95% CI, 0.43–0.59); neuroblastoma (OR = 0.46, 95% CI, 0.39–0.55)] in comparison to the children of US-born Hispanic women [ALL (OR = 1.23, 95% CI, 1.11–1.37); glioma (OR = 0.75, 95% CI, 0.62–0.90); neuroblastoma (OR = 0.63, 95% CI, 0.51–0.78); referent group was the children of US-born Whites]. The odds for rhabdomyosarcoma and acute myeloid leukemia were equivalent between Hispanics regardless of maternal place of birth. Hepatoblastoma was higher among the children of foreign-born mothers (OR = 1.35, 95% CI, 0.87–2.10) than those of US-born Hispanic mothers (OR = 0.93, 95% CI, 0.56–1.55) while bone tumors were higher among the children of US-born mothers (OR = 2.08, 95% CI, 1.11–3.88) compared to the children of foreign-born mothers (OR = 0.73, 95% CI, 0.38–1.41). Conclusions: With notable exceptions, the children of foreign-born Hispanic mothers tended to have cancer rates lower than those of US-born Hispanic mothers. Risk factors identified as driving the Hispanic paradox may be fruitful for study among these childhood cancer types.

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Are Women Willing to Change Breast Cancer Screening Guidelines?

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This purpose of this study is to evaluate the willingness of women to change their breast cancer screening practices if given personalized recommendations based on risk factors such as breast density, family history and lifestyle. Methods: A random sample of 1,024 Virginia women between age 35–70 years and without breast cancer, reached by landline and cell phone, completed a 24-minute interview. Results: Just over half (54.6%) of women are definitely or probably willing to reduce their frequency of breast cancer screening if provided with personalized recommendations. This compares to 81.9% who are definitely or probably willing to increase screening. The most cited disadvantage for reduced screening was delayed detection of breast cancer (77%) while the most cited advantage for increased screening is earlier detection (82%). Women are willing to change their type of screening (92.3%). Women who were more likely to be willing to reduce screening are those with a lower perceived risk of breast cancer, less familiarity with risk factors and recommendations. When asked what they needed to know to make a change, women cited advice of a doctor (52.1%), research/evidence (38.9%) and comparison with old recommendations (22.5%) most frequently. Advice of a radiologist was only stated by 2.3% of the women. Conclusions: These results suggest that most women will be willing to change their breast cancer screening frequency especially if recommended by their primary care physician. Women do not view their radiologist as having a primary role in delivering screening recommendations; this underscores the need to educate primary healthcare providers regarding breast screening recommendations.

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Associations of Obesity with Prostate Cancer Risk Differ Between U.S. African-American and Non-Hispanic White Men: Results from the Selenium and Vitamin E Cancer Prevention Trial

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African-American (AA) men have the highest rates of prostate cancer incidence and mortality in the US. Understanding underlying reasons for this disparity could identify preventive interventions important to AA men. PURPOSE: To determine whether the association of obesity with prostate cancer risk differs between AA and non-Hispanic white (NHW) men and whether obesity modifies the excess risk associated with AA race. METHODS: This is a prospective study among 3398 AA and 22673 NHW men who participated in the Selenium and Vitamin E Cancer Prevention Trial (2001–2011). Using Cox regression, we estimated hazard ratios (HRs) and corresponding 95% confidence intervals (CIs) associated with AA and NHW race and body mass index (BMI) [kg/m2] on total, low- (Gleason score <7), and high-grade (Gleason score ≥7) prostate cancer incidence while adjusting for relevant covariates. RESULTS: There were 270, 148, and 88 cases of total, low-, and high-grade prostate cancers among AA men and a corresponding 1453, 898, and 441 cases in NHW men (median follow-up of 5.6 years). BMI was not associated with risk of total cancer among NHW men, but was positively associated with risk among AA men (BMI < 25 kg/m2 vs. ≥35 kg/m2, HR = 1.49; 95% CI, 0.95–2.34; Ptrend = 0.03). Consequently, the risk associated with AA race increased from 28% (HR = 1.28; 95% CI, 0.91–1.80) among men with BMI < 25 kg/m2 to 103% (HR = 2.03; 95% CI, 1.38–2.98) among AA men with BMI≥35 kg/m2 (Ptrend = 0.03). BMI was inversely associated with low-grade prostate cancer risk among NHW men (BMI < 25 kg/m2 vs. ≥35 kg/m2, HR = 0.80; 95% CI, 0.58–1.09; Ptrend = 0.02), but positively associated with risk among AA men (BMI < 25 kg/m2 vs. ≥35 kg/m2, HR = 1.77; 95% CI, 1.14–2.76; Ptrend = 0.05). BMI was positively associated with risk of high-grade prostate cancer in both NHW (BMI < 25 kg/m2 vs. ≥35 kg/m2, HR = 1.33; 95% CI, 0.90–1.97; Ptrend = 0.01) and AA men (BMI < 25 kg/m2 vs. ≥35 kg/m2, HR = 1.81; 95% CI, 0.79–4.11; Ptrend = 0.02), but associations were not significantly different. CONCLUSION: Obesity is more strongly associated with increased prostate cancer risk among AA than NHW men and reducing obesity among AA men could reduce the racial disparity in cancer incidence. Research is needed to test mechanisms underpinning these associations.

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