19th Annual Minority Health Conference

COMMUNITIES OF COLOR FIGHTING BACK: OUR ROLE IN THE CANCER CRISIS

February 13 and 14, 1997
Chapel Hill, North Carolina

PROGRAM

Thursday, February 13, 1997

8:00 a.m. **REGISTRATION AND CONTINENTAL BREAKFAST**

9:00 **WELCOME** *Grumman Auditorium*

Sheryl D. Taylor
President, Minority Student Caucus
Master's Student, Department of Health Behavior and Health Education
School of Public Health, University of North Carolina at Chapel Hill

Michel Ibrahim, MD
Dean, School of Public Health
University of North Carolina at Chapel Hill

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Vice Provost for Health Affairs
University of North Carolina at Chapel Hill

Michael Hooker, PhD
Chancellor, University of North Carolina at Chapel Hill

Lumbé K. Davis
Chair, Minority Health Conference
Master's Student, Department of Health Behavior and Health Education
School of Public Health, University of North Carolina at Chapel Hill

9:20 **STATE OF THE STATE**

Delton Atkinson, MPH, Director
State Center for Health Statistics
NC Department of Environment, Health and Natural Resources

9:40 **STATE OF THE NATION**

Brenda Edwards, PhD
Associate Director for Cancer Control, National Cancer Institute
Bethesda, Maryland

10:00 **INTRODUCTION OF KEYNOTE SPEAKER**

James Pierce, Master's/Doctoral Student
Department of Epidemiology, School of Public Health
University of North Carolina at Chapel Hill

KEYNOTE ADDRESS

Gerald Durley, EdD, MDiv, Director
Health Promotion Research Center, Morehouse School of Medicine
Atlanta, Georgia

11:00 **BREAK**

11:15 **CURRENT STATE OF RESEARCH PANEL DISCUSSION**

Moderators: Lovell Jones, PhD, Professor and Director
Experimental Gynecology-Endocrinology
Department of Gynecologic Oncology
M.D. Anderson Cancer Center, University of Texas

Michelle Mendez, Doctoral Student
Department of Epidemiology, School of Public Health
University of North Carolina at Chapel Hill

Prostate Cancer: Fred Stallings, MD, MPH
Medical Epidemiologist, Centers for Disease Control and Prevention
Atlanta, Georgia

Breast Cancer: Otis Brawley, MD
Director, Office of Special Populations
National Cancer Institute, Bethesda, Maryland

Breast Cancer Prevention: Eugenia Eng, MPH, PhD
Associate Professor of Health Behavior and Health Education
School of Public Health, University of North Carolina at Chapel Hill

Jacqueline Smith, Project Coordinator
Save Our Sisters
Wilmington, North Carolina

Survivorship: Jorge L. Obeso, PhD
Project Director, National Hispanic Leadership Initiative on Cancer
University of Miami School of Medicine
Miami, Florida

12:30 p.m. **LUNCH (POSTER PRESENTATIONS)**

1:45 **CONCURRENT SESSIONS**

- **THE PROS AND CONS OF PROSTATE SCREENING** *Grumman Auditorium*

Moderator: Tonya Stancil, MS, Doctoral Student
Department of Epidemiology, School of Public Health
University of North Carolina at Chapel Hill

Pro: Isaac Powell, MD, Associate Professor
Wayne State University School of Medicine
Detroit, Michigan

Con: Paul Godley, MD, PhD, Assistant Professor
Division of Hematology/Oncology
University of North Carolina at Chapel Hill

- **CULTURALLY APPROPRIATE CANCER INTERVENTIONS** *Redbud Room*

Moderator: Angela D. Thrasher, Master's Student
Department of Health Behavior and Health Education
School of Public Health
University of North Carolina at Chapel Hill

Lillian Tom-Orme, PhD
Instructor/Researcher, Huntsman Cancer Institute
University of Utah, Salt Lake City, Utah

Jorge L. Obeso, PhD
Project Director, National Hispanic Leadership Initiative on Cancer
University of Miami School of Medicine
Miami, Florida

- **MIGRANT HEALTH** *Dogwood Room*

Moderator: D.J. McFadden, Master's Student
Department of Epidemiology, School of Public Health
University of North Carolina at Chapel Hill

Miguel Fuentes, Community Services Worker
Drug and AIDS Prevention Among African Americans
Smithfield, North Carolina

Rosamaria Murillo, LMSW
Director of Lay Health Education
National Center for Farmworker Health
Austin, Texas

3:00 **BREAK**

3:30 **CONCURRENT SESSIONS**

- **INCREASING MINORITY PARTICIPATION IN CLINICAL TRIALS** *Dogwood Room*

Moderator: Lamont Bryant, Doctoral Student, Department of Environmental Sciences and Engineering
School of Public Health
University of North Carolina at Chapel Hill

Jerome Wilson, PhD
Vice President for Biostatistics and Data Management
Scirex Biotechnology, Blue Bell, Pennsylvania

Lovell Jones, PhD, Professor and Director
Experimental Gynecology-Endocrinology
Department of Gynecologic Oncology
M.D. Anderson Cancer Center, University of Texas

- **BREAST CANCER** *Grumman Auditorium*

Moderators: Jo Anne Earp, ScD, Professor and Chair
Department of Health Behavior and Health Education
School of Public Health
University of North Carolina at Chapel Hill

Sheryl D. Taylor, Master's Student
Department of Health Behavior and Health Education, School of Public Health
University of North Carolina at Chapel Hill

Research: Harold Freeman, MD
Director, Surgery Department
College of Physicians and Surgeons of Columbia University
Harlem Hospital Center, New York

Early Detection/Screening: Sherry Mills, MD, MPH
Research Scientist
National Cancer Institute
Bethesda, Maryland

- **UNDERLYING ISSUES IN CANCER** *Redbud Room*

Moderator: Diana M. Sierra, MPH, Doctoral Student
Department of Maternal and Child Health
School of Public Health
University of North Carolina at Chapel Hill

Race and Research in Breast Cancer: Robert Millikan, DVM, MPH, PhD
Assistant Professor, Department of Epidemiology
The University of North Carolina at Chapel Hill

Nutritional Issues: Arnette Cowan, MS, RD, LDN
Head, Nutrition Branch, Division of Health Promotion
NC Department of Environment, Health and Natural Resources

4:45 **POSTER PRESENTATIONS** *Atrium*

5:30 **ADJOURN**

6:00 - 8:00 **SOCIAL** *Top of the Hill*

Conference participants are invited to attend a social at Top of the Hill, on the corner of Franklin and Columbia Streets (see the map in your conference packet). Light hors d'oeuvres and soft drinks will be served and a cash bar will be available.

Friday, February 14, 1997

8:00 a.m. **REGISTRATION AND CONTINENTAL BREAKFAST**

9:00 a.m. **COMMUNITY-BASED ORGANIZATIONS PANEL DISCUSSION** *Grumman Auditorium*

Moderators: Marion White, MSPH
Executive Director, Advisory Committee for Cancer Coordination and Control, Division of Health Promotion
NC Department of Environment, Health and Natural Resources

Sohini Sengupta, MPH, Doctoral Student
Department of Health Behavior and Health Education
School of Public Health
University of North Carolina at Chapel Hill

Joseph R. Sanders, Chair
NC Chapter, National Black Leadership Initiative on Cancer
American Cancer Society

Brenda Beatty, MPH, RD, Project Director
Black Churches United for Better Health
NC Department of Environment, Health and Natural Resources

Nelly Taveras, MPH
Clinical Coordinator, NC Primary Health Care Association
Cary, North Carolina

10:15 **BREAK**

10:30 **"FIGHTING BACK" AGENDA SETTING WORKSHOP**

Barbara Pullen-Smith, MPH, Executive Director
Office of Minority Health
NC Department of Environment, Health and Natural Resources

11:45 **CONFERENCE WRAP UP**

William T. Small, MSPH, Associate Dean for Students
School of Public Health
University of North Carolina at Chapel Hill

12:00 p.m. **ADJOURN**

SPEAKER SUBSTITUTION

UNDERLYING ISSUES IN CANCER:
NUTRITIONAL ISSUES
Thursday, February 13
3:30 - 4:45 p.m.

Allyson Ingram, MPH, RD
Nutrition Field Coordinator
Black Churches United for Better Health
Division of Health Promotion
NC Department of Environment, Health and Natural Resources

will be speaking in place of Arnette Cowan

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COMMUNITIES OF COLOR FIGHTING BACK: OUR ROLE IN THE CANCER CRISIS
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SPEAKERS

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Tonya Stancil
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Naviaria "Slim" Evans
Nakeisha Floyd
Olivia Gatei
Demetrius Harvey
Carlotta Lee
Tamelyn Motley
Angela Richardson
Darryl Spruill
Cherice Teal

SPECIAL THANKS TO

Barbara Baylor
George Crawford
Matthew Garvin
Phillip Graham
Rosa Laney
Michelle Mendez
Ted Parrish
John Sharo
Howard Straker
and
The Health Education Club at
North Carolina Central University

Visit our Booth!

University of North Carolina at Chapel Hill

Summer Public Health Research Institute on

MINORITY HEALTH

June 22-27, 1997

The third annual Summer Public Health Research Institute will feature courses designed to improve research methods, policy development, and program planning for minority health. Courses will emphasize issues and solutions related to: collecting, analyzing and interpreting data for racial and ethnic populations; disentangling and assessing the relationship between race and socioeconomic status; identifying and reducing barriers to conducting research in minority communities; and devising surveys to study minority populations and subpopulations.
Researchers, graduate students, postdoctoral fellows, and professionals in federal and local agencies and community organizations are invited to attend. A limited number of scholarships may be available.

- Meet and interact with colleagues who are conducting research on a variety of minority health issues.
- Enjoy topical and stimulating lectures by nationally and internationally recognized researchers and experts.
- Develop various research skills such as scientific writing and grant proposal writing.
- Share your own research ideas with others through informal luncheon discussions and poster sessions.
- See demonstrations of new minority health resources available on the Internet.

Attend the Institute by Videoconference

NEW!

This year the Institute is reaching out to a wider audience by making **selected** live sessions from the program available at various locations through videoconferencing. Toll-free telephone numbers provided during the videoconference will enable local participants to interact with the instructor. An updated list of videoconferencing sites will be maintained at http://www.minority.unc.edu/. **If your institution is interested in serving as a host site, please contact us immediately at 919/966-2248.**

For more information on either program:
Contact: Ms. Shelby Taylor
Phone: 919/966-7012
Fax: 919/966-0119
Email: minority_health@unc.edu
www.minority.unc.edu
Minority Health Project, Department of Biostatistics, CB# 7400, The University of North Carolina at Chapel Hill, Chapel Hill, NC 27599-7400

Sponsors
Department of Biostatistics
Department of Maternal and Child Health
Center for Distance Learning and Health Communications
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In Collaboration With
National Center for Health Statistics/Centers for Disease Control and Prevention
Association of Schools of Public Health
National Institutes for Health
International Telecommunications Consortium

School of Public Health
sph
UNC at Chapel Hill

For more information please stop by our booth in the conference exhibit hall.

I am interested in the Summer Public Health Research Institute on Minority Health. Please send more information on the:

☐ Conference in Chapel Hill
☐ Videoconference

Name _____ Day Phone _____

Affiliation _____ Evening Phone _____

Address _____ Fax _____

City State Zip _____ Email Address _____

Bibliography of Cancer Resources

Books

Altman, Robert with Michael J. Sarg, M.D. ***The Cancer Dictionary***. Facts on File, 1992. (Wait and buy the updated edition due out soon!)

Aureback, Michael, M.D. ***Conversations About Cancer: A Patient's Guide to Informed Decision Making***. Williams & Wilkins, 1996. Written by an oncologist, stresses the importance of the relationship between doctor and patient.

Babcock, Elease. ***When Life Become Precious: A Guide for Loved Ones and Friends of Cancer Patients***. Bantam, 1997. This was written by a cancer counselor.

Baron-Faust, Rita (with physicians of New York University Medical Center and the Kaplan Comprehensive Cancer Center). ***Breast Cancer: What Every Woman Should Know***. Hearst, 1995. Personal narratives also included in this book.

Bertino, Joseph, ed. ***Encyclopedia of Cancer*** (3 vols). Academic, 1996. (This is a fairly technical publication.)

Brenner, David J. ***Making the Radiation Therapy Decision***. Lowell House, 1996. Describes the radiation process and what to expect.

Calhoun, Susan and Jane Bradley. ***Nutrition, Cancer and You: What You Need to Know, and Where to Start***. Addax (due out in May 1997). This book was written by nutritionists for cancer patients who need alternative means of achieving proper nutrition.

Cooper, Geoffrey. ***The Cancer Book: A Guide to Understanding the Causes, Prevention, and Treatment of Cancer***. Jones & Bartlett, 1993. Author is from Harvard Medical School.

Cukier, Daniel, M.D. ***Coping with Radiation Therapy: A Ray of Hope***. Lowell House, 1993. Written by a radiation therapist, book discusses the fears of radiation and describes the purpose and process of the therapy.

Keane, Maureen. ***What to Eat If You Have Cancer: A Guide to Adding Nutritional Therapy to Your Treatment Plan***. Contemporary, 1996. This book was written by a nutritionist and a cancer survivor.

