This fall we are starting the launch of the I-SPY 2 TRIAL across 15-20 clinical centers in the United States. This unique and exciting collaboration includes the National Cancer Institute, the FDA, the NIH Foundation, academia, pharmaceutical and biotechnology companies. Together we hope to pioneer an efficient way to screen new “targeted” drugs and rapidly determine whether they will help improve the chances of curing women with high risk breast cancer, and, if so, which women, specifically, will benefit. We are building on the infrastructure from the first I-SPY TRIAL (Investigation of Serial studies to Predict Your Therapeutic Response with Imaging and molecular Anal.ysis). In this trial, we screen the most promising new agents by integrating imaging and biomarkers. We can then create a profile of the tumor and the biological characteristics of the patient to know which combination of drugs to use to lower risk and to ensure the best drugs get to market quickly.

Every few months, results from new clinical trials enable a change in practice. The ability to find trials in which to participate is getting easier, thanks to breastcancertrials.org, our clinical trial matching service that is now available on the web to women all over the country. Safeway sponsored our national launch, and they will be bringing the message about the importance of clinical trials to millions of people in October, by putting the message on grocery bags in Safeway stores, including Vons, Dominick’s and Genuardi’s, all over the United States. We are incredibly grateful to Safeway Corporation for their support and for making it a priority to improve health in general and breast cancer outcomes in specific.

Clinical trials can have enormous impact, even when they are not about life or death. For example, this past August, a study was published in the New England Journal of Medicine showing that weight lifting actually decreases the risk of lymphedema, dispelling the myth that women should not lift anything more than 10 pounds if they have had axillary lymph node surgery.1 From this incredibly important clinical trial from the University of Pennsylvania, we learn that exercise is good and protects against lymphedema. The result makes sense — exercise is a good way to help recover from surgery of all kinds, and now we know the old instructions are incorrect and should be replaced. The results from this study affect the day-to-day lives of millions of women who have had a sentinel or full node dissection. It reminds us that we should keep studying and asking questions about everything we do, to continue to learn and improve the advice we give. Every woman who faces treatment or survivorship decisions should be considering a clinical trial.

Check out breastcancertrials.org to find out about trials in which you might be able to participate.


— Laura J. Esserman, MD

**Forum Highlights Innovations**

In June, a breakfast forum hosted by Dr. Laura Esserman, Director of UCSF’s Carol Franc Buck Breast Care Center, explored a range of UCSF research initiatives: from efforts to deliver chemotherapy drugs directly to cancer cells while minimizing damage to healthy cells, to novel ways to treat Ductal Carcinoma In Situ (DCIS), a non-invasive breast cancer. Dr. Esserman also introduced the ATHENA Breast Health Network, a large-scale project among five University of California health centers, designed to revolutionize breast cancer care by more efficiently merging research, technology, financing and health care delivery in a way that reduces the time needed to translate research findings into patient care.
“The goal of all our work, both in research and clinical care, is to make a difference for our patients – to reduce morbidity and mortality from this disease,” Esserman said. “Translational research is all about taking discoveries from the lab to the clinic to benefit our patients.”

The audience included donors and Friends of the Breast Care Center whose financial support and advocacy have helped position UCSF at the forefront in breast cancer treatment and research.

“We have a fabulous team of faculty doing pioneering work right here at UCSF,” said Dr. Nancy Milliken, vice dean, UCSF School of Medicine, and director, UCSF National Center of Excellence in Women’s Health. “I see immense possibilities to impact patients locally, nationally and internationally.” The forum underscored the important connection between clinicians, researchers and community supporters who provide seed funding for new ventures that improve patient care. Over the past 13 years, the UCSF Breast Care Center has grown from seeing 175 patients per month to seeing 1400 a month today, earning a reputation for the highest-quality medical care and the integration of the latest research developments into clinical practice.

The featured speakers were:

Laura Esserman, MD, MBA: Director of the Breast Care Center since 1996, Esserman’s latest initiative, the ATHENA Breast Health Network, will unite breast cancer programs on five University of California campuses, enabling physicians and researchers to share data, analysis and treatment plans, and track long-term outcomes for women across the state. The design and scale of the project, currently in planning stages, are expected to yield significant advancements in prevention, screening, diagnosis and treatment.

With the planned new Women’s Specialty Hospital at Mission Bay, one of a cluster of three hospitals projected to open in 2014, UCSF is expanding its commitment to women’s unique health needs.

“With this new hospital, we will be translating 21st century science into innovative, personalized health care for women,” Milliken said.

Laura Van’t Veer, PhD: At UCSF on a one-year sabbatical from the Netherlands Cancer Institute, Van’t Veer, a molecular biologist, is continuing her groundbreaking work in the molecular profiling of cancers to guide treatment decisions. Van’t Veer specializes in analyzing various genes expressed in a breast tumor to identify patterns that help discriminate between an aggressive or indolent tumor, in order to tailor care. She is co-founder of a Dutch company that has developed a predictive test to inform physicians and patients if a cancer is likely to recur and the potential for chemotherapy benefit.

Hope Rugo, MD: Medical oncologist Rugo reviewed several clinical trials focused on new approaches to both early-stage and advanced disease. Finding new hormone therapies and chemotherapy regimens that are more effective while minimizing side effects and toxicity is the priority. Of particular concern: identifying targets for “triple negative” breast cancer, which is estrogen-receptor negative, progesterone-receptor negative and HER2/neu negative and thus not responsive to standard hormone therapies or the drug Herceptin.

Shelley Hwang, MD: Breast surgeon Hwang discussed her work with DCIS, a non-invasive cancer that generally does not spread but is treated today as if it were invasive cancer. Hwang is tracking a group of women with DCIS who have agreed to be treated first with hormonally targeted therapy –Tamoxifen or an aromatase inhibitor – prior to lumpectomy or mastectomy surgery. Some women have elected not to have any kind of surgery. The study is showing that this approach can work for some women, measured by Magnetic Resonance Imaging (MRI), with the area of abnormal cells “pruned back” and sometimes eliminated. The goal is to determine whether some DCIS can be managed nonsurgically, a “kinder and gentler approach.”

