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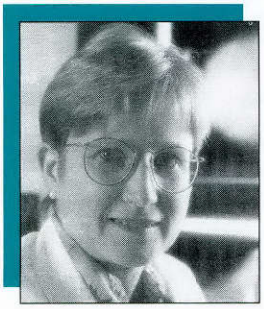
MD ANDERSON
CANCER CENTER

MD Anderson Oncolog

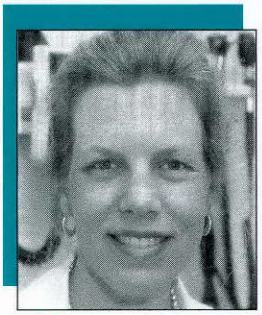
ACS, NCI step up screening recommendations

Breast cancer screening guidelines are reviewed and redefined for women 40 to 49 years old

Prevention Update



Carol B. Stelling, M.D., is medical director of the Breast Diagnostic Clinic and associate medical director of the Nellie Connally Breast Center.



Patricia Spencer-Cisek, M.S., R.N., is manager of the LifeCheq cancer prevention program.

Long a proponent of biennial mammography screening to detect breast cancer in women 40 to 49 years old, M. D. Anderson Cancer Center stepped up its recommendation this spring, joining the American Cancer Society (ACS) in endorsing annual screening for this age group.

Near the same time, the National Cancer Institute (NCI) recommended that women in this age group undergo mammography every one or two years. Between 1993 and 1996 the NCI had not supported screening for women 40 to 49.

"Finally, we have official backup that, yes, screening for women in this younger age group saves lives and is cost-effective," said Patricia Spencer-Cisek, M.S., R.N., manager of M. D. Anderson's LifeCheq cancer prevention program.

The new guidelines offer a haven from the whirlwind caused by the controversial refusal of the National Institutes of Health Consensus Development Conference on Breast Cancer Screening for Women Ages 40–49 to recommend regular mammography screening for these women. Instead, the panel urged women ages 40 to 49 to consult with their physicians in weighing the risks and benefits of mammography, a decision that raised the pitch of an already emotion-charged issue to an all-time high. (One scientist labeled it "tantamount to a death sentence.") Two of 12 panel members dissented from the majority's opinion.

"The basis for the controversy was the fact that, historically, there was no scientific proof that regular screening of women age 40 saved lives," said Dr. Carol B. Stelling, medical director of the Breast Diagnostic Clinic and associate medical director of the Nellie Connally Breast Center.

Because there was no study specifically designed to address the efficacy of screening in women age 40 to 49, statisticians performed meta-analyses of existing data. Over time, the results have shown a trend toward decreased mortality in women who begin regular screening in their 40s.

"These trends normally take a while to observe," according to Dr. Stelling, "because although the cancer may be identified early on, the death rate may not change in that group for many years. It may actually take 10 to 15 years to begin noticing a benefit from screening. Recently, however, the analyses have shown within standard statistical parameters that the breast cancer death rate has fallen 30 percent among women in their 40s who have regular mammography screening."

Experts have known for many years that regular screening after age 50 saved lives. "Available data show that the death rate from breast cancer decreases about 30 percent among women over age 50 who have regular mammograms compared with women in this age group who do not have mammograms," Dr. Stelling said. Both ACS and NCI recommend annual screening for women 50 years of age and older. According to the National Center for Health Statistics, 60% of American women age 40 to 49, 65% of women age 50 to 64, and 54% of women age 65 and above have had mammograms in the past two years.

"We know that the cancer detection rate increases as women grow older, but the evolution is gradual, rather than suddenly erupting at age 50," explained Dr. Stelling. "We also know that tumors in younger, premenopausal women are sometimes more aggressive: they grow faster than many cancers in older women. These factors clearly suggest that screening women in their 40s will provide us a better chance of detecting cancer early enough to save lives in this age group as well."

Though the risks of radiation exposure are of concern to physicians, even the consensus panel that failed to recommend regular screening for women 40 to 49 said that risk is minimal.

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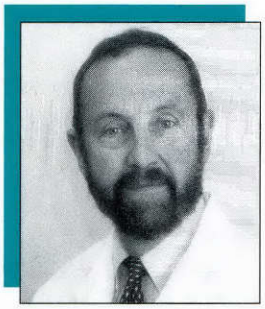
Pain research group strives to improve assessment and treatment in patients with metastatic cancer

Pain management



Charles S. Cleeland, Ph.D., is director of the Pain Research Group.