Lang, Susan and Richard B. Patt, M.D. ***You Don't Have to Suffer: A Complete Guide to Relieving Cancer Pain for Patients and Their Families***. Oxford University Press, 1994. This book was written by a cancer pain expert and discusses traditional painkillers as well as other options for relieving pain.

McKay, Judith and Nancee Hirano. ***The Chemotherapy Survival Guide***. new Harbinger, 1993. Written by Oncology nurses, this guide explains chemotherapy.

Zakarian, Beverly. ***The Activist Cancer Patient: How to Take Charge of Your Treatment***. Wiley, 1996. Written by the head of a cancer patient advocacy group.

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COMMUNITIES OF COLOR FIGHTING BACK: OUR ROLE IN THE CANCER CRISIS
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Chapel Hill, North Carolina

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19th Annual Minority Health Conference

Communities of Color Fighting Back: Our Role in the Cancer Crisis

http://icc.bcm.unc.edu

PROGRAM

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February 13-14, 1997
The William and Ida Friday Continuing Education Center
Chapel Hill, North Carolina

SPONSORS

The University of North Carolina at Chapel Hill, School of Public Health
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Division of Maternal and Child Health

The University of North Carolina at Chapel Hill
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Chancellor's Office
Office of the Vice Provost for Health Affairs
North Carolina Health Careers Access Program
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COSPONSORS

North Carolina Department of Environment, Health and Natural Resources
State Center for Health Statistics
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North Carolina Department of Human Resources
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North Carolina Central University
Department of Health Education

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9:00 WELCOME

Grumman Auditorium

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School of Public Health, University of North Carolina at Chapel Hill

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Dean, School of Public Health
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Michael Hooker, PhD
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Lumbé K. Davis
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Master's Student, Department of Health Behavior and Health Education
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Delton Atkinson, MPH, Director
State Center for Health Statistics
NC Department of Environment, Health and Natural Resources

9:40 STATE OF THE NATION

Brenda Edwards, PhD
Associate Director for Cancer Control, National Cancer Institute
Bethesda, Maryland

10:00 **INTRODUCTION OF KEYNOTE SPEAKER**

James Pierce, Master's/Doctoral Student
Department of Epidemiology, School of Public Health
University of North Carolina at Chapel Hill

KEYNOTE ADDRESS

Gerald Durley, EdD, MDiv, Director
Health Promotion Research Center, Morehouse School of Medicine
Atlanta, Georgia

11:00 **BREAK**

11:15 **CURRENT STATE OF RESEARCH PANEL DISCUSSION**

Moderators: Lovell Jones, PhD, Professor and Director
Experimental Gynecology-Endocrinology
Department of Gynecologic Oncology
M.D. Anderson Cancer Center, University of Texas

Michelle Mendez, Doctoral Student
Department of Epidemiology, School of Public Health
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Prostate Cancer: Fred Stallings, MD, MPH
Medical Epidemiologist, Centers for Disease Control and Prevention
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Breast Cancer: Otis Brawley, MD
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Breast Cancer Prevention: Eugenia Eng, MPH, PhD
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Jacqueline Smith, Project Coordinator
Save Our Sisters
Wilmington, North Carolina

Survivorship: Jorge L. Obeso, PhD
Project Director, National Hispanic Leadership Initiative on Cancer
University of Miami School of Medicine
Miami, Florida

12:30 p.m. **LUNCH (POSTER PRESENTATIONS)**

1:45 **CONCURRENT SESSIONS**

- **THE PROS AND CONS OF PROSTATE SCREENING** *Grumman Auditorium*

Moderator: Tonya Stancil, MS, Doctoral Student
Department of Epidemiology, School of Public Health
University of North Carolina at Chapel Hill

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Wayne State University School of Medicine
Detroit, Michigan

Con: Paul Godley, MD, PhD, Assistant Professor
Division of Hematology/Oncology
University of North Carolina at Chapel Hill

- **CULTURALLY APPROPRIATE CANCER INTERVENTIONS** *Redbud Room*

Moderator: Angela D. Thrasher, Master's Student
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Lillian Tom-Orme, PhD
Instructor/Researcher, Huntsman Cancer Institute
University of Utah, Salt Lake City, Utah

Jorge L. Obeso, PhD
Project Director, National Hispanic Leadership Initiative on Cancer
University of Miami School of Medicine
Miami, Florida

- **MIGRANT HEALTH** *Dogwood Room*

Moderator: D.J. McFadden, Master's Student
Department of Epidemiology, School of Public Health
University of North Carolina at Chapel Hill

Miguel Fuentes, Community Services Worker
Drug and AIDS Prevention Among African Americans
Smithfield, North Carolina

Rosamaria Murillo, LMSW
Director of Lay Health Education
National Center for Farmworker Health
Austin, Texas

3:00 **BREAK**

3:30 **CONCURRENT SESSIONS**

- **INCREASING MINORITY PARTICIPATION IN CLINICAL TRIALS** *Dogwood Room*

Moderator: Lamont Bryant, Doctoral Student, Department of Environmental Sciences and Engineering, School of Public Health, University of North Carolina at Chapel Hill

Jerome Wilson, PhD
Vice President for Biostatistics and Data Management
Scirex Biotechnology, Blue Bell, Pennsylvania

Lovell Jones, PhD, Professor and Director
Experimental Gynecology-Endocrinology
Department of Gynecologic Oncology
M.D. Anderson Cancer Center, University of Texas

- **BREAST CANCER** *Grumman Auditorium*

Moderators: Jo Anne Earp, ScD, Professor and Chair, Department of Health Behavior and Health Education, School of Public Health, University of North Carolina at Chapel Hill

Sheryl D. Taylor, Master's Student, Department of Health Behavior and Health Education, School of Public Health, University of North Carolina at Chapel Hill

Research: Harold Freeman, MD
Director, Surgery Department
College of Physicians and Surgeons of Columbia University
Harlem Hospital Center, New York

Early Detection/Screening: Sherry Mills, MD, MPH
Research Scientist
National Cancer Institute
Bethesda, Maryland

- **UNDERLYING ISSUES IN CANCER** *Redbud Room*

Moderator: Diana M. Sierra, MPH, Doctoral Student, Department of Maternal and Child Health, School of Public Health, University of North Carolina at Chapel Hill

Race and Research in Breast Cancer: Robert Millikan, DVM, MPH, PhD
Assistant Professor, Department of Epidemiology
The University of North Carolina at Chapel Hill

Nutritional Issues: Arnette Cowan, MS, RD, LDN
Head, Nutrition Branch, Division of Health Promotion
NC Department of Environment, Health and Natural Resources

4:45 **POSTER PRESENTATIONS**

5:30 **ADJOURN** *Atrium*

6:00 - 8:00 **SOCIAL**

Conference participants are invited to attend a social at Top of the Hill, on the corner of Franklin and Columbia Streets (see the map in your conference packet). Light hors d'oeuvres and soft drinks will be served and a cash bar will be available. *Top of the Hill*

Friday, February 14, 1997

8:00 a.m. **REGISTRATION AND CONTINENTAL BREAKFAST**

9:00 a.m. **COMMUNITY-BASED ORGANIZATIONS PANEL DISCUSSION** *Grumman Auditorium*

Moderators: Marion White, MSPH
Executive Director, Advisory Committee for Cancer Coordination and Control, Division of Health Promotion
NC Department of Environment, Health and Natural Resources

Sohini Sengupta, MPH, Doctoral Student
Department of Health Behavior and Health Education
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Joseph R. Sanders, Chair
NC Chapter, National Black Leadership Initiative on Cancer
American Cancer Society

Brenda Beatty, MPH, RD, Project Director
Black Churches United for Better Health
NC Department of Environment, Health and Natural Resources

Nelly Taveras, MPH
Clinical Coordinator, NC Primary Health Care Association
Cary, North Carolina

10:15 **BREAK**

10:30 **"FIGHTING BACK" AGENDA SETTING WORKSHOP**

Barbara Pullen-Smith, MPH, Executive Director
Office of Minority Health
NC Department of Environment, Health and Natural Resources

11:45 **CONFERENCE WRAP UP**

William T. Small, MSPH, Associate Dean for Students
School of Public Health
University of North Carolina at Chapel Hill

12:00 p.m. **ADJOURN**

- Acknowledgements - all persons whose names are on planning committee
- Special - Lunch
- Sponsorship
- importance of science in what we do; an opportunity to be heard; the right to agree to disagree
- Black church ?
- non-churched
- student diversity

Feb 19-20, 1998

SPEAKER SUBSTITUTION

UNDERLYING ISSUES IN CANCER: NUTRITIONAL ISSUES

Thursday, February 13
3:30 - 4:45 p.m.

Allyson Ingram, MPH, RD
Nutrition Field Coordinator
Black Churches United for Better Health
Division of Health Promotion
NC Department of Environment, Health and Natural Resources

will be speaking in place of Arnette Cowan

19th Annual Minority Health Conference
COMMUNITIES OF COLOR FIGHTING BACK: OUR ROLE IN THE CANCER CRISIS
February 13-14, 1997

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Matthew Garvin
Phillip Graham
Rosa Laney
Michelle Mendez
Ted Parrish
John Sharo
Howard Straker
and
The Health Education Club at
North Carolina Central University

Previous Minority Health Conference Titles and Keynote Speakers

1977
Perspectives on the Health of the Black Populations
Floyd McKissick, JD
President, Soul City Company
Soul City, North Carolina

1978
Health Policy Impacts: On and By Minority Peoples
John L.S. Holloman, MD
Past President
NYC Health and Hospitals Corporation
New York, New York

1979
Reaching Minorities Where They Are: A Challenge to Health Professionals
Bailus Walker, Jr, PhD
Administrator
Environmental Health Administration
Government of the District of Columbia

1980
The Deprivation of Life: Death and Disease in Minority Communities
E. Frank Ellis, MD, MPH
Regional Health Administrator, DHHS, Region V
Chicago, Illinois

1981
Dying for a Job: Health Status of Minorities in the Workplace
George L. Lythcott, MD
Special Assistant to the Surgeon General
U.S. Public Health Service, DHHS
Rockville, Maryland

1982
The Minority Elderly — We're Still Here
Theodore R. Sherrod, MD, PhD
Professor
Department of Pharmacology
University of Illinois at Chicago

1983
Quality Health Care: A Birthright?
Clay E. Simpson, PhD
Director, Division of Disadvantaged Assistance
Bureau of Health Professionals
Health Resources and Services Administration
Hyattsville, Maryland

1984
Fact vs Fiction: Crisis In the Workplace
Aileen T. Compton, PhD
Manager, Health Safety and Environmental Affairs
Research and Development
Smith Kline and French Laboratories
Philadelphia, Pennsylvania

1985
Current Issues In International Health Care Practice
John W. Hatch, DrPH
Professor of Health Behavior and Health Education
School of Public Health
The University of North Carolina at Chapel Hill

1986
Policy Implications for Improving Health In Minority Communities
Charles Cook, MD
Former Chief, Adult Health Section
NC Department of Human Resources
Raleigh, North Carolina

1987
Healthy Lifestyles: Preserving the Public's Health
Jesse F. Williams, MD
Director, Cumberland County Health Department
Fayetteville, North Carolina

1988
Improving Minority Health Status: A Public Health Challenge
Iris Shannon, PhD
Associate Professor
Rush College of Nursing
St. Lukes Medical Center
Chicago, Illinois

1991
Innovative Approaches to Minority Health Issues
Ronald Ferguson, PhD
Associate Professor of Public Policy
The Kennedy School of Government
Harvard University

1992
Beyond the Rhetoric: Developing Solutions to Minority Health Issues
Deborah L. Coates, PhD
Director, Institute for Healthier Babies
March of Dimes Birth Defects Foundation
White Plains, New York

1993
Operation Prevention: Mobilizing Community Action
Spencer Holland, PhD
Director, Center for Educating African-American Males
Morgan State University

1994
Youth and Families of Color: What's Going On?
Linda A. Randolph, MD, MPH
Clinical Professor, Department of Community Medicine
Mt. Sinai School of Medicine
New York, New York

1995
Healthy People of Color 2000: Are We On Track?
David Satcher, MD, PhD
Director, Centers for Disease Control and Prevention
Atlanta, Georgia

1996
Healthy People of Color 2000: Intervention Strategies
Byllye Avery, MEd
Founder and Past President
National Black Women's Health Project
Swarthmore, Pennsylvania

Helen Rodriguez-Trias, MD
President's Commission on Teen Pregnancy
Past President, American Public Health Association

19th Annual Minority Health Conference
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February 13-14, 1997
Chapel Hill, North Carolina

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19th Annual Minority Health Conference
COMMUNITIES OF COLOR FIGHTING BACK:
OUR ROLE IN THE CANCER CRISIS

PROGRAM EVALUATION FORM

1. STATE OF THE STATE

a. The topics were...	Irrelevant	1	2	3	4	5 Very relevant
b. The speaker was...	Boring	1	2	3	4	5 Stimulating
c. Information communicated was...	Useless	1	2	3	4	5 Very useful
d. Time for discussion was...	Too long	1	2	3	4	5 Too short
e. Follow up at future conference...	No interest	1	2	3	4	5 Great interest

2. STATE OF THE NATION

a. The topics were...	Irrelevant	1	2	3	4	5 Very relevant
b. The speaker was...	Boring	1	2	3	4	5 Stimulating
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3. KEYNOTE ADDRESS

a. The topics were...	Irrelevant	1	2	3	4	5 Very relevant
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d. Time for discussion was...	Too long	1	2	3	4	5 Too short
e. Follow up at future conference...	No interest	1	2	3	4	5 Great interest

