Fall 2010

Carol Franc Buck
BREAST CARE CENTER
NEWSLETTER

From the Director

At the Breast Care Center, the faculty and staff continue to push forward on initiatives that enable us to personalize treatment. Evidence is accumulating that shows that we can safely do less for certain tumor types (see ASCO update, page 2). At UCSF, Michael Alvarado, Cathy Park and I are also leading the testing of tools that enable women to complete all of their local therapy in one treatment, with the use of intraoperative treatment (see TARGIT, page 4). The early results are very promising, and as we think about when to adopt these new techniques, we need to think about the benefits and risks of early adoption as well as the consequence of failing to adopt early. For that analysis, you will need to wait until the Spring 2011 issue.

We look forward to integrating molecular markers into care settings to help us develop greater certainty about the value of our treatments and to improve our ability to learn which new drugs will work best for each tumor (I-SPY 2 , see **ispy2.org**). We are truly lucky to have been joined in this effort by one of the international leaders in molecular biology and breast cancer. Laura van't Veer arrived this summer to join the UCSF faculty and will be leading our breast cancer efforts in this area (see page 6).

At the end of the day, we want to make sure that we can improve the outcomes for every treatment and find ways to make the treatments less toxic. This fall, we are launching our "Hair to Stay" program and will be testing several different approaches to minimizing hair loss during chemotherapy. Hope Rugo and Michelle Melisko are the leaders of this investigation. And we will tell you all about it in our next newsletter!

– Laura J. Esserman, MD

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News from ASCO – Findings that Change Practice

by Laura Esserman, MD

At the American Society of Clinical Oncology (ASCO) annual meeting, there were a number of important studies presented that could or should change practice.

Local therapy

The message from this session is that increasingly there are opportunities to do less, safely. This is very good news for patients. The long term results of a randomized controlled trial (NSABP-32) comparing full axillary dissection to sentinel node dissection (with axillary dissection reserved for those women with a positive sentinel node) showed that both approaches resulted in equivalent survival rates, with no difference in local recurrence but less side effects with the sentinel node procedure. These data confirm that sentinel node dissection alone, in women who present without evidence of cancer in the nodes under their arm, is safe and effective, which is a good thing since it has become the standard of care already. But it is nice to know that we are doing the right thing!

The results of the American College of Surgeons clinical trials Z-10 and Z-11 were also reported. In Z-10, Dr. Kelly Hunt showed that the presence of microscopic metastases (cells that can only be detected with special stains) in the axillary lymph nodes does not impact outcome. In other words, the presence of these cells did not lead to higher recurrence rates, and in this study, the surgeons, oncologists and patients were not aware of the results so it did not lead to additional treatments. Other studies have shown that patients who are found to have microscopic metastases in the sentinel node by a special stains test (immunohistochemical staining) have more surgery (axillary dissections) and receive additional adjuvant therapy (chemotherapy), which they apparently do not need. At UCSF, we stopped the routine testing for microscopic metastases when this study began and are happy to know that we do not need to add this test back. Dr. Armand Guliano showed the results of the Z-11 study, which randomized patients with known cancer in the sentinel node to full axillary dissection versus no additional surgery. Patients who avoided axillary dissection did not have an increase in either local recurrence or distant metastases compared to those who had the additional surgery. One caveat is that this was a group of patients with relatively good risk disease, and all patients had to have a lumpectomy followed by radiation which does include the lower axillary area as part of standard treatment. So, we can say for most patients with early stage, smaller-sized breast cancers who have had a lumpectomy with planned radiation, cancer in the sentinel node does not require completion of axillary dissection.

In another large national trial (CALGB), Dr. Kevin Hughes showed the 12-year follow-up data for women aged 70 or older with hormone receptor positive cancers who were treated with lumpectomy followed by radiation therapy and tamoxifen versus tamoxifen alone. The patients in both arms of the study did extremely well. Patients receiving radiation and tamoxifen had less local recurrences compared to those receiving tamoxifen alone (2% vs. 9%) but there was no difference in the risk of distant recurrence (metastases) (3% in each arm of the study), or the ultimate mastectomy rate (2% vs. 4%). Most women who passed away did so from causes other than breast cancer. In summary, older women with small hormone receptor positive cancer can be safely treated with tamoxifen alone following lumpectomy without increasing their risk of distant recurrence or death.