Xin Shelley Wang, M.D., is a research scientist in the Pain Research Group.

"Look, I've been taking care of cancer patients for forty years. I know about pain." Thus speak oncologists and other physicians to Charles S. Cleeland, Ph.D., whose Pain Research Group (PRG) takes its findings out of the laboratory and into hospitals from Boston to Beijing.

By giving experienced physicians new understanding about drug use and dependence, adding validated pain assessments to their tools, and demonstrating the effect of more aggressive pain management, PRG investigators are improving cancer pain management practice.

"When they see the dramatic change in their patients," Cleeland said in a recent interview, "they are convinced."

Cleeland believes that inadequate assessment results in inadequate analgesia, and he is not alone. The 1990 National Cancer Institute's Workshop on Cancer Pain concluded that the undertreatment of pain and other symptoms related to cancer amounted to a "serious and neglected public health problem." Oncologists also know this, said Cleeland, who has worked in the field of cancer pain for 20 years.

The PRG joined the Section of Pain and Symptom Management of M. D. Anderson Cancer Center's Department of Neuro-oncology last year from the University of Wisconsin in Madison. It uses the Brief Pain Inventory, a two-page questionnaire employing a zero-to-10 scale, as the basis for treatment.

The assessment tool gives patients a way to describe their pain, recognizes its importance by formalizing the assessment, and provides physicians with an objective measure. "The scale is very helpful in that the patient isn't forced into figuring out the words for the pain," Cleeland said.

The form seeks information across time, asking about pain "right now," "today," "the last 24 hours," and about relief obtained with medication (from zero, or no, relief to 100%, complete relief). It also seeks to identify how much pain interferes with function (e.g., work, mood, social relations, sleep). The federal Public Health Service's Agency for Health Care Policy and Research recommends such a scale or ones similar to it. Cleeland says the scale from the BPI is now employed routinely in charting at some hospitals, and if a patient has pain of 5 or greater, it is reported to the supervisor. In the clinic, physicians employ a long version of the pain inventory, but according to Cleeland, physicians in private practice benefit from employing the zero-to-10 scale, even with one question from the inventory.

Cleeland emphasizes that the important thing is not just to chart severe pain but to do something about it. Through their work, members of the PRG have seen the first oral administration of morphine in Mexico and the first sustained-release opioid analgesics administered in China. This year cooperative research will take PRG back to China for the eighth time and for the first time to Japan, where morphine use is still a fraction of what is prescribed in other developed countries. Undertreatment of pain and patient resistance to opiods results often from a fear of addiction, but research indicates that risk of such addiction is virtually nonexistent in cancer pain treatment.

The PRG's international work began in Vietnam in 1987 when it collaborated on a World Health Organization (WHO) project. Recognizing that advanced cancer treatments would not be available in many parts of the world, WHO focused at that time on cancer prevention, early detection, pain relief, and, where feasible, surgical intervention, according to Cleeland.

The PRG's work in China demonstrates the collaboration necessary to bring practical applications of their work to patients. In 1992, two years after WHO had first introduced to China its approach to cancer pain, PRG, working with WHO and the Beijing Bureau of Public Health, jointly sponsored a symposium on cancer pain and palliative care in Beijing. Since that time, PRG, at the invitation of China's Ministry of

3. Please rate your pain by circling the one number that best describes your pain at its worst in the last 24 hours.										
0 No Pain	1	2	3	4	5	6	7	8	9	10 Pain as bad as you can imagine

This sample question from the Brief Pain Inventory asks patients to rate their worst pain in the last 24 hours.

Health, organized five national training seminars, distributed geographically and attended not only by rank-and-file physicians but also by other opinion leaders—public health officials, drug regulators, hospital administrators, and heads of nursing departments.

In its "train-the-trainer" programs, PRG brings physicians into a hospital where they are introduced to PRG's assessments and protocols and then they assess, treat, and follow patients in pain for eight to ten days, an experience that defeats many old myths and builds new confidence in aggressive treatment. In addition, PRG must work cooperatively with government regulators, drug manufacturers, and importation officials. M. D. Anderson physicians Richard Payne, chief of the Section of Pain and Symptom Management, and Stratton Hill, both of the Department of Neuro-Oncology, have participated with PRG in China as trainers.