7. COMMUNITY-BASED ORGANIZATIONS PANEL DISCUSSION

a.	The topics were...	Irrelevant				Very relevant
		1	2	3	4	5
b.	The speakers were...	Boring				Stimulating
	Marion White	1	2	3	4	5
	Joseph Sanders	1	2	3	4	5
	Brenda Beatty	1	2	3	4	5
	Nelly Taveras	1	2	3	4	5
c.	Information communicated was...	Useless				Very useful
		1	2	3	4	5
d.	Time for discussion was...	Too long				Too short
		1	2	3	4	5
e.	Follow up at future conference...	No interest				Great interest
		1	2	3	4	5

8. "FIGHTING BACK" AGENDA SETTING WORKSHOP

a.	The topics were...	Irrelevant				Very relevant
		1	2	3	4	5
b.	The speaker was...	Boring				Stimulating
		1	2	3	4	5
c.	Information communicated was...	Useless				Very useful
		1	2	3	4	5
d.	Time for discussion was...	Too long				Too short
		1	2	3	4	5
e.	Follow up at future conference...	No interest				Great interest
		1	2	3	4	5

9. OVERALL EVALUATION

a.	Overall, I consider this conference...	Poor				Excellent
		1	2	3	4	5
b.	The objectives of this conference were...	Not met				Met
		1	2	3	4	5
c.	My attendance at this conference was...	No benefit				Very beneficial
		1	2	3	4	5
d.	Time for informal discussion was...	Not sufficient				Very sufficient
		1	2	3	4	5
e.	I felt a part of the group...	Never				Always
		1	2	3	4	5
f.	The exhibits were...	Poor				Excellent
		1	2	3	4	5
g.	The poster presentations were...	Poor				Excellent
		1	2	3	4	5
h.	The meeting space at the Friday Center was...	Poor				Excellent
		1	2	3	4	5

THE SCIENTIST EDITORIAL (RELEASE DATE 2/17/97)

Racism Has An Impact On Research And Health Care Policy

By Lovell Jones

Benign neglect, or ignoring an often undesirable situation rather than dealing with it, is an attitude with which minorities are quite familiar. Couple it with politics and racism, and you face a system that has been unresponsive to the educational, research, and health care needs of minorities and the poor in the United States.

Few mainstream research institutions or government agencies have addressed minority health in a proactive manner. Most take a reactive approach--because someone pressures them, or in response to recent laws requiring involvement of women and minorities in clinical trials, or because they are trying to secure additional money targeted for minority health issues. A few institutions, such as the National Heart, Lung, and Blood Institute, have had a true interest in addressing health issues in minority populations.

This is not say that other effective research efforts dealing with minority populations are not taking place. On the contrary, they are. However, most efforts lack a clear focus on minority health issues. As a result, they have been neither culturally competent nor culturally relevant. When the staff of a hospital deals with the health problems of minority patients without the training, insight, or sensitivity needed to approach these individuals, efforts are doomed to failure. You might not see this as racism, but I do.

As a scientist who happens to be a member of a minority group, I am especially concerned about this lasting impact of racism and benign neglect on the health of minorities and the medically underserved. Despite protests to the contrary, minorities who act on this concern are generally stereotyped by some in the scientific community as not being real scientists.

The question is: Can you judge the content of someone's mind when you have already stereotyped him or her on the basis of race? Supreme Court Justice Thurgood Marshall once stated that he had never been anyplace in the U.S. where he had to put his hand up in front of his face to know he was black. He was alluding to the fact that lurking in the minds of many Americans was the idea of the fundamental inferiority of minorities, especially African Americans. This attitude still exists today, even in the areas of health and education.

The discipline of science knows no color. The pursuit of determining a reason for a situation should be not different. Yet when minorities try to address the disparities of one group in relationship to another, it is viewed as affirmative action. Ultimately, this limits the number of
individuals--especially minorities--who investigate these health disparities.

Is this a product of stereotyping and the ultimate value one places on the health of minorities and the medically underserved? In most cases, it is. For example, cancer is a major cause of death in minority populations, yet we know very little about this disease in these populations.

I grew up with science in my blood: My mother was a junior high school science teacher. I was sure that I could prove all of my friends wrong, that both efforts could be performed equally well. Little did I realize the full impact of turning my attention to the health needs of minorities and the medically underserved. However, as Henry David Thoreau wrote: "If one advances confidently in the direction of his dreams, and endeavors to live the life which he has imagined, he will meet with success." Unfortunately, Thoreau did not live in 1990s America. This is not to say that I have not been successful. But the price of success has been one I would not wish on anyone.

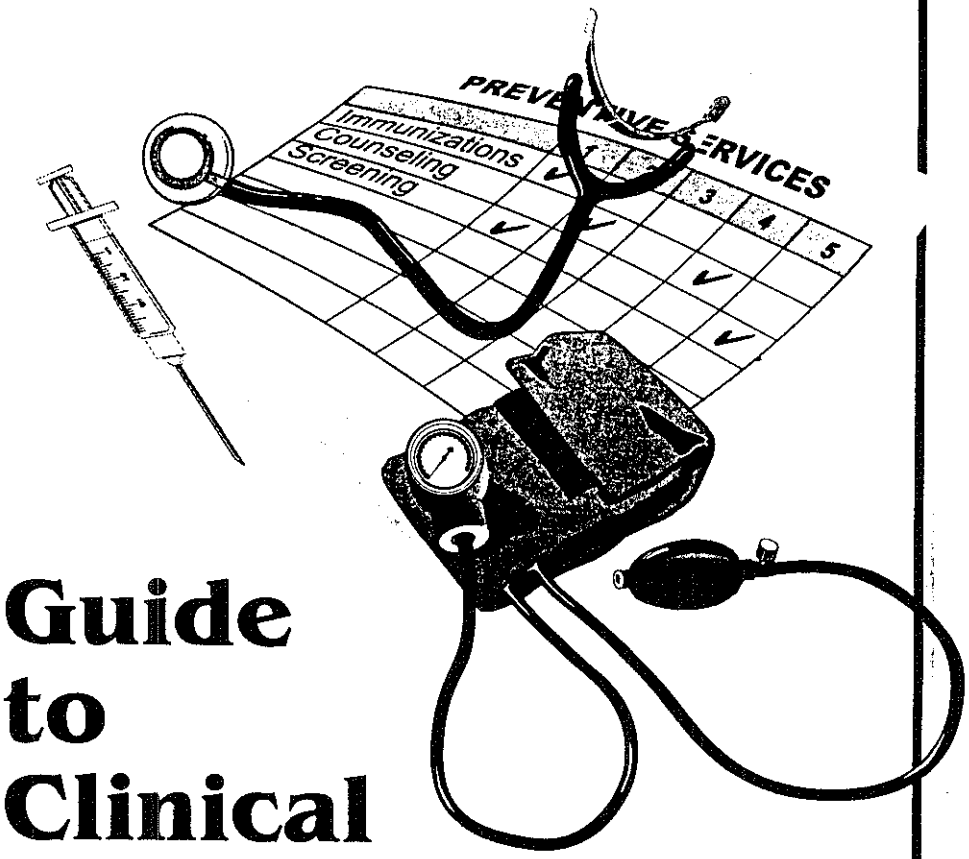
Success for me has had many faces" the opportunity to organize the Biennial Symposium Series (BSS) on Minorities, the Medically Underserved, and Cancer for the past 10 years as well as the recent accomplishments of the Intercultural Cancer Council (ICC). The BSS has become one of the most successful meetings attempting to provide a stage on which to spotlight the disproportionate incidence of cancer morbidity and mortality in minority and medically underserved populations in the U.S. Although in existence for only about 18 months, the ICC has attracted much attention to the issues surrounding cancer and the medically underserved, including coverage in the print media, professional society publications, and the Congressional Record. All of this occurred while I maintained an active and successful basic and clinical research program.

Unfortunately, the successes of the ICC and the BSS have cast a negative shadow over the research program. In 1996 I was nominated and selected by the University of Texas M.D. Anderson Faculty Senate for the Faculty Achievement Award in Cancer Prevention. The perception that soon surfaced was that the award was given because it was the "politically correct" thing to do and not for meritorious accomplishments. This might sound personal; to some extent, it is. However, what happened to me occurs more often to scientists of color than people would like to admit. These indignities, this lack of true recognition, occurs on a daily basis, and discourages many from speaking out and taking a stand.

Risk Attention

The ICC and BSS has been successful because of the unique blend of individuals willing to step forward to speak with one voice. These individuals believe that we all have something to contribute and that together we can make a difference. However, the BSS would not have survived its infancy if two special individuals had not stepped forward to accept part of the risk: Joseph Stewart at Kellogg Co. (ck) and Armin Weinberg, director of the Center for Cancer Control Research at Baylor College of Medicine. They were willing to accept the risk of being labeled as "troublemakers." Unfortunately, few minority scientists are willing to take this risk, and understandably so. Therefore, the system that fails to address the health care needs of their fellow citizens is seldom challenged in an effective manner. The ultimate result is benign neglect.

Benign neglect can be hazardous to your health! For example, a group of African American breast cancer survivors have been interviewed for eligibility for a clinical study. Like my mother, they were well educated middle income individuals and most had had radical or modified radical mastectomies with no follow-up care. This group of women had a large number of their friends with breast cancer die this past year. I don't know if all of the African American breast cancer survivors from this group did not have



Guide to Clinical Preventive Services

Second Edition

Report of the
U.S. Preventive Services
Task Force

10. Screening for Prostate Cancer

RECOMMENDATION

Routine screening for prostate cancer with digital rectal examinations, serum tumor markers (e.g., prostate-specific antigen), or transrectal ultrasound is not recommended.

Burden of Suffering

Prostate cancer is the most common noncutaneous cancer in American men.[1] After lung cancer, it accounts for more cancer deaths in men than any other single cancer site. Prostate cancer accounted for an estimated 244,000 new cases and 40,400 deaths in the U.S. in 1995.[1] Risk increases with age, beginning at age 50, and is also higher among African American men. Because it is more common in older men, prostate cancer ranks 21st among cancers in years of potential life lost.[2] The age-adjusted death rate from prostate cancer increased by over 20% between 1973 and 1991.[3] The lifetime risk of dying from prostate cancer is 3.4% for American men.[3] The reported incidence of prostate cancer has increased in recent years by 6% per year, a trend attributed to increased early detection efforts.[4] Because local extension beyond the capsule of the prostate rarely produces symptoms, about one to two thirds of patients already have local extracapsular extension or distant metastases at the time of diagnosis.[5] Ten-year survival rates are 75% when the cancer is confined to the prostate, 55% for those with regional extension, and 15% for those with distant metastases.[6] The potential morbidity associated with progression of prostate cancer is also substantial, including urinary tract obstruction, bone pain, and other sequelae of metastatic disease.

Accuracy of Screening Tests

The principal screening tests for prostate cancer are the digital rectal examination (DRE), serum tumor markers (e.g., prostate-specific antigen [PSA]), and transrectal ultrasound (TRUS). The reference standard for these tests is pathologic confirmation of malignant disease in tissue obtained by biopsy or surgical resection. The sensitivity and specificity of screening tests for prostate cancer cannot be determined with certainty, however, because biopsies are generally not performed on patients with negative screening test results. False-negative results are unrecognized un-

less biopsies are performed for other reasons (e.g., abnormal results on another screening test, tissue obtained from transurethral prostatic resection). The resulting incomplete information about the number of true- and false-negative results makes it impossible to properly calculate sensitivity and specificity. Only the positive predictive value (PPV)—the probability of cancer when the test is positive—can be calculated with any confidence.

Even the PPV is subject to uncertainty because of the inaccuracies of the usual reference standard. Needle biopsy, the typical reference standard used for calculating sensitivity and specificity, has limited sensitivity. One study suggested that as many as 19% of patients with an initially negative needle biopsy (but abnormal screening test results) had evidence of cancer on a second biopsy.[7] Moreover, studies vary in the extent to which the gland is sampled during needle biopsy. Recent studies, in which larger numbers of samples are obtained from multiple sections of the gland, provide a different reference standard than the more limited needle biopsies performed in older studies. These methodologic problems account for the large variation in the reported sensitivity, specificity, and PPV of prostate cancer screening tests and the current controversy over their true values.