IN THIS ISSUE:

HER2 and Translational Research.....3
Lessons Learned from I-SPY 1........4
FACES: Living Better with Cancer....5
Dear Dianne.................................7
Avon Walkers.................................8
Falling in Hope..............................9
Writing poetry..............................10
Survivor Takes.............................11
Calendar of Events.......................12
BCC in the News.........................13
Breast Care Center Honor Roll........14

CONT’D on page 15
While it had been thought for many years that the activating partner for HER2 could be another HER2 protein, our laboratory research group and others discovered that this partner is actually its sister protein HER3. In fact HER2 cannot cause breast cancer without the help of HER3 and research in our laboratory has now re-defined the causative driver of this disease as the HER2-HER3 dimer, not just HER2. Too much HER2-HER3 interaction leads to uncontrolled and irrational cancer cell behavior and growth and dysfunction of the many cellular mechanisms that ordinarily makes cells respect their neighbors and not damage each other.

We have found that HER2-HER3 signaling in cancers is much more difficult to inactivate with the current types of drugs than would have been predicted. This is because HER3 brings to the complex many mechanisms to protect it, exemplifying how important the HER2-HER3 complex is in cancer cells. Inactivating HER2-HER3 is possible, but it requires much higher doses of our current types of drugs, or a new generation of drugs that acts through new mechanisms. We are currently testing the effect of much higher dosing of a HER2 inhibitor in a clinical trial at our center with the hope that high doses can cripple HER2-HER3 signaling. Ultimately, our studies suggest that to treat this disease very effectively we need to stop the HER2-HER3 complex either by preventing them from coming together or preventing HER3 from activating HER2. Our laboratory is working on the details of how the HER2-HER3 handshake takes place, how the HER3 key fits into the HER2 ignition, and what kind of drug it takes to interfere with the HER2-HER3 interaction and to completely inactivate this complex. We believe that the next generation of therapies that arise from this research will finally be the ones that will eradicate this disease in affected patients. We are working towards this endeavor in collaboration with numerous other scientists, including scientists who create new types of drugs, scientists who study the structures of proteins, and scientists who study many of the other signaling proteins that are affected by HER2 and HER3.

Nature developed mechanisms whereby HER2 and HER3 are kept apart and only allowed to come together in certain panic situations when cells are under stress, or under inflammation, or need help to survive. However, this restraint is overcome in HER2-positive breast cancer cells because the massive amount of HER2 essentially ambushes HER3, overriding the natural restraints that limit their interactions and turning on cell signals that are highly inappropriate leading to malignant behavior. These revelations have now made transparent the inner workings of these cancer cells, identifying the key culprits and events, and efforts to intervene are underway. The dedication of researchers is absolute, and their will inexhaustible. As long as people and government continue to fund these efforts, and patients continue to participate in studies, the future holds great promise that the curse of this disease will eventually be lifted.

Dr. Moasser is a Medical Oncologist in the UCSF Breast Care Center and Associate Professor in Residence, Department of Medicine, Division of Hematology/Oncology.
Lessons Learned from I-SPY 1

By Cheryl Lin, MD and Laura J. Esserman, MD

I spy with my little eye... The evocative name of this study has less to do with the children’s guessing game, but everything to do with breast cancer research. The I-SPY TRIAL is an acronym that stands for “Investigation of Serial Studies to Predict Your Therapeutic Response with Imaging And molecular Analysis.” This study, which was spearheaded in 2002 by Dr. Laura Esserman, is for women with tumors at least 3 cm in size who will receive chemotherapy before surgery to shrink the tumor. During chemotherapy, the breast mass’s progression or regression is be monitored with multiple MRIs. These MRIs may be thought of as “before, during and after” photos of the tumor. Small tissue samples of the tumor are also taken throughout the study. The goal of the I-SPY 1 study is to understand the tumor biology of breast cancer.

Traditionally, screening recommendations for women 40 years old and older have been annual mammography and clinical exams combined with monthly self breast exams. However, results from the I-SPY study show that not all breast cancers are detectable by these current screening guidelines.

For women undergoing screening mammography every one to two years, two types of cancers may occur: tumors that are detected by screening mammogram, referred to as screen-detected cancers, and masses that appear during the time period between screening mammograms, which are known as interval cancers. For example, a screening mammogram is obtained in January 2009, with a normal result. The next screening mammogram is scheduled for the following year, in January 2010. However, six months from the normal mammogram, a breast mass is palpated during self-exam. This is an interval cancer.

It is often thought that the principle reason for large tumors on initial presentation is neglect, either by the patient or by the physician, who fails to recognize the presence of cancer. However, from the I-SPY study, we found that, of the women getting screened, 85% had interval cancers. We have learned that the biology of some of these larger cancers is such that they grow rapidly and come to attention between screens as so-called interval cancers.

Data from I-SPY suggest that many of the women who present with large cancers have interval cancers which are faster-growing and present as larger, more aggressive disease at the time of diagnosis. Interval cancers occur more frequently in younger women.

Another key finding from the I-SPY TRIAL is that the majority of interval cancers are classified as “cancers with a poor prognosis,” as defined by the Netherlands Cancer Institute (NKI) 70 gene test. What does this mean? The NKI 70 gene test, known as Mammaprint, was pioneered by a leader in the field of molecular medicine, Dr. Laura van’t Veer. This test is designed to analyze a set of genes from an individual tumor, and based on these genes, tell us how likely the tumor will or will not recur and/or metastasize in the future. So these are the cancers where we really want to get the treatment right, which is why we recommend starting with chemotherapy.

The implication of this study is very important. A high index of suspicion for a growing breast mass, regardless of a recent normal mammogram, must be maintained by both you and your physician. If you find a lump in your breast, even if your most recent mammogram was normal, contact your physician to evaluate the mass with a clinical exam, and to possibly obtain additional imaging and biopsy.

With these findings, new screening modalities for prevention and early detection in women at high risk for interval cancers are clearly needed. In the meantime, awareness and familiarity of your own breasts is critical, and is achieved with frequent self-examination.

