The comfort of learning that AIDS—acquired immune deficiency syndrome—cannot be transmitted by casual contact is chilled by the knowledge that this lethal disease may be acquired by anyone.

"If people would realize that AIDS is not a disease confined to a small number of high-risk groups, we could, through education, halt its progress," said Peter W. A. Mansell, M.D., UT MDAH professor of medicine and medical director of the Institute for Immunological Disorders.

Formerly Citizens General Hospital, the institute opened in Houston last September as a center for research and treatment of AIDS and of ARC (AIDS-related complex). Owned and managed by American Medical International (AMI), the institute is staffed by UT MDAH physicians, with consultants from the UT Medical School at Houston. Partial financial support comes from a $5.8 million five-year contract between UT MDAH and the National Institute of Allergy and Infectious Diseases.

Mansell's experience illustrates the now commonly heard warning about the shared danger of AIDS. At the institute, he said, 10% of new patients seen in the first six weeks were heterosexuals, and nationally the proportion of heterosexual AIDS patients is growing. The disease is spread mainly by sexual intercourse, shared drug needles, and—although now less so because of antibody testing—by blood transfusion.

The number of people affected by AIDS has multiplied each year so that, by 1991, 270,000 people could have the disease if its spread is not stopped. Twenty-five thousand of these—the total number of AIDS patients now—would be heterosexuals. Nearby 180,000 people would die.

In Houston, the conversion of Citizens General Hospital to the Institute for Immunological Disorders was a response to this dark prospect. "This place is quite literally unique," Mansell said. "We have the coexistence of an AIDS treatment and evaluation unit funded by the contract. From the point of view of faculty and clinical and basic research, it is a branch of MDAH and the UT Medical School. We are here to provide patients with the very best care possible, based on our experience at Anderson in the last four and a half years, and to use this institute as a center for research, education, and prevention."

**Most Are Outpatients**

Six weeks after the institute opened, at the time of this interview, Mansell and his staff had seen more than 120 new patients, mainly as outpatients, and they had accumulated a month-long waiting list despite efforts to avoid it. Diagnostic testing is faster and cheaper for outpatients, Mansell explained, less troublesome to the patients, and provides the needed information. "That's something we learned to do at M. D. Anderson where we had only four beds for AIDS patients other than those with AIDS-related cancer," he said.

No more than 15 patients have been hospitalized in the new institute at any one time, and the average stay has been less than eight days, compared with 20 or 30 days elsewhere, Mansell said. The institute has a home-care unit, so discharge planning for patients can begin almost as soon as they are admitted. Social workers see every patient and run an active counseling program for patients and families.

The characteristics of the disease divide the patient population: those who have the profound immune deficiency of AIDS that makes patients subject to potentially lethal opportunistic infections like Pneumocystis carinii pneumonia, autoimmune and neurologic disorders, Kaposi's sarcoma, and lymphomas, and those who have ARC, the complex that includes less severe systemic defects, no severe opportunistic infections, and no Kaposi's sarcoma nor lymphoma. Patients with ARC may or may not develop AIDS, so the clinical treatment and counseling of the two groups is quite different.

**Something Can Be Done**

Although the existence of an institute devoted entirely to AIDS research and treatment underscores the foreboding statistics of this disease, the atmosphere of the place strongly suggests the hope that something can and will be done about it. Given a choice of reassignment by AMI or staying on, for example, 70% of the Citizens General staff members kept their posts.

continued on page 4
The Realities of Cancer in Minority Communities

by Lovell A. Jones, Ph.D.
Associate Professor of Gynecology (Biochemistry); Director, Experimental Gynecology Laboratory

The University of Texas M. D. Anderson Hospital and Tumor Institute, along with the Texas Division of the American Cancer Society, is sponsoring a national symposium April 22-25, 1987, The Realities of Cancer in Minority Communities. Believed to be the first such meeting of cancer specialists from a variety of disciplines, the conference is an opportunity to discuss a problem that has needed more attention for a long time.

In 1984, the National Cancer Institute (NCI) set a goal of reducing the cancer mortality rate in the United States to 50% by the year 2000. This is an ambitious but achievable task if current technology is applied equally to the community at large.