Beijing oncologist Xin Shelley Wang, M.D., joined PRG after directing a pain study at three Beijing cancer hospitals, together having almost one thousand beds. Besides conducting research and training physicians, she has also supervised the translation of the U.S. government's clinical practice guideline *Management of Cancer Pain* into Chinese, a book that PRG employs as a textbook in its Chinese seminars and whose use is endorsed by the Chinese Ministry of Health. (Copies of the 257-page *Management of Cancer Pain* are available in English at no charge by calling the National Cancer Institute's Cancer Information Service toll free at 1-800-4-CANCER.)

Research PRG has performed indicates that pain thresholds are similar across cultures and that pain is not magnified or diminished according to cancer site. What is important, according to Cleeland, is the jump in pain (approximately a tripling) patients experience when their cancers metastasize. That is why the PRG focuses its work on patients with solid tumors that have metastasized.

In a study of 1308 patients PRG researchers performed with the Eastern Cooperative Oncology Group, they found that despite having taken analgesia, 42 percent of patients were inadequately treated. Patients at clinics serving primarily blacks and Hispanics were more likely to be undertreated than were patients in other settings. Others whose undertreatment was statistically significant were patients who were 70 years or older, women, and those patients whose physician's perception of their pain was most discrepant from theirs.

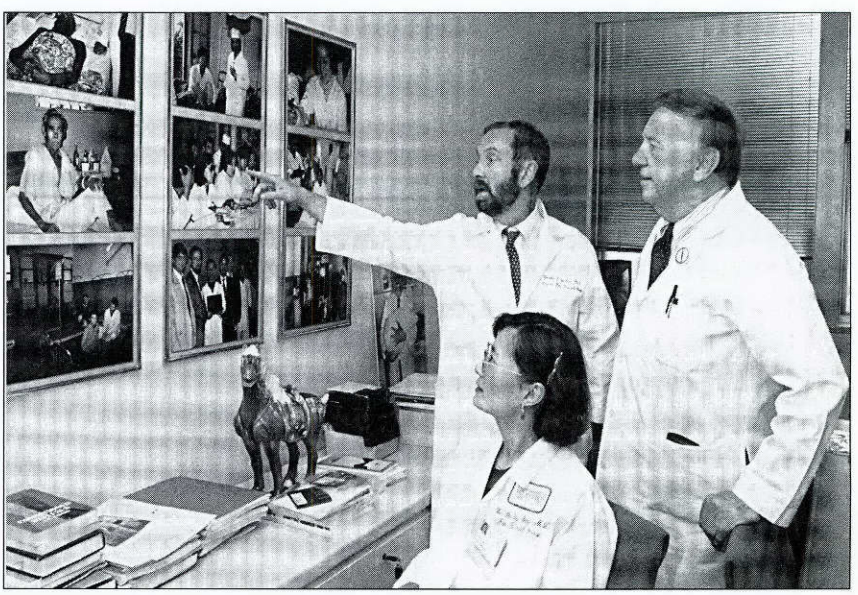
Some clinical studies are ongoing through the Eastern Cooperative Oncology Group, and Dr. Wang anticipates initiating new clinical studies at Anderson soon. Extending beyond cancer, their assessments and approaches have been used in France and the United States for patients with acquired immunodeficiency syndrome. The Brief Pain Inventory has been translated into Spanish, French, Japanese, Italian, Hindi, Vietnamese, and Scandinavian languages. A German version is being developed.

Laboratory studies include work in collaboration with the Department of Diagnostic Radiology (with Karen Anderson, Ph.D., Edward Judsson, Ph.D., and Norman Leeds, M.D.) investigating functional magnetic resonance imaging as a way to observe change quickly. In addition PRG is studying the effect of analgesics on normal subjects and the use of behavioral interventions, such as distraction, relaxation, and imagery, as supplementary ways to manage pain.

But Cleeland sees PRG's laboratory and clinic as virtually borderless. "We have some idea of what the problems are," he said, "and we can test potential solutions out in other countries as well as the United States." He points at the opportunities to observe changes in practice and stages in the acceptance of pain relief. "It is almost," he said, "like a world laboratory."