DRE is the oldest screening test for prostate cancer. Its sensitivity is limited, however, because the examining finger can palpate only the posterior and lateral aspects of the gland. Studies suggest that 25–35% of tumors occur in portions of the prostate not accessible to the examining finger.[8] In addition, Stage A tumors, by definition, are nonpalpable. Most recent studies report that DRE has a sensitivity of 55–68% in detecting prostate cancer in asymptomatic men,[9,10] but values as low as 18–22% have also been reported in studies using different screening protocols.[11,12] The DRE also has limited specificity, producing a large proportion of false-positive results. The reported PPV in asymptomatic men is 6–33%[10,13–15] but appears to be somewhat higher when performed by urologists rather than by general practitioners.[16]

Elevations in certain serum tumor markers (e.g., PSA and prostatic acid phosphatase) provide another means of screening for prostate cancer. In screening studies, a PSA value greater than 4 ng/dL has a reported sensitivity of over 80% in detecting prostate cancer in asymptomatic men,[10] although a sensitivity as low as 29% has also been reported in studies using different screening protocols.[11] Prostatic acid phosphatase has a much lower sensitivity (12–20% for Stage A and B disease) and PPV (below 5%) than PSA,[17] and its role in screening has largely been replaced by PSA. PSA elevations are not specific for prostate cancer. Benign prostatic conditions such as hypertrophy and prostatitis can produce false-positive results; about 25% of men with benign prostatic hypertrophy (BPH) and no malignancy have an elevated PSA level.[18]

In most screening studies involving asymptomatic men, the reported

PPV of PSA in detecting prostate cancer is 28–35%.[10,19–21] In many instances, however, other screening tests (e.g., DRE) are also positive. The PPV of PSA when DRE is negative appears to be about 20%.[22] It is unclear whether the same PPV applies when screening is performed in the general population. Participants in most screening studies are either patients seen in urology clinics or volunteers recruited from the community through advertising. Studies suggest that such volunteers have different characteristics than the general population.[23] For example, in one screening study, 53% of the volunteers had one or more symptoms of prostatism.[10] Since PPV is a function of the prevalence of disease, routine PSA testing of the general population, if it had a lower prevalence of prostate cancer than volunteers, would generate a higher proportion of false-positive results than has been reported in the literature. A significant difference in prevalence in the two populations has not, however, been demonstrated.

Several techniques have been proposed to enhance the specificity and PPV of the PSA test. The serum concentration of PSA appears to be influenced by tumor volume, and some investigators have suggested that PSA density (the PSA concentration divided by the gland volume as measured by TRUS) may help differentiate benign from malignant disease.[24–26] According to these studies, a PSA density greater than 0.15 ng/mL may be more predictive of cancer. Other studies suggest that the rate of change (PSA velocity), rather than the actual PSA level, is a better predictor of the presence of prostate cancer. An increase of 0.75 ng/mL or higher per year has a reported specificity of 90% and 100% in distinguishing prostate cancer from BPH and normal glands, respectively.[27] PSA values tend to increase with age, and investigators have therefore proposed age-adjusted PSA reference ranges.[28,29] Current evidence is inadequate to determine the relative superiority of any of these measures or to prove conclusively that any is superior to absolute values of PSA.[30] The most effective method to increase the PPV of PSA screening is to combine it with other screening tests. In a large screening study, the combination of an elevated PSA and abnormal DRE achieved a PPV of 49%. Even with this improved accuracy, however, combined DRE and PSA screening led to the performance of needle biopsies on 18% of the screened population,[10] raising important public policy issues (see below).

A large proportion of cancers detected by PSA screening may be latent cancers, indolent tumors that are unlikely to produce clinical symptoms or affect survival. Autopsy studies indicate that histologic evidence of prostate cancer is present in about 30% of men over age 50. The reported prevalence of prostate cancer in men without previously known prostate cancer during their lifetimes is 10–42% at age 50–59, 17–38% at age 60–69, 25–66% at age 70–79, and 18–100% at age 80 and older.[31–37] Recent autopsy studies have even found evidence of carcinoma in 30% of men aged 30–49.[38] Although patients who undergo autopsy may not be entirely rep-

resentative of the general population, these prevalence rates, combined with census data,[39] suggest that millions of American men have prostate cancer. Fewer than 40,000 men in the U.S. die each year from prostate cancer, however, suggesting that only a subset of cancers in the population are clinically significant. Natural history studies indicate that most prostate cancers grow slowly over a period of many years.[40] Thus, many men with early prostate cancer (especially older men) will die of other causes (e.g., coronary artery disease) before their cancer becomes clinically apparent. Because a means of distinguishing definitively between indolent and progressive cancers is not yet available, widespread screening is likely to detect a large proportion of cancers whose effect on future morbidity and mortality is uncertain.

Recent screening studies have suggested, however, that cancers detected by PSA screening may be of greater clinical importance than latent cancers found on autopsy. Studies of asymptomatic patients with nonpalpable cancers detected through PSA screening have reported extracapsular extension, poorly differentiated cell types, tumor volumes exceeding 3 mL, and metastases in 31–38% of cancers that were pathologically staged.[20,41–43] In a retrospective review of radical prostatectomies performed on patients with nonpalpable prostate cancer detected by PSA screening, 65% had a volume greater than 1 mL, and surgical margins were positive in 26% of cases.[44] In a similar series, the mean tumor volume was 7.4 mL and 30% of the tumors had penetrated the capsule.[45]

The sensitivity of PSA for clinically important cancers was examined in a recent nested case-control study among 22,000 healthy physicians participating in a long-term clinical trial.[46] Archived blood samples collected at enrollment were compared for 366 men who were diagnosed clinically with prostate cancer during a 10-year follow-up period and 1,098 matched controls without cancer. PSA was elevated (>4 ng/mL) in 46% of the men who subsequently developed prostate cancer and 9% of the control group (i.e., sensitivity 46%, specificity of 91%). For cancers diagnosed within the first 4 years of follow-up, the sensitivity of PSA was 87% for aggressive cancers but only 53% for nonaggressive cancers (i.e., small, well-differentiated tumors), suggesting that PSA is more sensitive for clinically important disease. Given the low incidence of aggressive prostate cancer in this study (1% over 10 years), the reported specificity of 91% would generate a PPV (10–15%) that is lower than that reported from studies using routine biopsies (28–35%).[10] Furthermore, this study could not address the central question of whether PSA would have identified aggressive cancers at a potentially curable stage.

TRUS is a third means of screening for prostate cancer, but its performance characteristics limit its usefulness as a screening test. In most studies, TRUS has a reported sensitivity of 57–68% in detecting prostate cancer

in asymptomatic men.[9,10] Because TRUS cannot distinguish between benign and malignant nodules, its PPV is lower than PSA. Although a PPV as high as 31% has been reported for TRUS,[47] its reported PPV when other screening tests are normal is only 5–9%.[15,19] Even when cancers are detected, the size of tumors is often underestimated by TRUS. The discomfort and cost of the procedure further limit its role in screening.

Effectiveness of Early Detection

There is currently no evidence that screening for prostate cancer results in reduced morbidity or mortality, in part because few studies have prospectively examined the health outcomes of screening. A case-control study found little evidence that DRE screening prevents metastatic disease; the relative risk of metastatic prostate cancer for men with one or more screening DREs compared with men with none was 0.9 (95% confidence interval, 0.5–1.7).[48] A cohort study also reported little benefit from DRE screening,[49] but its methodologic design has been criticized. Randomized controlled trials of DRE and PSA screening, which are expected to provide more meaningful evidence than is currently available, are currently under way in the U.S. and Europe.[50] The results of these studies, however, will not be available for over a decade. Therefore, recommendations for the next 10 years will depend on indirect evidence for or against effectiveness.

Indirect evidence that early detection of prostate cancer improves outcome is limited. Survival appears to be longer for persons with early-stage disease; 5-year survival is 87% for Stage A (nonpalpable) tumors, 81% for Stage B (palpable, organ-confined cancer), 64% for Stage C (local extracapsular penetration), and 30% for Stage D (metastatic).[5] Due to recent screening efforts, prostate cancer is now increasingly diagnosed at a less advanced stage. As with survival advantages observed with other cancers, however, it is not known to what extent lead-time and length biases account for differences in observed survival rates (see Chapter ii). The frequently indolent nature of prostate cancer makes length bias a particular problem in interpreting stage-specific survival data. Successful treatment of indolent tumors may give a false impression that "cure" was due to treatment. Prostate cancers detected through screening are more likely to be organ-confined than cancers detected by other means.[20] Proponents of radical prostatectomy often argue that such cancers are potentially curable by removing the gland. As already noted, however, current evidence is inadequate to determine with certainty whether these organ-confined tumors are destined to progress or affect longevity; thus the need for treatment is often unclear.

Even if the need for treatment is accepted, the effectiveness of available treatments is unproven. Stage C and Stage D disease are often incurable, and the efficacy of treatment for Stage B prostate cancer is uncertain. Cur-

rently available evidence about the effectiveness of radical prostatectomy, radiation therapy, and hormonal treatment derives largely from case-series reports without internal controls, usually involving carefully selected patients and surrogate outcome measures for monitoring progression (e.g., PSA levels).[51–55] Although men treated for organ-confined prostate cancer have a normal life expectancy, it is not clear how much their prognosis owes to treatment. The only randomized controlled trial of prostate cancer treatment, which compared radical prostatectomy with expectant management, reported no difference in cumulative survival rates over 15 years, but the study was conducted in the 1970s and suffered from several design flaws.[56,57] Randomized controlled trials to evaluate the effectiveness of current therapies for early disease are being launched in the U.S. and Europe, but results are not expected for 10–15 years.[58,59]

Some observational studies suggest that survival for early-stage prostate cancer may be good even without treatment. A Swedish population-based cohort study of men with early-stage, initially untreated prostate cancer found that, after 12.5 years, 10% had died of prostate cancer and 56% had died of other causes. The 10-year disease-specific survival rate (adjusted for deaths from other causes) for the study population was 85%. Cancer-related morbidity was significant, however. Over one third of the cancers progressed through regional extension, and 17% metastasized. The patient's age and the tumor stage did not significantly influence survival rates, but tumor grade (degree of differentiation) did affect survival; the 5-year survival rate was only 29% for poorly differentiated tumors.[59-61] Critics of the study have argued that the high survival rates were due to the relatively large proportion of older men and of tumors detected incidentally during transurethral prostatic resection, and that Swedish data are not generalizable to the U.S.[22,62] Other studies have reported similar results; in one series of selected men with well- and moderately differentiated cancer and extracapsular (nonmetastatic) extension, 5- and 9-year survival rates were 88% and 70%, respectively, without treatment.[63] Reported 10-year disease-specific survival for expectant management of palpable but clinically localized prostate cancer is 84–96%.[64–66] Finally, it is unclear whether reported survival rates in these studies, in which many cancers were detected without screening, are generalizable to screen-detected cancers.

Reviewers have attempted to compare the efficacy of treatment and watchful waiting by pooling the results of uncontrolled studies. An analysis of six studies concluded that conservative management of clinically localized prostate cancer (delayed hormone therapy but no surgical or radiation therapy) was associated with a 10-year disease-specific survival rate of 87% for men with well- or moderately differentiated tumors and 34% for poorly differentiated tumors.[67] The assumptions used in the model are not universally accepted, however.[68,69] A structured literature

review concluded that the median annual rates of metastatic disease and prostate cancer mortality were 1.7% and 0.9%, respectively, without treatment.[70] This study was criticized for including a large proportion of patients with well-differentiated tumors and those receiving early androgen deprivation therapy.[71] Another review concluded that the annual rates for metastasis and mortality were higher (2.5% and 1.7%, respectively), but the review was limited to patients with palpable clinically localized cancers and excluded studies of cancers found incidentally at prostatectomy. In this population, disease-specific survival was estimated to be 83% for deferred treatment, 93% for radical prostatectomy, and 74% for external radiation therapy.[72] Thus, the effectiveness of treatment when compared with watchful waiting remains uncertain.

Uncertainties about the effectiveness of treatment are important because of its potentially serious complications. Needle biopsy, the diagnostic procedure performed on about 20% of men screened with DRE and PSA,[10] is generally safe but results in infection in 0.3–5% of patients, septicemia in 0.6% of patients, and significant bleeding in 0.1% of patients.[19,73–75] The potential adverse effects of radical prostatectomy are more substantial. Although urologists at specialized centers report operative mortality rates of 0.2–0.3%,[55,76] published rates in clinical studies and national databases range between 0.7% and 2%.[6,70,77–79] An examination of Medicare claims files estimated that the 30-day mortality rate was 0.5%.[80] The reported incidence of impotence varies between 20% and 85%,[11,51,70,79,81,82] depending on definitions for impotence and whether bilateral nerve-sparing techniques are used. Other complications of prostatectomy include incontinence (2–27%), urethral stricture (10–18%), thromboembolism (10%), and permanent rectal injuries (3%).[11,51,70,77,83–87] A study of Medicare patients who underwent radical prostatectomy in the late 1980s reported a 30-day operative mortality rate of 1% and a 4–5% incidence of perioperative cardiopulmonary complications. Over 30% wore pads to control wetting, 6% underwent corrective surgery for incontinence, and 2% required the use of an indwelling catheter. Over 60% reported partial erections and 15% underwent treatment for sexual dysfunction; 20% had dilatations or surgical procedure for strictures.[88] Studies of generally healthy and younger patients who have undergone radical prostatectomy in recent years have noted considerably fewer complications.[55]

Complications of radiation therapy include death (about 0.2–0.5%), acute gastrointestinal and genitourinary complications (8–43%), chronic complications requiring surgery or prolonged hospitalization (2%), impotence (40–67%), urethral stricture (3–8%), and incontinence (1–2%).[89] Three-dimensional conformal radiotherapy, a recently introduced technique for more precise, high-dose treatment, is reported to produce acute and chronic gastrointestinal or genitourinary complications in 55–76%

and 11–12% of patients, respectively.[90] Complication rates in studies of radiation therapy cannot be compared with confidence to reported complication rates for surgery because of differences in study designs and patient populations.

