CME Background Information

This CME activity is sponsored by Brown Medical School.

Target Audience
This enduring material is designed for physicians licensed in Rhode Island.

CME Objectives
At the conclusion of this course, participants should be able to:
* describe diagnosis, staging and treatment of non-small cell lung carcinoma
* describe multidisciplinary approach to breast cancer, including the long-term maintenance of breast cancer survivors
* describe recommendations for colorectal screening
* describe the childhood cancers and their treatments
* describe treatment and prognosis of common brain tumors

Needs Assessment
Diagnosis and treatment of cancer have made dramatic advances in the past decade. This issue will inform Rhode Island physicians of those advances.

Accreditation Statement
Brown Medical School is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians.

Credit Designation
Brown Medical School designates this education activity for 2 hours in category 1 credit toward the AMA Physician's Recognition Award. Credit can be obtained by reading the issue and comleting the following quiz. The estimated time for completion of this activity is 2 hours.

Date of Original Release
This issue was published January 2002. This actvity is eligible for CME credit through December 2002.

Faculty Disclosure
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The following authors have disclosed that they have no commercial relationships to report.
Lloyd Alderson, MD, DSci, Paul Calabresi, MD, William Ferguson, MD, Mary Anne Fenton, MD, Edwin Forman, MD, Arvin Glicksman, MD, Todd Moore, MD, Neal Ready, MD, PhD

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To Obtain Credit
To obtain credit, please submit answer grid and $25 fee to Office of Continuing Medical Education, Brown University. Respondents must receive a score of 70 or higher for credit.

CME Registration Form

Print or type

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Deadline for Submission
For credit to be received, please mail your registration with $25 fee to Office of Continuing Medical Education, Brown University School of Medicine, Box G-A2, Providence, RI 02912. Submit your answers no later than December 31, 2002.

Keep a Copy for Your Files.
Retain a copy of your answers and compare them with the correct answers, which will be made available upon request, and receipt of submission requirements.

Evaluation

Please evaluate the effectiveness of the CME activity on a scale of 1 to 5 (1 being poor; 5 being excellent) by circling your choice.

1. Overall quality of this CME activity	1	2	3	4	5
2. Content	1	2	3	4	5
3. Format	1	2	3	4	5
4. Faculty	1	2	3	4	5
5. Achievement of educational objectives					
* Describe diagnosis, staging and treatment of non-small cell lung carcinoma	1	2	3	4	5
* Describe multidisciplinary approach to breast cancer, including the long-term maintenance of breast cancer survivors	1	2	3	4	5
* Describe recommendations for colorectal screening	1	2	3	4	5
* Describe the childhood cancers and their treatments	1	2	3	4	5
* Describe treatment and prognosis of common brain tumors	1	2	3	4	5

Please comment on the impact that this CME activity might have on your practice of medicine.

_____

_____

Additional comments and/or suggested topics for future CME activities.

_____

_____

_____

Cancer in the New Millenium Questions

1) The percentage of patients with cancer that can be cured in 2001 is approximately:
A) 20%
B) 40%
C) 60%
D) 80%
E) None of the above

2) The median age for patients with cancer in the United States is:
A) 50 years
B) 55 years
C) 60 years
D) 65 years
E) 70 years

3) The largest number of cancer deaths in the United States occurs from:
A) Brain tumors
B) Prostate cancer
C) Lung cancer
D) Colorectal cancer
E) Breast cancer

4) During the past 40 years we have made the most progress in the treatment of:
A) Tumors in the elderly
B) Tumors of childhood
C) Colorectal tumors
D) Brain tumors
E) Breast tumors

5) The intervention that would have the most impact on decreasing mortality from non-small cell lung cancer would be:
A) Public health programs that decreased the number of teenagers who start smoking.
B) Screening programs using high resolution CT scan of the chest.
C) Aggressive surgery for stage I and II lung cancer.
D) More extensive use of multi-agent chemotherapy.
E) Use of positron emission scanning to identify surgically curable sub-clinical disease.

6) Standard therapy for stage I or II non-small cell lung cancer would be:
A) Surgery followed by post-operative chemotherapy.
B) Surgery followed by post-operative radiation.
C) Surgery alone.
D) Pre-operative chemotherapy followed by surgery.
E) Surgery followed by post-operative chemotherapy and radiation.