—Beth W. Allen

Contact Dr. Cleeland or Dr. Wang at the Section of Pain and Symptom Management, Department of Neuro-Oncology (Box 100), 1515 Holcombe Boulevard, Houston, Texas 77030, or call (713) 745-3470.■



Dr. Charles S. Cleeland points to a photograph depicting the Pain Research Group's work abroad. With him are Dr. Stratton Hill and Dr. Xin Shelley Wang.

Free Project S.A.F.E.T.Y. kit teaches basic ray-wise ways

Taking the message of skin cancer prevention to children in their early years when skin protection habits are first learned is an award-winning video and a five-lesson classroom guide produced by The University of Texas M. D. Anderson Cancer Center.

"Project S.A.F.E.T.Y. (Sun Awareness for Educating Today's Youth) for Elementary Schools: Killer Tans," the third in a series of projects meant to teach skin cancer awareness to young people, is available free to any Texas school that requests it. Physicians may want to alert their neighborhood schools to the project's availability.

The video, "Killer Tans," recently received national acclaim by being named a finalist in the American Medical Association's 1996 International Health and Medical Film competition. No other film produced in Texas received that honor. "Killer Tans" was also a silver medal winner in the Houston International Film Festival's 1996 WorldFest Houston.

Most important, the video has been critically acclaimed by Texas educators who realize the need for better information about skin cancer. The evidence of their acceptance of "Killer Tans" lies in the more than 3,000 requests for the video submitted by Texas elementary schools.

"The success of the program is unprecedented," said Michael Ahearn, Ph.D., M. D. Anderson Cancer Center associate vice president for academic affairs. "It is very encouraging that the state educational community has taken such an interest in this important program. With the intense ultraviolet radiation that we experience in Texas, it is especially important to begin educating people about the risks of sun exposure at the earliest possible age."

The startling rise in skin cancer incidence over the past decade—about 4 percent annually—emphasizes the need for skin cancer education, Dr. Ahearn said. With ultraviolet radiation on the increase in Texas, the prevention measures spelled out in "Killer Tans" could turn out to be lifesaving measures.

"A person who gets three or more blistering sunburns during the adolescent years increases their lifetime risk for developing melanoma by two to five times," Ahearn said. "This is especially significant since melanoma is the deadliest form of skin cancer."

The Project S.A.F.E.T.Y. series began in 1994 with "Tan Lines," a video for high school students. The second in the series was "Sun Spots," a 1995 video for middle school students. Project S.A.F.E.T.Y. continues today with a video for parents of very young children called "Protect Your Child from the Sun," which is the first cancer prevention program of its kind to be translated into Spanish. Released in April, this five-minute video was shown in a continuous loop in clinical waiting rooms throughout Texas in conjunction with "Shots across Texas," a statewide immunization drive aimed at children up to two years old. Dr. Ahearn said that about 100,000 information packets containing brochures and sunscreen samples were given out during that drive.

"Killer Tans" takes a well-rounded approach to teaching children about skin cancer prevention. The video is accompanied by a kit containing a teaching guide and classroom exercises. The latter includes a "family tree" that lets students examine their family history for evidence of skin cancer.

Project S.A.F.E.T.Y. is available to schools outside Texas for $65 plus $4.50 for shipping and handling. Call (713) 745-1205 or see the Project S.A.F.E.T.Y. World Wide Web home page at www.mdanderson.org/~safety/ for more details about the program.

—Don Norwood

Patient education

The M. D. Anderson *Oncolog* offers in this issue for the first time a patient education sheet that physicians may feel free to copy and pass along to their patients. (See facing page.) Skin cancer is a threat whose main cause—repeated overexposure to the sun—is controllable. Summertime is a time when taking control is especially important, and no one is too old or too young to learn the proper way to protect skin from the sun's damaging rays.

In future issues, *Oncolog* will publish patient information sheets on various cancer topics all meant to help you, *Oncolog*'s physician-readers, better serve your patients.

