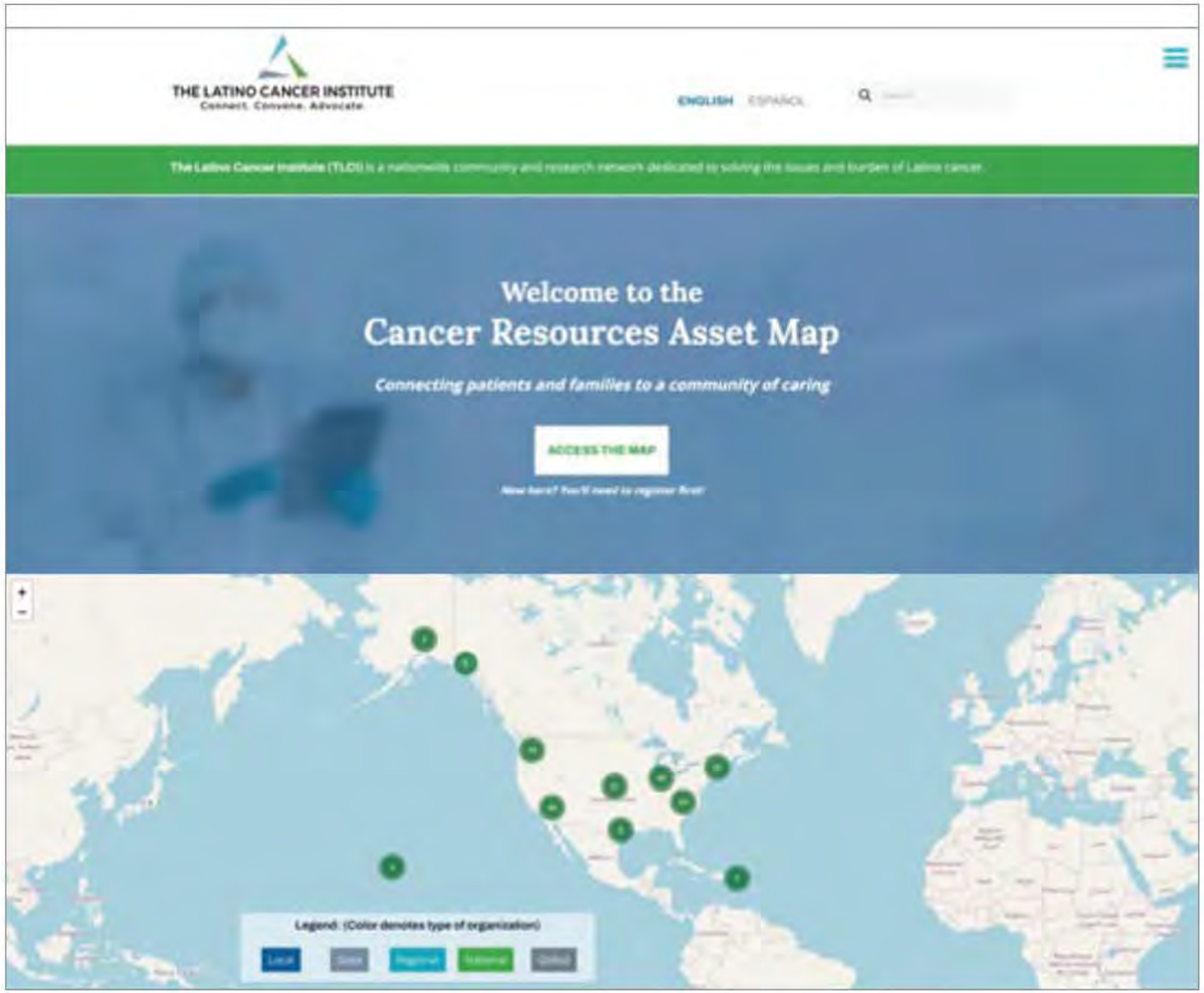
Participation is voluntary.
For more information, please contact:

