

## Oral Presentations

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## Non-Communicable Disease: Cancer

OP01

**HYPERTENSION AND RISK OF CANCERS OF THE KIDNEY AND URINARY TRACT IN UK WOMEN**

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**Background** Hypertension has been associated with an increased risk of kidney cancer, but evidence of association with cancers elsewhere in the urinary tract is mixed. We examined the association between hypertension and the incidence of cancers of the kidney (by histotype), and urinary tract, in a large cohort of UK women.

**Methods** Participants were recruited in 1996–2001 from 66 NHS breast-screening centres, and completed a questionnaire on anthropometric, reproductive and lifestyle factors, and medical history, including self-reported hypertension requiring treatment. They were followed for cancer and death via record linkage to national registries. We used Cox regression models to estimate relative risks (RRs) of cancers of the kidney and urinary tract, associated with self-reported hypertension requiring treatment at recruitment, adjusted for potential confounders. Analyses were conducted in Stata 15.

**Results** In 1,319,718 women without previous cancer, 211,663 (16%) reported at recruitment that they were currently being treated for hypertension. After 16.9 years' (SD 4.6) mean follow-up, 5391 kidney cancers, including 4248 renal cell carcinomas and 442 urothelial carcinomas, accrued. Hypertension requiring treatment at recruitment was associated with a significantly greater increase in the risk of renal cell carcinomas (RR=1.69, 95% CI: 1.57–1.82) than urothelial carcinomas of the kidney (RR=1.27, 95% CI: 1.00–1.62); heterogeneity by histotype,  $p=0.02$ . There were no clear associations between hypertension at recruitment and the risk of urothelial carcinomas elsewhere in the urinary tract (ureter:  $n=249$ , RR=0.82, 95% CI: 0.57–1.17; bladder:  $n=2929$ , RR=1.00, 95% CI: 0.91–1.11). The association seen with renal cell carcinomas persisted even after exclusion of the first 10 years of follow-up (RR=1.69, 95% CI: 1.54–1.85), suggesting it was not an artefact of reverse causation.

**Conclusion** Hypertension is strongly associated with an increased risk of kidney cancer, with significant heterogeneity by histotype. The risk of renal cell carcinoma is substantially increased in those with a history of hypertension, but there is little or no association with urothelial carcinomas, either in the kidney or the rest of the urinary tract.

OP02

**THE ROLE OF LEADERSHIP IN DRIVING CHANGE IN CANCER OUTCOMES IN HIGH INCOME COUNTRIES**

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**Background** There is well-established variation in cancer survival and, despite general improvements over time, differential progress has been made across high-income countries with seemingly similar health systems. Research has explored the source of these differences in outcomes, but the role of leadership in cancer care systems has been under-researched. Leadership is one of the WHO 'building blocks' that underpin a functioning health system. It is variously defined as including governance, stewardship, responsibility and accountability.

As part of the International Cancer Benchmarking Partnership, this study looked at these diverse aspects of leadership to identify drivers of change and improvement across a range of high-income countries.

**Methods** Cancer strategy documents were analysed from 22 jurisdictions: Australia (3 states), Canada (10 provinces), Denmark, Ireland, New Zealand, Norway and UK (4 countries). Key informants in 15 of these jurisdictions, representing a range of stakeholders at the different tiers of the system, were recruited: hospital managers; regional and/or government officials; representatives from arms' lengths bodies, professional bodies and patient associations; experts within the cancer field and with wider health policy expertise. Key informants were identified through a combination of purposive and 'snowball' strategies. They participated in semi-structured interviews held in English, using online conferencing software. Documents and interview transcripts were analysed using a thematic approach using a framework based on the WHO health systems framework and previous work analysing national cancer control programmes.

**Results** Different facets of leadership emerged: diffused across health boards *vs* centralised (including the central role of a cancer agency in some places); the interplay between national, regional and local leadership structures; the establishment of links between primary and secondary care. The study demonstrated a central role of sustained leadership and political commitment, crucial for initiating and maintaining progress, as was a coherent vision that supported the implementation of national policies locally. Clinical leadership of the cancer care system emerged as vital for translating policy into action.

**Conclusion** Certain aspects of cancer care leadership emerged as underpinning and sustaining improvements. Improving cancer outcomes is challenging and complex, but it is unlikely to be achieved without effective leadership and sustained political commitment that can create effective co-ordination of care. These lessons can be applied to jurisdictions which are struggling to achieve the progress they might otherwise be able to, and to a variety of conditions.

OP03

**FACTORS ASSOCIATED WITH NON-ATTENDANCE FOR CERVICAL SCREENING IN ENGLAND**

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**Background** Previous studies have shown some differences in uptake of cervical screening by sociodemographic factors. However, the available evidence on other lifestyle, reproductive and hormonal factors is limited and inconsistent. We examined screening uptake in relation to sociodemographic, lifestyle, reproductive and hormonal factors by linking data