

Knowledge of Obesity's Health Related Outcomes among Hispanic Women living in Puerto Rico

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Objective: The primary aim of this cross-sectional study was to assess, according to previous cancer diagnosis, the knowledge Puerto Rican women have on the link between obesity-endometrial, -breast, and -colon cancer, and determine women's most common source for medical information.

Methods: In this cross-sectional study, eligible female patients (n=234) from the Gynecology and Gynecology-Oncology Clinics completed a self-administered survey from October 2014 to March 2016. Participants were evaluated on sociodemographic, body mass index, knowledge of the obesity-cancer link, and source of medical information.

Results: About 49% and 31% of women in the study were obese and overweight, respectively. Less than 52% of the women knew about the link between obesity-breast, -colon, and/or -endometrial cancers. Women with previous cancer diagnoses were more likely aware of the association between obesity-colon cancer than women without previous cancer diagnoses (58% vs. 44%, $p<0.05$); no differences were found for breast and endometrial cancer ($p>0.05$). Higher incomes showed increased odds for the knowledge obesity-cancer link among women with a cancer history, but the odds decreased for women without previous cancer diagnoses ($p>0.05$). Higher education showed a trend towards a better knowledge of the obesity-cancer association. The most common sources of information were the primary doctor (80%) and the internet (54%).

Conclusion: Counseling about preventable cancer risk factors through primary care to all women must be encouraged especially in young healthy females. Further studies should address qualitative aspects of the odds differences in the obesity-cancer link knowledge observed between income categories for women with/without previous cancer diagnoses. [*P R Health Sci J* 2023;42(4):291-297]

Key words: Obesity, Endometrial Cancer, Breast Cancer, Knowledge, Puerto Rico, Hispanics

The prevalence of obesity has increased at alarming rates in the United States (U.S.) and Puerto Rico (P.R.), reaching epidemic levels of 33.0% and 36.0%, respectively, in the year 2021 (1). In a span of 5 years the number of obese adults in the U.S. and P.R. has increased by 12.8% and 17.3% (percent changes from 2016 to 2021), respectively (1). The increase in obesity through the years is concerning due to its association with chronic diseases, such as certain types of cancers (2). According to the Centers for Disease Control and Prevention, overweight and obesity factors are associated with approximately 55% of cancer diagnoses in women (1). Meanwhile in P.R. an increasing incidence of breast (3), colorectal (4), and endometrial (5) cancers has been observed as compared to other racial/ethnic groups.

Even though most Americans recognize obesity as a major health issue, only about 50% are aware of the obesity-cancer risk association (6). Hence, U.S. researchers have evaluated their respective populations' knowledge about the physiological influence of obesity on various types of cancer. Soliman et al., for example, found that 42%, 53%, and 54% of women in a

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Houston, Texas community (mainly African Americans) were aware of the link between obesity-endometrial, -colon, and -breast cancers. Meanwhile, a study of Beavis et al (7), showed that less than 40% of women (mainly U.S. Hispanics) correctly identified obesity as a risk factor for endometrial and breast cancers; women with cancer diagnosis showing more awareness than healthy women.

Are women in P.R. aware of the obesity-cancer association? What is the source of health information of women in P.R.? To our understanding, no studies have assessed the knowledge of the association between obesity and these cancers in the Puerto Rican population. To enable future efforts the primary aim of this cross-sectional study was to assess, according to previous cancer diagnosis (yes/no), the knowledge Puerto Rican women have on the link between obesity-endometrial, -breast, and -colon cancer, and determine women's most common source for obtaining medical information. Our study secondary aims were focused on assessing the association between demographic, and body mass index (BMI) of women in P.R. and their knowledge of obesity-endometrial, -breast, and -colon cancer risk, by stratifying for previous cancer diagnosis.

Methods

In this cross-sectional study, a total of 234 female participants (21 years and older) were recruited from the University of P.R. School of Medicine's Gynecology and Oncology clinics while in waiting room; none of the participants were pregnant. Written consent forms and detailed instructions were provided before the survey questionnaire (available in English and Spanish) was delivered to the participants. No monetary incentive was offered for their participation. This study was approved by the University of P.R. Institutional Review Board; protocol A0180114.