7) The current standard treatment for unresectable stage III non-small cell lung cancer in patients with good performance status is:
A) Chemotherapy alone.
B) Radiation alone.
C) Sequential chemoradiotherapy (chemotherapy followed by radiation).
D) Concurrent chemoradiotherapy (chemotherapy and radiation given at the same time).
E) Twice per day radiation therapy.

8) Which women are not candidates for partial mastectomy?
A) Patients who live too far from a radiation facility to receive 6 weeks of breast radiation
B) Pregnant patients
C) Patients with connective tissue disorder
D) Patients with multicentric cancer in the breast
E) All of the above

9) Which statement is true?
A) There is no significant difference in outcome between 5 years of tamoxifen therapy and two years.
B) Chemotherapy is associated with a large increased risk of secondary leukemia.
C) Capecitabine does not include alopecia as a side effect.
D) Bisphosphonates provide no benefit in patients with bone metasis.
E) No statement is true.

10) Which statement is true?
A) For patients with a genetic susceptibility to breast cancer, the Claus model is more appropriate than the Gail model.
B) Clinical data support the use of raloxifen for breast cancer risk reduction.
C) To monitor patients for disease recurrence, physicians should screen with bone scans and CT scans.
D) A and C are true.
E) No statement is true.

11) Screening for colorectal cancer was performed on less than _____ % of the Rhode Island population.
A) 40%)
B) 50%
C) 60%
D) 80%
E) Not known

12) Both primary care physicians and endoscopists preferred which study for high-risk individuals?
A) FOBT and sigmoidoscopy
B) Flexible sigmoidoscopy
C) Colonoscopy
D) Double-contrast barium enema
E) None of the above

13) If the recommendation for standard risk individuals to be screened using colonoscopy once at age 50 and every 10 years thereafter unless some pathology is found for high-risk individuals every two years were to be implemented, current resources could handle the load.
A) True
B) False

14) An individual's risk of developing cancer between birth and 20 years of age is approximately
A) 1 in 500
B) 1 in 1000
C) 1 in 5,000
D) 1 in 10,000
E) 1 in 25,000

15) In a child with newly diagnosed acute lymphoblastic leukemia, all of the following are required/important for therapeutic decisions except
A) Lumbar puncture
B) Chest x-ray
C) Testicular biopsy
C) Cytogenetics of leukemic cells
D) None of the above

16) The number of Rhode Island children newly diagnosed with cancer each year is approximately
A) 20
B) 40
C) 80
D) 160
E) 250

17) The most common primary brain tumor is:
A) Glioma
B) Pituitary adenoma
C) Meningioma
D) CNS lymphoma
E) Medulloblastoma

18) The chance a meningioma recurs within 10 years of complete surgical resection is:
A) Less than 5%
B) Less than 20%
C) 50%
D) Greater than 60%
E) 80%

19) The most common source of brain metastases is:
A) Melanoma
B) Breast cancer
C) Lung cancer
D) Lymphoma
E) Prostate cancer

Rhode Island Quality Partners, Inc.

Prevention and Treatment Recommendations for Community Acquired Pneumonia

Deidre Spellisey Gifford, MD, MPH

Each year in the United States there are an estimated two to three million cases of **community acquired pneumonia (CAP)**, resulting in approximately ten million physician visits, 500,000 hospitalizations, and 45,000 deaths.[1] Pneumonia is the sixth most common cause of death in the US, and the overall rate of death due to pneumonia (together with influenza) is rising. Appropriate and timely antibiotic therapy for CAP has been shown to decrease mortality rates. Three recently published guidelines have evaluated the available evidence on the appropriate treatment of CAP.[2-4] Below is a summary of some of their treatment recommendations. The reader is referred to the specific guidelines for a discussion of the evidence supporting the recommendations, and for additional detail on treating CAP in patients with specific complications.

Prevention of Pneumococcal Pneumonia

All patients 65 years and older who are not allergic to the pneumococcal vaccine and who have not received the vaccine (or received it more than five years ago, if prior to age 65), should be offered the pneumococcal vaccine. If a hospitalized vulnerable elderly patient is eligible and not up-to-date with the pneumococcal and influenza vaccines, then the patient should receive the vaccines while hospitalized.