Tatiana Sanchez Nolasco
Tatiana.Sancheznolasco@nyulangone.org
(646) 501-2550

Mariana Rangel
Mariana.RangelCamacho@nyulangone.org
(646) 501-2552

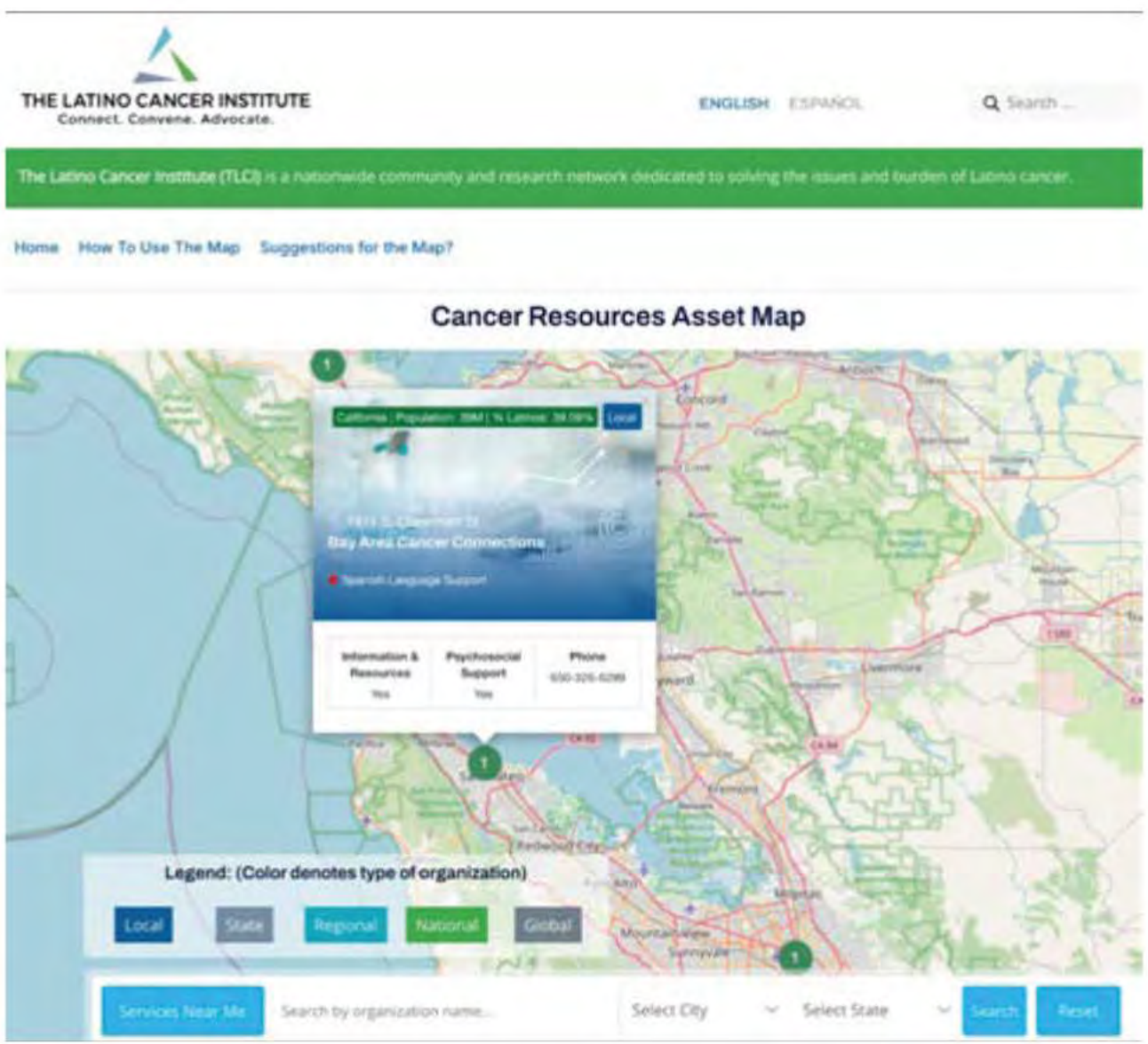
Principal Investigator is Dr. Stacy Loeb, Professor, Departments of Urology and Population Health, NYU Grossman School of Medicine