Patient education

Skin cancer: Reduce risk, promote early detection

The commonest of all cancers, skin cancer affects almost a million people each year in the United States. In 1997, the American Cancer Society predicts 900,000 cases of basal and squamous skin cancer will be diagnosed along with 40,300 cases of melanoma, the deadliest of all skin cancers. Skin cancer is being diagnosed more and more frequently, and lifetime risk of melanoma is expected to rise to one in every 90 persons by the year 2000. Contributing to this rise is the aging of the Baby Boom generation. Fifty is the average age for first diagnosis of skin cancer, and every day in 1997, 10,000 people will turn 50 years of age in the United States.

In Texas, where about 75% of all daylight June through August is sunny, keeping the brimmed hat and the long-sleeved shirt handy is recommended. Avoiding the sun when its rays are strongest (between 10 A.M. and 3 P.M.) and using a sunscreen with a sun protection factor of 15 are excellent protective measures. Children in particular need sunscreen protection because of their vulnerability to the sun's rays and their high level of outdoor activity.

Risk factors

Repetitive overexposure to sunlight causes most cases of skin cancer. This means that those whose vocations put them in the sun daily and those whose avocations expose them to heavy doses of sunlight are most at risk. Heavy exposure early in life—a blistering sunburn before age 18—is coupled with higher risk of melanoma, the most deadly form of skin cancer. In Texas, skin cancer appears more frequently in men than in women.

Having fair skin, light hair (red, blond, or light brown), and light-colored eyes (blue, green, hazel, or gray) also increases risk of skin cancer. This makes those of Irish or Scottish descent at higher risk. Incidence of melanoma in whites was more than six times that in Hispanics in Texas in recent years, and incidence in African-Americans is about one-twentieth that in whites.

Characteristics that may put someone in the category of higher risk include having a personal or family history of skin cancer, a history of X-ray treatment for skin conditions, birthmarks greater than seven inches, or burn scars. If a family member has melanoma, other family members should step up surveillance because their risk is increased.

Warning signs

Warning signs that should prompt inspection by a physician include a mole whose color, shape, or border changes or a sore, blemish, or other crusty skin irregularity that fails to heal and disappear. Melanomas often appear within moles, but they transform the single-color regularly shaped skin marks into larger, irregular shapes with bumpy and sometimes scaly interiors. They sometimes look like a cluster of irregular moles. Their color is also irregular, mottled with shades of brown, black, and red.

Unlike melanomas, squamous cell carcinomas appear as red nodules or sometimes red crusty patches; like melanomas, they can metastasize. Look for them near ears and on the face, especially near the mouth. Basal cell carcinomas are generally white, gray, or pearl-colored, but sometimes pink or red. These slow-growing tumors, which do not metastasize, appear most often on the head, neck, or hands.

The method of self-examination below, recommended by the American Cancer Society, will help detect any suspicious areas early. Basal and squamous skin cancers are highly curable. The five-year survival rate for melanoma detected before it spreads to other parts of the body is 95%, but it falls for regional and distant disease.

For more information about cancer treatment or services, call the M. D. Anderson Information Line: (713) 792-6161 or (800) 392-1611.

Monthly self-examinations boost prevention

Experts recommend that you examine your own skin routinely once a month. Try to integrate the examination into a normal time when you are undressed, such as before or after showering or when changing clothes to go to bed. Before you begin, make sure you have a stationary mirror, a hand mirror, and good lighting. What you are looking for are new sores or irregularities on the skin or any sore that has persisted for more than three weeks. You should also examine familiar moles, freckles, and birthmarks for any changes.

1. Take a general look at both front and back and both sides with arms raised.
2. Examine the top and underside of your arms. Raise you hands over your head. Include examination of your palms.
3. Inspect the backs of your legs, the skin webs between your toes, and the soles of your feet.
4. Use the hand mirror to look at the back of your scalp, your neck, your back, and your buttocks. Using a blow dryer or a brush or parting your hair with your fingers will help in examining the scalp.

Oncolog Survey

Indicate the degree of your interest in the following topics by circling the corresponding number.