Your doctor can discuss simple self-exam techniques with you.

Cheryl Lin, MD, is a Resident Fellow in the UCSF Breast Care Center, and a Resident in the Department of Surgery.

Laura J. Esserman, MD, is the Director of the UCSF Breast Care Center.
FACES: LIVING BETTER WITH CANCER
AN INTERVIEW WITH DAVID SPIEGEL, MD IN TWO PARTS

David Spiegel is Professor and Associate Chair of the Department of Psychiatry & Behavioral Sciences, Member of the Stanford Cancer Center, and Medical Director of the Stanford Center for Integrative Medicine at Stanford University School of Medicine. He has long been interested in stress and health, and his research continues to probe the relationships among stress, cancer progression and the interplay of cognition and physical well-being. The second part of this interview with Dr. Spiegel will appear in our Spring 2010 newsletter.

— Catherine Metzger

PART I

CM: Your published work on psycho-social support groups for women with breast cancer is widely quoted. Since recent studies indicate that group therapy’s purported effect of extending life in women with metastatic breast cancer may be limited to patients with a particular type of disease, what would you say is the benefit of group therapy for breast cancer patients and survivors?

DS: Ever since I’ve done research on support groups, starting in the 1970’s, the goal has been to help people live better. It happened, in some circumstances that they also seemed to live longer, and that was icing on the cake. Women in my group used to joke “Am I living longer yet?”

Unlike the pop psychology, positive attitude, put-on-a-happy-face, don’t-let-it-get-you-down kind of stuff, our groups were dealing with dying and death, dealing with fears of mortality, grieving members who died, hoping for the best but preparing for the worst. From the beginning, there was never the idea that this [group therapy] was some way to wish away your cancer. However, a recent study published in the journal Cancer, by Barbara Andersen at Ohio State University, replicated our finding that group therapy for women with breast cancer is associated with longer survival.

CM: How does someone learn to live better with cancer?

DS: One way that I try to teach people to live with cancer is to use the acronym FACES. The F is for Facing, rather than fleeing. You don’t pretend the problem isn’t there. You don’t run away from it. You look it right in the eye and decide what to do about it.

The A is for Altered perception. So when you look at something, you can see it from a different point of view. Groups are great for that. One of the things that bedevils breast cancer patients is that out in the real world, in this country, there are lots of people with cancer, but your context, outside of the medical setting, is that you seem to be the only sick one, everyone else seems fine. You’re the one who’s lost her hair and is feeling too fatigued to do the normal things, and people, many people, not everyone, don’t want to talk about it. They’re afraid to mention the “e” word (“cancer”), or the “d” word (“death”). Being in a group completely changes your assessment of the situation because you can see that there are lots of people living with the disease. You’re not alone. You’re not some social outcast. It puts into perspective the kinds of things you’re struggling with.

There’s a psychologist at UCLA named Shelley Taylor, who studied social comparisons in support groups. What she found is that patients will make downward comparisons. So, for example, a woman who has very bad cancer and a nice husband, will look across the room at a woman who has a much better prognosis for cancer but a really lousy husband and say, “You know what, I wouldn’t trade places with her. I’d rather die than live with that guy.” And the other one says, “Well, my husband’s a piece of work, but I’m going to live longer than her.” So group members find ways to put their own situation into a different perspective.

The C in FACES is for Cope actively. The idea is find something you can do actively in any situation. The most extreme example is dying and death itself. We can’t do anything about the fact that we all die, but we can about how we die. There’s a great oncologist, Ernie Rosenbaum, in San Francisco, who’s done wonderful things with survivor-
ship. One of the things he’s sponsored is a project wherein you prepare a kind of living will for your family. There’s a list of questions, and you make a DVD or video that is your moral will to your family. You review what’s important to you about your life for your family and offspring. It derives from the old idea of last will and testament. The will is what you did with your property. The testament is what you want your family to remember about your life and how you want them to live their life. Now, that’s a hard thing to do if you’ve got cancer, because it involves facing the possibility that cancer will shorten your life. Certainly we’re all going to die, but people emerge from facing the possibility of dying from cancer stronger. One thing I’ve seen in three decades of research is that you don’t hasten death by admitting that cancer may kill you, you live better and maybe even longer. So, Cope actively, find something you can do about the stress of having cancer, some way that you can actively respond to it. You may not be able to change the whole situation, but you can find something to do about it.

E is for Express Emotion. In medical school, we’re taught to treat crying as though it were bleeding. You know what to do if someone is bleeding: you apply direct pressure until it stops. And that’s what we tend to do with emotion in medicine and in the culture in general. I’ve seen people in the face of horrible tragedy trying to be strong, trying to suppress tears. And that to me isn’t being strong. There’s nothing weak about crying when you have a good reason to cry. So I think emotion can be a source of orientation and closeness. Emotion is a means of telling yourself and others what really matters and what is important. That’s what our emotions are there for, to alert us to danger, fear or grief, and also to love and other positive things. Number two, emotion can bring people together. Sharing sadness over an illness or a loss is something that can strengthen bonds. So expressing rather than suppressing emotion is an important thing that goes on in support groups.

The S is for Social Support. We have this bizarre idea in Western culture that we are really just a bunch of individuals, but we’re actually social creatures. We’re much more like ants than eagles. We couldn’t survive without a social network. You know, the human infant has the most prolonged period of dependency of any mammal. If it couldn’t immediately engage its mother for nurture and protection, it wouldn’t survive. Our very survival depends on social networking. And we’re physically weak creatures. If we couldn’t organize ourselves socially, we wouldn’t survive. I sometimes think that support groups reflect how we keep reinventing social structure in this culture. We have to keep reinventing social structure in this culture. We have to reinvent [social structure] because we keep devising things that destroy it. We build cities and suburbs around the automobile rather than people. We have no casual social contact with other people. We isolate ourselves, communicating electronically, working 60-70 hour weeks. We move across the country from our family of origin, so, for instance, my family of origin is in New York, but my sister is Arizona, and I’m in California.