The TARGIT study, which compared a single dose of intraoperative radiation (radiation given in the operating room at the time of breast cancer surgery) to standard radiation (3-6 weeks), was also reported (see page 4). The local recurrence rate was very low for both groups, only 1% in each arm. These results were published in *The Lancet* in June, 2010. The study shows that for postmenopausal women with low risk tumors (node negative and grade 1 or 2), that the single intraoperative dose is not inferior to external beam radiation, which is given daily over 3-6 weeks. UCSF was the first center in the United States to participate in this very important international trial and we now offer this new treatment option to women with low risk cancers. We will be testing the use of the intraoperative device in women with higher risk tumors in the near future. Taking all of this data together, now women age 70 and older can choose hormonal therapy alone after lumpectomy or intraoperative radiation at the time of lumpectomy as options to mastectomy or lumpectomy and external beam radiation.

What did we learn from all of these studies? Combinations of chemotherapy, hormone therapy, and surgery are continuing to improve outcomes; now we can work on

when and in what circumstance less treatment is safe and just as effective. All of these studies will really improve local treatment options for women who want breast conservation.

Adjuvant Therapy and Lifestyle

There were two very important studies looking at the impact of co-morbidities such as diabetes and obesity on breast cancer outcome. The most recent data suggests that women with diabetes who have better glucose control have improved breast cancer outcomes compared to those with poorly controlled disease. A medication commonly used in patients with diabetes, metformin, will be studied in women with early stage breast cancer in a large multicenter trial based in Canada using data that suggests reduced recurrence in women with diabetes who were also taking this drug. Biologic data supports a potential anti-cancer effect. Previous studies have suggested that significant weight gain is associated with worse outcome after a diagnosis of early stage breast cancer. In the Austrian study that treated premenopausal women with ovarian suppression and either tamoxifen or aromatase inhibitors, increased body mass index was associated with a higher rate of death in women taking aromatase inhibitors. Women with a Body Mass Index (BMI – calculate your own BMI at **www.nhlbisupport.com/bmi/bminojs.htm**) over 25% who were taking aromatase inhibitors had three times the risk of breast cancer recurrence compared to those taking tamoxifen. The reason for this could be poor suppression of ovarian production of estrogen in heavier premenopausal women, and higher levels of estrogen in the fat cells in the body. There was no difference in outcome for premenopausal women whose body mass index was less than 25%, regardless of whether they took tamoxifen or the aromatase inhibitor. This raises the issue of whether aromatase inhibitors are the best treatment for postmenopausal women who are overweight. Additional data is needed to answer this question. To aid in breast and general health, we will ensure that every woman in the ATHENA Breast Health Network (see page 8) will be counseled about a weight loss program and have the opportunity to participate in studies to help them lose weight and incorporate more exercise in their daily routine. Dr. Fabian, a researcher focusing on prevention, showed that women with high risk breast lesions (but not cancer) who participated in a weight loss program and lost 5-10% of their body weight had improvement in high risk biomarkers. So there is increasing evidence that investing in your health, minimizing weight gain and trying to stay in the range of normal body weight can help avoid breast cancer recurrence as well as occurrence.

One of the big challenges with hormone therapy is predicting and managing side effects. There were several posters* on the rate of joint stiffness and muscle aches in patients taking aromatase inhibitors (a wide range from about 35% to almost 50%). One poster was presented by Dr. Angie De'Michele (our I-SPY 2 collaborator) and focused on identifying markers that could possibly predict who will be at risk for these symptoms and suggesting potential strategies what might help with lessoning their severity. Unfortunately, we still cannot reproducibly identify who is at risk for side effects, but these studies are a step in the right direction.

Metastatic disease

There were some important practice changing reports for the metastatic setting. First, the anti-angiogenic therapies (that target abnormal vessel growth in tumors) that are currently on the market may not provide long term benefit. We have not as yet figured out which patients or which tumors derive the most benefit from targeting this important pathway. Dr. Rugo presented a review of the novel anti-angiogenic agents, showing that the therapies are very costly, and are not effective for all patients. She reviewed a small study testing low-dose chemotherapy (metronomic chemotherapy), and suggested that we may be achieving the same results as the anti-angiogenic agents at 1/50th of the cost. Clearly, some patients benefit from anti-angiogenic therapy but the modest benefit seen when all patients are treated has generated controversy at the FDA regarding approval of the anti-angiogenic drug bevacizumab (Avastin) in combination with chemotherapy. A final ruling is expected by the FDA in September of this year.

A number of studies compared receptor status (estrogen and progesterone receptors, and HER2/neu) at the time of

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*Scientific posters graphically present scientific work at symposia such as ASCO and are often peer-reviewed and searchable as abstracts.

Carol Franc Buck
BREAST CARE CENTER
NEWSLETTER

This newsletter is distributed free of charge to our current patients, providers and caregivers. We are very grateful for any support we receive to help offset our printing and distribution costs. If you wish to make a donation, please contact Meridithe Mendelsohn at (415) 476-3793 or mendelsohnm@cc.ucsf.edu. Thank you!