The survey consisted of 16 independent items that originated from the Behavioral Risk Factor Surveillance System (8). Demographic information collected included: age, birthplace, marital status, employment status, annual household income, and highest level of education. Participants body mass index (BMI) was obtained and calculated at the vital signs station on the day the self-administered questionnaire, aimed at determining their understanding of obesity related health outcomes, was completed; height and weight were measured with the clinic's scales, without heels or heavy accessories. The classification outlined by the World Health Organization (9) was used for underweight (BMI < 18.5), normal weight (18.5 ≤ BMI < 25.0), overweight (25.0 ≤ BMI < 29.9) and obese (class I, II, and III as BMI ≥ 30) categories in our study.

Sources of medical information were obtained by asking participants to rank the three most frequented sources: primary care physician (PCP), television program, Internet, information pamphlets, other people, or "other specific source". Knowledge on obesity related outcomes was evaluated via a 3-point Likert

scale "yes, no, do not know". Various conditions were given for the participant to determine which, if any, was influenced by increased body weight. Correct responses for risk knowledge questions were categorized as "know" while incorrect/do not know were grouped as "do not know".

Description of the study sample was made using proportions, and central tendency measures (i.e., mean, standard deviation, median, interquartile range). Chi-squared test and Fisher's Exact test were performed, as appropriate, to determine differences between females with and without previous cancer diagnosis. These statistical tests, as well as multiple logistic regression models, were used to determine the association between patient demographics, BMI (as predictors) and their knowledge of the link between obesity and cancer risk (endometrial, breast, and colon). Regression models (stratified by previous cancer diagnoses) were adjusted for age and education level to estimate odds ratios (ORs) and 95% confidence intervals (95% CI). Interaction terms were assessed using likelihood ratio (LR) tests. All statistical analysis was performed using Stata v.17 (College Station, Texas, USA). P values <0.05 were considered statistically significant.

Results

The mean age of women in our study was 49 (±15) years. Most women were married (44%) and unemployed (61%). About 48% and 31% of women in the study were obese and overweight, respectively. Other socio-demographic characteristics of participants are shown in Table 1. Approximately 42% of the women had been previously diagnosed with cancer during their lifetime. Less than 52% of the participants knew about the existent association between obesity and endometrial (51%), colon (50%) or breast (46%) cancers. Figure 1 shows the awareness of the obesity-cancers risk association according to participants' previous cancer diagnosis status.

Knowledge on Obesity-Colon Cancer (CC) Association

Women with previous cancer diagnosis were more likely to be aware of the association between obesity-CC risk than women without previous cancer diagnosis (58% vs. 44%, $p=0.036$). Among women with previous cancer diagnosis, BMI was associated to the knowledge on the link between obesity and CC ($p=0.03$); overweight and obese women had about 5.71 (95% CI: 1.39, 23.38) and 2.17 (95% CI: 0.62, 7.64) times greater odds, respectively, of being aware of the link between obesity and CC. No associations were observed among women without cancer diagnosis ($p>0.05$, Table 2). Even though no significant interaction was observed between income and cancer history (LR test = 3.03, $p = 0.08$), women with higher incomes had increased odds for the knowledge on obesity-colon cancer link among women with previous cancer diagnoses than those with inferior incomes; lower odds were observed among women without previous cancer diagnoses. (Table 2).