***Mono-lingual Spanish speakers are encouraged to participate. See Spanish flyer in the chat.**

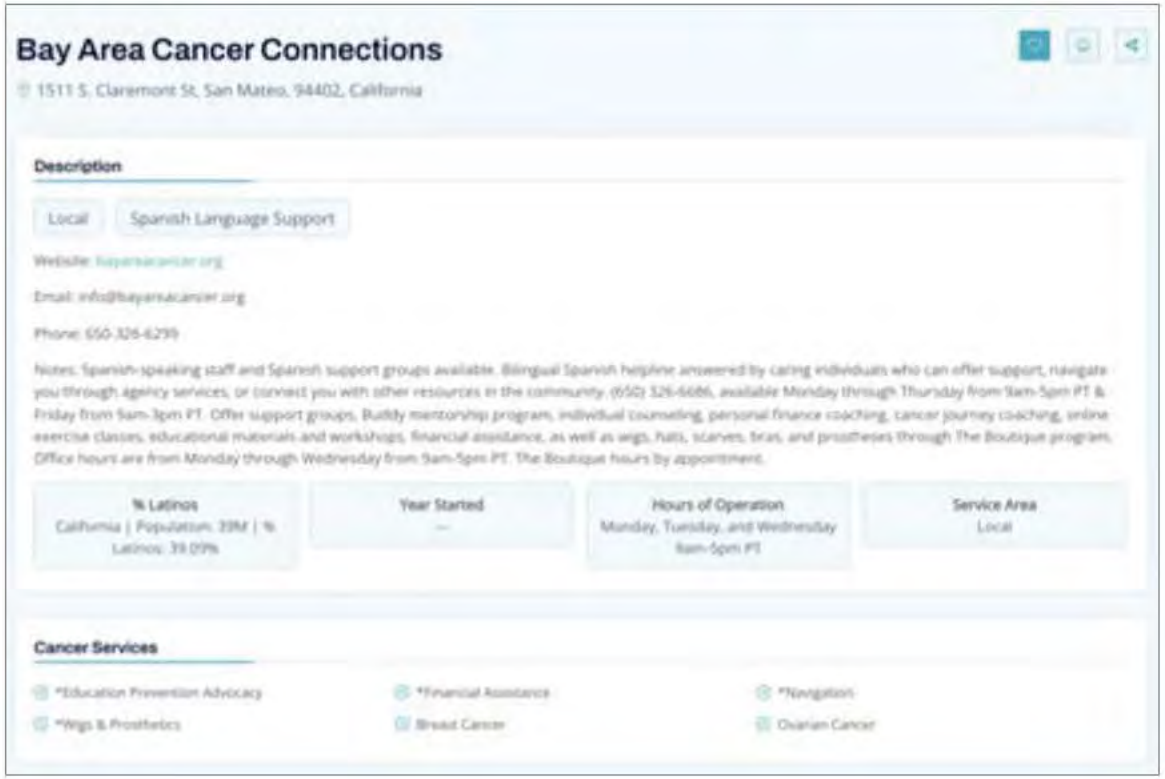


Our Cancer Resources Asset Map, available in both English and Spanish and can be used by everyone:

- Patients and families
- Community health workers aka promotores working in clinics, agencies or acting as navigators
- Clinics and community-based organizations (CBOs)
- Social workers in clinics and public health care systems
- Navigators in comprehensive cancer centers



300 agencies invited and counting!



Launching Soon!

Want to be on the Map?

