disease increased their risk of getting it, only 62% had been screened for prostate cancer with the prostate-specific antigen (PSA) blood test and a digital rectal examination (DRE) in the past two years.

The numbers highlight a “disconnect” between what men know about their health, and what they do to protect it, said study coauthor Mark S. Litwin, MD, MPH, a professor of urology and public health at UCLA. It also points to a challenge for the public health community. “We’ve done a good job imparting knowledge,” he said, “but we haven’t done as good a job of getting men to act on that knowledge.”

When the researchers examined factors that influenced whether men got screened, one stood out—the influence of their doctors. Men who discussed prostate cancer screening with their doctors were 18 times more likely to get a PSA blood test and a DRE than men who did not talk to their doctors about screening.

Because all these men were at higher than average risk for prostate cancer, it seemed surprising that 20% reported they did not recall their doctor discussing prostate cancer screening. The authors propose two possible reasons. Some of the doctors may be unaware of a patient’s family history of prostate cancer. Another likely reason is the controversy within the medical community over prostate cancer screening.

The American Cancer Society (ACS) recommends that men at average risk should be offered testing beginning at age 50, if they have a life expectancy of at least 10 years, and that men at increased risk for prostate cancer, such as African Americans and those with a history of the disease in a father or brother at a young age, should begin testing with both the PSA blood test and the digital rectal examination at age 45, or even younger if they have multiple relatives with the disease. The guidelines also recommend that all men should be advised of the potential benefits and risks of early detection and treatment of prostate cancer.

“A significant number of men who have a family history don’t know that means they’re at markedly increased risk,” said Durado Brooks, MD, MPH, director of prostate and colorectal cancer for the ACS. “But even when men do understand their risk, they may not be taking appropriate measures to prevent prostate cancer or detect it early.”

“We feel providers should be talking with all their patients about benefits and limitations, and in particular, they need to talk with patients at increased risk and let them know they stand a greater chance of having a benefit from screening,” Brooks said.

Litwin agreed. “If there’s any consensus, it’s that men who are at high risk ought to seriously consider being screened. Primary care physicians and prostate cancer specialists need to be sure and counsel their prostate cancer patients to talk to their own brothers and sons,” he said.

NEW DATA ON COMBINED HORMONE REPLACEMENT THERAPY AND BREAST CANCER

Two articles in the June 25 issue of JAMA (2003; 289:3243–3253) provide additional information on combined hormone replacement therapy (CHRT) as a breast cancer risk factor.

In a new analysis of data from the Women’s Health Initiative (WHI), a randomized, controlled trial comparing the effects of combination hormone therapy (estrogen plus progestin) with placebo, Rowan Chlebowski, MD, MPH and colleagues report that not only did women who took CHRT have a 24% greater incidence of breast cancer, but their cancers were harder to detect by mammography and were found at a more advanced stage. In addition, breast cancer risk rises within five years of starting CHRT—much sooner than previous observational epidemiologic studies had suggested.

More than 16,000 postmenopausal women ages 50 to 79 took part in the WHI trial of CHRT versus placebo, which after a mean follow-up interval of 5.2 years, was stopped ahead of schedule in 2002 when researchers
found that CHRT increased the incidence of breast cancer, coronary heart disease, stroke, and pulmonary emboli.

The earlier analysis demonstrated an overall negative impact on risk of several serious chronic diseases, and clearly showed that long-term CHRT is not an effective intervention for preventing chronic disease, as had been suggested by earlier observational studies. But, the safety of short-term CHRT for treating menopausal symptoms remained in question. The new analysis adds several pieces of new information relevant to choices about short-term CHRT. First, the WHI data show an increase in false-positive mammograms, leading to unnecessary biopsies, which is evident within the first year of CHRT.

Second, breast cancer incidence appeared to be reduced during the first four years of CHRT. At that time, the incidence curves cross, and the excess risk associated with CHRT continues to increase. However, this initial drop in incidence is bad news for CHRT, the authors explain. The likely reason is that CHRT increases breast density, making mammography less sensitive. Consequently, within one year, CHRT starts increasing the false-negative mammography rate, and it takes several additional years before many of these cancers are eventually discovered, at a later stage than they would have been otherwise.

The practical implication is that even one year of CHRT prescribed for relief of menopausal symptoms may cause harms associated with increased false-positive and false-negative mammograms.

Writing in the same issue of JAMA, editorialists Peter H. Gann, MD, ScD, and Monica Morrow, MD, both of Northwestern University concluded that, “The increased risk of breast cancer and the mammographic abnormalities among women in the WHI study provide further compelling evidence against the use of combination estrogen plus progestin hormone therapy.” But, some questions regarding CHRT remain to be answered. According to Gann and Morrow, “...the risks and benefits of short-term use of hormone replacement therapy for menopausal symptoms need to be clarified in rigorous investigations, and studies examining lower dosage formulations and alternative delivery methods, such as skin patches, would be useful.”