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TARGIT Trial Shows One-Dose Radiation Effective for Early Breast Cancer

By Catherine Metzger

The results of a 10-year, international, multicenter clinical trial indicate that a single dose of radiotherapy delivered during surgery may be as safe and effective for some patients with early breast cancer as the standard radiation therapy that takes up to six weeks. Breast surgeons Laura Esserman, MD, and Michael D. Alvarado, MD, were members of the TARGIT-A International Steering Committee, and Michael Alvarado and radiation oncologist Catherine Park, MD, were the principle investigators on the UCSF research team that participated in the TARGIT-A trial (Targeted Intra-operative Radiation Therapy).

"Radiation therapy for women who have had a lumpectomy typically lasts three to six weeks, Monday through Friday," said Alvarado. "This can be a significant burden for women across all socioeconomic levels. It can be especially difficult for women who need to travel a significant distance on a daily basis. By giving radiation as a one-time dose during the lumpectomy, the woman does not need to come back for radiation treatments.

"What is exciting and new is that the radiation is actually delivered during surgery. The radiation given in the operating room treats the area more precisely and the fact that it is immediate may also be beneficial," said Alvarado, who also sits on the international study's writing committee.

"The benefits are not only convenience; we believe it may, in the long run, be less dangerous than irradiating the whole breast because there is less 'scatter' to the lungs and heart, and fewer problems with the breast becoming hard after radiation."[A]

UCSF enrolled nearly 100 of the 2,232 breast cancer patients in the trial, and was the lead cancer center in the US and one of the first six sites to participate in the United States. Twenty-eight centers in nine countries throughout Europe, North America and Asia participate in the randomized controlled trial enrolling women aged 45 years or older with invasive ductal breast carcinoma undergoing breast conserving surgery.[C]

The study's findings, published in the June 5 online edition of The Lancet (**www.thelancet.com/journals/lancet/article/PIIS0140-6736(10)60837-9/fulltext**) showed that a single dose of targeted intraoperative radiotherapy was as effective, in terms of local recurrence rates, as a five to six-and-a-half week course of daily whole-breast radiation treatments. For selected patients with early breast cancer, these findings indicate that the new technique of dosing once in surgery should be considered an alternative to the standard daily, weeks-long protocol of external beam radiation, for select women (over age 50, postmenopausal, with grade 1 or 2 disease).[C]

Preliminary results of the trial were presented at the 46th annual meeting of the American Society of Clinical Oncology (ASCO) in Chicago on June 7, 2010 (see page 2).

The UCSF Breast Care Center is deeply grateful for Michael and Pepper Jackson's donation that allowed us to purchase the Intrabeam, the intraoperative radiation device that made it possible to participate in the TARGIT-A trial. Intrabeam is a device that allows the delivery of a dose of radiation (in this case lower energy photons) over a 20-35 minute period directly to the tumor bed, after the tumor is surgically removed in the operating room.[B]

"The device is truly an innovation in radiation oncology and helps change our thinking about how to achieve breast conservation," said Esserman who also co-authored The Lancet article. "For many women, the radiation therapy can be completed in one visit, instead of visits over a few weeks."

"This truly revolutionizes patient management and the patient experience," said Esserman. "For patients, this is amazing. We have identified a subset of patients for whom it is safe, and we should ensure that all such patients can access this technology. We will continue to study this device in higher risk patients to see if its role can be expanded and to explore why it is that the single treatment is so effective."[A]

"We are now trying to get a U.S.-based trial off the ground with major academic institutions across the country," Alvarado continued. "We are very excited about moving forward with this new technology."[A]

The single-dose therapy will be offered in conjunction with the ATHENA Breast Health Network (see page 8). ■

[A] Elizabeth Fernandez, news.ucsf.edu
[B] Breast Care Center Newsletter, Winter 2004
[C] The Lancet, Volume 376, Issue 9735, pages 91-102, 10-July 2010

Dear Beth

Our guest editor this fall is **Beth Crawford, MS, GCC,** *Director of Clinical Services of the Cancer Risk Program at the UCSF Helen Diller Comprehensive Cancer Center. Beth and her team identify families and individuals at high risk for cancer by analyzing the personal and family history, assessing the potential risk for inheriting cancer and testing for specific genetic mutations. For more information about The Cancer Risk Program including appointment scheduling, go to www.ucsfhealth.org/adult/special/c/59907.html or call (415) 885-7779.*

I was diagnosed with invasive breast cancer when I was 45 and my daughter was 10. I did not have any genetic counseling or testing. Now it is 10 years later, my daughter is 20 and I am wondering if I should look into this. Is it too late?