Prompt Initiation Of Therapy

For patients requiring hospitalization, the importance of prompt initiation of empirical antibiotic therapy cannot be over-emphasized. In an analysis of 14,000 patients hospitalized for pneumonia, initiation of antibiotic therapy within eight hours of hospital admission was associated with a 15% reduction in 30 day mortality.[5] However, in this national study, nearly one quarter of patients received their first dose of antibiotics more than eight hours after hospital arrival, emphasizing the opportunity for improvement in this area. Empirical antibiotic therapy based on the most likely causative organism should begin as soon as the diagnosis of CAP is made, and should not be delayed pending results of blood culture, sputum gram stain, or any other microbiological studies. For most patients, this will require that the initial antibiotic dose be given in the emergency department rather than waiting until the patient is transferred to a medical ward or intensive care unit.

TABLE I
Causative Agents and Initial Therapy for Community Acquired Pneumonia

Patient Characteristics	Most likely causative agents	Recommended initial antibiotic therapy
Outpatients	S. pneumoniae, M. pneumoniae, C. pneumoniae, Legionella , H. influenzae, viruses, M. tuberculosis, endemic fungi	Advanced generation macrolides (azithromycin or clarithromycin); OR, doxycycline
Outpatients with cardiopulmonary disease or other modifying factors* +	S. pneumoniae, M. pneumoniae, C. pneumoniae, mixed infection C. influenzae, enteric gram-negatives, viruses, Moraxella catarrhalis, Legionella, anaerobes, M. tuberculosis, endemic fungi	Beta-lactam PLUS macrolide or doxycycline; OR, antipneumococcal fluoroquinolone (alone)
Hospitalized: General medical ward, no cardiopulmonary disease or other modifying factors* +	S. pneumoniae, H. influenzae, M. pneumoniae, C. pneumoniae, mixed infection, viruses, Legionella, M. tuberculosis, endemic fungi, P. carinii.	IV azithromycin alone; OR, antipneumococcal fluoroquinolone (alone)
Hospitalized: General medical ward, with cardiopulmonary disease or modifying factors* +	S. pneumoniae, H.influenzae, M. pneumoniae, C. pneumoniae, mixed infection, enteric gram-negatives, aspiration, viruses, Legionella, M. tuberculosis, endemic fungi, P. carinii.	IV beta-lactam PLUS IV or oral macrolide or dyoxycycline; OR, IV antipneumococcal fluoroquinolone alone
Hospitalized: ICU	S. pneumoniae, Legionella, H. influenzae, enteric gram negatives, S. aureus, M. pneumoniae, viruses, C. pneumoniae, M. tuberculosis, endemic fungi	IV beta-lactam, PLUS either IV macrolide or IV fluoroquinolone (modify for patients at risk for P. aeruginosa+)

*Age >65, beta lactam therapy within past 3 mo., alcoholism, immune-suppressive illness, multiple medical comorbidities, exposure to a child in a day care center, nursing home resident. underlying cardiopulmonary disease.
+ structural lung disease, corticosteroid therapy, broad-spectrum antibiotic therapy for >7d in past month, malnutrition.

Etiology and Antibiotic Selection

In nearly half of cases, the etiologic agent of CAP is never identified. Epidemiological studies have shown that the causative agents of CAP differ depending on the site of acquisition, the severity of the infection and the comorbidities and immune status of the patient.[2-4] Table 1 summarizes the recommended initial antibiotic therapy for various patient characteristics, based on the guidelines of the American Thoracic Society.[4] Advanced generation macrolides are recommended for uncomplicated outpatient CAP, because of *H. Influenzae* resistance to erythromycin and the improved side-effect profile of the advanced generation drugs. Initial recommended therapies for inpatients and outpatients, with and without additional risk factors are described Table 1.

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The author assumes full responsibility for the accuracy and completeness of the ideas presented. This article is a direct result of the Health Care Quality Improvement Program initiated by the Health Care Financing Administration, which has encouraged identification of quality improvement projects derived from analysis of patterns of care, and therefore required no special funding on the part of this Contractor. Ideas and contributions to the author concerning experience in engaging with issues presented are welcomed.

Information for Contributors, *Medicine & Health/Rhode Island*

Medicine & Health/Rhode Island is a peer-reviewed publication, listed in the Index Medicus. We welcome submissions in the following categories.

Contributions

Contributions report on an issue of interest to clinicians in Rhode Island: new research, treatment options, collaborative interventions, review of controversies. Maximum length: 2500 words. Maximum number of references: 15. Tables, charts and figures should be camera-ready. Photographs should be black and white. Slides are not accepted.

Creative Clinician

Clinicians are invited to describe cases that defy textbook analysis. Maximum length: 1200 words. Maximum number of references: 6. Photographs, charts and figures may accompany the case.