Cancer is more than 100 diseases that are not randomly distributed among the general population. In certain small segments of the population, the cancer mortality rate is already close to this goal. Among Seventh Day Adventists, for example, cancer mortality is 61% of the general population's; among Mormons, cancer incidence is 72% of the general rate. Black Americans, however, have an overall cancer incidence and mortality rate that has a disproportionately severe impact (Figures 1 and 2).

Recent epidemiologic studies by the NCI showed that the overall cancer survival rate for the general population rose while the survival rate for some ethnic groups declined. The incidence, mortality, and survival among black and Hispanic Americans, in particular, are significantly different from those of the general population. If the goal of a 50% cancer survival rate is to be met by the year 2000, special programs will have to be developed for minority communities.

Consciousness-Raising Efforts

A feasible approach to addressing the cancer needs of minority groups is through intervention, research, and application of cancer prevention and control principles. For these activities to be effective in addressing the needs of U.S. minorities, however, an effort has to be made to involve the staffs of comprehensive cancer centers like ours, black and Hispanic community health care professionals, and the public.

In 1985, the NCI along with several minority groups organized events to publicize the need for minority group members to become more aware of the cancer problem. Since black Americans are the largest U.S. ethnic minority and the minority population for which the most cancer data exist, the NCI focused attention first on black populations. Several ideas were proposed. One was to hold four regional planning sessions—in New York, Atlanta, Chicago, and Los Angeles—to inform the public of the NCI's intentions and to generate interest in submitting cancer intervention grant applications. Another was the designation of May 1985 as Black American Cancer Awareness Month. In Texas, the legislature proclaimed this, but throughout the state and specifically in Houston, May 1985 went by with little attention paid to the proclamation, and little activity or awareness was reported from other metropolitan centers.

My reaction to this lack of attention was to propose holding a national conference sponsored by a major cancer center such as UT MDAH. The aim was to structure a program that would not only benefit physicians and health care professionals from minority communities but health care professionals generally. After senior staff members at the National Institutes of Health reviewed it, the UT MDAH Research Council approved the
program, and invitations went out to a group of outstanding speakers. These will include Phillip L. Cole, M.D., University of Alabama Comprehensive Cancer Center, Jerome Wilson, Ph.D., Howard University Cancer Center, Mario Gonzalez, M.D., Rio Grande Cancer Treatment Center, Carlos Vallbona, M.D., Baylor College of Medicine, and Mary Claire King, Ph.D., University of California.

Data for Hispanics Are Puzzling

The cancer problem is not only a black and white problem. The 1980 census enumerated 14.6 million Hispanic residents; with the addition of undocumented Hispanic persons, the estimate is that more than 20 million Hispanics currently live in this country. The impoverished people in this group suffer from lack of jobs, lack of adequate education, overcrowded schools, inadequate housing and overcrowding of urban dwellings, lack of medical care, and chronic malnutrition. Added to this are the relatively high smoking rates of elderly Hispanics and trends of increasing smoking by young Hispanic males. All these are factors known to contribute to a higher incidence, case fatality rates, and mortality from cancer generally as well as from neoplasms at specific sites.

One would guess, therefore, that cancer is a more severe problem in the Hispanic than in the white population. Yet data on five-year survival rates from the Surveillance, Epidemiology and End Results (SEER) Program (San Francisco/Oakland and New Mexico) show that, except for the rates for bladder cancer and Hodgkin's disease, the rates are similar among the Hispanic and white non-Hispanic populations. Hispanic women have a slightly higher survival rate from cancer of the ovary than do white non-Hispanic persons, whereas Mexican-American women with breast cancer are reported to have a prognosis worse than that of women in the general population.

Why these apparent paradoxes and this recital of isolated facts? One clue to this contradictory information is that virtually no national mortality data exist on Hispanics in the U.S., and there is no source of data on cancer incidence that represents the whole Hispanic population in the U.S.

Information Base Is Not Reliable

Although the information concerning black Americans is not as limited as that for Hispanics, the data on cancer incidence provided by the SEER Program come from 11 locally based cancer registries that cover only a small percentage of the minority population. Minority groups have expressed concern recently about the SEER Program's limited data collection because the SEER data, despite inadequacies, are perceived as authoritative by policy makers and health care professionals.

