

ings are clear: to be maximally effective in reducing morbidity and mortality, early breast- and cervical-cancer detection programs should target groups with a combination of high incidence of disease and a high proportion of that disease diagnosed in late stages.³ Since incidence rates of postmenopausal breast cancer among Black women are now approaching those of Whites,⁴ and cervical cancer rates among Blacks remain two to three times higher than those among Whites,⁴ the findings of our study support targeting elderly, low SES, Black women—particularly those using the public hospital system—in cancer control efforts. □

Jeanne Mandelblatt, MD, MPH

Requests for reprints should be sent to Jeanne Mandelblatt, MD, MPH, Division of Cancer Control, Department of Epidemiology and Biostatistics, Sloan-Kettering Cancer Center, Box 60, 1275 York Ave, New York, NY 10021.

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Screening Behaviors among Relatives of Breast Cancer Patients

In their article on the breast screening behaviors of relatives of women with breast cancer, Kaplan et al.¹ report data collected from relatives of breast cancer patients in five pilot projects conducted in Pennsylvania from 1984 to 1987. Their hypothesis—that health care providers would more effectively screen women known to be at elevated risk of breast cancer—was identical to my and my colleagues' hypothesis when we examined screening behaviors among the participants in the American Cancer Society 1987 Texas Breast Screening Project.² When we compared women with first-degree relatives with breast cancer to

women without a family history of breast cancer, we found that, after controlling for age, there was no difference in the proportion of women who reported ever having mammography (35.1% vs 31.5%, not significant). The data from Kaplan et al. are virtually identical to our earlier data.

We collected our data from participants in a low-cost promotional project designed to improve utilization of mammographic screening. However, the Pennsylvania researchers contacted all women known to be alive after a diagnosis of breast cancer between 1980 and 1986 and subsequently surveyed their first-degree female relatives. Nevertheless, only 37% of these relatives of breast cancer patients contacted between 1984 and 1987 reported ever having a mammogram. This is remarkably similar to the figure we reported among Texas women in 1987.²

When we reported our data, we were concerned that it may not accurately reflect the screening behaviors of all women with family histories of breast cancer because our subjects were volunteers, "compliers" who can have better mammography completion records than noncompliers.³⁻⁵ The population-based data from Pennsylvania suggest that our data are representative of women with family histories of breast cancer. Although Kaplan and her colleagues cite potential methodological problems with their data (as we did with ours), the similarity of both the data and the conclusions is notable.

Our data and the data from Kaplan et al. clearly indicate a need to improve compliance with mammographic screening recommendations, especially among women with family histories of breast cancer who are at increased risk. We know that women in Texas who were not having regular mammograms reported lack of a physician's recommendation and cost as their reasons for not having mammography. Our data also show that the relatives of breast cancer patients will improve their screening behavior following an educational campaign.⁶ These efforts should continue. □

Victor G. Vogel, MD, MHS

Requests for reprints should be sent to Victor G. Vogel, MD, MHS, Assistant Professor of Medicine and Epidemiology, University of Texas, MD Anderson Cancer Center, 1515 Holcombe Blvd, Houston, TX 77030.

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The Accuracy of Pharmacists' HIV and Condom Counseling

In a 1990 letter to the editor of this journal¹ researchers from Harvard Medical School described a sample of pharmacies in the Boston, Mass, area that failed to provide accurate information on the use of condoms in preventing human immunodeficiency virus (HIV) transmission. Because the Harvard researchers did not distinguish between registered pharmacists and nonprofessional personnel (who were identified as "assistants"), it is unclear who in the pharmacies provided the inaccurate information. My colleagues and I conducted a study² that addressed the performance of pharmacists in particular. We evaluated the accessibility and willingness of pharmacists to answer questions from the general public on the effectiveness and selection of condoms and lubricants to prevent HIV transmission, and we evaluated the quality of the information that the pharmacists provided.

Thirty-one randomly selected San Francisco Bay Area pharmacies (seven [23%] chain stores and 24 [77%] independently owned stores) were surveyed in a single-blinded manner. Approximately 50% of the study pharmacists were both accessible and inclined to answer the surveyor's questions. Pharmacists in independently owned stores were significantly more available than pharmacists in chain stores ($P < 0.05$, Fisher exact test).

Eighty-one percent of 26 pharmacists correctly conveyed that condoms are effective, but not 100% effective, in preventing HIV transmission. Seventy-three percent of 26 pharmacists correctly conveyed that only latex condoms prevent HIV transmission and that skin, or natural