In olden times, you grew up in a village. You knew everyone and everyone knew you. And there were problems with that, but you couldn’t be alone, and you didn’t get written off just because you were sick. And so I think a lot of what we have to do with groups involves rebuilding the kind of community that we have lost in our high-tech, overdeveloped culture.

I had several support groups that ran for over 10 years. Women would say “this is the least superficial thing I do in my life.” They would come once a week for 10 years. They would see people come and go. They would see people die. They were experiencing cancer, not just from the perspective of someone who was dying, but of one who had lost somebody. So they better understood their family and friends because they knew what it felt like to lose somebody that you cared about. It was hard but it’s a part of life and it makes you feel like you have value even though you’re sick, even if you’re dying.

Forming those social bonds is very important, and these women helped one another right down to the last hours of one another’s lives. We would visit people in each other’s homes when someone could no longer get out of bed. Building that kind of intense social support is very helpful because nobody knows how to live with cancer, particularly because in this culture, you may have never seen anybody living with cancer or dying of cancer. You know, we invest more resources into teaching people how to drive a car than how to live with a life-threatening illness. Patients are a tremendous source of information about how to do that. So good support groups can really help people deal with all the aspects of emotional, social, cognitive and experiential aspects of cancer, and get through it better by helping one another.

To be continued in our next issue.
Dear Dianne,

I am an attractive 58-year old divorcee with an active social life. I met a man on an online dating site, but did not know how to tell him about my breast cancer, my mastectomy, or that I am planning to get a reconstruction within the next year. I simply left the entire last few months out of our online and phone encounters. We met first at dinner and I wore a prosthesis, even though I felt strangely ashamed. I like this man very much, and though I know I wouldn't want to get involved with someone who would be put off by my having been treated for breast cancer, I still don't want to be rejected. What do you recommend? What is the best way to let him know that this aging body is even more imperfect than meets the eye?

– F.G., San Francisco

Dear F.G.,

It is normal to be concerned about our attractiveness to potential romantic partners even when we haven’t been through breast cancer, but post-cancer things seem even more complicated. We’re worried about what meets the eye and how we will be seen or perceived, but as you stated in your question, we are also worried about being rejected on a more fundamental level. Will this person remind me that I am somehow less than other people or that I am “damaged goods?” Most women, in the months following cancer treatment, struggle to make sense of the body changes, adjusting to not having a breast or having reconstructed but less than perfect breasts. For some women, weight gain and lingering tiredness are a concern and just feeling alien in their own bodies. Women also struggle to make sense of the total experience of having had cancer and cancer treatment – of the life changing nature of it, both bad and good. Perhaps understanding what all this means for you may help you in how you might frame it to him.

When you get up the courage to have the conversation, and it sounds like you know that you will need to do so whether with this person or a future date if you are going to have a meaningful relationship, you might first just start with sharing that you have had breast cancer. This breaking of the ice may make it easier to share other details. It might also be helpful to remember that there are many responses he may have. Some potential partners will embrace your experience and your body with respect and appreciation, while others will not be able to out of fear or weakness. Some will be coping with their own health or aging issues and will be relieved that they are “not the only one.” Most men need your guidance as to how to interpret your experience and your body.

It may be difficult to have this conversation, but with time it will be easier. It is certainly worth the risk. As one single breast cancer survivor told me, “There is love after breast cancer. I met a man and he told me that I am beautiful in every way.” Here’s to love.

Dear Dianne,

I feel angry because I can’t get over the fact that I got another cancer even though I am youngish (42), athletic, and take care about what I eat and drink. The second breast cancer is not related to the first, according to my doctors, but I can’t help but think that there must be some reason why I would develop breast cancer twice, some reason other than the luck of the draw. Everyone around me seems so full of joy and gratefulness, even though they are often suffering from cancers that have a worse prognosis, or are more obviously disfiguring. I don’t feel like being happy, and I don’t feel grateful really, even though I know that I should be happy that I have a good job that’s waiting for me to return to, and family and friends that love and care for me. Do you know any attitude adjustments? Working out doesn’t help, and I just can’t seem to get the hang of prayer or meditation, but I’m willing to try almost anything because my resentment has started to poison my relationships.

– MME, San Anselmo

Dear MME,

I don’t think there is anyone who wouldn’t agree that you have been the recipient of some profound unfairness. There are some things we have been taught to rely on as far as our health: 1) that...
DEAR DIANNE
from page 7

virtuous behaviors like eating well and exercising earn us good health; 2) that we can enjoy our youth without the specter of devastating disease; and 3) lightning is just not meant to strike the same place twice. You really do have some good reasons for being low. In fact, when I think about this unfairness, I can feel myself getting both mad and sad. And yet, it sounds to me like you have had enough of missing out on the joy and gratefulness that even other cancer patients can seem to feel.

And you are right, much of what is wonderful about living is being able to feel the full spectrum of our emotional experience. Our emotional life can be rich and complex. Seemingly conflicting emotions can co-exist, like when we experience beauty in sadness, or joy that emerges from pain. We can also get stuck on the low side, thinking over and over the same thoughts that lead to more bad feelings. And with all these negative thoughts and feelings, we just don’t feel like doing anything that might be fun or lead to positive feelings. This gets us even more stuck.

There are also some underlying biochemical reasons that might make it difficult for someone recovering from cancer to be able to feel pleasure. Take the repeated onslaught of stress that cancer brings with it, add additional body stress from treatments, shift the internal endocrine balance as in the case of hormonal therapies for breast cancer and add in a not well-elucidated, but probable link between cancer itself and depressive symptoms and you have a emotional system that is dysregulated. It makes it harder to bounce back emotionally.

So what to do? If you are “willing to try anything,” how about a few behavioral experiments? Schedule pleasant activities every day whether you feel like it or not.

Surround yourself with funny people and vow not to complain about your cancer for the whole evening. Go out to nature, a forest or the ocean and breathe the fresh air. Do something fun and new for exercise so that you need to concentrate and won’t be apt to ruminate. Dancing would be great. Notice your mood before and after these things. If it improves even a couple of degrees, you are on to something.