1. Impact of cancer on your geographic region

1 2 3 4 5 6 7 8 9 10
Not at all Very much

2. Cancer prevention and detection

1 2 3 4 5 6 7 8 9 10
Not at all Very much

3. Interpretive articles about research covered by the mass media

1 2 3 4 5 6 7 8 9 10
Not at all Very much

4. One- or two-paragraph news stories about cancer treatment or research

1 2 3 4 5 6 7 8 9 10
Not at all Very much

5. Ethical issues related to cancer care

1 2 3 4 5 6 7 8 9 10
Not at all Very much

6. Case reports including workup, staging, and treatment selection

1 2 3 4 5 6 7 8 9 10
Not at all Very much

7. Patient education sheet that could be photocopied and passed to patients

1 2 3 4 5 6 7 8 9 10
Not at all Very much

8. Treatment protocols at M. D. Anderson

1 2 3 4 5 6 7 8 9 10
Not at all Very much

Rank the following within each column (1 = Most important).

__Brevity of articles
__Timeliness of articles
__Depth of reporting

__Relevance to general practice
__Relevance to patient
__Relevance to practice at Anderson

__Understanding oncology practice in general
__Understanding Anderson's approach to treatment

Circle one of the options to complete the following sentences.

I **do** / **do not** currently read *Oncolog.*
I **do** / **do not** think that pharmaceutical sponsorship diminishes a newsletter's authority.
I **would** / **would not** be willing to pay for a subscription to *Oncolog.*

Complete the following sentences by filling in the blank.

The cancer-related topic I am most interested in is _____.

My favorite periodical for cancer information is _____. 422A

Return your survey to Oncolog Survey, Scientific Publications, Box 234, M. D. Anderson Cancer Center, 1515 Holcombe Boulevard, Houston, Texas 77030. Or fax it to (713) 794-1370.

Survey, changes to update Oncolog

Oncolog, published as a service to physicians for more than 40 years, will be undergoing transformation from a quarterly to a monthly publication over the summer. Understanding your interests is crucial to publishing a vital, robust periodical. So do us a favor, and we'll do one for you. Fill out the survey on the left and return it in an envelope with your return address, and we'll send you a copy *of M. D. Anderson's Road Map to Cancer Prevention,* a new colorful and concise award-winning guide to reducing cancer risk. Mail it to Oncolog Survey, Scientific Publications, Box 234, M. D. Anderson Cancer Center, 1515 Holcombe Boulevard, Houston Texas 77030. Or you can add your name and address to the bottom of the survey, and fax it to (713) 794-1370. This is the first of an ongoing effort to serve you better by understanding your needs and interests. You can also e-mail comments to oncolog@www.mdacc.tmc.edu. We look forward to hearing from you.

—The Editors

Screening frequency should increase with risk: Applying the 10-year rule

Having a first-degree relative (mother, sister, or daughter) with breast cancer places a woman at a higher-than-average risk for breast cancer and sometimes at a younger age. To help these women determine when to begin screening, M. D. Anderson uses the 10-year rule: begin screening 10 years before the age at which the blood relative was diagnosed, but not before 30 years.

Dr. Carol Stelling, medical director of the Breast Diagnostic Clinic and associate medical director of the Nellie Connally Breast Center at M. D. Anderson Cancer Center, explains: "For a 29-year-old woman whose mother was diagnosed with breast cancer at age 52, it would be reasonable to begin screening at age 40—about 10 years earlier than the mother's age at diagnosis. If, for example, a woman has a sister who was diagnosed with breast cancer at age 38, we would recommend that she begin annual mammography at age 30."

If the 29-year-old woman's only familial association with breast cancer was a grandmother who was diagnosed at age 65, Dr. Stelling said, she would be advised to begin screening at the regular age of 40. "The grandmother's case may have been sporadic rather than genetically linked, so no special risk is indicated," according to Dr. Stelling.

This woman would, however, be advised to perform regular self-examinations and to have clinical breast examinations annually. When should self-examinations begin? "We recommend that women begin examining their own breasts as older teenagers or young adults," said Dr. Stelling. "It is never too early to become familiar with one's normal body in order to be better prepared to detect a change as one gets older. Fortunately, a breast mass in women less than age 30 is most often a benign process," she said.

—Vickie J. Williams

Breast cancer facts

- The overall age-adjusted breast cancer incidence rate for 1992 per 100,000 women was 110.6. It was higher in white women (113.1) than for black women (101.0). Nonetheless, in women younger than 70 years of age, black women were more likely to die of breast cancer than were white women.