Point of View

Readers share their perspective on any issue facing clinicians (e.g., ethics, health care policy, relationships with patients). Maximum length: 1200 words.

Advances in Pharmacology

Authors discuss new treatments. Maximum length: 1200 words.

Advances in Laboratory Medicine

Authors discuss a new laboratory technique. Maximum length: 1200 words.

Medical Myths

Authors present an iconoclastic, research-based analysis of long-held tenets. Maximum length: 1200 words.

For the above articles: Please submit 4 hard copies and an electronic version (Microsoft Word or Text) with the author's name, mailing address, phone, fax, e-mail address, and clinical and/or academic positions to the managing editor, Joan Retsinas, PhD, 344 Taber Avenue, Providence, RI 02906. phone: 272-0422; fax: 272-4946; e-mail: JRetsinas@aol.com

Images in Medicine

We encourage submissions from all medical disciplines. Image(s) should capture the essence of how a diagnosis is established, and include a brief discussion of the disease process. Maximum length: 250 words. The submission should include one reference. Please submit the manuscript and one or two cropped 5 by 7 inch prints with the author's name, degree, institution and e-mail address to: John Pezzullo, MD, Department of Radiology, Rhode Island Hospital, 593 Eddy St., Providence, RI 02903. Please send an electronic version of the text to: JPezzullo@lifespan.org.

Rhode Island Hispanics Have Mainstream Cancer Rates

John P. Fulton, PhD, and Jay S. Buechner, PhD

The 2000 US Census enumerated more than 85,000 persons in Rhode Island who self-identified as Hispanic, representing about 8.5% of the state's total population and comprising the state's largest racial or ethnic minority group. Producing regular health statistics for Hispanics is challenging because ethnicity is difficult to measure in health surveillance systems of even the best design. Here we have evaluated the ability of two major surveillance systems, the Rhode Island Cancer Registry and the Vital Records death certificate file, to measure cancer morbidity and mortality among resident Hispanics.

Methods

Because Census Bureau inter-censal estimates of the number of resident Rhode Island Hispanics were inconsistent with counts from the 2000 Census, new inter-censal estimates were constructed for resident Rhode Island Hispanics by year, sex, and age group for the years 1989-1998, using linear interpolation and extrapolation from 1990 and 2000 Census counts.

Data on resident cancer cases and deaths identified as Hispanic were extracted from Cancer Registry case reports and from Vital Records death certificates for the ten years 1989-1998 and aggregated by age group, sex, and year of event.

Alternative counts of cases and deaths for resident Rhode Island Hispanics were estimated using a validated US Census technique for identifying Hispanics by surname.[1] For resident males, data on surname from cancer case reports and from death certificates with cancer as the cause of death for the years 1989-1998 were searched for any of "639 most frequently occurring heavily Hispanic surnames" identified by the Bureau of the Census. ("Heavily Hispanic" means that 75% or more of the people with a particular surname self-identified as Hispanic on the survey.) For resident females, data on father's surname from death certificates with cancer as the cause of death for the years 1989-1998 were searched for any of the 639 names. (Data on father's surname are not available on Rhode Island Cancer Registry case reports.)

Synthetic aggregates of Hispanic cancer cases and cancer deaths were created by adding the additional cases and deaths classified as Hispanic on the basis of the surname analysis to those deaths identified as Hispanic in case reports and on death certificates. These

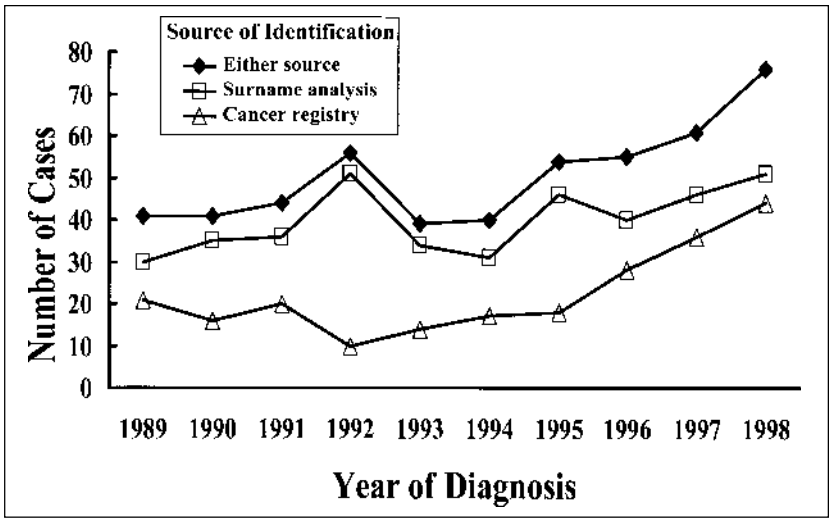

Figure 1. Number of Diagnosed Cases of Cancer among Hispanic Males, by Year and Source of Hispanic Identification, Rhode Island, 1989-1998.