Don’t go this alone. You can talk to your doctor about how you are feeling. She may suggest an antidepressant and refer you for psychological counseling with someone who understands the needs of cancer patients. The field of psycho-oncology is devoted to addressing the psychosocial needs of people with cancer. Although it is common and understandable for someone to feel angry about having cancer, there are many interventions that psycho-oncology can offer to help you get you back to living a life you can enjoy.

AVON WALKERS GET WARM RECEPTION

Despite the early morning fog, an enthusiastic group from the UCSF Carol Franc Breast Care Center and BreastCancerTrials.Org turned out to cheer 2,800 women and men along the San Francisco Avon Walk for Breast Cancer on July 11. Twenty-five staff and supporters (and three dogs) bundled up to pass out buttons, candy, hugs and high-fives at mile four or the 39-mile walk, which raised $6 million dollars. “We were happy to go out and support this year’s walkers! It was really energizing to see all those smiling faces putting one foot in front of the other to support the Avon Foundation!” commented Elly Cohen, Program Director for BreastCancerTrials.org.

The mission of the Avon Foundation Breast Cancer Crusade is to raise funds and awareness for advancing access to care and finding a cure for breast cancer, with a focus on the medically underserved. The focus is on four areas of need:

- Breast Cancer Education and Screening for Medically Underserved Women
- Gaps in Support to Complete Diagnostic and Treatment Regimens
- Scientific Research and Clinical Care
- Professional Education: Special Needs

Next year, the two-day Avon Walk for Breast Cancer will take place in San Francisco on July 10-11, 2010. To find out more information walk.avonfoundation.org.
Falling in Hope

Three months after her last radiation treatment for breast cancer, Judy Waterman sat on the edge of an airplane door open at 12,000 feet before deliberately falling down to Queenstown, New Zealand below. Judy, 68, who dreamed of parachuting since her early 30’s, had never tried the sport due to bad knees and an understandable fear of further injury upon landing. And though she gained a new appreciation for each day and a deeper awareness of living in the present through breast cancer, Judy believes that her decision to skydive was not directly inspired by facing breast cancer, but rather the natural step taken by an “intelligent risk taker” who noticed that she was in the right place at the right time.

Judy had been enjoying retirement with Bob Waterman, her husband of 50 years, travelling frequently, when she was diagnosed with breast cancer in 2008. Though she had had a clear mammogram seven months earlier, her tumor was so large at diagnosis that Dr. Hope Rugo recommended treatment before surgery in order to better manage the tumor. Unfortunately, Judy’s underlying Meniere’s disease, was triggered by one of the chemotherapies so she landed in bed several days a week throughout the treatment regimen.

No matter how tired Judy felt, however, she continued to have “faith in Hope.” And as a therapist, she felt it was important not to keep her cancer a secret from friends and acquaintances. She says that she wasn’t on a “pity campaign,” though, but a “sharing campaign.”

When Bob considered taking a course at Stanford, Judy decided that, however difficult the treatments were for her, she would sign up for and attend a course once a week when he drove to Palo Alto. She loves to write, and found a writing class. Getting herself out the door on a Monday, seemed to have to begin on Saturday, however, when her red and white blood cells were low. But though the class was an intense challenge, Judy says that doing it gave her a profound “sense of connection to the world” during her treatment.

When the tumor did respond to chemo, and surgery followed, Waterman’s high spirits and sense of wellbeing returned in a few short weeks. Elated to realize that she continued to feel good while undergoing radiation, Judy began planning the New Zealand vacation she and her husband had been forced to cancel at diagnosis.

Next to their Kiwi hotel, the Watermans noticed a small shack advertising skydiving, and looking up, spotted skydivers parachuting into a field. Judy watched how they landed and began wondering if there was another way to control the impact. A friend suggested tandem skydiving – jumping in the arms of an instructor – a method often used in training before solo jumps. The instructor lands first and controls the speed. Judy interviewed instructors and parachuters, found a skydiving school with a stellar reputation, and asked for someone tall.

When she jumped, Judy felt no fear, only a little fluttering in her stomach. First out the door, she felt herself dangling momentarily from the plane before the instructor pushed off. While a photographer took pictures for posterity and so Judy could show her friends, she thrilled at the beauty of the sky, and the amount of air pressure rushing at her. She had to keep her mouth closed or it flapped in the wind!

When the parachute “finally” opened, after 45 seconds of free fall, the jolt made her feel as though she were ascending, it so abruptly cut the speed of the descent. And then she drifted peacefully to the ground.

Would she do it again? Yes, but this jump was enough for that trip, and the landing was painless. Though it still hurts over her surgical site, Judy had no pain while sky diving.

Hmmmm. Could we try this pain control plan or does it only work in New Zealand?
Writing poetry on your path to healing

By Catherine Metzger

Healing is a matter of time, but it is sometimes a matter of opportunity. – Hippocrates

Writing poetry about breast cancer can be a way to reframe the trauma, to take feelings that are sensed but aren’t pretty, place them on a page in front of you and look them straight in the eye. The act of making verbal art out of your feelings and the situations that give rise to them gives you control in creatively confronting them. When your rant, lament, confession, nightmare, complaint, praise, or regret is visible, readable as image-filled, sound-rich text, you may find it reduces your pain and suffering. Just as singing the words of a popular tune sometime helps to clarify a confusing relationship because of the apt juxtaposition of rhyme, thought and tune, so fleshing out your feelings in your own poems leads to an ability to cope with and manage the emotional effects of diagnosis and treatment.

The UCSF Helen Diller Comprehensive Cancer Center’s Art for Recovery program offers an 8-week Healing Through Writing and Power of Poetry workshop “for anyone who is dealing with cancer and its effects and is interested in self-exploration and sharing.” While writing is no substitute for medical care, research indicates that it can reduce stress and produce measurable improvement in the immune system. And though one can’t eliminate breast cancer simply by railing against it, you can add tools to your coping arsenal by learning new ways of addressing your rage, doubt, or fears.