![Figure 1. Age-adjusted cancer incidence (per 100,000) by racial/ethnic group: 1978-1981—all sites combined. (From Cancer Among Blacks and Other Minorities: Statistical Profiles, National Cancer Institute, 1986.)](image)

In addition to the overall lower survival rate from cancer, the data on black Americans show that their survival rates for certain types of cancer continue to be significantly lower than those of white Americans. The five-year survival rate of 63% for black women with breast cancer, for instance, is significantly lower than the 75% rate for white women with the same disease. Although the majority of white and black women discover their tumors, the tumors in black women are larger, more often involve nodes, and are more extensive by the time they are diagnosed. Black women delay longer in seeking treatment.

Barriers to Health Care

Failure to reduce the incidence and mortality rate of cancer in the minority communities can be ascribed to the barriers between these communities and health care, barriers that are both structural and institutional and are kept in place by problems of money, access, and availability. Behavioral and cultural barriers also exist, maintained by outdated knowledge, attitudes, and practices.

Many of these barriers are deeply set in socioeconomic circumstances and require creative methods to circumvent and overcome. One way of beginning to solve the problem is to bring together professionals from major cancer centers, minority researchers and physicians, primary care community physicians, persons in the minority community involved in health care,
AIDS Hospital . . .

continued from page 1

One reason for hope, Mansell explained, is that the disease lost some of its mystery when, in 1983, French scientists identified the virus, now called human immunodeficiency virus (HIV)—and formerly human T-cell lymphotropic virus type III/lymphadenopathy-associated virus (HTLV-III/LAV)—as a necessary factor in the disease, though not its total cause.

It’s easy now to do the antibody test, Mansell said. Culturing the virus, which is not easy, is being done by F. Blaine Hollinger, M.D., a virologist at Baylor College of Medicine.

Drug Trials and Vaccination

“We have a peculiar opportunity here in the sense that we have a physical plant, and we have the largest continually followed up group of patients with AIDS-related problems in the world,” Mansell said. “We will be testing new drugs as we’ve done at Anderson since January 1982. The large number of biological response modifiers we tested were unsuccessful for the simple reason that, at least in the early days, we had a virus we didn’t know working against us. It’s like pouring water into a bucket that has a hole in the bottom. Until you can plug up the hole by getting rid of the virus, no biological response modifiers will work.”

Counseling Patients with AIDS and ARC Begins with Unconditional Acceptance

“I think a very important thing is that we have to accept each person, and it cannot be conditional. That’s what I tell people now.”

That’s how Sue Cooper, M.S.W., explains her job as director of the Department of Social Services of the newly opened Institute for Immunological Disorders.

“I really had to look at what my motivation was and if I thought I could do it. I had to look at my own value system and make sure that I was not more of a hindrance than a help. Oftentimes I think the patients read us as quickly as we read them,” she said.

Cooper came to her job from UT MDAH, where she had worked with patients with AIDS (acquired immune deficiency syndrome) since UT MDAH began treating these patients about four and a half years ago.

“I see our patients as human beings who are sick and need care. I don’t have to be into moral judgments. My place is to do what I do well, and I hope that is to be a good social worker,” said Cooper, a former housewife who returned to school at midlife to earn a master’s degree. She interned at MDAH and changed from working there as a student one Friday to working as a full-time paid employee the next Monday.

Problems of starting from scratch—being part of a new hospital, acting as the only social worker, and facing the task of hiring other support staff members seem conquerable to Cooper, and she has high expectations of the people she hires.

Asked about horror stories concerning the disease, Cooper answered the question in her own way. “There are horror stories about AIDS,” she said, “because AIDS patients have so few resources. One horror story, for example, might be: ‘John had no place to go, and he was so sick that he just curled up and died.’ That’s a horror story, not so much about the disease, but...
The first essential step, he said, is to be able to get rid of the virus. Equally important is education for prevention, because the development of a vaccine will take several years, and even then the vaccine will be useful only for people not infected by the virus.