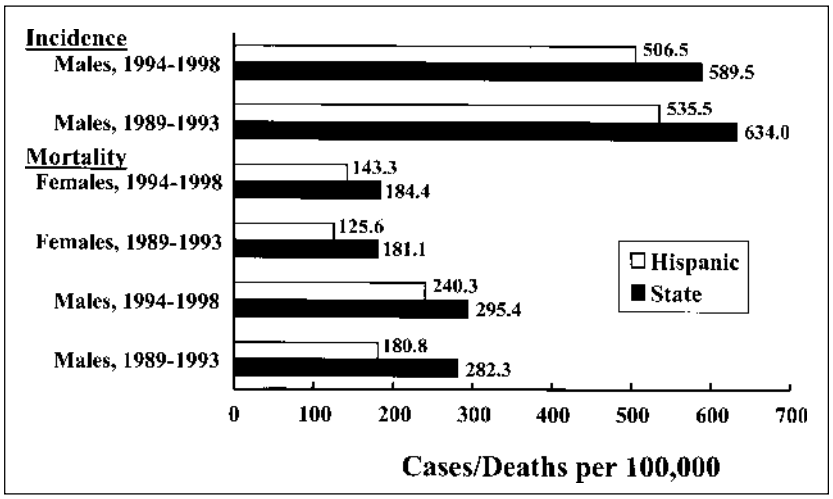

Figure 2. Age-adjusted Cancer Incidence and Mortality Rates per 100,000 Population, Hispanics and All Residents, by Sex and Year (Grouped), Rhode Island, 1989-1993 and 1994-1999.

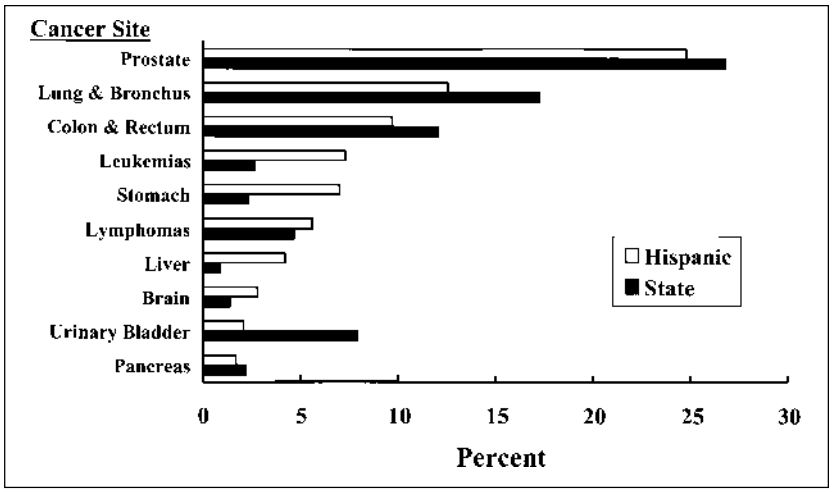

Figure 3. Anatomic Site of Diagnosed Cases of Cancer among Hispanic Males and among All Males, Rhode Island, 1994-1998.

estimates were combined with the estimates of the Hispanic population of Rhode Island for 1989-1998 to construct age-adjusted cancer incidence rates (males only) and age-adjusted cancer mortality rates (males and females). The year 2000 standard U.S. population was used for age-adjustment.

The synthetic aggregates of Hispanic cancer cases were also used to examine the proportion of cancer cases by anatomic site, comparing them with similar data for the Rhode Island population as a whole.

Results

Over the ten-year period examined, a total of 507 diagnosed cases of cancer were identified among Hispanic males, identified either from case reports or from the surname analysis. Of these, 224 (44.2%) were identified from case reports, and an additional 283 (55.8%) were identified only by Hispanic surname. By year, aggregation of cases from the two methods more than doubled the number of cases originally reported to the Cancer Registry as Hispanic in each of the first eight years of observation, and enhanced case counts substantially in 1997 and 1998 as well. (Figure 1) The number of cancer deaths among Hispanic males and females during this period showed similar enhancements from the surname analysis.