Abba Kovner, a poet who was a leader in the Vilna ghetto uprising during World War II, writes of his throat cancer experience in his book Sloan-Kettering. Though he does not equate the pain of undergoing surgery or the discomforts of treatment with the horrors of the holocaust, he explores how the body forces these comparisons—of being alone, worrying about invaders, early death, and the loss of control over one’s privacy when undergoing treatment. In the poem Under the Skin, he talks about how he dreamed of Vilna and World War II at night after ‘Every morning at a fixed time he had an appointment/with an injection. Every night took him back/to the life that was, beyond the distance/and regret. You ask him: “will we ever/get out of this terrible forest?”’

A poetry writing workshop led by a good leader would invite you to make sense of your feelings about breast cancer by linking those experiences to memories significant in your life, and by inviting intimacy and banishing judgment in the group. Even if you have never written a poem in your life, writing about your cancer experience in poems—not necessarily rhymed or in verses—gives structure to the new, strange, or strong feelings that accompany a major blow to our health.

Since each person understands breast cancer from her own individual perspective, the best poetry about your cancer will be rich in images, sounds, and words that are pertinent to you. No one can regenerate your memory of it or know just what images conjure up your sense of loss, or wonder, or confusion. Since we each inhabit our own discrete body, our perception of getting imaged, or having anesthesia, undergoing surgery, or sitting in a survivorship meeting, is different. We alone taste those sensory experiences that are the scaffolding for writing poetry. And because of our mortality, creating an account of what it was like to be the master and commander of that body’s confrontation with illness and possible death during cancer is a way of busting out, of living beyond the body.

As May Swenson who faced breast cancer asks in her poem Question “Body my house/my horse my hound/what will I do/when you are fallen...Where will I sleep/How will I ride? What will I hunt?” She is more than her body, and yet it is incomprehensible for her to imagine life without it.

So, go for it – write a few lines and try to capture a better picture of your treatment experience in words. Though the poem might not be what anyone else wants to read, it may give you a handle on your stress.

If you would like more information about the Art for Recovery program’s poetry workshop, please contact Cynthia Perlis at (415) 885-7221 or visit cancer.ucsf.edu.

Survivor Takes

This month, we asked some breast cancer survivors the question: What got you through cancer treatment? A person, place or thing? An attitude?

Sharon Tong-Robinson
My breast cancer support group helped more than anything. During my treatments, I referred to those ladies as my lifeline. My family was an enormous help, but they were just as much in the dark as I was, and just as on edge too!

Janet Williams
1. Primarily my husband's loving attention and support as well as support from family and friends.
2. The care and personal attention I received from the Cancer Center, particularly from my surgeon Dr. Shelley Hwang, who gave me her cell phone number and told me to call anytime day or night if I had questions.
3. A personal trainer who kept my energy up allowing me to work throughout the 6½ weeks of radiation treatments.

Susan Kuner
My Rule. Cancer treatment was scary but it kept me busy. Then treatment was over. The cancer was supposedly gone. I was back at my job but life hadn’t returned to normal. Suddenly, I would burst into tears. So I made myself a rule: Crying? Close the door to my office. Sobbing? Go home. The intense crying stopped after a year or two. That was 10 years ago. My rule got me through.

Irmgard
I did and do meditate daily, morning and evening, and join in group meditation with the Parmahansa yogananda teachings and meditation techniques. On the day of radiation after my session, I would travel via BART and bus and meditate with other people. I still recharge my battery like this week after week, month after month, year after year. I am now in my 7th year of remission.

Sally Love Saunders
I was blessed to be in the UCSF Cancer Survivorship Program. I had tremendous support from the staff at Mt. Zion and support groups in the American Cancer Society and peer buddies, my sisters and niece. I was able to draw on my own creativity and write poems about my cancer journey. I also spent time helping others throughout my treatment, which was very empowering for me, and meditated often.

Carolee Arca
While in the operating room before the surgery, I felt a presence (not just of the doctors and nurses) of overwhelming love. The “light” was so bright and I had no fear. After recovery, it was still with me. My room was strangely filled with this same energy.

Though at first I called tamoxifen my “Cancer” pill, I realized that I didn’t have cancer anymore. Now when I take my “Femara” (tamoxifen), I hold it in my hand, give thanks, and bless the pill, surrounding myself with that beautiful, healing “white light.” I feel it’s my guardian angel’s presence.

Julie Wong, PT, CLT
The problems I faced after breast cancer surgery included nerve pain in my arms from lymphedema swelling, and scarring from radiation. In desperation, I sought the advice of experts who directed me to advanced manual physical therapy classes addressing the whole body and a lymphedema certification course. I am fortunate that my personal research and quest to find solutions to my problems associated with surgery led me to discoveries in physical therapy treatments that have proven invaluable to helping my patients choose life and movement!

Kim Waldron
Humor. I got lots of real laughs in treatment – calling a wig a “cranial prosthesis,” that table with the hole in it for core biopsies, and much more. The healthcare staff is so used to the procedures that they see all of this as normal, which always gave me an extra laugh. Every genuine laugh counts as spitting in the eye of cancer.
Director’s Circle Reception
November 20, 2009, 5:30 – 7:30 pm
(please note date change from October 8, 2009)

The Friends of the Breast Care Center’s annual Director’s Circle Campaign raises funds for Dr. Esserman and her team to offer personal, high quality care to each patient in a setting with access to cutting-edge treatments and innovation. Funds from the Director’s Circle directly support clinical care delivery, clinical trials, and the training of the next generation of surgeons and oncologists.

For information on or to make reservations for the annual reception, please call (415) 353-9899.

Breast Cancer Forum
Under the direction of Hope Rugo, MD, the Forum is a monthly gathering of health care providers, researchers, patients, patient advocates, friends and families. The topic varies from session to session but the emphasis is on clinical trials and research. A light dinner is served. Contact Lauren Metzroth at (415) 885-7213 or lauren.metzroth@ucsfmedctr.org for more information. All sessions take place in room H3805 on the 3rd floor of the Cancer Center.

Topic to be determined
Wednesday, November 4, 6 – 7:30 p.m.

San Antonio Breast Cancer Symposium Update
Wednesday, January 6, 6 – 7:30 p.m.