Good news – it is not too late to find out about your daughter's risk for breast cancer. Women who have been diagnosed with breast cancer or have others in their family with a breast cancer diagnosis are generally concerned about how to protect and inform their family members, especially their daughters at any age. Worry and guilt about passing susceptibility for cancer on to your daughter may keep you awake at night. Instead of getting stressed, you may want to seek a genetic cancer risk assessment to determine if there is an inherited cause for the cancer in your family.

Thankfully, most breast cancers are not caused by an inherited genetic mutation – a change in the DNA code that can lead to disease. But, a small proportion are and the presence of such a gene puts people with it at higher risk for developing breast cancer. When such a gene is found in a family member, the rest of the family can be told to see if it has been passed to them (some will have it and others won't). Signs of a possible inherited genetic mutation include an early age of cancer diagnosis (in your 20's, 30's or early 40's), multiple family members with breast cancer or ovarian cancer, a family member with multiple primary (separate) cancers, male breast cancer, or a history of breast or ovarian cancer in a family with Ashkenazi (Eastern European) Jewish or Latina ancestry. A visit with a genetic counselor can be a proactive way to learn about preventive measures and actual risk.

Following an in-depth review of family and personal cancer history, the genetic counselor will discuss whether genetic testing is likely to provide additional information about the cause of cancer in your family. Psychological support through this process is also available. Family history, sometimes combined with genetic testing results, is used to stratify (or rank by a variety of factors) your cancer risk, so the genetic counselor and the clinical team can develop a personalized prevention plan to suit your personal situation. You would be giving your daughter a way to protect herself that you did not have.

Hereditary cancers are rarely seen in a person's teens or early 20's, with the risk increasing after age 25. Lifestyle modifications can reduce risk. Walk or hike with your daughters, exercise is an important way to reduce risk and also great fun.

What does it mean to my family and me if the genetic assessment shows that we are at high risk for cancer? Could my insurance be cancelled?

The more information that you have about your family's risk for cancer, the more actively you can pursue early detection and prevention options. People worry about this, but since the time that genetic testing was introduced in the late 90's, no case of insurance discrimination has been reported on the basis of a genetic test for cancer. Through education classes offered at UCSF and other major centers, you can learn about inherited cancer predisposition, risks of developing breast, ovarian, colorectal and other cancers, as well as available prevention and early detection procedures. UCSF has multiple specialized clinics for people who are identified as having an increased chance of developing cancer. These clinics allow patients to consult with experts in the field about ways that they can pursue personalized screening and prevention of cancer. Multiple state and federal laws prohibit health insurers and employers from using genetic testing results to determine insurance coverage or employment.

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Research Pioneer Joins Cancer Center

By Catherine Metzger

We are thrilled to introduce Laura van't Veer, PhD, our newest Breast Care Center team member, who joins us as professor of Laboratory Medicine at UCSF, leader of the Breast Oncology program and Director, Applied Genomics Research. During a year-long research sabbatical from The Netherlands Cancer Institute (NKI) in 2009, van't Veer worked on extensive and ongoing collaborative projects with Laura Esserman, MD, Joe Gray, PhD, and other UCSF Comprehensive Cancer Center researchers. Van't Veer says that "the [UCSF] breast cancer program is a good instrument for integrating basic research with patients' needs, with the capability to evaluate new clinical approaches." After her one year sabbatical, Esserman said, "We just could not imagine going forward without her!"

Van't Veer's research at the NKI resulted in the first FDA test to predict "good and poor" risk and led to the development of many tests that are now used to determine if chemotherapy is needed for breast cancer treatment.

As a Breast Care Center patient, you probably have not had the opportunity yet to meet van't Veer, though her work has profoundly affected the way your physician chooses the treatment that is best for you. Van't Veer's research at the NKI resulted in the first FDA test to predict "good and poor" risk and led to the development of many tests that are now used to determine if chemotherapy is needed for your breast cancer treatment.

When van't Veer was growing up in the Netherlands, no one imagined that she would become a scientist- and, indeed, go on to make significant contributions to our understanding of cell biology. Her parents were not medical professionals or oriented to look at their world scientifically, but from an early age, Laura was interested in the nature of things. She thinks that her passion for research was a direct result of growing up among journalists pursing their work, journalists who pursue a line of questioning for different sorts of investigations. Eventually, a high school biology class kindled her already keen interest in wanting to understand the natural world, and that led to a bachelor's degree in biology, graduate work, and her PhD in cancer research.