Table 1. Characteristics of the study participants

Characteristics	Overall (n =234)	Previous Cancer Dx		P-value ^a
		Yes (n = 99)	No (n = 135)	
Age (in years), Mean ± SD	49.26 ± 15.30	54.69 ± 13.38	45.29 ± 15.44	<0.0001
Age categories (in years), (%)				
< 45	97 (41.45)	26 (26.80)	71 (73.20)	<0.001
45-64	90 (38.46)	45 (50.00)	45 (50.00)	
≥ 65	47 (20.09)	28 (59.57)	19 (40.43)	
Civil status, (%)				
Single	82 (35.19)	27 (27.55)	55 (40.74)	0.08
Married/Living with partner	103 (44.21)	46 (46.94)	57 (42.22)	
Divorced/separated	29 (12.45)	13 (13.27)	16 (11.85)	
Widowed	19 (8.15)	12 (12.24)	7 (5.19)	
Missing Values = 1				
Education, (%)				
< High School	45 (19.23)	22 (48.89)	23 (51.11)	0.32
≥ High School	189 (80.77)	77 (40.74)	112 (59.26)	
Employment, (%)				
Employed	52 (22.51)	12 (23.08)	40 (76.92)	0.001
Unemployed	143 (61.90)	64 (44.76)	79 (55.24)	
Retired	36 (15.58)	22 (61.11)	14 (38.89)	
Missing values = 3				
Annual income, (%)				
< \$15,000	49 (29.70))	19 (38.78)	30 (61.22)	0.41
≥ \$15,000	116 (70.30)	53 (45.69)	63 (54.31)	
Missing Values = 69				
BMI, (%)				
Underweight	6 (2.56)	3 (50.00)	3 (50.00)	0.47 ^b
Normal weight	43 (18.38)	15 (34.88)	28 (65.12)	
Overweight	72 (30.77)	28 (38.89)	44 (61.11)	
Obese	113 (48.29)	53 (46.90)	66 (53.10)	

^aChi-squared test or Student’s t-test (equal variances) was used to calculate p-values unless otherwise specified.

^bFisher’s Exact test was used to calculate the p-value.

Knowledge on Obesity-Breast Cancer (BC) Association

Statistical differences were not shown for awareness of the link between obesity- BC between women with and without previous cancer diagnosis (53% vs. 41%, respectively; p>0.05). Among women with and without previous cancer diagnosis, older women (≥ 65 years) had about 3.35 (95% CI: 1.00, 11.21) and 3.09 (95% CI: 1.01, 9.48) times greater odds of being aware of the association between obesity and BC, respectively, than younger women (< 45 years) after adjusting for their education level. Women without cancer diagnosis showed no statistical differences for the awareness of obesity-BC association between BMI categories (p > 0.05; Table 2). Meanwhile, among women with previous cancer diagnosis, overweight (OR = 4.71, 95% CI: 1.18, 18.75) and obese (OR = 2.17, 95% CI: 0.62, 7.64) women had elevated odds of having knowledge on the association between obesity and BC as compared to women with normal weight. Despite no significant interaction was observed between income and cancer history (LR test = 2.12, p = 0.15), women with previous cancer diagnosis with higher income

showed increased odds for the knowledge on obesity-BC link than those with lower income, while women without previous cancer diagnosis with higher income showed lower odds (Table 2).

Knowledge on Obesity-Endometrial Cancer (EC) Association

Awareness of the association between obesity and EC was not related to demographics or BMI in our study. However, after controlling for education level, women with no cancer history and 45-64 years of age showed 2.24 times (95% CI: 1.03, 4.87) higher odds of being aware of the link between obesity and EC than those < 45 years of age; for those ≥ 65 years of age the adjusted odds ratios were of 2.08 (95% CI: 0.69, 6.26). Even though no significant interaction was observed between income and cancer history (LR test = 2.13, p = 0.14), higher income revealed a trend towards better knowledge of the obesity-EC association among women with previous cancer diagnosis but towards lower knowledge of the existent link among those without a history of cancer diagnosis (Table 2).

Sources of Information

The most common sources of medical information among women in our study were the primary doctor (79.9%) and the internet (54.3%). The knowledge regarding obesity as a risk factor for cancers ranged

between 39-53% for BC, 46-59% for CC, and 52-58% for EC according to the source used to receive medical information, as shown in Figure 2. For both, women with and without cancer diagnosis who knew about the obesity-cancers link, the primary

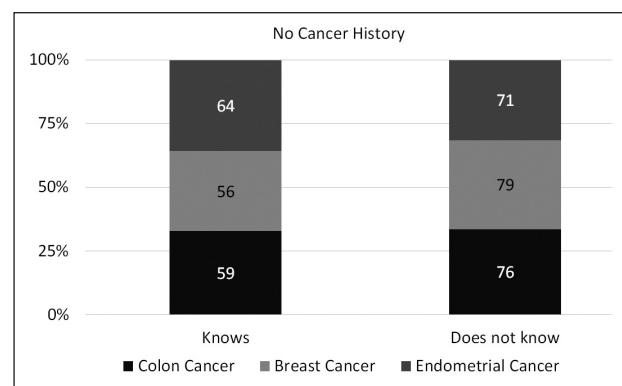


Figure 1. Obesity-cancers risk awareness in participants without previous cancer diagnosis status.