Recent decision analyses have combined current estimates of the benefits and harms to predict whether early treatment improves survival. A frequently cited decision analysis for men aged 60–75 concluded that, in most cases of clinically localized prostate cancer, neither surgery nor radiation therapy significantly improved life expectancy.[91] According to the model, treatment generally results in less than 1 year of improvement in quality-adjusted survival. In men over age 70, the analysis suggested that treatment was more harmful than watchful waiting. The study has been criticized because the subjects consisted largely of older men with low-volume, low-grade tumors and because the probability estimates used in the model may be incorrect.[71,92] Defenders of the study note that the data were adjusted for age and tumor grade (but not stage). Retrospective quality-of-life analyses have reported similar findings, noting that men who have undergone radical prostatectomy or radiation therapy for localized prostate cancer generally report lower quality of life due to impaired sexual, urinary, and bowel function than untreated men, even after controlling for the sexual and urinary dysfunction that is common in this age group.[93]

Other decision analyses have examined whether screening itself improves survival. Although older analyses suggested a modest benefit from screening,[94,95] more recent models have reached more pessimistic conclusions when quality-of-life adjustments are incorporated. One analysis concluded that screening and treatment result in an average loss of 3.5 quality-adjusted months of life.[96] Another decision analysis concluded that one-time screening of men aged 50–70 with either DRE or PSA would increase life expectancy by 0–0.2 days and 0.6–1.6 days, respectively, but quality-adjusted life would be decreased by 1.8–7.1 days and 2.1–9.5 days, respectively, per patient screened.[97] The assumptions and calculations used in this model have also been criticized.[98] A recent analysis of annual screening after age 50 concluded that screening would result in an average loss of 0.7 quality-adjusted life-years per patient screened.[98a]

Recommendations of Other Groups

The American Cancer Society[99] recommends an annual DRE for both prostate and colorectal cancer, beginning at age 40. It recommends that the annual examination of men age 50 and older should include a serum PSA measurement and that PSA screening should begin at age 40 for African American men and those with a family history of prostate cancer.[100] Similar recommendations have been issued by the American Urological Association[101] and the American College of Radiology.[102] In 1994, the Food and Drug Administration expanded the licensure for the PSA test to include screening.[103] The Canadian Task Force on the Periodic Health Examination (CTF) recommended against the routine use of PSA or TRUS as part of the periodic health examination; while recognizing the limitations of DRE, they concluded that the evidence was not sufficient to recommend that physicians discontinue use of DRE in men aged 50–70.[104] A 1995 report by the Office of Technology Assessment concluded that research to date had not determined whether or not systematic early screening for prostate cancer with PSA or DRE would save lives, and that the choice to have screening or forego it would depend on patient values.[105] The recommendations of the American College of Physicians and American Academy of Family Physicians are currently under review. In 1992, the American Urological Association concluded that the value of TRUS as an independent screening procedure has not been established and should be reserved for patients with an abnormal DRE or PSA.[106]

Discussion

In summary, prostate cancer is a serious public health problem in the United States, accounting for 35,000–40,000 deaths each year and substantial morbidity from disease progression and metastatic complications. Autopsy studies indicate, however, that these cases arise from a much larger population of latent prostate cancers that are present in over nine million American men. Although screening tests such as PSA have adequate sensitivity to detect clinically important cancers at an early stage, they are also likely to detect a large number of cancers of uncertain clinical significance. The natural history of prostate cancer is currently too poorly understood to determine with certainty which cancers are destined to produce clinical symptoms or affect survival, which cancers will grow aggressively, and which will remain latent. Prostate cancer has a complex biology with many unanswered questions about heterogeneity, tumor-host interactions, and prognostic stratification.

More fundamentally, there is no evidence to determine whether or not early detection and treatment improve survival. For men with well- and moderately differentiated disease, treatment appears to offer little benefit over expectant management, whereas the most aggressive tumors may have spread beyond the prostate by the time they are detected by screening. Observed survival advantages for men with early-stage disease may be due to length bias and other statistical artifacts rather than an actual improvement in clinical outcome. Although it is possible that treatment is beneficial for an unknown proportion of men with early prostate cancer, definitive evidence regarding effectiveness will not be available for over a

decade, when ongoing randomized controlled trials are completed. In the interim years, during which thousands of deaths from prostate cancer are predicted, screening might be justified for its potential benefit were it not for its potential harms. Widespread screening will subject many men to anxiety from abnormal test results and the discomfort of prostate biopsies; aggressive treatment for screen-detected cancers will expose thousands of men to the risks of incontinence, impotence, death, and other sequelae without clear evidence of benefit. Decision-analysis models suggest that the negative impact of these complications on quality of life may outweigh the potential benefits of treatment, but the designs and assumptions of these models are controversial. The absence of proof that screening can reduce mortality from prostate cancer, together with the clear potential that screening will increase treatment-related morbidity, argues against a policy of routine screening in asymptomatic men.

The economic implications of widespread prostate screening, although not a principal argument against its appropriateness, also warrant attention. A full discussion of the cost effectiveness of prostate screening is beyond the scope of this chapter. Moreover, cost effectiveness cannot be properly determined without evidence of clinical effectiveness. Nonetheless, it is clear that routine screening of the 28 million American men over age 50,[39] as recommended by some groups, would be costly. Researchers have predicted that the first year of mass screening would cost the country $12–28 billion.[6,11] This investment might be worthwhile if the morbidity and mortality of prostate cancer could be reduced through early detection—given certain assumptions, prostate cancer screening might even achieve cost-benefit ratios comparable to breast cancer screening[107]—but there is currently little evidence to support these assumptions. The costs of this form of screening, with its emphasis on older men, is likely to increase in the future with the advancing age of the United States population; the number of American men over age 55 is expected to nearly double in the next 30 years, from 23 million men in 1994 to 44 million by 2020.[39]

There is some evidence that the recent increase in prostate screening may be generating a poorly controlled expansion in the performance of radical prostatectomies, creating an unnecessary iatrogenic morbidity in a growing population of surgical patients. The rising incidence of prostate cancer due to increased screening has been accompanied by a tripling in rates for radical prostatectomy in the U.S.[4] If early detection and treatment are effective, they are most likely to benefit men under age 70 rather than older men. As already noted, 10-year survival for early-stage prostate cancer approaches 90%. Thus, most men over age 70, who face a life expectancy of just over 10 years, are more likely to die of other causes than of prostate cancer. Subjecting these men to the risks of biopsy and treatment is often unwarranted, and many proponents of prostate screening therefore recommend against screening after age 70. Nonetheless, studies indicate that radical prostatectomy rates for men aged 70–79 increased 4-fold in 1984–1990, and the trend appears to be continuing in this decade. Population-based rates for prostatectomy in men aged 70–79, many of whom are unlikely to benefit from the procedure, appear to be the same as in men aged 60–69.[78] According to an American College of Surgeons survey, one out of three men undergoing radical prostatectomy in 1990 was age 70 or older.[79]

The lack of evidence regarding the benefits of prostate screening and the considerable risks of adverse effects make it important for clinicians to inform patients who express an interest in screening about the consequences of testing before they consent to screening. Although such counseling is proper for all forms of screening, the need for informed consent is especially important for prostate cancer screening because of current uncertainty about its effectiveness and because the proper choice for an individual is highly dependent on personal preferences. Screening is more likely to be chosen by men with strong fears of prostate cancer and by those who can accept the risks of incontinence, impotence, and other treatment complications. Screening is less likely to be chosen by men who are skeptical of the risks of cancer and the effectiveness of treatment and who have strong fears that treatment complications will jeopardize their quality of life.

CLINICAL INTERVENTION

Routine screening for prostate cancer with DRE, serum tumor markers (e.g., PSA), or TRUS is not recommended ("D" recommendation). Patients who request screening should be given objective information about the potential benefits and harms of early detection and treatment. Patient education materials that review this information are available.[108] If screening is to be performed, the best-evaluated approach is to screen with DRE and PSA and to limit screening to men with a life expectancy greater than 10 years. There is currently insufficient evidence to determine the need and optimal interval for repeat screening or whether PSA thresholds must be adjusted for density, velocity, or age.

The draft update of this chapter was prepared for the U.S. Preventive Services Task Force by Steven H. Woolf, MD, MPH. See also the relevant background paper: U.S. Preventive Services Task Force. Screening for prostate cancer: commentary on the recommendations of the Canadian Task Force on the Periodic Health Examination. Am J Prev Med 1994;10:187–193.

REFERENCES

1. Wingo PA, Tong T, Bolden S. Cancer statistics, 1995. CA Cancer J Clin 1995;45:8–30.
2. Ries LAG, Hankey BF, Miller BA, et al. Cancer statistics review 1973–88. Bethesda: National Cancer Institute, 1991. (NIH Publication no. 91-2789.)
3. Ries LAG, Miller BA, Hankey BF, Kosary CL, Harras A, Edwards BK, eds. SEER Cancer statistics review, 1973–1991: Tables and graphs. Bethesda: National Cancer Institute, 1994:371. (NIH Publication no. 94-2789.)
4. Lu-Yao GL, Greenberg ER. Changes in prostate cancer incidence and treatment in USA. Lancet 1994;343:251–254.
5. Mettlin C, Jones GW, Murphy GP. Trends in prostate cancer care in the United States, 1974–1990: observations from the patient care evaluation studies of the American College of Surgeons Commission on Cancer. CA Cancer J Clin 1993;43:83–91.
6. Kramer BS, Brown ML, Prorok PC, Potosky AL, Gohagan JK. Prostate cancer screening: what we know and what we need to know. Ann Intern Med 1993;119:914–923.
7. Keetch DW, Catalona WJ, Smith DS. Serial prostatic biopsies in men with persistently elevated serum prostate specific antigen values. J Urol 1994;151:1571–1574.
8. McNeal JE, Bostwick DG, Kindrachuk RA, et al. Patterns of progression in prostate cancer. Lancet 1986;1:60–63.
9. Catalona WJ, Smith DS, Ratliff TL, et al. Measurement of prostate-specific antigen in serum as a screening test for prostate cancer. N Engl J Med 1991;324:1156–1161.
10. Catalona WJ, Richie JP, Ahmann FR, et al. Comparison of digital rectal examination and serum prostate specific antigen in the early detection of prostate cancer: results of a multicenter clinical trial of 6,630 men. J Urol 1994;151:1283–1290.
11. Optenberg SA, Thompson IM. Economics of screening for carcinoma of the prostate. Urol Clin North Am 1990; 17:719–737.
12. Vihko P, Kontturi O, Ervast J, et al. Screening for carcinoma of the prostate: rectal examination and enzymatic radioimmunologic measurements of serum acid phosphatase compared. Cancer 1985;56:173–177.
13. Chodak GW, Keller P, Schoenberg HW. Assessment of screening for prostate cancer using the digital rectal examination. J Urol 1989;141:1136–1138.
14. Varenhorst E, Berglund K, Lofman O, Pedersen K. Inter-observer variation in assessment of the prostate by digital rectal examination. Br J Urol 1993;72:173–176.
15. Babaian R, Mettlin C, Kane R, et al. The relationship of prostate-specific antigen to digital rectal examination and transrectal ultrasonography. Cancer 1992;69:1195–1200.
16. Pedersen KV, Carlsson P, Varenhorst E, et al. Screening for carcinoma of the prostate by digital rectal examination in a randomly selected population. BMJ 1990;300:1041–1044.
17. Lowe FC, Trauzzi SJ. Prostatic acid phosphatase in 1993: its limited clinical utility. Urol Clin North Am 1993; 20:589–595.
18. Oesterling JE. Prostate-specific antigen: a critical assessment of the most useful tumor marker for adenocarcinoma of the prostate. J Urol 1991;145:907–923.
19. Cooner WH, Mosley BR, Rutherford CL Jr, et al. Prostate cancer detection in a clinical urological practice by ultrasonography, digital rectal examination and prostate specific antigen. J Urol 1990;143:1146–1152.
20. Catalona WJ, Smith DS, Ratliff TL, Basler JW. Detection of organ-confined prostate cancer is increased through prostate-specific antigen-based screening. JAMA 1993;270:948–954.
21. Bretton PR. Prostate-specific antigen and digital rectal examination in screening for prostate cancer: a community-based study. South Med J 1994;87:720–723.
22. Andriole GL, Catalona WJ. Using PSA to screen for prostate cancer: the Washington University experience. Urol Clin North Am 1993;20:647–651.
23. Demark-Wahnefried W, Catoe KE, Paskett E, Robertson CN, Rimer BK. Characteristics of men reporting for prostate cancer screening. Urology 1993;42:269–275.
24. Benson MC, Whang IS, Pantuck A, et al. Prostate-specific antigen density: a means of distinguishing benign prostatic hypertrophy and prostate cancer. J Urol 1992;147:815–816.
25. Bazinet M, Meshref AW, Trudel C, et al. Prospective evaluation of prostate-specific antigen density and systematic biopsies for early detection of prostatic carcinoma. Urology 1994;43:44–52.