Not to Repeat African Experience

We know now, Mansell said, that AIDS has been in Africa for 15 or 20 years, started by a simian virus that transferred itself to humans. “And when we look at what is happening in Central Africa, we may be looking through a window into our future. In Kinshasa, Zaire, for example, which has a population about the size of Houston’s, the AIDS incidence is 100 cases per 100,000 population. Ten percent of children are infected by the virus and equal numbers of men and women.

“AIDS is a threat to everybody. As Surgeon General Everett Koop urged in his report, we ought to be teaching school children how to avoid it. We have the knowledge, if people would accept it, to reduce the incidence of the disease significantly by teaching people to avoid multiple promiscuous sexual partners and not to inject drugs with dirty needles.

“A few years ago many people regarded AIDS as a just visitation on people who had earned it, but it’s obvious now that this is a sexually transmitted disease that is as much a menace to society in general as it is to any particular risk group. Although the great majority of AIDS patients will continue to be in certain high-risk groups, of which drug abusers are becoming one of the most significant, no group in society is innately not at risk,” Mansell said.

He and his associates are determined “to get really involved at the grass roots of education,” he said. “We hope that this institute with its focus of interest and, I hope, expertise will enable us to speak with a strong voice.”

This hope was expressed also by Adan A. Rios, M.D., director of the institute’s Department of Medical Oncology and an assistant professor at UT MDAH. “Right now,” Rios said, “we are looking at this place as a potential source for AIDS education, prevention, therapy, and research, and we hope to develop the institution in a way that will be attractive for all who want to learn about this disease and to participate in our work.”

“We have a feeling here,” Mansell added, “of being pioneers in a sense, of trying to address a problem as well as it can be done.”

Physicians who desire additional information may write Peter W. A. Mansell, M.D., Institute for Immunological Disorders, 7407 North Freeway, Houston, Texas 77076.

Institute for Immunological Disorders

about loss of support systems.”

The institute’s social support groups for patients, family members, and life partners started to meet a month after the hospital opened. Cooper pointed out that patients with AIDS and ARC (AIDS-related complex), though treated in the same environment, have different needs.

Lives Long or Short

“ARC patients have been labeled ‘the worried well’ because they are so afraid they are going to get AIDS that it sometimes immobilizes them. They are trying to carry on a normal life, but they are afraid to make decisions. They don’t know their future—they may get AIDS or they may live another 50 years,” she said.

Having AIDS forces a completely different view on patients. “People who have AIDS face the reality that they probably will not to be able to work much longer,” Cooper said, “and they have to start making very ‘now’ sorts of decisions: Where am I going to live? Where do I want to be treated? How far do I want to go with treatment? Do I want to go home and not do anything? And most important, What’s important to me now?”

Cooper said that counseling those with AIDS is not dissimilar from counseling others with chronic diseases, except that these patients’ chances of surviving are much lower, and they have probably seen many of their friends die or become sick from the same disease.

“You take the normal person off the street and ask him what he knows about cancer. Do you think he could tell you very much? You ask someone if he knows about arthritis, or multiple sclerosis, or even Alzheimer’s disease. But you ask a man who is gay what he knows about AIDS, and you get a lot of information,” Cooper said.

“They are very aware of what it means to have AIDS,” she said.
Texans Plan Network of Cancer Resources

The Texas Cancer Plan, a design to advance control of cancer in Texas through four major initiatives, was formally presented to Texas House Speaker Gib Lewis in September by a legislative task force, whose members included UT System Cancer Center President Charles A. LeMaistre, M.D., and Joseph T. Painter, M.D., a UT MDAH vice president.

Ordered developed and implemented by the 69th Texas Legislature, the Texas Cancer Plan is the product of the 52-member Legislative Task Force on Cancer appointed in 1984 by Lewis and chaired by James D. Dannenbaum, a UT MDAH volunteer and seven-year member of the Board of Visitors. The task force was charged with evaluating the burden of cancer on Texans and designing methods of reducing it.