Figure 2 presents age-adjusted cancer incidence and mortality rates for resident Rhode Island Hispanic males and age-adjusted cancer mortality rates for resident Rhode Island Hispanic females in 1989-1993 and in 1994-1998, along with comparable rates for the state as a whole. In all comparisons, Hispanics have age-adjusted cancer rates that fall near but below age-adjusted cancer rates for the state as a whole.

The three most frequently occurring cancers by anatomical site during 1994-1998 were the same for Hispanic males in Rhode Island as for all males: prostate; lung and bronchus; colon and rectum. (Figure 3) Among other major sites, resident Hispanic males were more likely than resident males overall to develop cancers of the stomach and liver and leukemias, and less likely than resident males overall to develop cancer of lung and bronchus and of the urinary bladder. Patterns for the period 1989-1993 were similar.

Discussion

This analysis of data on cancer incidence and mortality among Hispanic Rhode Island residents supports conclusions concerning both patterns of disease and the reliability of the underlying data.

The use of an authoritative list of Hispanic surnames to augment Hispanic origin information on cancer registry case reports and death certificates approximately doubles the number of cancer cases that are presumably Hispanic in each of the two databases. Thus, these reporting systems are substantially understating the extent of cancer in this population.

Based on the rates produced from the synthetic aggregates, Hispanic cancer rates are generally similar to statewide cancer rates for all sites.

The site distribution for cancer incidence among male Hispanics follows the statewide distribution with two divergences worth noting. The observed higher proportions of stomach and liver cancers may be linked to the dietary patterns and infectious disease patterns (e.g., Hepatitis B) in developing countries and in immigrants from those countries. The high proportion of leukemias is consistent with a population whose age distribution is heavily weighted towards the very young.

Healthy People 2010 set a national goal of eliminating health disparities, in particular among disadvantaged racial and ethnic populations.[2] To support the accomplishment of this sweeping goal, public health surveillance data must have accurate and consistent reporting of race and ethnicity. The Rhode Island Department of Health has recently revised its policy on the collection of data on race and ethnicity and intends to improve the quality of the collected data as the changes in policy are implemented.[3] The findings of this analysis show the clear need for such quality improvement efforts.

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The Rhode Island Cancer Council

Arvin S. Glicksman, MD, and Paul Calabresi, MD

Although Rhode Island's cancer incidence rate is not above the national average for an aging population in an urban industrial state in the Northeast, the number of deaths from cancer in Rhode Island exceeds the national average. Even with the state's excellent hospitals and educational facilities, coupled with a large corps of dedicated physicians, Rhode Island has a significant cancer problem. Based on the rule that "all politics is local," programs to improve the well being of Rhode Islanders must be local.

The Rhode Island Cancer Council was established to encourage cooperative, comprehensive and complementary planning among the public, private and volunteer sectors of the State by maintaining an integrated information network of resources for all to use. The Council became operational in May 1999; the Governor, the Senate Majority Leader, and the Speaker of the House of Representatives appointed the nine members to the Board, chosen for their leadership in oncology and in the community (Table I). [The national plan, "Conquering Cancer," calls for the establishment of comprehensive State-based cancer action plans in collaboration with all experts in the region - See "Cancer in the New Millenium," this issue).

In conjunction with the Department of Health, the Rhode Island Cancer Council has the responsibility to keep the Cancer Plan for the State of Rhode Island current and broadly applicable for all residents.

As one of our first tasks we re-examined the treatment algorithm for breast cancer. A panel of experts addressed the issue of screening and diagnosis. Another panel developed treatment guidelines. A third panel is addressing supportive care and quality of life. [This responds to the recommendation of the NCLAC (Table II, Goal 10).] The cooperation and collegiality of the participants in developing the algorithm for breast care is encouraging and bodes well for its incorporation into medical practice in the State. Although mammography utilization in Rhode Island is above the national average, our death rate is 10% above the national average.

Colorectal cancer is the second leading cause of cancer deaths after lung cancer. Our death rate is 34% higher than the national average for men and 21% higher for women. Although early detection by regular screening can reduce our death rate, fewer than 50% of the population over the age of 50 have ever been screened for colorectal cancer. We recently surveyed two groups: the sixty-two gastroenterologists and surgeons who perform colonoscopy, and over 120 primary care physicians. The data point to a good deal of uniformity on screening guidelines across the specialists and the primary care physicians. [See "Colorectal Screening," this issue.]