doctors were the main source of medical information (EC: 85% and 77%, respectively; BC: 81% and 80%, respectively; CC: 71% and 47%, respectively). Among women with previous cancer diagnoses, similar proportions of women who knew about the obesity and cancer association obtained medical information from TV programs (EC: 42%, BC: 38%, and CC: 47%) and/or internet (EC: 61%, BC: 40%, and CC: 46%). Among women without cancer diagnosis who knew the link between obesity and cancers, the medical information was obtained more from the internet (EC: 61%, BC: 52%, and CC: 54%) than from TV programs (EC cancer: 28%, BC: 27%, and CC: 29%).

Discussion

The increasing prevalence of obesity translates to a higher incidence of obesity related conditions, including EC, DM and cardiovascular comorbidities (10-11). While other U.S. and international populations have been evaluated to determine their obesity related awareness, limited information exists regarding Hispanic women living in P.R. (12). This study focused on assessing P.R. women's knowledge of obesity-cancer risks to obtain baseline information that could aid in creating initiatives emphasizing education and weight-loss strategies as preventive measures.

It was reasonable to expect that a previous cancer diagnosis leads to more knowledge on its risk factors, for which reason the data was stratified for cancer diagnosis to identify key demographic targets. After adjusting, a previous cancer diagnosis was not found to be statistically significant for women's awareness of obesity's association with BC or EC. Only for CC was a previous cancer diagnosis shown to be associated to increase awareness of obesity-CC risk when compared to women without previous cancer diagnosis.

When assessing our sample's knowledge of the association between obesity and BC development it is alarming that 53.8% are categorized as not knowing, since BC is the most prevalent of all cancers in P.R., accounting for 30.3% of all female cancers and the highest mortality of all cancers in this population (11). Women in our study were less likely to know about the existent link between obesity and BC than women assessed by Soliman et al (6) (46% vs. 54%, $p=0.02$). Nevertheless, our sample was more aware of the association than the group of women assessed by Beavis et al (7) (46% vs. 34%, $p<0.001$). Women with previous cancer diagnosis with higher income were more likely to know an obesity-BC link than those with lower income, while women without previous cancer diagnosis with higher income showed lower odds of knowing the association of obesity-BC.

Women ≥ 45 years of age were more likely to know obesity's association to cancer when compared to women <45 years of age. These findings raise the question: Why older women demonstrated greater knowledge? Is it an expected phenomenon that older patients are more informed in health measures presumably due to more frequent contact with health care? Possible explanations include enhanced awareness and

education targeted at the older age group. Education about the association between obesity and risk of cancer development should target all ages. One is more receptive to information depending on its likeliness of it affecting oneself. Since increased body weight affects earlier than other conditions for which it represents a risk, it may serve to lure a younger population and alarm of its outcomes. Preventive measures must be implemented, starting in childhood without limiting our target on the age group already at risk of developing these conditions. Education efforts should be directed to children, as impact will be greatest if the information is provided at an early age. Understanding the risks from a young age could lead to informed decisions in everyday lives that can change the trend we see today. Children can be reached through educational campaigns in schools as well as through internet applications.

Among women with previous cancer diagnosis, BMI was associated as a predictor of knowledge on the link between obesity and CC. Women without cancer diagnosis showed no statistical differences for the awareness of obesity-BC association between BMI categories. Meanwhile, among women with previous cancer diagnosis, overweight and obese women had elevated odds of having knowledge on the association between obesity and BC as compared to women with normal weight. Awareness of the association between obesity and EC was not related to demographics or BMI in our study. As PCP advise patients to reduce weight to prevent and control EC preceding symptoms of menorrhagia, inter-menstrual spotting, infertility related to increased BMI, emphasis should also be placed in its association to cancer. Because obesity is the most important preventable risk factor for EC development it may serve as warning and motivation for weight reduction.