Photograph by Catherine Metzger

Laura van't Veer, PhD

At that time (1984-1989), understanding human cell biology translated to a lot of work on cell biology gone wrong, pathological processes like cancer. As the study of cell biology began to identify cell processes on the molecular and genetic levels, however, van't Veer was there, working to define and illuminate gene activity in different breast cancer tumor cells.

What van't Veer's research revealed about breast tumor biology and gene activity has profoundly influenced how oncologists now use gene testing to make treatment decisions. As a Clinical Molecular Geneticist at NKI, van't Veer led a team that found that various patterns of gene activity could be mapped to help doctors find a treatment personalized for each patient. Van't Veer subsequently took the idea from the NKI laboratory into the clinical sphere in order to make sure the discovery could benefit those with a breast cancer diagnosis. To do so, she started a company, Agendia, to make and develop a product that is now marketed under the name MammaPrint. MammaPrint is a lab test on a chip that helps predict which patients have high or low risk of breast cancer recurrence (in the absence of any treatment!).

Currently, van't Veer is an author and leader of the biomarker group of our I-SPY 2 study (see Spring 2010 issue) and collaborates with the ATHENA Breast Health Network team on clinical and research issues. To watch a video of Dr. van't Veer answering questions about her work, see **www.ecancermedicalscience.com/tv/?play=361** ■

initial diagnosis, to the receptor status of metastatic tumors in the same patient. About 15% of patients who develop metastatic disease will have changes in the receptor profile of their tumor that could affect treatment choice. We believe that patients with a distant recurrence should have a biopsy to characterize the tumor, and this data strongly supports this approach. One group that may not change receptor status much are those with triple negative disease (hormone receptor and HER2/neu negative).

In this era of targeted biologic therapies for breast cancer, there are still new chemotherapy drugs that provide improved treatment options for patients. A randomized trial compared the novel agent eribulin to a treatment of the physician's choice in women with heavily pre-treated metastatic breast cancer who had previously received Adriamycin and taxane-based chemotherapy. Eribulin is a synthetic agent initially derived from the marine sea sponge that blocks cell division in a way similar to drugs like Taxol. It is given intravenously weekly, two weeks out of every three. Patients treated with eribulin lived longer, and had better disease shrinkage and control than those treated with the physician's choice. The side effects of eribulin include low blood counts, which can be managed by growth factor shots, or reducing the dose or frequency of drug. Hair loss occurs in about 30% of women. We hope that eribulin will be available for use in the clinic by sometime in 2011.

In addition to eribulin, there were a number of presentations on new and intriguing targeted biologic agents that we are sure to hear more about in the near future. PARP (Poly ADP [Adenosine Diphosphate]-Ribose Polymerase) inhibitors that block the ability of DNA to repair itself are one group of particularly interesting new agents. These drugs appear to improve the ability of chemotherapy to work in some patients with triple negative breast cancers. By themselves, they are only effective in some women with BRCA mutation associated cancers. We have a lot to learn about how to use PARP inhibitors most effectively; more data will be available in the near future. At UCSF, we have several studies using PARP inhibitors that are either open or will open soon.

UCSF at ASCO

The UCSF team had lots of exciting things to present at ASCO, including our study showing that biologically low risk tumors (measured by a test called Mammaprint) have become more common today compared to 20 years ago, and are likely to be detected in women undergoing screening. We proposed a new threshold to identify especially low risk tumors, that could help us determine, at the time of diagnosis, whether a tumor is IDLE (indolent lesion of epithelial origin) or not, and help us to study less aggressive interventions (Yiwey Shieh, Laura Esserman, Laura van't Veer and the Netherlands Cancer Institute team). In order to spur interest, Dr. Melisko presented the aims and study design for the ongoing SIS.NET trial. The SIS.NET trial is investigating a novel approach to follow-up care in order to reduce unnecessary clinic visits and monitor patient's symptoms remotely through electronic surveys. UCSF patients who are between one and five years from their diagnosis of breast cancer may be eligible to participate. Our Early Detection Research Network (EDRN) team showed our strategy for developing signatures for high risk hormone receptor negative tumors (which recur predominantly in the first 5 years), and early (within 5 years) vs. late (5-15 years) recurrence in hormone receptor positive tumors. We think that understanding the timing for when a patient is at risk for recurrence will help us tailor our treatments and follow-up strategies. A visiting fellow from Australia, Dr. Sally Greenberg, presented the results of a study by Dr. Rugo and colleagues treating patients who have rare tumor cells in their bone marrow after completing chemotherapy with 2 years of the potent bisphosphonate zoledronate. Treatment with zoledronate (Zometa) was associated with a decrease in the number of cells in the bone marrow and treatment was well tolerated. These data support two randomized trials that showed less recurrence in women with early stage breast cancer who received zoledronate along with their hormone therapy, versus those who received hormone therapy alone. In order to make a final decision about clinical use, we need to wait for data from the large AZURE trial, that should be presented in December of this year. Two other trials, presented by Drs. Michelle Melisko, Jo Chien and Hope Rugo, evaluated circulating tumor cells in blood as a marker of response to therapy in women with high risk or metastatic breast cancer using a laboratory method developed by Dr. John Park. This research test is now being used to try to evaluate tumor biology as well in ongoing studies at UCSF. ■