In the second JAMA article, Christopher I. Li, MD, PhD, and colleagues from the University of Washington, Seattle, report on a population-based case-control study of breast cancer risk associated with several forms of hormone replacement therapy. An excess risk of breast cancer was associated with CHRT use, and its magnitude (a 50% increase with CHRT duration of 5 to 14.9 years) was similar to that reported in the WHI trial.

This study addresses two additional issues. The first question is whether the form of CHRT (sequential versus continuous) influences the association with breast cancer risk. The answer is, “no.”

The second question is whether estrogen replacement therapy (ERT) also increases breast cancer incidence. Li and colleagues did not find any appreciable increase in breast cancer incidence associated with ERT, although they note the size of the study was not sufficient to detect a small effect. Interestingly, WHI is also conducting an ERT versus placebo study among women who have had a hysterectomy, and are, therefore, unaffected by the association of ERT and endometrial cancer. Chlebowski and colleagues mention that, as of May 31, 2002, the WHI data and safety monitoring board (the group that terminated the CHRT versus placebo study last year when CHRT was found to increase breast cancer incidence) found no such increase associated with estrogen replacement alone. A more definitive answer is still a couple of years away; that portion of the study is scheduled to be completed in 2005.

Meanwhile, Gann and Morrow raise an interesting question concerning ERT—“If the observational studies are again correct, estrogen-only use could have much less impact on breast cancer risk than estrogen plus progestin use. The findings related to heart disease in the estrogen-only use will be of particular interest. If estrogen-only use reduces the risk of...
heart disease and has little impact on breast cancer risk, a reanalysis of the risk-benefit ratio of estrogen-only use in women with an intact uterus would seem warranted.”

**INSTITUTE OF MEDICINE RELEASES REPORT ON CANCER PREVENTION AND EARLY DETECTION**

A new report from the Institute of Medicine (IOM) of the National Academies estimates that 60,000 deaths and 100,000 new cases of cancer could be prevented each year by 2015 if more Americans used the cancer prevention and early detection knowledge and recommendations currently available. The report, “Fulfilling the Potential of Cancer Prevention and Early Detection,” was highlighted during an ACS-IOM symposium on June 30, 2003 in Washington, D.C. The symposium featured speakers including Andrew C. von Eschenbach, MD, director of the National Cancer Institute (NCI), and John R. Seffrin, PhD, chief executive officer of the ACS, as well as the coauthors of the report, and other health experts from the federal, academic and private sectors.

“Many of the behaviors placing people at increased risk for cancer are well recognized, and calls for change are not new,” said Seffrin. “What is new, however, is the growing body of evidence confirming the effectiveness of interventions helping people improve their health-related behaviors.”

The report suggests that to save the most lives from cancer, health care providers, health plans, insurers, employers, policy makers, and researchers should concentrate their resources on helping people stop smoking, maintain a healthy weight and diet, exercise regularly, and keep alcohol consumption at low to moderate levels. The IOM report also reviews the evidence supporting interventions for cancer prevention and early detection, and recommends the following 12 steps to increase the prevalence and impact of cancer prevention and early detection behaviors:

- Federal and state legislatures should enact laws that reduce and eliminate health consequences of tobacco use and exposure.
- A national strategy should be developed and applied to address the epidemic of obesity, unhealthy diet, and physical inactivity in America.
- Congress should provide sufficient appropriations to support development, implementation, and evaluation of community-based prevention and early detection programs by the Centers for Disease Control and Prevention (CDC).
- Health care insurers and providers should cover and provide evidence-based cancer prevention and early detection services.
- Congress should increase support for programs that provide primary care (including cancer prevention and early detection) to uninsured and low-income people.
- Additional support for the National Breast and Cervical Cancer Early Detection Program is needed for the program to reach all uninsured women. A similar program is needed to provide colorectal cancer screening for uninsured and low-income people.
- The extent to which federal health programs are offering and successfully delivering evidence-based prevention services should be reviewed by the Department of Health and Human Services (DHHS).
- Adherence to evidence-based prevention and early detection guidelines should be monitored. Improvements in health professionals’ education and in the infrastructure of health care systems should be undertaken to enhance delivery of cancer prevention and early detection services.
- Congress should provide support to DHHS and the US Taskforce on Community Prevention Services for assessments of cancer prevention and early-detection interventions.
- Public and private organizations should work to help the public understand and make informed lifestyle and medical choices regarding cancer prevention and early detection.