The main source of information for women with knowledge of obesity-cancer risk association was their PCP in both those with and without cancer history. Women without a cancer history who knew obesity-cancer risk association used the internet as the second most frequent source of information. It is interesting to notice the internet as an important source of information for women who knew the association between obesity-cancer among those with and without a previous cancer diagnosis. Among women with knowledge of obesity-cancer association, those without a previous cancer diagnosis used the internet remarkably more when compared to women with a previous cancer diagnosis. If PCP is followed by the internet as the next most used source of information in women who demonstrated knowledge in this study, an important strategy to discuss is the PCP's presence on the internet. Primary doctors may use social media and/or other available internet outlets for patient and public health education, extending an accurate source of information's reach to a wide variety of persons (especially the younger population).

Educating about cardio-metabolic risks of increased body weight is as important as educating about the increased risk for numerous other women health conditions. This study demonstrates our study population relies mostly on their PCP for health information and therefore are crucial in educating

Table 2. Frequency distribution of the knowledge of Obesity as a Risk for Cancer among women attending the School of Medicine’s Gynecology and Gynecology-Oncology clinics at the University of Puerto Rico, according to women’s characteristics and previous cancer diagnosis (n =234).

Previous Cancer Dx - Yes (n =99)									
Characteristics	Knowledge about Obesity-BC Association n (%) ^a	χ ² test P-values ^b	Adjusted OR ^c (95% CI)	Knowledge about Obesity-BC Association n (%) ^a	χ ² test P-values ^b	Adjusted OR ^c (95% CI)	Knowledge about Obesity-BC Association n (%) ^a	χ ² test P-values ^b	Adjusted OR ^c (95% CI)
<i>Age categories</i>									
< 45 (Ref.)	11 (42.31)	0.14	1.00	14 (53.85)	0.53	1.00	13 (50.00)	0.60	1.00
45-64	22 (48.89)		1.30 (0.49, 3.45)	23 (51.11)		0.90 (0.34, 2.36)	28 (62.22)		1.65 (0.62, 4.42)
≥ 65	19 (67.86)		3.35 (1.00, 11.21)*	18 (64.29)		1.41 (0.44, 4.50)	16 (57.14)		1.81 (0.56, 5.88)
<i>Civil status</i>									
Single (Ref.)	15 (55.56)	0.71	1.00	12 (44.44)	0.63	1.00	15 (55.56)	0.82	1.00
Married/Living with a partner	23 (50.00)		0.72 (0.26, 1.99)	27 (58.70)		1.83 (0.67, 4.96)	28 (60.87)		1.23 (0.45, 3.36)
Divorced/separated	6 (46.15)		0.54 (0.12, 2.33)	8 (61.54)		2.15 (0.49, 9.40)	6 (46.15)		0.61 (0.14, 2.63)
Widowed	8 (66.67)		1.07 (0.21, 5.47)	7 (58.33)		1.46 (0.30, 6.99)	7 (58.33)		1.23 (0.25, 6.00)
Missing values = 1									
<i>Education</i>									
< High school (Ref.)	12 (54.55)	0.83	1.00	14 (63.64)	0.39	1.00	10 (45.45)	0.19	1.00
≥ High school	40 (51.95)		1.45 (0.49, 4.35)	41 (53.25)		0.78 (0.27, 2.28)	47 (61.04)		2.15 (0.73, 6.27)
<i>Annual income</i>									
< \$15,000 (Ref.)	20 (51.28)	0.43	1.00	20 (51.28)	0.29	1.00	21 (53.85)	0.40	1.00
≥ \$15,000	20 (60.61)		2.09 (0.74, 5.92)	21 (63.64)		1.85 (0.68, 5.05)	21 (63.64)		1.69 (0.62, 4.66)
Missing values = 27									
<i>BMI</i>									
Underweight	3 (100.00)	0.04* f	-	0 (0.00)	0.07 f	-	1 (33.33)	0.03* f	1.37 (0.09, 20.85)
Normal weight (Ref.)	5 (33.33)		1.00	6 (40.00)		1.00	4 (26.67)		1.00
Overweight	19 (67.86)		4.71 (1.18, 18.75)*	19 (67.86)		3.65 (0.95, 14.06)	19 (67.86)		5.71 (1.39, 23.38)*
Obese	25 (47.17)		2.17 (0.62, 7.64)	30 (56.60)		2.39 (0.70, 8.13)	33 (62.26)		4.70 (1.28, 17.31)*
Previous Cancer Dx - No (n = 135)									
<i>Age categories</i>									
< 45 (Ref.)	23 (32.39)	0.04*	1.00	28 (39.44)	0.14	1.00	27 (38.03)	0.36	1.00
45-64	21 (46.67)		1.74 (0.80, 3.79)	26 (57.78)		2.24 (1.03, 4.87)*	22 (48.89)		1.51 (0.70, 3.25)
≥ 65	12 (63.16)		3.09 (1.01, 9.48)*	10 (52.63)		2.08 (0.69, 6.26)	10 (52.63)		1.65 (0.55, 4.91)
<i>Civil status</i>									
Single (Ref.)	18 (32.73)	0.16 f	1.00	22 (40.00)	0.43 f	1.00	19 (34.55)	0.34 f	1.00
Married/Living with a partner	27 (47.37)		1.59 (0.72, 3.53)	31 (54.39)		1.58 (0.72, 3.45)	29 (50.88)		1.78 (0.81, 3.90)
Divorced/separated	6 (37.50)		0.89 (0.26, 3.04)	7 (43.75)		1.03 (0.32, 3.37)	8 (50.00)		1.60 (0.50, 5.15)
Widowed	5 (71.43)		2.70 (0.42, 17.29)	4 (57.14)		1.49 (0.26, 8.40)	3 (42.86)		0.99 (0.18, 5.56)
Missing Values									
<i>Education</i>									
< High School (Ref.)	13 (56.52)	0.11	1.00	10 (43.48)	0.68	1.00	12 (52.17)	0.37	1.00
≥ High School	43 (38.39)		0.69 (0.26, 1.83)	54 (48.21)		1.61 (0.60, 4.33)	47 (41.96)		0.79 (0.30, 2.08)
<i>Annual income</i>									
< \$15,000 (Ref.)	15 (42.86)	0.52	1.00	18 (51.43)	0.54	1.00	17 (48.57)	0.18	1.00
≥ \$15,000	21 (36.21)		0.75 (0.31, 1.83)	26 (44.83)		0.70 (0.29, 1.67)	20 (34.48)		0.56 (0.23, 1.36)
Missing Values = 42									
<i>BMI</i>									
Underweight	0 (0.00)	0.46 f	-	0 (0.0)	0.14 f	-	0 (0.00)	0.51 f	-
Normal weight (Ref.)	11 (39.29)		1.00	10 (35.71)		1.00	11 (39.29)		1.00
Overweight	17 (38.64)		0.72 (0.26, 2.00)	21 (47.73)		1.52 (0.56, 4.17)	20 (45.45)		1.14 (0.42, 3.08)
Obese	28 (46.67)		1.07 (0.41, 2.78)	33 (55.00)		1.88 (0.72, 4.90)	28 (46.67)		1.19 (0.46, 3.07)