Laura Esserman, MD, MBA, Professor, Surgery and Radiology, and Affiliate Faculty, Institute for Health Policy Studies, UCSF. She is the Director of the Carol Franc Buck Breast Care Center, Associate Director, Medical Informatics, and Co-Leader, Breast Oncology Program, UCSF Helen Diller Family Comprehensive Cancer Center.

ATHENA Health Care Network

The ATHENA Health Care Network – an ambitious, long-term breast health program that aims to do for breast cancer what the Framingham Heart Study did for cardiovascular disease – is poised to begin accepting the first cohort of women this fall.

ATHENA will personalize breast cancer prevention, screening, and treatment for each individual to more effectively prevent and combat the disease. Women who present for breast cancer screening and treatment at UCSF and the other four UC medical centers and their affiliates will be offered the opportunity to enroll and be part of the ATHENA Breast Health Network. This represents an exciting opportunity for the entire community (patients, clinicians and researchers) which will enable us to personalize care and improve our ability to rapidly learn from every patient we care for. Initially, ATHENA will include 150,000 women who get routine screening and 10,000 who will be diagnosed with breast cancer. Women will contribute information about themselves and any risk factors they have – including health status, lifestyle behaviors, environmental factors, co-morbidities, and family risk – and will be followed for years.

As part of the routine of care, ATHENA patients will go through a risk assessment process and be offered preventive interventions as appropriate. They will then be able to choose more tailored options for screening, prevention, and treatment, if cancer is diagnosed.

By collaborating on collecting the right information one time and integrating it with cutting edge, emerging new biomarkers, ATHENA's researchers and clinicians hope to identify common elements in those healthy women who do eventually develop breast cancer and to better learn who is at risk for what type of breast cancer. Eventually, the goal will be to find opportunities to personalize prevention and care.

Look for more news about ATHENA's launch at **www.athenacarenetwork.org** ■

Meet the Breast Care Center Administrative & Ancillary Clinic Staff

Front row *(from left):* *Stephanie Camat, Marie Bigornia, Diana Bretzinger*

Middle row *(from left):* *Stephanie Gee, Tamara Wyzanski, Jessica Davis, Ivy Liu, Sandra Chu*

Back row *(from left):* *Michelle Williams-Jones, Cindy Cruz, Shivaan Muttu, Alex Millaris, Andrew Hudak, Amalia Lane, Lianne Umali, Shay Lorseyedi*

Not pictured: *Sara Schwab (Manager), Claudia Castro, Kristen Tsan*

Photograph by Catherine Metzger

UCSF Patient Health Library

By Catherine Metzger

Ari Kleiman, Patient Health Librarian, shows Meridithe Mendelsohn some of the reference periodicals available in the very accessible new Patient Health Library.

The first UCSF Medical Center Patient Health Library is an inviting place for those who want to learn about their health. Equipped with three computer stations, a copier, fax, and scanner for patient use, and stocked with a variety of books, periodicals and health newsletters, the small, welcoming library is just steps away from the elevator bank in Mount Zion's A building.

Since opening in December 2009, the library has aimed to: offer comprehensive information about a wide range of medical conditions, and to empower patients and their loved ones as they seek to educate themselves about their health. With the help of Ari Kleiman, MLIS, a medical librarian, whose job is to provide professional consultation to visitors, the library appears to be meeting its goals. Kleiman finds that "a lot of fear and anxiety can be allayed just by having somewhere to go where questions are welcomed."

Most teaching hospitals have a medical library, but not a separate one dedicated to helping patients wend their way through medical texts, journal articles, Medline Plus, or other top-rated medical web sites. Limited resources, staff and space often mean that the very information that might lead to a patient's understanding of a complicated disease is inaccessible to them. Even those familiar with web searches in general often find the amount and quality of information online difficult to navigate when it comes to their health.