Contact Miriam Juarez-Vargas
ProgramMgr@latinocancerinstitute.org

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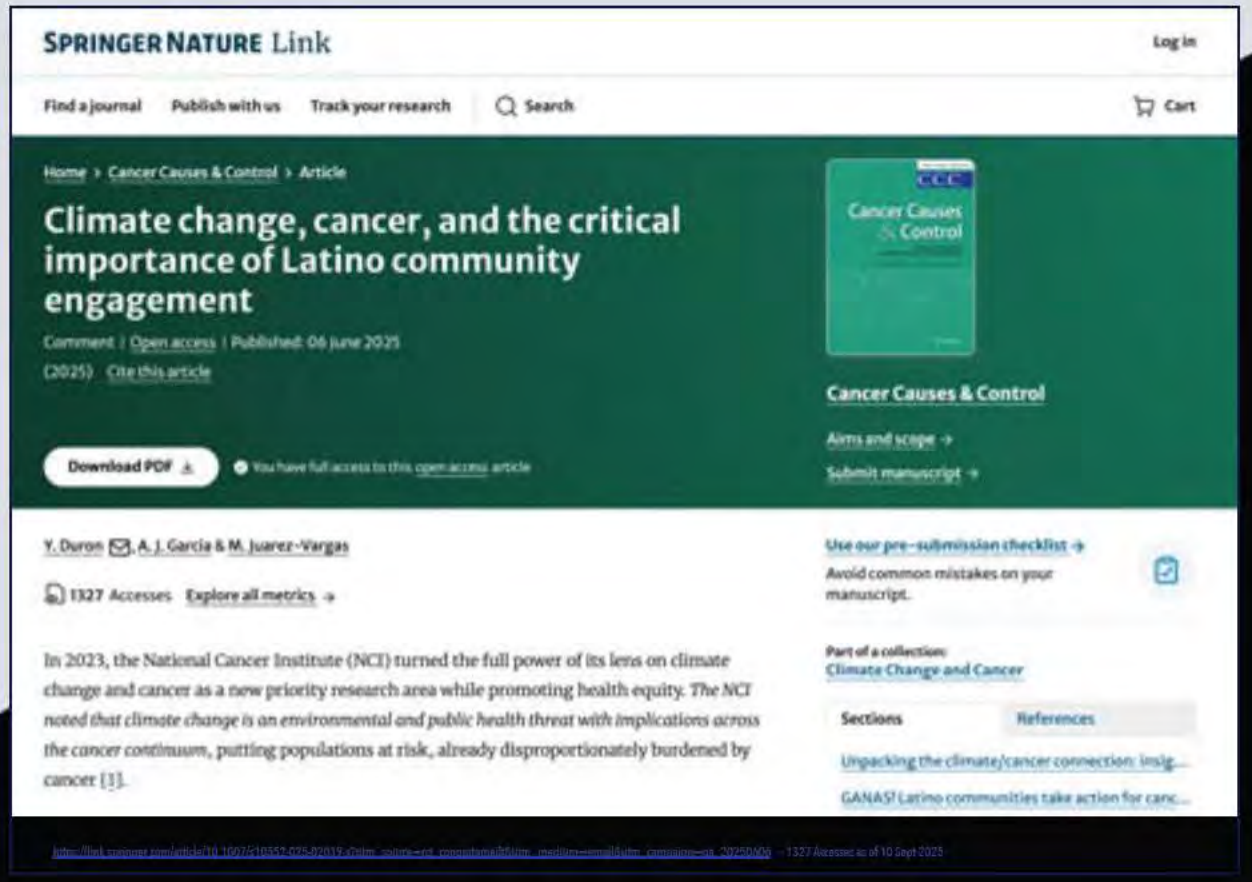
TLCI: We're Published! … in Cancer Causes and Control



"…It's time for institutional systems – academic, public health, and government entities – to put aside biased views of community helplessness, and instead embrace them as equal partners, budgets and all."

Coming up on the next Friday Forum Series

Liver Cancer Awareness Month

October 3, 2025

Keynote:
Luis Arturo Valdez, PhD MPH, Drexel University, Dornsife School of Public Health

Lisa Goldman Rosas, PhD MPH, Stanford School of Medicine

Luis Carvajal-Carmona, PhD UC Davis

Maria Constanza Camargo, PhD, MS, MHA, National Cancer Institute

Enrique Velazquez Villarreal, MD, PhD, MPH, MS, City of Hope

Catherine Metayer, MD, PhD UC Berkeley

Katherine McGlynn, PhD, MPH, National Institutes of Health / National Cancer Institute

Leticia Nogueira, PhD, MPH American Cancer Society

HR 1. Keynote – Luis A. Valdez * Lisa Goldman Rosas

HR 2. Luis Carvajal Carmona * María Constanza Camargo * Enrique Velazquez Villarreal

HR 3. Leticia Nogueira * Catherine Metayer * Katherine McGlynn

THANK YOU!

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SURVEY

Before you leave be sure to take our post Forum survey.

We want to know your thoughts.

English

Spanish

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THANK YOU

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Save the Date

The Latino Cancer Institute's

8th Annual National Forum

Fall 2026

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