Wide-Ranging Goals

The Texas Cancer Plan’s four major goals are (1) lowering the risk of developing cancer; (2) detecting, diagnosing, and treating cancer earlier when cure is more likely; (3) improving the accessibility, availability, and quality of cancer resources, services, and programs; and (4) advancing control of cancer through development and application of new prevention, detection, diagnostic, and therapeutic methods. On the basis of the task force’s initial report, which was an interim plan addressing immediate priorities, the Texas Legislature created the 16-member Texas Cancer Council (TCC), and it appropriated $7 million for the 1986-1987 biennium to put the interim plan into operation. Now it is the Texas Cancer Council’s job to implement and monitor the development of a coordinated, comprehensive network of cancer resources in this state. Painter, who is UT MDAH vice president for physician referral development and extramural programs, directed the task force staff and now serves on the TCC executive committee.

First State Cancer Plan

The Texas Cancer Plan is the first state-level plan of its kind in the country. “A program focusing on prevention, early detection, and networking became feasible based on the success against cancer nationwide,” said Owen F. McCrory, director of extramural programs at UT MDAH. “The state of Texas has a long history of being interested in cancer, as evidenced by its creation and support of M. D. Anderson Hospital. Our knowledge of how to prevent cancer, and specific tools and techniques for detection, are relatively recent developments.”

The TCC has already put some of the interim objectives into practice. For example, cancer screening programs in local health departments and nurses’ training in cancer prevention and detection techniques were expanded. In addition, the Office of Smoking and Health in the Texas Department of Health (TDH) was created to promote prevention and cessation of tobacco use. As a result of the comprehensive school health education program developed by the Texas Education Agency and supported by the TCC, 82% of Texas schoolchildren are being taught about cancer and other health issues. This program will be developed further during the next fiscal year as teacher training in health education is extended.

Special projects began operating. In the Rio Grande Valley cancer screening in public health clinics is now coupled with diagnostic follow-up by local physicians or transportation to the nearest cancer center when necessary, and a valleywide cancer prevention program has been developed. In East Texas, the TCC supported a study on nutrition and cancer among black people. In addition, the TCC provided funds to help the state health department expand collection and analysis of cancer incidence data and to create the Texas Cancer Data Center for collecting and correlating information on cancer resources, services, and programs.

Through the hospital-based Statewide Cancer Registry Program operated by the TDH, comprehensive data are being collected from seven of the 12 public health regions, and eventually information will be obtained from the others to create a statewide cancer incidence profile.

Money to Keep Program Going

The TCC has requested $8.9 million from the legislature to operate the Texas Cancer Plan during 1988-1989. About 75% is earmarked for continued organization and operation of cancer prevention programs; 10% is allocated to maintaining the Rio Grande Valley programs; about 7% will be used to establish a jointly funded communication network among community cancer centers; and 6% is assigned to continuing the cancer resources data system and evaluating TCC initiatives. The remaining funds are for administration.

The objectives of the Texas Cancer Plan are twofold: first, to thoroughly educate every Texan about cancer, and second, to make cancer care easily accessible. The hope is that new cancer cases and deaths from this disease will decrease significantly; that the pain, suffering, and disability of those afflicted with cancer will be diminished; and that the substantial personal and economic costs of caring for those who have cancer will be reduced.

Copies of the Texas Cancer Plan are available from the Office of the Vice President for Physician Referral Development and Extramural Affairs, The University of Texas M. D. Anderson Hospital and Tumor Institute at Houston, 1515 Holcombe Boulevard, Houston, Texas 77030.
What Types of Conferences Do Texas Physicians Want?

To help the Office of Conference Services at UT M. D. Anderson Hospital meet the needs of Texas physicians for oncology education, OncoLog readers are asked to fill out the questionnaire below.

Please check each category that applies to you.