26. Semjonow A, Hamm M, Rathert P, Hertle L. Prostate-specific antigen corrected for prostate volume improves differentiation of benign prostatic hyperplasia and organ-confined prostatic cancer. Br J Urol 1994;73:538–543.
27. Carter HB, Pearson JD, Metter EJ, et al. Longitudinal evaluation of prostate-specific antigen levels in men with and without prostate disease. JAMA 1992;267:2215–2220.
28. Oesterling JE, Jacobsen SJ, Chute CG, et al. Serum prostate-specific antigen in a community-based population of healthy men: establishment of age-specific reference ranges. JAMA 1993;270:860–864.
29. Dalkin BL, Ahmann FR, Kopp JB. Prostate specific antigen levels in men older than 50 years without clinical evidence of prostatic carcinoma. J Urol 1993;150:1837–1839.
30. Shinohara K, Wolf JS Jr, Narayan P, Carroll PR. Comparison of prostate specific antigen with prostate specific antigen density for 3 clinical applications. J Urol 1994;152:120–123.
31. Franks LM. Latent carcinoma of the prostate. J Pathol Bacteriol 1954;68:603–616.
32. Bostwick DG, Cooner WH, Denis L, et al. The association of benign prostatic hyperplasia and cancer of the prostate. Cancer 1992;70:291–301.
33. Breslow N, Chan CW, Dhom G, et al. Latent carcinoma of prostate at autopsy in seven areas. Int J Cancer 1977;20:680–688.
34. Baron E, Angrist A. Incidence of occult adenocarcinoma of the prostate after fifty years of age. Arch Pathol 1941;32:787–793.
35. Edwards CN, Steinthorsson E, Nicholson D. An autopsy study of latent prostatic cancer. Cancer 1953;6:531–554.
36. Halpert B, Schmalhorst WR. Carcinoma of the prostate in patients 70 to 79 years old. Cancer 1966;19:695–698.
37. Scott R Jr, Mutchnik DL, Laskowski TZ, Schmalhorst WR. Carcinoma of the prostate in elderly men: incidence, growth characteristics and clinical significance. J Urol 1969;101:602–607.
38. Sakr WA, Haas GP, Cassin BF, Pontes JE, Crissman JD. The frequency of carcinoma of the prostate in young male patients. J Urol 1993;150:379–385.
39. U.S. Bureau of the Census. Statistical Abstract of the United States, 1993. 113th ed. Washington, DC: U.S. Bureau of the Census, 1993.
40. Scardino PT. Early detection of prostate cancer. Urol Clin North Am 1989;16:685–655.
41. Epstein JI, Walsh PC, Carmichael M, Brendler CB. Pathologic and clinical findings to predict tumor extent of nonpalpable (stage T1c) prostate cancer. JAMA 1994;271:368–374.
42. Smith DS, Catalona WJ. The nature of prostate cancer detected through prostate specific antigen based screening. J Urol 1994;152:1732–1736.
43. Mettlin C, Murphy GP, Lee F, Littrup PJ, Chesley A, Babaian R, et al. Characteristics of prostate cancer detected in the American Cancer Society National Prostate Cancer Detection Project. J Urol 1994;152:1737–1740.
44. Scaletscky R, Koch MO, Eckstein CW, Bicknell SL, et al. Tumor volume and stage in carcinoma of the prostate detected by elevations in prostate specific antigen. J Urol 1994;152:129–131.
45. Stormont TJ, Farrow GM, Myers RP, et al. Clinical stage B0 or T1c prostate cancer: nonpalpable disease identified by elevated serum prostate-specific antigen concentration. Urology 1993;41:3–8.
46. Gann PH, Hennekens CH, Stampfer MJ. A prospective evaluation of plasma prostate-specific antigen for detection of prostatic cancer. JAMA 1995;273:289–294.
47. Lee F, Littrup PJ, Torp-Pedersen ST, et al. Prostate cancer: comparison of transrectal US and digital rectal examination for screening. Radiology 1988;168:389–394.
48. Friedman GD, Hiatt RA, Quesenberry CP Jr, et al. Case-control study of screening for prostatic cancer by digital rectal examinations. Lancet 1991;337:1526–1529.
49. Gerber GS, Thompson IM, Thistad R, et al. Disease-specific survival following routine prostate cancer screening by digital rectal examination. JAMA 1993;269:61–64.
50. Gohagan JK, Prorok PC, Kramer BS, Cornett JE. Prostate cancer screening in the Prostate, Lung, Colorectal and Ovarian Cancer Screening Trial of the National Cancer Institute. J Urol 1994;152:1905–1909.
51. Walsh PC, Partin AW, Epstein JI. Cancer control and quality of life following anatomical radical retropubic prostatectomy: results at 10 years. J Urol 1994;152:1831–1836.
52. Catalona WJ, Smith DS. 5-year tumor recurrence rates after anatomical radical retropubic prostatectomy for prostate cancer. J Urol 1994;152:1837–1842.
53. Hanks GE, Hanlon A, Schultheiss T, Corn B, Shipley WU, Lee WR. Early prostate cancer: the national results of radiation treatment from the Patterns of Care and Radiation Therapy Oncology Group stud-

ies with prospects for improvement with conformal radiation and adjuvant androgen deprivation. J Urol 1994;152:1775–1780.
54. Bagshaw MA, Cox RS, Hancock SL. Control of prostate cancer with radiotherapy: long-term results. J Urol 1994;152:1781–1785.
55. Zincke H, Oesterling JE, Blute ML, Bergstralh EJ, Myers RP, Barrett DM. Long-term (15 years) results after radical prostatectomy for clinically localized (Stage T2c or lower) prostate cancer. J Urol 1994;152:1850–1857.
56. Byar DK, Corle DK. VACURG randomized trial of radical prostatectomy for Stages I and II prostate cancer. Veterans Administration Cooperative Urological Research Group. Urology 1981;17(suppl): 7–11.
57. Graversen PH, Nielsen KT, Gasser TC, et al. Radical prostatectomy versus expectant primary treatment in stages I and II prostatic cancer: a 15-year follow-up. Urology 1990;36:498–498.
58. Wilt TJ, Brawer MK. The Prostate Cancer Intervention Versus Observational Trial: a randomized trial comparing radical prostatectomy versus expectant management for the treatment of clinically localized prostate cancer. J Urol 1994;152:1910–1914.
59. Johansson JE. Expectant management of early stage prostatic cancer: Swedish experience. J Urol 1994; 152:1753–1756.
60. Johansson JE, Adami HO, Andersson SO, et al. High 10-year survival rate in patients with early, untreated prostatic cancer. JAMA 1992;267:2191–2196.
61. Johansson JE. Watchful waiting for early stage prostate cancer. Urology 1994;43:138–142.
62. Walsh PC. Using prostate-specific antigen to diagnose prostate cancer: sailing in uncharted waters. Ann Intern Med 1993;119:948–949.
63. Adolfsson J. Deferred treatment of low grade stage T3 prostate cancer without distant metastases. J Urol 1993;149:326–329.
64. Adolfsson J, Carstensen J, Lowhagen T. Deferred treatment in clinically localised prostatic carcinoma. Br J Urol 1992;69:183–187.
65. Adolfsson J, Ronstrom L, Lowhagen T, Carstensen J, Hedlund PO. Deferred treatment of clinically localized low grade prostate cancer: the experience from a prospective series at the Karolinska Hospital. J Urol 1994;152:1757–1760.
66. Warner J, Whitmore WF Jr. Expectant management of clinically localized prostatic cancer. J Urol 1994;152:1761–1765.
67. Chodak GW, Thisted RA, Gerber GS, et al. Results of conservative management of clinically localized prostate cancer. N Engl J Med 1994;330:242–248.
68. Catalona WJ. Conservative management of prostate cancer [letter]. N Engl J Med 1994;330:1830–1831.
69. Scardino PT, Beck JR, Miles BJ. Conservative management of prostate cancer [letter]. N Engl J Med 1994; 330:1831.
70. Wasson JH, Cushman CC, Bruskewitz RC, Littenberg B, Mulley AG Jr, Wennberg JE, and the Prostate Disease Patient Outcome Research Team. A structured literature review of treatment for localized prostate cancer. Arch Fam Med 1993;2:487–493.
71. Walsh PC. Editorial comments on: A decision analysis of alternative treatment for clinically localized prostate cancer. J Urol 1993;150:1330–1331.
72. Adolfsson J, Steineck G, Whitmore W. Recent results of management of palpable clinically localized prostate cancer. Cancer 1993;72:310–322.
73. Desmond PM, Clark J, Thompson IM, et al. Morbidity with contemporary prostate biopsy. J Urol 1993;150:1425–1426.
74. Aus G, Hermansson CG, Hugosson J, et al. Transrectal ultrasound examination of the prostate: complications and acceptance by patients. Br J Urol 1993;71:457–459.
75. Hammerer P, Huland H. Systematic sextant biopsies in 651 patients referred for prostate evaluation. J Urol 1994;151:99–102.
76. Andriole GL, Smith DS, Ganeesh R, Goodnough L, Catalona WJ. Early complications of contemporary anatomical radical retropubic prostatectomy. J Urol 1994;152:1858–1860.
77. Catalona WJ, Avioli LV. Diagnosis, staging, and surgical treatment of prostatic carcinoma. Arch Intern Med 1987;147:361–368.
78. Lu-Yao GL, McLerran D, Wasson J, Wennberg JE. An assessment of radical prostatectomy: time trends, geographic variation, and outcomes. JAMA 1993;269:2633–2636.

79. Murphy GP, Mettlin C, Menck H, Winchester DP, Davidson AM. National patterns of prostate cancer treatment by radical prostatectomy: results of a survey by the American College of Surgeons Commission on Cancer. J Urol 1994;152:1817–1819.
80. Mark DH. Mortality of patients after radical prostatectomy: analysis of recent Medicare claims. J Urol 1994; 152:896–898.
81. Catalona WJ, Bigg SW. Nerve-sparing radical prostatectomy: evaluation of results after 250 patients. J Urol 1990;143:538–544.
82. Walsh PC. Radical prostatectomy, preservation of sexual function, cancer control. Urol Clin North Am 1987;14:663–666.
83. Andriole GL, Catalona WJ. Prostate carcinoma. Annu Rev Med 1994;45:351–359.
84. Narayan P, Jajodia P. Prostatic oncology. Clin Geriatr Med 1990;6:131–161.
85. Gibbons RP, Correa RJ, Brannen GE, et al. Total prostatectomy for localized prostatic cancer. J Uro 1984;131:73–77.
86. Ahmann FR. Dilemmas in managing prostate carcinoma (Pt 1): localized disease. Geriatric 1985;40:34–42.
87. Middleton RG, Smith JA, Melzer RB, et al. Patient survival and local recurrence rate following radica prostatectomy for prostatic carcinoma. J Urol 1986;136:422–431.
88. Fowler FJ, Barry MJ, Roman A, et al. Patient-reported complications and follow-up treatment follov ing radical prostatectomy: the national Medicare experience: 1988–1990. Urology 1993;42:622–629.
89. Shipley WU, Zietman AL, Hanks GE, et al. Treatment related sequelae following external beam rad ation for prostate cancer: a review with an update in patients with stages T1 and T2 tumor. J Ur 1994;152:1799–1805.
90. Leibel SA, Zelefsky MJ, Kutcher GJ, Burman CM, Kelson S, Fuks Z. Three-dimensional conformal r diation therapy in localized carcinoma of the prostate: interim report of a phase 1 dose-escalation stud J Urol 1994; 152:1792–1798.
91. Fleming C, Wasson JH, Albertsen PC, Barry MJ, Wennberg JE, et al. A decision analysis of alternati treatment strategies for clinically localized prostate cancer. JAMA 1993;269:2650–2658.
92. Beck JR, Kattan MW, Miles BJ. A critique of the decision analysis for clinically localized prostate ca cer. J Urol 1994;152:1894–1899.
93. Litwin MS, Hays RD, Fink A, Ganz PA, Leake B, Leach GE, Brook RH. Quality-of-life outcomes in m treated for localized prostate cancer. JAMA 1995;273:129–135.
94. Thompson IM, Rounder JB, Teague JL, et al. Impact of routine screening for adenocarcinoma of t prostate on stage distribution. J Urol 1987;137:424–426.
95. Love RR, Fryback DG, Kimbrough SR. A cost-effectiveness analysis of screening for carcinoma of t prostate by digital examination. Med Decis Making 1985;5:263–278.
96. Mold JW, Holtgrave DR, Bisonni RS, et al. The evaluation and treatment of men with asymptoma prostate nodules in primary care: a decision analysis. J Fam Pract 1992;34:561–568.
97. Krahn MD, Mahoney JE, Eckman MH, Trachtenberg J, Pauker SG, Detsky AS. Screening for prost cancer: a decision analytic view. JAMA 1994;272:773–780.
98. Miles BJ, Kattan MW, Giesler RB, et al. Screening for prostate cancer [letter]. JAI 1995;273:1173–1174.
98a. Cantor SB, Spann SJ, Volk RJ, Cardenas MP, Warren MM. Prostate cancer screening: a decision an sis. J Fam Pract 1995;41:33–41.
99. American Cancer Society. Guidelines for the cancer-related checkup: an update. Atlanta: Ameri Cancer Society, 1993.
100. Mettlin C, Jones G, Averette H, et al. Defining and updating the American Cancer Society guideli for the cancer-related checkup: prostate and endometrial cancers. CA Cancer J Clin 1993;43:42–
101. American Urological Association, Executive committee report. Baltimore: American Urological A ciation, January 1992.
102. American College of Radiology, Resolution #36, approved October 1991.
103. Prostate specific antigen test approved. FDA Medical Bulletin, vol 25 no 1, February 1995:4.
104. Canadian Task Force on the Periodic Health Examination. Canadian guide to clinical preventive he care. Ottawa: Canada Communication Group, 1994:812–823.
105. Office of Technology Assessment. Costs and effectiveness of prostate cancer screening in elderly r Washington, DC: Government Printing Office, 1995. (Publication no. OTA-BP-H-145.)
106. American Urological Association. Early detection of prostate cancer and use of transrectal ultraso

In: American Urological Association 1992 Policy Statement Book. Baltimore: American Urological Association, 1992.
107. Littrup PJ, Goodman AC, Mettlin CJ, et al. The benefit and cost of prostate cancer early detection. CA Cancer J Clin 1993;43:134–149.
108. Hahn DL, Roberts RG. PSA screening for asymptomatic prostate cancer: truth in advertising. J Fam Pract 1993; 37:432–436.