- Between 1973 and 1992 breast cancer incidence increased in the United States by 34%, but the breast cancer death rate declined between 1989 and 1992. Earlier diagnosis and improved treatment, according to the federal government, were responsible in part for the decline.

Mammography participation rises 1987–1993

Percentage of Women in the United States Having a Mammogram 1987–1993 by Ethnic Group, Age, and Economic Status

Age and Year	White	Black	Hispanic	All Women below Poverty Line
Age 40–49 yr				
1987	34.3	27.9	15.3	19.0
1990	57.0	48.4	45.1	33.2
1993	61.6	55.6	52.6	37.3
Age 50–64 yr				
1987	33.6	26.4	23.0	14.5
1990	58.1	48.4	47.5	25.6
1993	66.2	65.5	59.2	46.8
Age ≥65 yr				
1987	24.0	14.1	13.7	13.4
1990	49.8	39.7	41.1	28.0
1993	54.7	56.3	36.7	41.0

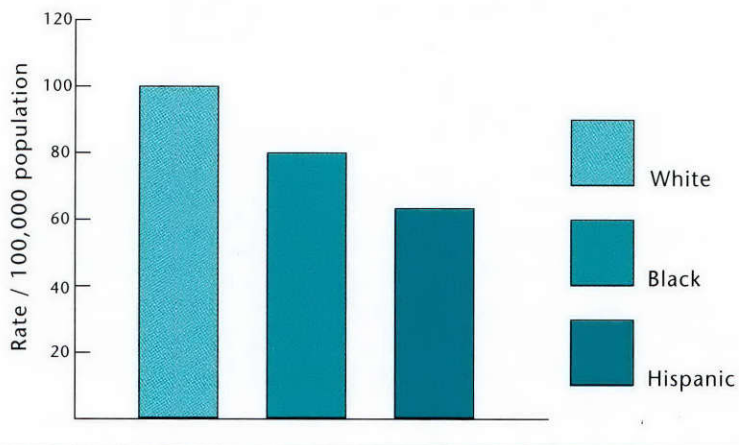
SOURCE: Center for Health Statistics, 1995.

Between 1987 and 1993, the percentage of women in the United States having a mammogram grew across the white, black, and Hispanic ethnic groups and among women living below the poverty line within the age groups shown (40 to 49, 50 to 64, and those 65 years or older). Of these groups, the oldest and the poorest (women 65 years or older living below poverty status) had the lowest percentage undergoing mammography (13.4% in 1987) and white women, age 50 to 64 years, had the highest percentage (66.2% in 1993). The biggest gain was registered in black women, 65 years of age or older, whose rates almost quadrupled between 1987 and 1993, and participation tripled among older poor women during the same period. Improving early detection is important to black women. Though their rate of incidence has been lower by 12% to 29% than that of white women between 1973 and 1992, they were in 1993 28% more likely to die from breast cancer than were white women, according to the Centers for Disease Control. Medicare began funding mammography screening in 1991.

—BETH W. ALLEN

Breast cancer incidence in Texas

Among women in Texas, incidence of breast cancer was 60% higher for whites than for Hispanics and 25% higher for whites than for blacks between 1985 and 1991. (Adapted from the sixth edition of the *Impact of Cancer on Texas,* 1995, available on the World Wide Web at http://tcdc.mdacc. tmc.edu.)



Dr. Carol Stelling (left), medical director of the Breast Diagnostic Clinic, encourages patients who are 40 years old or more to maintain regular mammography screening to detect breast cancer early: "We at M. D. Anderson feel strongly that the chance of saving lives is greater than the risk of causing harm."

Breast screening redefined

continued from page 1

"Current mammography methods expose women to very low levels of radiation," said Spencer-Cisek. "For women age 40 and beyond, we feel the benefits of screening outweigh the risks associated with radiation exposure. But for a woman under 40, routine mammograms are not recommended."

Some experts have concerns about the consequences of false-negative results (delayed treatment), and false-positive results (overtesting and unnecessary anxiety), the psychosocial ramifications of both false-positive and true-positive findings, and the risk of overtreatment in cases in which ductal carcinoma in situ (DCIS) is diagnosed. For DCIS cases, Spencer-Cisek sees stepped-up screening as a way to monitor them more closely, which should yield more information about DCIS characteristics.