Cancer Resource Center
For the following programs, please call the Cancer Resource Center at (415) 885-3693 to register. These programs are offered at no charge. Donations are kindly accepted.

The Cancer Fighting Kitchen
Rebecca Katz, Greta Macaire, RD, and Donald I. Abrams, MD
Tuesday, October 13, 5:30 – 7:30 p.m.

Please join us for a nutrition seminar with UCSF Cancer Center nutritionist, Greta Macaire, RD and UCSF Osher Center oncologist, Donald Abrams, MD, followed by a cooking demonstration with well-known author/chef, Rebecca Katz. Discussion will include updates on nutrition and cancer research, and the importance of maintaining a healthy diet during cancer treatment. You will hear cooking strategies for maximizing the cancer-fighting potential of your diet while minimizing cancer treatment-related side effects. Rebecca’s new cookbook, The Cancer Fighting Kitchen, and her popular first cookbook, One Bite at a Time, will be available for purchase.

UCSF Medical Center, 1600 Divisadero Street, 2nd floor, Herbst Auditorium. CEU’s available for RN’s.

Nutrition & Breast Cancer
Greta Macaire, RD

Wednesday, October 21, 12 – 1:30 p.m.
Tuesday, November 24, 4:30 – 6 p.m.

Learn about the latest research on nutrition and breast cancer and how to better meet your nutritional needs.

No charge. Held at the UCSF Medical Center, 1600 Divisadero Street, 6th floor, room B-601. Registration required.
Limited to 10 patients.

Nutrition & Chemotherapy: Coping with side effects
Greta Macaire, RD

Wednesday, October 28, 12 – 1:30 p.m.
Thursday, November 19, 9:30 – 11 a.m.

In this seminar you will learn tips to help minimize nausea, vomiting, diarrhea, & constipation. You’ll hear about how to gain/lose weight in a healthy manner, the importance of food safety during cancer therapy, and also supplements that may interact with your treatment. Caregivers welcome to attend.

No charge. Held at the UCSF Medical Center, 1600 Divisadero Street, 6th floor, room B-601. Registration required.
Limited to 10 participants.

Guided Imagery During Cancer Treatment
Pauline Beggs, RN

Tuesday, November 17, 4 – 6 p.m.

Imagery is the most fundamental language we have. The technique of guided imagery is based on the idea that the mind can affect the functions of the body. Guided imagery has been found to be effective in managing stress, anxiety, depression, pain and the side effects of chemotherapy such as nausea, vomiting and fatigue. These practices can also promote healing and support patients during complex treatment programs and procedures. In this free seminar, you will experience firsthand the powers of guided imagery and learn tools to take with you through your cancer journey and beyond.

UCSF Medical Center, 1600 Divisadero, 3rd floor, room H3805. Please register with the Cancer Resource Center at 415-885-3693.
BCC in the News

On August 2, 2009, The New York Times published an article by Gina Kolata called Lack of Study Volunteers Hobbles Cancer Fight. Kolata describes the lack of patient participation for clinical trials. Dr. Laura Esserman’s new investigative study, which attempts to use available money and existing patients more efficiently, is one trial Kolata cites as circumventing the problems of attracting patients to participate. Read it: nytimes.com

The Wall Street Journal published Weighty Choices in Patients’ Hands by Laura Landro in The Informed Patient column August 4, 2009. Landro states that “The current health-policy debate comes down to a very personal issue: how to make ever-more-complex decisions when faced with multiple options, each with no clear advantage and with risks and harms that patients may value differently.” The article noted that Jeff Belkora directs the UCSF Decision Services program, and that the BCC has a website to help decision making: www.decisionservices.ucsf.edu. Read it online at: wsj.com

The San Francisco Chronicle featured Laura Esserman, MD, in their cover article of the paper’s feature section July 20, 2009. The piece was entitled Doctor tries to personalize cancer treatment and not only mentions the ATHENA Project, but Dr. Esserman’s metallic nail polish and fabulous singing! Read it online at: sfgate.com

Ductal Carcinoma In Situ (DCIS) is the most common type of non-invasive breast cancer. It develops in the ducts of the breast and is also called in situ disease. Listen to the Breast Care Center’s Shelley Hwang MD, MPH, breast surgeon and the Chief of Breast Surgical Oncology at the UCSF Helen Diller Family Comprehensive Cancer Center discuss issues that are being discussed among breast surgeons today. Is DCIS a risk factor for future breast cancer or is it cancer? Dr. Hwang will bring you up to date on this important topic. Go to www.youtube.com and type “Shelley Hwang, DCIS” in the search field.

Cancer Survivorship Program

For the following programs, please call (415) 476-0275 to reserve your place or for more information. Space is limited.

Coping with Uncertainty
Cheryl Krauter, MFT
Saturday, October 10, 10 – 11:30 a.m.
As a psychotherapist focused on health and wellness, Cheryl will present a sample session of her more extensive workshop for women who have completed their active breast cancer treatment. Whether you have just finished your treatment or are several years from your last treatment session, Cheryl offers strategies and tools that women may adapt to their own unique way of managing the stress and anxiety that often affects breast cancer survivors.
UCSF Cancer Center, 1600 Divisadero St. 3rd floor, room 3608

“Fighting for Our Future”
Film Screening and Discussion
Tuesday, October 20, 6 – 8:30 p.m.
Join the Young Survival Coalition’s Northern California Affiliate group for a screening of this film which discusses the frequent misdiagnoses of younger women. Combining anecdotes from breast cancer patients who have undergone treatment with emerging scientific research, this film is a clear and non-judgmental guide to negotiating treatment and living with the illness. Following the film, a discussion of coping with uncertainty will be led by a UCSF medical professional joined by several survivors. Light refreshments will be provided.
UCSF Cancer Center, 1600 Divisadero St. Herbst Hall, 2nd floor.