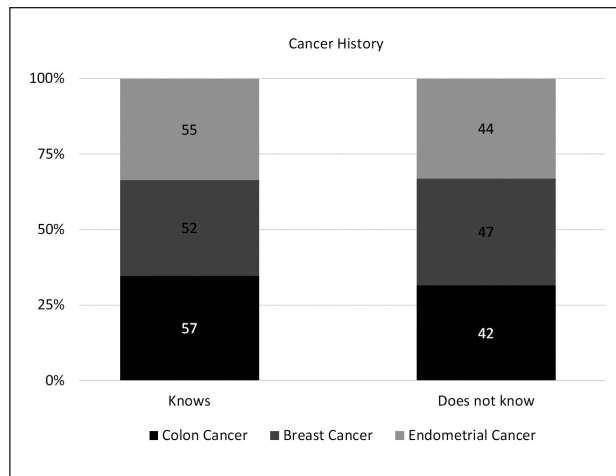


Figure 2. Obesity-cancers risk awareness in participants’ with a previous cancer diagnosis status

patients. Preventive interventions, before reaching increased weight, are needed to educate the public, encouraging healthy lifestyles and potentially increasing knowledge on the existing association between obesity and cancer. Knowledge on obesity’s increased cancer risk empowers patients to advocate for themselves and help reduce healthcare burden.