Patients used the H.M. Fishbon Memorial Library, the medical staff library at Mt. Zion, prior to the new Patient Health Library opening. But as the number of patients and family members who needed access to health information increased, Gail Sorrough, MLIS, Director of Library Services, says that she and other librarians began to dream of a better, more HIPAA compliant way to share their resources. Eventually, the library staff, backed by a gift from the Mt. Zion Health Fund, carved out the patient library from one end of the Fishbon. In August 2010, UCSF Medical Center recognized Sorrough's efforts with a PRIDE award (for continuous demonstration of our core values: Professionalism, Respect, Integrity, Diversity and Excellence) noting her work in creating the library.

Now with Kleiman's skilled assistance and the Patient Health Library's free resources, visitors are able to research treatment options, read about the latest research and clinical trials, and educate themselves about prevention and healthy living. Web searches done in the library allow visitors access to many web resources such as databases that are not available offsite without a subscription.

Kleiman and Sorrough hope that patients, their friends and family will stop by to see how the library might meet their information needs. The Patient Health Library is open Monday through Friday, 9:00 am – 5:00 pm. ■

Survivorship Program – Two Years and Counting!

By Meridithe Mendelsohn

September marks the second anniversary of the UCSF Cancer Survivorship Program at the Breast Care Center. Designed specifically for those who have completed their active therapy for cancer (surgery, chemotherapy and/or radiation), the focus is on specific types of support that are different from active treatment needs. By providing guidelines for clinical care and resources for improving general health and well being, the Survivorship Program enables patients to concentrate on their path to wellness. Michelle Melisko, MD, is the Medical Director for this program.

Photograph by Catherine Metzger

Yoga in the UCSF Women's Health Center Healing Garden (Pictured here: Natalie Cox)

How does the program work?

Once your doctor or nurse practitioner has referred you to the program, you will be scheduled for a one-time group session by our coordinator. In this 90-minute meeting, Debby Hamolsky, Clinical Nurse Specialist, will explain the process of recovery and healing following breast cancer treatment and help you to understand the resources and support that you may access through the Survivorship Program. One of the Breast Care Center physicians will be on hand to answer any questions that you might have and report on the latest research in breast cancer care. You will also be introduced to the online health questionnaire, if you have not completed it already.

One of the Breast Care Center physicians will be on hand to answer any questions that you might have and report on the latest research in breast cancer care.

Who will I see at my clinic appointment?

You may see one of our Survivorship nurse practitioners, but you will most likely just continue to see the nurse practitioner who has been seeing you during treatment. Mary Lou Ernest, NP, our lead nurse practitioner, helped develop the program. Educated at UCSF and part of the Breast Care Center for 15 years. Mary Lou is recognized for her clinical expertise, teaching and many years of diverse experiences in oncology. Her leadership in breast care combined with her holistic and comprehensive approach to patient care, has led

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Survivorship Program – Two Years and Counting! *from page 10*

her to her key role in clinical care and program development. Bridget Hogue, NP, is another Survivorship nurse practitioner and member of our team. She joined the program in 2008, adding her clinical experience in oncology, breast care, and women's health. Bridget has worked as a clinical research nurse at the National Institutes of Health in Bethesda, MD in medical oncology/stem cell transplant and as a chemotherapy infusion nurse. She earned her nurse practitioner degree from the University of Washington.

Your nurse practitioner, who is already familiar with your care, will summarize your diagnosis and treatment, and personalize your program for follow-up care. She will be in close communication with your doctor and if a new problem or issue arises that requires attention from your oncologist or surgeon, she will facilitate a timely appointment. We will also provide follow-up information to your other care providers about post-treatment care and symptom management for your specific situation. There may be resources that will help for persistent or new issues such as depression, a new family history of breast or ovarian cancer, and problems with sexuality.

What resources are available to survivors?

Monthly "Spotlight on Survivorship" educational events take place at the Jewish Community Center of San Francisco. These lectures and events are open to all cancer patients and their family members and there is no charge. Upcoming events include an all day retreat focused on diet, exercise and wellness, and our Taste for the Cure Event featuring educational lectures by Breast Care Center clinicians and tasty yet healthy foods. Past lectures have included topics such as Coping with Uncertainty, Pilates, Nifty Nutrition, Yoga, and Sexuality After Cancer. To receive monthly emails with upcoming event listings, contact Meredith Bock at **meredith.bock@ucsfmedctr.org**. Events are always listed in the Breast Care Center Newsletter in the Calendar section (page 14 in this issue).

Coming Soon!

The Breast Care Center's website is undergoing a much needed renovation. Check out the new look online coming soon to **www.ucsfbreastcarecenter.org**.