19th Annual Minority Health Conference

COMMUNITIES OF COLOR FIGHTING BACK: OUR ROLE IN THE CANCER CRISIS

February 13-14, 1997

EXHIBITORS

Breast and Cervical Cancer Control Program
Division of Health Promotion
North Carolina Department of Environment, Health and Natural Resources

Caring Program for Children
Durham, North Carolina

Lineberger Comprehensive Cancer Center
University of North Carolina at Chapel Hill

Minority Health Project
Department of Biostatistics, School of Public Health
University of North Carolina at Chapel Hill

Moore Regional Hospital Mobile Health Services
Carthage, North Carolina

North Carolina Sickle Cell Syndrome Program and
Duke-UNC Comprehensive Sickle Cell Center

Save Our Sisters of Wake
Wake County Health Department
Raleigh, North Carolina

19th Annual Minority Health Conference

Communities of Color Fighting Back: Our Role in the Cancer Crisis

ABSTRACTS OF POSTER PRESENTATIONS

February 13 and 14, 1997
Chapel Hill, North Carolina

Body Image and Dieting: On the Road to Understanding Food Behavior among Inner-City African-American Female Adolescents

Phyllis K. Newby, MS, MPH

Introduction: African-American women have twice the rate of obesity as white women (48%), and are therefore at greater risk for developing obesity-related health problems. Pre-menopausal obesity, including both the distribution of weight and the modification of estrogen levels, has been found to be a risk factor for certain diseases, including breast cancer. Research efforts in recent years have therefore focused on diet as a possible mechanism to decrease risk of breast cancer, and many cancer organizations now recommend a low-fat-high-fiber diet. Because eating behaviors evolve and often solidify during adolescence, nutritional epidemiological research using African-American adolescent subjects which incorporates behavioral components is an important aspect of primary prevention efforts to control breast cancer and other obesity-related diseases.
Purpose: This exploratory study was undertaken to examine eating, dieting, and exercise behavior in this population. In this paper, data on dieting behavior and body image are presented and discussed. Increased understanding of food behaviors and body image preferences will hopefully lead to prevention strategies that are culturally and developmentally appropriate.
Methods: Middle-school adolescents (n=113) responded to questions about their feelings on body weight and body image along with their participation in various eating, dieting, and exercise behaviors. Anthropometric data on weight and height were collected and BMI (Body Mass Index) was calculated based on these data. Subjects were broken into weight groups based on BMI. SPSS (Statistical Package for the Social Sciences) was used to analyze data. For this paper, dieting variables were cross-tabulated using chi-square analyses to show their relationship to body image variables and BMI weight group.
Results: A high percentage of subjects reported satisfaction with their body weight and body shape (71.6% and 64.5%, respectively), in spite of what appeared to be a high prevalence of overweight in the sample. Two-thirds of underweight subjects and slightly less than one-third of overweight subjects were satisfied with their weight. Almost half of underweight subjects and close to 20% of overweight subjects rated their weight as "just right." Only 7.1% of subjects reported being on a diet, and qualitative data identified excess weight as a problem associated with eating among subjects.
Conclusions: Whereas some subjects seem to have incorporated the thin body ideal as predominant in the American culture, other subjects show a preference for the heavier weights associated with the African-American culture. Future research in this area is needed to clarify the reasons for differing weight standards among this population, that nutrition education efforts may help these individuals adopt a weight that is healthy both physically and psychologically. As eating behavior is better understood as a function of many variables, including body image preferences and cultural influences, interventions may be more successful in altering the risk to diet-related diseases such as breast cancer.

Breast Cancer Screening Practices: Behavioral Risk Factor Surveillance System 1992

Verna L. Lamar, MPH; Donna Brogan, Ph.D.

Objectives: To estimate mammography utilization and adherence rates among asymptomatic women 50 years of age or over, and to determine factors related to utilization and adherence.
Methods: The data were abstracted from the 1992 Behavioral Risk Factor Surveillance System (BRFSS) state-wide surveys. SUDAAN was used to analyze the data. The sample subjects were 21,601 women 50 years of age and older residing in the 48 states and the District of Columbia.
Results: An estimated 72.2% of U.S. women have obtained a mammogram during their lifetime and an estimated 51.1% have had a mammogram in the previous year. The variables representing older age, less education, lower annual household income, no health care plan, Southern region and the interaction of race with marital status were predictors of never having a mammogram in logistic regression. Older age, lower education, lower annual household income and no health care plan were predictors of not having a mammogram during the year prior to the survey according to the recommended guidelines in logistic regression.
Conclusions: Although many women received mammograms during their life, efforts are needed to increased adherence to recommended guidelines. The data suggest targeting individuals who are older, with low income, less education and no health care plan.

Community-Based Approaches to Improving Breast and Cervical Cancer Screening

Cathy Tatum, M.A., Electra Paskett, Ph.D., Julia Rushing, M.S., Ramon Velez, M.D., Robert Michielutte, PhD., Mark Dignan, Ph.D.

The FoCaS (Forsyth County Cancer Screening) Project is one of six projects funded by the NCI "Public Health Approaches to Breast and Cervical Cancer" initiative. The goal of this project is to improve the use of breast and cervical cancer screening among low-income, predominately African-American, women aged 40 and older. Strategies implemented in the intervention community included community health clinic in-reach strategies (chart reminders, exam room prompts, in-service meetings, and patient directed literature) and community out-reach strategies (educational sessions, literature distribution, community events, media and church programs). Baseline and follow-up data from surveys among a cohort of women and two independent cross-sectional samples of women in both the intervention and comparison communities were used to evaluate the effects of the intervention program. The proportion of women reporting regular use of mammography increased in both the cohort (46% to 56%; $p=.04$) and the cross-sectional(31% to 56%; $p=<.001$) samples in the intervention community. In the comparison community, a non-significant increased trend (46% to 54% and 33% to 40% cohort and cross-sectional samples, respectively) in mammography utilization was observed. This increase in screening was significantly greater in the intervention community ($p = .05$). Pap smear screening improved only among the cross-sectional sample in the intervention community (73% to 87%; $p=.003$), and was significantly greater than the increase in the comparison group ($p = .004$). These results have important implications for community-based research and efforts in underserved populations.

The National Cancer Institute's Office of Cancer Communications' Clinical Trials Training Program: A Pilot Project

Monica Bynoe, BSN, MPH

The National Cancer Institute's (NCI) Office of Cancer Communications (OCC) developed a Clinical Trials Training Program (CTTP) in 1988 for use by the Cancer Information Service (CIS) Telephone Service. The Telephone Service began using the Clinical Trials Training Program in January of 1989 to answer the public's questions about cancer treatment options. Changes in the structure of the CIS as well as in the health care system overall have necessitated that the training program be revised. In addition to expanding the training program for use in the CIS Outreach Program, a relatively new component of the CIS, there was a need to revise the training program for use by organizations and individuals dedicated to cancer control and treatment. Thus, efforts focused on getting the input of various audiences on how the program should be revised and what it should contain. Four CIS regional offices were chosen to be pilot sites for revision of the CTTP. The Region 6 CIS of the Carolinas and Georgia was one of the sites that worked with professionals, community leaders and organizations involved in cancer control and treatment, to review four core modules of the CTTP.

In Georgia, we collaborated with the National Black Leadership Initiative on Cancer, the American Cancer Society, a Minority-Based Community Clinical Oncology Program, and the Georgia Department of Human Resources. In South Carolina we collaborated with Hollings Cancer Center's Access Network Program, and in North Carolina we worked with the Duke University Medical Center Women's Health Services. Each of these organizations provided a critical review of the four core modules and offered their suggestions for revising the CTTP. These suggestions included: increasing representation of minorities in brochures, booklets and videotapes; emphasizing pros and cons of cancer clinical trials participation; and presenting all information in clear, understandable language. This presentation will highlight the methods used to involve community groups and organizations in the review of educational programs and resources, and the ultimate impact of their participation.

A Neigborhood Approach: "Celebrating Our Strengths and Growing Together"

Cheryl Silver-Emanuel, B.S. Community Health Education, M.S. Adult Education

Overview: We are a community struggling to reach out in a prevention effort that will impact and educate people at all levels. History has proven that one of the most effective ways to reach people are to involve persons who are known and active within their respective communities. In 1994, residents of low and moderate income neighborhoods in Charlotte, N.C. united with human services providers to address the disparities in health between white and non-white infants. The Healthy Families, Healthy Communities Conference was developed to address the high incidence of infant deaths and low-birth weight births to African American women. It was later expanded to a broader range of health issues, including HIV/AIDS, drug abuse, violence, breast and prostate cancer, teen pregnancy and other issues. Healthy Families builds upon the strengths of neighborhoods rather than agencies. The annual event, which is planned and coordinated by lay people,("grassroots leaders") provides a viable mechanism for updating community residents on contemporary health issues affecting their families and communities.

1) Objectives: a) To provide neighborhood residents the knowledge, skills and abilities necessary to reduce mortality and morbidity from preventable and manageable conditions, b) to conduct monthly neighborhood meetings throughout the year where residents explore the nature, scope and impact of health-related problems, c) to provide forums which specifically address health-related problems of youths, adults and senior citizens, and d) to integrate the data collected from neighborhood sessions into a full-day Conference of information sharing, action planning and coalition building.

2) Partnership Description: More than 40 grassroots neighborhoods organizations, churches and community -based groups representing virtually every aspect of Charlotte's African-American community have participated in the conference. This body is supported by staff from more than 25 public and private health and social services agencies. These organizations with support from the majority and African-American business communities provide funding for all Conference expenses.

3) Strengths and Weakness: The primary strengths of the Conference lie in a) the coalition-building that has occurred and the increased ability of residents to affect change/improvement in health attitudes, behaviors and access to care, b) bottom-up approach rather than agency-centered, c) fully integrated with religious social, educational and local neighborhood, d) targets entire family, focusing on the needs of single parent households, non-traditional households and the lost, the forgotten and underserved neighborhoods, e) identifies for service providers those communities and participants that have been lost in the system of continuum care. Weaknesses center around the challenge of how to expand community involvement and program content while recognizing cost and time limitations and agency's willingness to buy into a health initiative that it is neighborhood driven as opposed to agency-controlled.

North Carolina Colon Cancer Study

Chris Martin

ABSTRACT:

Between 1973 and 1991 the incidence of colon cancer increased 26.6% in blacks compared to 1.6% in whites. The mortality rate increased 12.4% in blacks but decreased 17.6% for whites. These observations have not been explained. In fact, black-white differences in colon cancer incidence and mortality have not been adequately studied. This application seeks funds to conduct a population-based study of colon cancer in blacks and whites in a 33-county area of North Carolina. The primary goal of the proposed research is to examine possible exposure, susceptibility and health care factors that might explain diverging incidence and mortality trends in blacks and whites.

The specific aims of this research are: (1) To identify environmental and lifestyle risk factors for colon cancer in blacks and whites. The study will explore a range of exposures that may be related to colon cancer, with special emphasis on meat cooking practices and the heterocyclic amines generated during cooking. (2) To assess the prevalence of specific inherited susceptibility characteristics in a large mixed-race population. The study will focus on the known alleles of the two human N-acetyltransferase enzymes (NAT2/NAT1) using DNA obtained from blood samples. (3) To assess the possibility of gene-environment interactions between exposures to dietary carcinogens and genetic susceptibility risk factors. (4) To explore whether the excess colon cancer mortality among blacks might be explained by differences in (a) exposure to environmental risk factors, (b) tumor characteristics, and/or (c) access or availability of health services. A secondary aim is to collect biological specimens for subsequent analyses such as the role of other inherited genetic characteristics and the presence or absence of specific somatic genetic alterations.

The study will recruit 800 cases of colon cancer age 40-84 and 800 population-based controls. Cancer cases (400 blacks and 400 whites) will be identified using the rapid ascertainment system of the North Carolina Central Cancer Registry. Controls will be selected using Department of Motor Vehicle Registry data for those under age 65 and HCFA files for those 65 and over. Dietary, lifestyle and environmental exposure information will be obtained for cases and controls by personal, in-home interviews. The interview instrument includes comprehensive questions concerning meat cooking practices, and seeks information about education, occupational status, poverty, and health care access and utilization. DNA extracted from peripheral blood lymphocytes will be used to determine NAT genotypes.

Promoting Health In The African-American Community: The Role of The Church

Lorna H. Harris, Ph.D., R.N

An important factor in developing and implementing health programs in the African-American community is the use of information networks as a means of exchanging information. The church has historically been a principle vehicle used by researchers as entry into the African-American community. It has been demonstrated that the church can also serve as a provider of health services to the community. Using the coalition partnership approach advocated by Braithwaite (1992), a community-based project using the members of the North Carolina Interdenominational Ushers' Association to provide health education was developed.