"We are not certain what percentage of DCIS evolves into invasive cancer. Studies are under way to help us understand the natural history of these growths, which will help us determine whether and when to treat them," she said.

To lower the risk of inaccurate readings and to control unnecessary testing, Spencer-Cisek says it is important for the radiologist to be able to compare a woman's new films to previous films. One way to ensure this, she suggests, is by having mammograms performed in the same mammography center as consistently as possible.

Both ACS in its recommendations and the NIH consensus panel in its statement urged that financial barriers to mammography be removed by having health maintenance organizations or third-party payers assume screening's cost. Proponents of screening the younger age group believe that these short-term costs for prevention will translate into long-term savings.

Dr. Stelling considers the financial responsibility issue a separate debate and not one to be settled on the scientific front. Nonetheless, she points out that the inclusion of a statement regarding who should pay further establishes the importance of early screening.

"The goal of breast cancer screening is to reduce the mortality rate associated with this disease," commented Dr. Stelling. "We at M. D. Anderson feel strongly that the chance of saving lives is greater than the risk of causing harm, and that is why our position has always been that women should begin regular screening mammograms at age 40."

—Vickie J. Williams

Contact Dr. Carol B. Stelling by calling (713) 745-1207 or by writing her in the Department of Diagnostic Radiology, Box 67. You can reach Patricia Spencer-Cisek by calling (713) 792-3011, or by writing her in Clinical Cancer Prevention, Box 236. The street address is M. D. Anderson Cancer Center, 1515 Holcombe, Houston, Texas 77030.■

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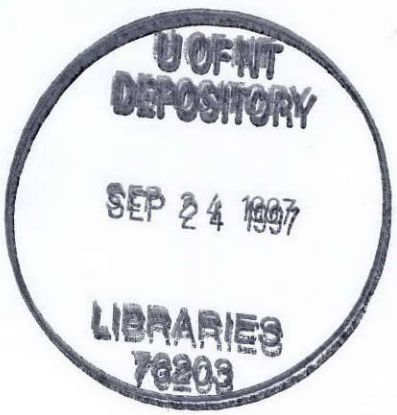

Researcher recommends educational intervention

Hispanics in study lag in breast screening practice

Through a telephone survey in Nueces County, researchers found that Hispanics were less likely than non-Hispanics to have ever had a mammogram (65% vs. 79%, respectively), to have ever had a clinical breast examination (86% vs. 96%), to know how to do a breast self-examination (91% vs. 96%), and to do a breast self-examination monthly (37% vs. 49%).

Cultural beliefs and limited access to health education materials and programs can influence compliance with breast and cervical cancer screening guidelines, according to Guillermo Tortolero-Luna, M.D., Ph.D., of the Department of Gynecologic Oncology at M. D. Anderson Cancer Center. Dr. Tortolero-Luna and colleagues studied differences between Hispanic and non-Hispanic white women in cancer screening practices and in knowledge and attitudes toward cancer.

"We found a lot of misconceptions about recommendations for screening," Tortolero-Luna said. Among women who said they performed breast self-examinations, frequency ranged from seven times a day to 12 times a year. Attitudes toward cancer and illness also differed between the two groups: Hispanics were more likely than non-Hispanics to believe that illness is a matter of fate. Hispanics were also more likely to express fear of getting cancer. After adjusting for sociodemographic factors (age, marital status, education, employment status, and health insurance status), the researchers found Hispanics were still less likely than non-Hispanics to do a breast self-examination monthly.

Dr. Tortolero-Luna recommends education to correct these misunderstandings. "Interventions to increase knowledge about cancer and screening practices are needed among minority women, especially low-income minority women," he said. Both whites ($14,629) and blacks ($8,102) outpaced Hispanics ($6,633) in per capita income in Texas in 1989, according to 1990 census data.

The survey, reported in 1995, included 233 Hispanic and 332 non-Hispanic white women, age 35 years and older in the county whose seat is Corpus Christi. In 1995, Hispanics made up 53.6% of the county's population, whereas in Texas overall, Hispanics accounted for 27.6% of the population. Unlike in the nation at large in 1995, breast cancer in Nueces County accounted for a greater proportion of cancer deaths in Hispanics (8.4%) than in whites (5.4%), according to the Texas Cancer Data Center.

—Sunita C. Patterson