The Council has embarked upon a broad public and professional education program. To reduce cancer deaths in Rhode Island, we must remove barriers to Rhode Island's state-of-the-art cancer programs. The Council maintains an integrated information network of resources. Our website, www.ricancercouncil.org, provides cancer-related information for Rhode Island, much of which is not available anywhere else (Table II).

Each month the Rhode Island Cancer Council provides a health column for an e-magazine, www.findri.com. Shortened versions of these columns are distributed to the churches, synagogues and mosques in Rhode Island for inclusion in their monthly bulletins.

The Rhode Island Cancer Council maintains a Cancer Forum (message board) on the Internet. In addition, the Council receives inquiries by telephone. Frequently people ask for assistance with the cost of medications. We relay information on the Drug Assistance Program at the University of Rhode Island and state programs. When appropriate we recommend clinical trials, referring callers back to their oncologists to discuss the appro-

TABLE I
Members of The Rhode Island Cancer Council
(for bioosketches, see www.ricancercouncil.org)

Paul Calabresi, MD, MACP - Medical Oncologist, Chairman
The Honorable J. Joseph Garrahy - Former Governor of Rhode Island
Arvin S. Glicksman, MD, FACR - Radiation Oncologist, Executive Director
Laura Hilderley, RN, MS - Nurse Oncologist
Louis Luzzi, PhD - Dean, School of Pharmacy, University of Rhode Island
Marlene McCarthy - Breast Cancer Activist
Charles McDonald, MD - Dermatologist
Patricia M. Nolan, MD, MPH - Director, Department of Health
The Honorable George Panichas - Former Member of the State Legislature, Treasurer

TABLE II
Cancer Resources in Rhode Island
(available on www.ricancercouncil.org)

Oncologists:
- Subspecialties
- Geographic Area

Mammography Centers:
- Geographic Area
- Handicap Accessibility
- Hours of Operation
- Languages Spoken

Support Groups:
- Disease Specific
- Geographic Area

Clinical Trials:
- Disease Site
- Stage of Disease
- Principal Investigator
- Contact Information

Smoking Cessation Programs:
- Geographic Area

priateness of their participation. Health insurers in Rhode Island cover the costs associated with Phase II, III, and IV clinical trials, as well as the costs of drugs used off-label.

The Rhode Island Cancer Council has developed free printed "Fact Sheets" on the most prevalent cancers and brochures on screening guidelines. (Table III)

Following up on Resolution 2000-H-6942 of the House of Representatives, the Rhode Island Cancer Council has contacted every city and town in Rhode Island, making our services available to develop cancer awareness programs. To date, Pawtucket, Foster, Warren, Warwick, Cranston, Tiverton, and Cumberland have responded; program development is in progress.

The Council has produced thirty-second information spots, shown on cable television, as well as on the wide screen in the Food Court at the Warwick Mall. The Council broadcasts radio spots on most of the popular stations. Frequently, the Council places cancer-related announcements in local newspapers.

Initially the Legislature asked the Council to catalogue all laws and resolutions in Rhode Island relating to the detection and/or treatment of cancer. We have completed this task. The Secretary of State now has a new category "cancer."

Last fall the Council sponsored a public information forum, "Successful Survivorship After Cancer." Dr. Julia Rowland, Director of the Office of Survivorship at the National Cancer Institute, was the keynote speaker. Over 150 individuals attended. Another public forum in conjunction with the Oncology Nurses Society on Quality of Life issues associated with end-of-life was held in spring of 2001, again drawing an audience of over 150. In the fall, a public forum on complementary care was held, a joint effort with the Rhode Island Chapter of the Leukemia and Lymphoma Society and The Rhode Island Breast Cancer Coalition. The Council will repeat this program in different parts of the State.

Last year the Council renewed the Waterman Dialogue lectureships in conjunction with the American Cancer Society. Dr. Judah Folkman and Dr. James F. Holland spoke on "Cancer Treatment for the 21st Century." The Council will continue the Waterman Dialogue, bringing experts to Rhode Island. The Council has also sponsored lectures by visiting professors on bladder cancer, prostate and other urological cancers, and breast cancer.

The Rhode Island Cancer Council encourages new research programs. Last year the newly-formed Transition Support Grant Program, awarded four grants (each approximately $15,000) to individuals who were in the process of applying for funds from national agencies but required support to enhance their competitiveness in the national pool. Three of the four were successful for a total of approximately $6,000,000 in research funds coming into Rhode Island. The fourth grant is under review. This year the Council hopes again to fund four or five promising projects.