Complementary and Alternative Medicine Information for Survivors
Beverly Barnes, MS, Lac, Chinese medicine practitioner and acupuncturist at UCSF’s Osher Center for Integrative Medicine
Tuesday, November 10, 6 – 7:30 p.m.
Beverly will discuss ways that Survivors can include complementary and alternative medicine practices in their wellness program.
UCSF Osher Center for Integrative Medicine, 1701 Divisadero St. 1st Floor
BREAST CARE CENTER
HONOR ROLL

Your Support Keeps Us Going!

We want to thank these generous benefactors for contributions received during the period between March 1, 2009 and July 15, 2009.

$2,000,000+
Safeway Foundation Northern California Division

$500,000 – $2,499,000
Martha & H. Brewster Atwater
The Breast Cancer Research Foundation
The Susan G. Komen Breast Cancer Foundation

$100,000 - $499,000
Ivette & Charles H. Esserman
Pepper & Michael Jackson

$20,000 – $99,999
Estate of Alison Bermond
Ginn Family Charitable Foundation
Estate of Patricia Lorentzen
Estate of Deborah Mosley

$10,000 - $19,999
Nancy & Joachim Bechtle Foundation
Linda Reeve & Bill Williams

$1000 - $9,999
Josefina & Arnold Baptiste
Alan Blum Family Fund
Cheryl & Philip Genet
Jan & Mark Laret
in honor of Pamela Munster, MD,
Mindy Goldman, MD and
Laura Eisserman, MD, MBA

$500 - $999
Armstrong Relocation
in memory of
Maria Carramo Hosea
Climb Real Estate Group, Inc.
Pamella Earing and Jeff Thomas
Eivind Lange
in memory of Betty Ivey Lange
Colleen E. McCarty
in memory of M. Alison Council
Claudette Parrish
Barbara Tyler

Aimee Buenviaje & Xavier Upshaw
Clotilde Carcamo
in honor of Marcia Carratubers
Colleen Casey & Leonard Balter
Charles Kingston
Sophie Breen & Brendan Cormack
in memory of Shelley Huang, MD
Leonor Clark
in memory of Annette Heller
in memory of M. Alison Council
Colony Oak School Staff
Sherry & Richard Braunscombe
Deanna and David Bing
Janet Conn & Julie Bishop
Rosemary and Robert Bronzan
Michael Weststeyn Farming
Karen and James Holtz
Terri Horton
Timothy Huff & Associates, Inc.
Livermore Area Recreation & Park District
Lynnette and Mark Lucchesi
Maureen B. Morley
Mollie and Francis Ratto
Helen Whitmore and Julia Smit
Joan Cambray & Charles Hansen
in memory of Cynthia Carsmith-Cresti
Margaret & Raymond De Gennaro
Kevin Rossi
David Forrester
in memory of Shing-na Sonia Gei
Donna and Robert Adamski
Emily & Edward Chan, MD
Elizabeth Chiu
Dolly Chou
Kay & Steve Fike
Wilson Gee
Jane & Shelby Hyde
Joseph Fine Art School
Eileen and Jude Laspa
Debbie & Dennis Lee
Colleen & Gordon Lee
Janet and U. Shou Wu Liou
Shaochan Lo
Roseline Ma
Dolly Mah &
Kenneth Rosenberg
Su & Arthur Mar
Susan & William Mar
Margaret & Daniel McCabe
Lanny Nizar & Henry Oentojo
Kathryn & Sunil Kohla
Nancy & Jerome Solar
Diane & Robert Spence
James St. Clair
Marwil & Ted Wong
Gretchen & Charles Gooding
in memory of
Margaret Geran Tabsharani
Malcolm Heinicke
in honor of Hope Rugo, MD
& Lori Nichols
in memory of Marisa Carramo Hosea
Bruce Addis
Agent for Mayflower
Gilda & Augusto Cano
Clotilde Carcamo
Melissa Chiesa
Clancy Moving Systems, Inc.
Cummings Moving Company
Thelma & O. David Gutierrez
Horizon Moving Systems, Inc.
Anita & Benjamin Leong
Mary Jo & Lawrence Nejasmich
John Potts & Brett Plummer
Trans Advantage, Inc.
United Van Lines, LLC
M. Carolina Velez
Catherine & Douglas Winnett
Bau Huyth
Jacquelyn Jones & Martin Lipton
Eleanor & Joseph Keller, Jr.
in memory of Betty Ivey Lange
Rose Marie & Edwin Bauer
Aimee Buenviaje &
Xavier Upshaw
Jean & Floyd Mays
in memory of Jayne Veld
Nannette McKay
Ragni & Marc Pasturel
Sally Tomlinson
UC Davis Women's LaCrosse
Alumni
in memory of Carol Davis
Tryp Wittstruck
Forum Highlights
Innovations from page 2

Elly Cohen, PhD: Cohen is program director for BreastCancerTrials.org, a free, online clinical trial matching service developed by UCSF and the National Cancer Institute, with major funding support from The Safeway Foundation. The nationwide service matches women with appropriate clinical trials and links them with the closest participating research site. Every major advance in the breast cancer field has come from clinical trials, yet only 3-5% of eligible women enroll. Clinical trials provide women access to innovative treatments that have the potential to become the new standard of care and are the safest, most effective means to improve breast cancer care. The website link is www.BCT.org.
TASTE FOR THE CURE
Living Well Beyond Breast Cancer

Saturday, November 7, 12:30 – 4:30 p.m.
Jewish Community Center • 3200 California Street, San Francisco

Presented by The UCSF Cancer Survivorship Program
and the Jewish Community Center, San Francisco

- Presentations by UCSF Breast Care Center practitioners on issues specific to
  those who have finished their active breast cancer treatment, plus research
  updates
- Supercharged Smoothies cooking demonstration by cookbook authors Alison
  Eastwood, RD, Mary Barber and Sara Whiteford. Learn how to incorporate
  super foods such as flax, hemp, greens and berries into your daily diet.
- Personal chefs from all over the Bay Area offering samples of their wares
- Live music
- Valuable resource information from the Art for Recovery Program, Friend to
  Friend Gift Shop, and the Cancer Resource Center

Tickets are $10, scholarships are available. Space is limited!
To reserve your place, call (415) 476-0275.