The purpose of this project was to identify a process using a conference format to educate an interdenominational group of churches on the role they can play in providing health services to their congregations and local communities. The goal of the conference was to create awareness among church ushers of the (1) health status and health problems that have been identified in the African-American community, (2) emphasis state agencies are placing on these health problems through programs designed to meet the objectives of Healthy People 2000, and (3) strategies that could be used to set up a health advocacy committee in the local congregations.

The poster will describe the collaborative approach used with this established leadership group within the African-American church. The outcomes of the conference used to initiate health promotion activities within the churches include the: (1) establishment of ten health advocacy committees within local churches, (2) compilation of a proceedings booklet which includes a resource directory, and (3) creation of a Health Steering Committee in the Ushers' Association to function as an intermediary between the Ushers' Association, the University of North Carolina at Chapel Hill, and other agencies instrumental in assisting churches with health promotion activities.

If the African-American church is to be an effective means of reaching people, it is important that the church, as well as nurses, have a clear understanding of how to work in a collaborative partnership. The church must also understand the role it can play in providing health services to the community.

Relative importance of factors affecting the likelihood of participation in medical research stratified by race and sex

Lisa E. Hensley, M.H.S, Valerie G. Smith, M.H.A., Deborah S. Cousins, B.A., Tonya D. Armstrong, M.A., Larry Crum, Ph.D.

The underrepresentation and the failure to include minorities and women in medical research has been problematic and has often been left unaddressed. Variations in the pathogenesis of disease, metabolic pathways, the prevalence and incidence of disease have all been shown to exist by sex and, or ethnic group. The insufficient numbers of minorities or women included in these studies makes generalization of the results to these groups difficult if not impossible. Although the lack of external validity in studies has recently been recognized and federal guidelines have been established to ensure their inclusion, the participation of minorities and women in research studies remains disproportionately low. In part this may be attributed to the observation that when recruited, ethnic minorities have been found to be less likely to participate in research studies. In this paper we attempt to identify differences in factors or determinants of the likelihood of participation between males, females and ethnic groups. The realtive importance of 12 factors: economic reimbursement, familiarity with research, prevalence of disease, severity of disease, familiarity or knowledge of the disease, familiarity or knowledge of medical research, the lack of control an individual may feel upon entering a medical research trial, being in an uncomfortable environment during a research study, possible health consequences of participation, the presence and extent of safety measures, demands on the individuals' time, and past historical experiences and the likelihood of participation in a research study were examined and the results stratified by both race and sex. The identification of differences in factors affecting the likelihood of participation is of great importance in improving the recruitment and participation of minorities in medical research studies.

Reproductive risk factors for breast cancer among African-American women in the Carolina Breast Cancer Study

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Reproductive events are recognized as established breast cancer risk factors. Early age at menarche, low parity, late age at first full-term pregnancy, and absence of lactation appear to confer elevated risk. These conclusions are based on research performed primarily in older, white women. The small number of case-control studies that have examined risk in African-American women suggest that the associations between reproductive factors and breast cancer are similar to those in white women. The Carolina Breast Cancer Study, a population-based, case-control study that over-sampled African-American women (n=295 cases, 296 controls), provided us the opportunity to investigate the associations of the aforementioned reproductive factors with breast cancer risk in this infrequently-studied population, and to compare them with associations among white women. In our data, African-American women who experienced menarche before the age of 12 had a slightly elevated risk relative to those with menarche at age 14 or later (odds ratio (OR): 1.3, 95% confidence interval (CI): 0.8-2.1). A late age at first full-term birth (30 or older) did not appear to increase risk of breast cancer relative to an early birth (before 20); in fact, the odds ratio suggested the possibility of a protective effect (OR: 0.7, CI: 0.3-1.4). Relative to women who had 3 or more full-term births, those who had one or two were not at increased risk (one birth: OR: 1.1, CI: 0.7-1.8, two births: OR: 1.2, CI: 0.8-2.0). Parous women who never lactated had a significant, nearly two-fold increase in risk (OR: 1.9, CI: 1.3-2.9) versus those who had lactated. Our data suggest that age at menarche and lactation, but not parity and age at first full-term birth, affect breast cancer risk in black women in the manner we would have predicted from previous research. Among white women, these reproductive factors were associated with breast cancer risk in the expected manner. Selection bias, residual confounding, and other explanations for the unusual reproductive associations among African-American women in our data need further investigation.

Prostate Cancer: FAQs

Last Revised July 11, 1995

The answers to questions listed below are based on information available from the National Cancer Institute and other reputable resources. Please note that these answers are general in nature and are not intended to provide specific advice to or for individual patients. Individual patients should always discuss any specific course of action regarding the detection, diagnosis, or management of any disorder with their personal physician(s).

Answers to frequent questions asked by patients

What and where is the prostate?

The prostate is a part of every man's reproductive system. In the average mature male, it is about the size of a walnut. The prostate is located immediately below the bladder and in front of the rectum. You can find more information in the section "Where is your prostate and what does it do?"

What is prostate cancer?

Prostate cancer is the most common type of cancer in men in America. It is usually found in older men, and the risk of having prostate cancer increases with age. It is mainly found in men of 55 years and above. In this disease, cancer cells are first formed in the prostate and can then spread (metastasize) to other parts of the body, particularly the bones and other selected structures.

What are the symptoms of prostate cancer?

A man can actually have prostate cancer for many years before symptoms become apparent. When symptoms do occur, they may include one or more of the following: frequent urination (especially at night), inability to urinate, trouble starting or holding back urination, pain on ejaculation, a weak or interrupted urine flow, pain or a burning feeling during urination, blood in the urine or semen, frequent pain or stiffness in the lower back, hips, or upper thighs. *However*, *these symptoms can also be caused by other conditions as well as prostate cancer*. If you have one or more of these symptoms, it would be wise to visit your doctor for a check-up.

Can we find prostate cancer before a man has symptoms?

Certainly. In fact it is now very common for prostate cancer to be detected long before symptoms could be expected to develop. The problem is that prostate cancer often takes years to grow. We just do not know whether early detection of this cancer -- before the symptoms become apparent -- can help to reduce the number of deaths caused by the disease. In addition, the tests used to detect prostate cancer early in its development do not tell us enough about "how" it will develop. The result is that many doctors are still concerned about the problems that can be caused by the follow-up tests and procedures required when prostate cancer is detected early.

What is the right way to treat prostate cancer?

Four methods are often used in the United States to treat prostate cancer today. The first is surgery to remove the cancer. The second is radiation therapy, which uses different types of high energy radiation to kill the cancer cells. The third is cryotherapy or cryoablation, which is a way of freezing the prostate to destroy the organ. (Cryotherapy is widely considered to be an experimental procedure at this time.) The fourth is hormonal therapy, in which different types of hormone are used on their own or in combination with other methods to stop the cancer cells from growing. All these methods have benefits and risks.

There is no one "right" way to treat prostate cancer. The treatment that offers the best option for one patient may be quite wrong for another patient. Making the proper choice of treatment for a particular patient is sometimes very difficult. The doctor will want to consider the age and general health of the patient, the extent of the patient's disease, how the patient feels about the different treatment options, and what the risks are for each possible treatment. It is true that for some patients treatment may be unnecessary or even unwise. In these patients the doctor will usually practice what is called "watchful waiting," and will monitor the patient carefully by giving regular check-ups.<p>

Does treatment of prostate cancer have side effects?

Every form of treatment currently available for the management of prostate cancer is associated with significant risks and possible side effects. If you are told that you have prostate cancer that needs to be treated, you should ask your physician to explain to you carefully what those risk and side effects are.

Why have we seen an increase in the incidence of prostate cancer?
It is generally believed that the single most important reason for the increase in the incidence of prostate cancer is new tests and procedures that deliberately or incidentally allow the detection of asymptomatic prostate cancer. The single most important one of these tests is almost certainly the PSA test, which first became available in the 1980s and started to achieve widespread use in the late 1980s and early 1990s. It has been reported by the American College of Surgeons that in 1984 only 5.8% of prostate cancer patients had been given a PSA test; by comparison, in 1990, 68.4% of prostate cancer patients had been given a PSA test. It is probable that today (July 1995) close to 100% of patients diagnosed with prostate cancer will have been given a PSA test.

Why have we seen an increase in prostate cancer mortality?
By comparison with the increase in the incidence of prostate cancer from 1973 to 1990 (reported at 3.3% per year), the increase in mortality from this disease is still relatively small at an average of 1% per year over the same time period. This is even more striking when one considers the period 1986 to 1990, when the average increase in the incidence of the disease was 8.2% per year and the average increase in the mortality was only 2.6%. There are serious questions associated with these data. Four major reasons for the increase in prostate cancer have been proposed. (1) There has been a general increase in the longevity of men, and thus more men are living to ages at which they might expect to die from prostate cancer. (2) There has been a considerable decline in mortality from heart disease since the late 1960s. (3) As more men are diagnosed with prostate cancer, their deaths are being attributed to this disease even if the actual causes of death are not related to their cancer. (4) Unidentified factors could be contributing to a genuine increase in age-specific mortality for males of age 85 and over -- which is the group of men in which prostate cancer mortality has most clearly increased.

Have prostate cancer survival rates changed?
According to the epidemiological data, survival rates have indeed increased over time based on 5-year survival data from the time of diagnosis. What is not yet clear is whether this apparent increase in the survival rates is a real increase. We are clearly diagnosing prostate cancer earlier in the course of the disease. As a consequence, we know that prostate cancer patients must be living for a longer time with the knowledge that they have prostate cancer.

Does that mean that we have increased their survival time?
No, it does not. All that means is that we have increased the time that they are living with a diagnosis of prostate cancer. On the other hand, there have been several major advances in our ability to treat patients with prostate cancer, and some of these have been clearly associated with increases in disease-free survival, cancer-specific survival, and overall survival in very carefully controlled clinical trials involving hundreds of patients. The likelihood is that the apparent increase in prostate cancer survival rates includes two components: an increase due to earlier diagnosis and an increase due to improvements in therapy.

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University of North Carolina at Chapel Hill

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June 22-27, 1997

The third annual Summer Public Health Research Institute will feature courses designed to improve research methods, policy development, and program planning for minority health. Courses will emphasize issues and solutions related to: collecting, analyzing and interpreting data for racial and ethnic populations; disentangling and assessing the relationship between race and socioeconomic status; identifying and reducing barriers to conducting research in minority communities; and devising surveys to study minority populations and subpopulations.
Researchers, graduate students, postdoctoral fellows, and professionals in federal and local agencies and community organizations are invited to attend. A limited number of scholarships may be available.

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- See demonstrations of new minority health resources available on the Internet.

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For more information on either program:
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Fax: 919/966-0119
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Bibliography of Cancer Resources

Books

Altman, Robert with Michael J. Sarg, M.D. ***The Cancer Dictionary***. Facts on File, 1992. (Wait and buy the updated edition due out soon!)

Aureback, Michael, M.D. ***Conversations About Cancer: A Patient's Guide to Informed Decision Making***. Williams & Wilkins, 1996. Written by an oncologist, stresses the importance of the relationship between doctor and patient.

Babcock, Elease. ***When Life Become Precious: A Guide for Loved Ones and Friends of Cancer Patients***. Bantam, 1997. This was written by a cancer counselor.

Baron-Faust, Rita (with physicians of New York University Medical Center and the Kaplan Comprehensive Cancer Center). ***Breast Cancer: What Every Woman Should Know***. Hearst, 1995. Personal narratives also included in this book.

Bertino, Joseph, ed. ***Encyclopedia of Cancer*** (3 vols). Academic, 1996. (This is a fairly technical publication.)

Brenner, David J. ***Making the Radiation Therapy Decision***. Lowell House, 1996. Describes the radiation process and what to expect.

Calhoun, Susan and Jane Bradley. ***Nutrition, Cancer and You: What You Need to Know, and Where to Start***. Addax (due out in May 1997). This book was written by nutritionists for cancer patients who need alternative means of achieving proper nutrition.

Cooper, Geoffrey. ***The Cancer Book: A Guide to Understanding the Causes, Prevention, and Treatment of Cancer***. Jones & Bartlett, 1993. Author is from Harvard Medical School.

Cukier, Daniel, M.D. ***Coping with Radiation Therapy: A Ray of Hope***. Lowell House, 1993. Written by a radiation therapist, book discusses the fears of radiation and describes the purpose and process of the therapy.

Keane, Maureen. ***What to Eat If You Have Cancer: A Guide to Adding Nutritional Therapy to Your Treatment Plan***. Contemporary, 1996. This book was written by a nutritionist and a cancer survivor.

Lang, Susan and Richard B. Patt, M.D. ***You Don't Have to Suffer: A Complete Guide to Relieving Cancer Pain for Patients and Their Families***. Oxford University Press, 1994. This book was written by a cancer pain expert and discusses traditional painkillers as well as other options for relieving pain.

McKay, Judith and Nancee Hirano. ***The Chemotherapy Survival Guide***. new Harbinger, 1993. Written by Oncology nurses, this guide explains chemotherapy.

Zakarian, Beverly. ***The Activist Cancer Patient: How to Take Charge of Your Treatment***. Wiley, 1996. Written by the head of a cancer patient advocacy group.