Last year the Council held a roundtable on "Women's Issues in Cancer," bringing together twelve community leaders in this field. Copies of this report are available from the Council office.

The NCLAC report stresses the importance of implementing a National Cancer Prevention Initiative that eliminates tobacco use, increases physical activity, and improves nutrition (Table II, Goal 12). The Rhode Island Cancer Council has been an active participant in the tobacco wars as a member of the Rhode Island Tobacco Leadership Coa-

TABLE III

Cancer Fact Sheets and Resource Brochures
(available on www.ricancercouncil.org and in printed form)

Cancer Fact Sheets:
- Bladder Cancer
- Breast Cancer
- Cervical Cancer
- Chemotherapy
- Colorectal Cancer
- Head & Neck Cancer
- Hodgkinís Disease
- Lung Cancer
- Ovarian Cancer
- Melanoma
- Prostate Cancer
- Stomach (Gastric) Cancer
- Testicular Cancer

Resource Brochures:
- Breast Prostheses
- Cancer Screening Guidelines
- Smoking Cessation Programs
- Support Groups
- Wigs

lition, a group representing essentially all of the organizations and programs working to reduce tobacco use in the State. The Coalition will launch a major advertising campaign to reduce tobacco use in Rhode Island.

The Rhode Island Cancer Council has undertaken a study of tobacco use on the campuses of the eleven colleges and universities in the State. We developed a questionnaire based, in large part, on the published Centers for Disease Control and Prevention (CDC) questionnaire, modified with questions concerning readiness to quit for current smokers. In the first year, this was administered to approximately 100 freshmen at each campus. Students have also been offered the opportunity to participate in focus groups concerning tobacco use. Referrals to smoking cessation programs are available. Of particular importance has been information from Focus Groups held on three campuses last year, giving us unusual insights to students' attitudes and influences. The questionnaire to the second group of freshmen have been distributed on the various campuses throughout the State and some of this year's data have already come in for collation.

This population is the fastest growing tobacco users. It had been generally accepted that children who did not start smoking by the age of 18 would probably never be addicted to tobacco; however, since the tobacco settlement, tobacco companies have targeted their media campaigns on 18 year-olds. Accordingly, we are seeing a rise in smoking among college students. Our program is designed to understand how students balance the pressures from the tobacco industry and from the various public health anti-tobacco campaigns. This program will yield information concerning attitude, about pressures coming from multiple sources. Importantly, the Behavioral Study Group of The Miriam Hospital/Brown University provides an intervention component.

"Conquering Cancer" urges a National Cancer Screening Initiative to increase substantially the early detection of cancer (Goal 9). The State of Rhode Island has been involved in screening programs for some time and has published a "Guide to Cancer Screening." In addition the Council has initiated a mammography program for early detection of breast cancer.

Annual screening mammograms are provided to all insured women in Rhode Island and are covered by Medicare for women over 65. For women without health insurance, the Department of Health has received funds from the Centers for Disease Control and Prevention to support mammograms for underinsured and uninsured women between the ages of 50 and 64. The program, working through the Community Health Centers, provides for outreach to the at-risk population. In addition, the program provides medical attention for women with positive mammograms. This includes a biopsy of the suspicious area of the breast and a pathological analysis leading to a diagnosis. If cancer is detected, a network of providers is prevailed upon so that necessary surgery, medical oncology, radiation oncology, and psychosocial support are available. This program is not available to women below the age of 50 under the CDC grant. However, the State Legislature enacted legislation last year that established a comparable program for women between the ages 40 to 49. The State Health Department uses the existing network by extending the age eligibility. The Rhode Island Cancer Council funds this program under the legislation as passed. In the first six months of the fiscal year, 154 women have been screened. Since this program is now established by law, it will continue to provide services for women between the ages of 40 and 49 in future years.

Since its inception the Council has emphasized providing information in a timely and usable way to the public. It has developed programs with the assistance of a broad array of recognized leaders of oncology, and it has found strong support from many civic-minded public leaders without whom we could not have moved so rapidly to establish our programs. We believe that in this environment we can achieve our goal to diminish the burden of cancer in Rhode Island and improve cancer literacy throughout the State. The Council can also serve as a model for other community cancer programs as envisioned by the National Cancer Legislation Advisory Committee.

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