- Hospital-based
- Clinic
- Research
- Academic
- Private
- Other

Size of practice

Location of practice
- Rural
- City

Area of specialty
- Subspeciality

How many years in practice?
- 0-5
- 6-10
- 11-15
- 16-20
- 20+

1. How many major medical conferences a year do you normally attend?
   - At M. D. Anderson
   - Others

2. Why do you attend?
   - Education/CME
   - Content
   - Resort
   - Location

3. Does your spouse attend conferences with you?
   - Yes
   - No
   - Sometimes
   - Always

4. Do offerings for spouses influence your attendance?
   - Yes
   - No
   - Sometimes
   - Always

5. Please list by priority three topics you would like to see presented.
   1. ____________________________
   2. ____________________________
   3. ____________________________

6. What other medically related topics would you be interested in learning more about?

7. When do you prefer to attend conferences?
   - Weekdays
   - Weekends
   - Combination

8. What time of year do you prefer for conferences?
   - Spring
   - Summer
   - Fall
   - Winter

9. Is the cost of a conference a factor?

- Yes
- No

10. What do you consider an appropriate fee for:
   - Hotel
   - Registration

11. Do you regularly receive information about M. D. Anderson conferences?

- Yes
- No

12. If yes, how?
   - Direct mail
   - OncoLog
   - Journal announcements
   - Advertisements
   - Other

13. If not, would you like to receive information?

- Yes
- No

Your address:

General comments

Thank you for answering these questions. We promise to use the information for developing programs that will meet the needs of Texas physicians and others.

Please return to: Office of Conference Services
M. D. Anderson Hospital—HMB Box 131
1515 Holcombe Boulevard
Houston, Texas 77030

Change of Mailing Address

The mailing address of UT M. D. Anderson Hospital has changed from 6723 Bertner Avenue to 1515 Holcombe Boulevard, with the same 77030 zip code. Neither the hospital nor departments in the Houston Main Building have moved—the change was made to make the hospital easier to find.
1985 Research Report: Long Story, Tersely Told

To assemble a cadre of talented scientists working in new spaces, to gain a clearer understanding of cancer causes and design new therapies—near goals almost met, according to Frederick F. Becker, M.D., vice president for research, in his foreword to the UT System Cancer Center's Annual Research Report 1985.

Enumerating "the recruitment of an outstanding scientific staff, the development of new technology, the construction of superior facilities, and the instigation of collaborative studies between basic and clinical research groups," Becker expressed the belief that the results of "this enormous expansion and improvement of our research capabilities" will be rapidly evident.

The 230-page illustrated research report contains brief descriptions of the work of each division, department, and section. William J. Lennarz, Ph.D., chairman of the Department of Biochemistry and Molecular Biology, begins it by describing work related to the biosynthesis and function of cell-surface glycoproteins, which are believed to play a role in cell recognition events in both normal and abnormal growth and differentiation.

Toward the end of the alphabetically arranged department reports is one by Garth L. Nicolson, Ph.D., chairman of the Department of Tumor Biology, on work directed to detecting and eliminating tumor cells: "understanding basic mechanisms of neoplastic transformation, aberrant cell growth, genetic instability, and other tumor cell properties; determining how host antitumor mechanisms recognize and kill or inhibit the growth of tumor cells; and determining how differences in tumor cell properties can be used to identify and remove malignant cells from normal cell populations."

Between these two sections are necessarily terse summaries of the institution's range of basic and clinical work—from biomathematics, through cell biology, diagnostic imaging, genetics, immunology, laboratory medicine, medicine, pathology, pediatrics, radiotherapy, and surgery, to veterinary medicine and resources.

The 1985 research report is a mirror of one part of the institution's work, a place to start if one wants a quick look at what goes on here in cancer research.

The report will have national and international library distribution. A limited number of copies are available free from the Department of Scientific Publications, The University of Texas M.D. Anderson Hospital and Tumor Institute at Houston, 1515 Holcombe Boulevard, Houston, Texas 77030 -- (713) 792-3305.

Minority Communities ... 

and persons at the national level involved in health care planning. That is the overall aim of the symposium to be held in Houston.

Cancer is an "equal opportunity disease" and a major public health problem. The majority of participants in this symposium are nationally known, but the true success of the conference will be its ability to attract primary care physicians and oncologists of all racial and ethnic backgrounds, as well as the general public, so that they may become acquainted with the realities of the cancer problem.

Physicians who desire additional information may write Lovell A. Jones, Ph.D., Department of Gynecology, Box 67, The University of Texas M. D. Anderson Hospital and Tumor Institute at Houston, 1515 Holcombe Boulevard, Houston, Texas 77030.