Limitations/Strengths

This study aimed at assessing the knowledge that Hispanic women living in P.R. had towards obesity as a risk for cancer. A limitation of this study is the homogeneity of the researched population, preventing generalizability, or external validity, in the U.S. and Hispanic population. However, given the higher incidence of obesity among Hispanic women and escalating prevalence of EC in P.R., it was pertinent to determine the baseline understanding this group had to develop an efficient education program.

A high number of patients that opted not to participate may differ from those who did, leading to nonresponse bias. Research volunteers recruited about 8 participants out of 20 or more patients scheduled in a day. Nevertheless, a strength of this study is that self-administered surveys were completed on an individual basis minimizing external influences and verified after completion, limiting unanswered responses. Previous studies have gathered our population’s knowledge of obesity’s risks of infertility, but this is the first performed to evaluate knowledge of its relationship to cancer in P.R.

The clinics from which participants were recruited may have allowed for bias given that many of the participants were from the gynecology-oncology clinic. The questionnaire may have also led to response bias since its title and instructions could have alluded to cancer being associated to obesity.

Further studies should address qualitative aspects of the odds differences in the obesity-cancer link knowledge observed between income categories for women with/without previous cancer diagnoses. Awareness of obesity-related cancer risk may

influence obese women in the population, but its effectiveness has not been studied. Knowledge of increase in cancer risk among obese women might not change their behavior. This study highlights the importance of preventive measures, and the need to educate young and normal weight women.

Conclusion

Obesity and overweight rates have increased at alarming rates in the Hispanic female population living in P.R., influencing the incidence of medical conditions in the Island. Being a modifiable comorbidity, this study assessed the underlying knowledge women have toward the health effects of obesity. Participants knowledge of obesity’s increased cancer risk was limited in nearly half of our study population. Age, BMI and previous cancer diagnosis were found to be associated to awareness of obesity’s relation to EC, BC, and CC respectively. There is a gap in knowledge overall, providing opportunity for public education. We encourage physicians to openly discussing weight status and the risks of obesity as often with overweight and obese patients as with normal weight women. These results can hopefully serve as baseline for future education strategies in the primary care setting aimed at the dissemination of obesity related risk information and subsequent promotion of lifestyle changes.

Resumen

Objetivo: El objetivo principal de este estudio transversal fue evaluar, de acuerdo con el diagnóstico previo de cáncer, el conocimiento que tienen las mujeres puertorriqueñas sobre el vínculo entre la obesidad y el cáncer de endometrio, de mama y de colon, y determinar la fuente de información médica más común en estas mujeres. Métodos: En este estudio transversal, las pacientes elegibles (n=234) de las Clínicas de Ginecología y Ginecología-Oncología completaron una encuesta autoadministrada desde octubre de 2014 hasta marzo de 2016. Las participantes fueron evaluadas en términos sociodemográficos, índice de masa corporal, conocimiento del vínculo obesidad-cáncer, y fuente de información médica. Resultados: Alrededor del 49% y el 31% de las mujeres del estudio eran obesas y tenían sobrepeso, respectivamente. Menos del 52% de las mujeres conocían la relación entre la obesidad y los cánceres de mama, colon y/o endometrio. Las mujeres con diagnósticos previos de cáncer eran más conscientes de la asociación entre la obesidad y el cáncer de colon que las mujeres sin diagnósticos previos de cáncer (58 % frente a 44%, p<0,05); no se encontraron diferencias para el cáncer de mama y de endometrio (p>0,05). Ingresos más altos mostraron mayores probabilidades de conocer el vínculo obesidad-cáncer entre las mujeres con antecedentes de cáncer, pero las probabilidades disminuyeron para las mujeres sin diagnósticos previos de cáncer (p>0.05). Niveles de educación superior mostró una tendencia hacia un mejor conocimiento de la asociación entre obesidad-cáncer. Las fuentes de información más comunes fueron el médico de cabecera (80%) e internet (54%).

Conclusión: Se debe fomentar el asesoramiento sobre los factores de riesgo de cáncer prevenibles a través de la atención primaria a todas las mujeres, especialmente en mujeres jóvenes sanas. Estudios adicionales deben abordar los aspectos cualitativos de las diferencias de probabilidades en el conocimiento del vínculo obesidad-cáncer observado entre las categorías de ingresos para mujeres con o sin diagnósticos previos de cáncer.

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