
Researchers evaluated overall survival (OS) differences in economics and sociodemographics and economic differences among 5,412 study patients with penile squamous cell carcinoma. Survival did not change over the study period, but the authors found that black patients had worse median OS and presented with a more advanced stage of disease. Those who had median incomes of at least $63,000 and carried private insurance had better median OS and presented with a lower stage of disease. Thus, the researchers determined that racial and economic differences exist in the OS rates of patients with penile squamous cell carcinoma.


Racial and ethnic differences were studied among patients who had enrolled in, refused to enroll, were ineligible to enroll, or wanted to participate in a clinical trial enrollment. Age 65 years or older, male sex, and non-Hispanic black race were significantly associated with more medical or physical conditions. Those who were aged 65 years or older were significantly more likely to have low clinical trial enrollment; by contrast, being male was significantly associated with low refusal rates. The authors concluded that better management of physical or medical conditions before and during treatment might increase the pool of patients eligible to enroll in clinical trials.


A retrospective review of individual patient data was conducted to determine the racial distribution among samples sequenced within The Cancer Genome Atlas (TCGA) and the number of samples still needed to detect select mutational frequencies in racial minorities. Of the 5,729 samples analyzed, 77% were white, 12% were black, 3% were Asian, 3% were Hispanic, and less than 0.5% were Native Americans. These percentages, thus, over-represent whites compared with the US population and under-represent Asians and Hispanics. All tumor types from whites contained enough samples to detect a 10% mutational frequency; however, group-specific mutations with a 10% frequency were detectable for black patients with breast cancer alone. It is probable but not well understood that ethnic diversity may be related to the pathogenesis of cancer and may have an impact on the generalizability of these study findings.


A review of the medical literature reporting on the prevalence and/or spectrum of *BRCA1* and *BRCA2* variants was conducted. A total of 4,835 individuals from Latin America, the Caribbean, and Hispanics from the United States were included, of which 167 unique pathogenic variants were reported. In unselected breast cancer cases, the prevalence ranged from 1.2% to 27.1%. Some countries presented with few recurrent pathogenic variants, whereas others were characterized by diverse, nonrecurrent variants. The proportion of *BRCA* pathogenic variants shared between US Hispanics and Latin American populations was estimated to be 10.4%. Within Latin America and the Caribbean, 8.2% of the *BRCA* variants were present in more than 1 country. Countries with a high prevalence of *BRCA* pathogenic variants may benefit from more aggressive testing strategies, and testing of recurrent variant panels might present a cost-effective solution for improving genetic testing in some countries.


Researchers sought to determine the prevalence and type of *BRCA1* and *BRCA2* mutations among Hispanics in the southwestern United States and their potential impact on genetic cancer risk assessment. Deleterious *BRCA4* mutations were detected in 25% of 746 samples. A total of 11% of 189 samples were large rearrangement mutations, of which 62% were *BRCA1* exon 9 to exon 12 deletions. Nine recurrent mutations accounted for 53% of the total. Among these, *BRCA1* exon 9 to exon 12 deletions appear to be a Mexican
founder mutation representing up to 12% of all BRCA1 mutations in select cohorts. The authors conclude that the high frequency of large rearrangement mutations warrants screening in every case.


The genetic heterogeneity and complexity of advanced cancers support rationale for interrupting the carcinogenic process early and target prevention to reduce the burden of cancer; however, the focus of cancer prevention should be on persons at high risk and on primary localized disease, for which screening and detection should also play a role. The timing and doses of chemopreventive interventions also affect response. The intervention may be ineffective if the target population is very high risk or presents with preneoplastic lesions and irreversible cellular changes. The field must begin to focus on targeted organ-site prevention approaches in patients at high risk. The authors also suggest that comparative effectiveness research designs and the value of information obtained from large-scale prevention studies are necessary so that preventive interventions become a routine part of cancer management.


This article describes the rationale for resource-stratified guidelines and the methodology for developing the National Comprehensive Cancer Network (NCCN) Framework. Disparities in available resources for cancer care are enormous, which is one reason why the NCCN developed a framework for stratifying its clinical practice for cancer. NCCN also hopes to help health care systems with varying levels of available resources provide optimal care for patients with cancer. The framework is modified from a method developed by the Breast Health Global Initiative. The NCCN Framework for Resource Stratification identifies 4 resource environments and presents the recommendations in a graphic format that maintains the context of the NCCN guidelines.


Approximately 189,910 new cases of cancer and 69,410 cancer-related deaths will occur among blacks in 2016. Although blacks continue to have higher rates of cancer-related mortality than whites, the disparity has narrowed for all cancers combined in men and women and for lung and prostate cancers in men. The racial gap in death rates has widened for breast cancer in women and remained stable for colorectal cancer in men. In men, incidence rates from 2003 to 2012 decreased for all cancers combined as well as for the top 3 cancer sites. In women, overall rates during the corresponding time period remained unchanged, reflecting increasing trends in breast cancer combined with decreasing trends in lung and colorectal cancer rates. The 5-year relative survival rate is lower for blacks than whites for most cancers at each stage of diagnosis. The extent to which these disparities reflect unequal access to health care vs other factors remains an active area of research.


The authors sought to identify disparities in cancer incidence, mortality, and survival rates in relation to race and ethnicity. For all cancer sites combined, residents of poorer counties had 13% higher death rates from cancer in men and 3% higher rates in women when compared with individuals living in more affluent counties. Among both sexes, the 5-year survival rate for all cancers combined was 10% lower among persons who live in poorer rather than more affluent census tracts. When the census tract poverty rate was accounted for, African American, American Indian, Alaskan Native, and Asian/Pacific Islander men and African American, American Indian, and Alaskan Native women had lower 5-year survival rates than non-Hispanic whites. Detailed analyses of select cancers showed large variations in rate of cancer survival by race and ethnicity.


The authors review the literature on 7 cancer sites that may disproportionately affect lesbian, gay, bisexual, transgender/trans-sexual, and queer/questioning populations. For each cancer site, descriptive statistics, primary prevention, secondary prevention and preclinical disease, tertiary prevention and late-stage disease, and clinical implications are discussed. The authors also provide an overview of psychosocial factors related to cancer survivorship as well as strategies for improving access to care.