As always, this newsletter and previous editions are accessible and downloadable from the website. To reduce our costs and the amount of paper in your mail box, please subscribe to the e-version of the newsletter at **bccnews@ucsfmedctr.org**.

Additional Survivorship Program resource information can be found at the following UCSF sites:

- **The Breast Cancer Forum**
  (podcasts of previous lectures)
  cit.ucsf.edu/podcast/description.php?id=80
- **Helen Diller Family Comprehensive Cancer Center**
  cancer.ucsf.edu/
- **Ida and Joseph Friend Cancer Resource Center**
  cancer.ucsf.edu/crc/
- **Art for Recovery**
  cancer.ucsf.edu/afr/
- **Osher Center for Integrative Medicine**
  www.osher.ucsf.edu/
- **Center of Excellence in Women's Health**
  coe.ucsf.edu/coe/

If you have any questions or would like more information, please contact me, Meridithe Mendelsohn, Survivorship Program Manager, at (415) 476-3793 or **mendelsohnm@cc.ucsf.edu** ■

BCC Makes Connections at *Many Faces, One Voice*

Dr. Laura Esserman, MD, Director of the UCSF Breast Care Center, and Elly Cohen, PhD, Program Director of BreastCancerTrials.org (BCT.org), a clinical trial matching service developed at UCSF, recently participated in *Many Faces, One Voice*, a breast cancer conference sponsored by the San Francisco affiliate of Susan G. Komen for the Cure. The June 30 conference attracted over 150 attendees and covered topics such as the new breast cancer screening guidelines, advances in treatment, and culturally-sensitive approaches to breast cancer care.

Esserman spoke as part of the conference's keynote panel on recent changes to screening mammography guidelines. The panelists gave their perspectives on whether women of average risk should start breast cancer screening at age 50, which has been proposed, or age 40, which is the current practice. The panel also discussed how screening for younger women should be tailored to their individual risk for developing breast cancer.

BCT.org reached out to attendees with a booth in the conference's marketplace health fair. The well-attended event gave BCT.org the opportunity to raise awareness about clinical trials and how the interactive website and program can help users find trials that might be right for them. BCT.org representatives were also able to connect with a variety of organizations, including the Shanti LifeLines Breast Cancer Program, and the Chinese Community Health Resource Center, two San Francisco Bay area community health organizations that work with underserved populations. "We talked about how BCT.org might be better able to help them assist their clients to find and join trials," said Cohen. "Just by visiting our web site **www.BreastCancerTrials.org** women learn more about what their options are."

Photographs by Susan Colen

Elly Cohen, PhD, sharing information at the BreastCancerTrials.org table during the "Many Faces, One Voice" conference.

Laura Esserman, MD presenting during the keynote panel at the Komen-sponsored breast cancer conference "Many Faces, One Voice."

Also pictured: Maria Sousa, SF Komen for the Cure; Jon M. Greif, DO, Bay Area Breast Surgeon; Robert W. Carlson, MD, Professor, Stanford University

What is Peer Support at UCSF? *By Mimi Roth*

The trauma of being diagnosed with cancer is enormous. The questions that can race through your mind, even while the physician is still trying to explain the situation, are unending and traumatic. Will I die? Will I be an invalid? Will I have terrible pain? What do I tell my family? What do I tell my friends? How will I handle my work? Will I have to endure those painful treatments I have heard about? How will I pay for all of this? Has anyone ever survived this? Where do I get the answers? Who can help me? How do I ask for help? Where do I start?

Idonah Molina, Peer Support Program Coordinator

We have a number of programs at UCSF that range from support during your consultation (Consultation Planning) to programs such as Art for Recovery. The Ida & Joseph Friend Cancer Resource Center (CRC) is part of the UCSF network of support programs. One resource that our patients find extremely helpful is Peer Support – this support from someone who has been "through it all" can make all the difference. The UCSF Peer Support Program connects patients via telephone with a cancer survivor who has had a similar diagnosis or treatment, though it is not limited to matching based on diagnosis and treatment. Peer Support offers cancer patients the opportunity to speak to survivors or other veterans who have already "been there." These volunteers have special training and are available to share their experience, providing emotional and informational support. Talking to someone via the phone who has been through the anxiety of a new diagnosis, facing a surgery or treatment choice, a recurrence, or feeling the anxiety, fear and uncertainty of cancer can provide hope and reduce isolation.

The UCSF Peer Support Program was started in the mid-1990's by a cancer survivor who realized the value and importance of talking to others "who've been there" to share experiences and knowledge. Since its inception the program has matched approximately 100 to 150 patients a year with volunteer survivors. When no one is available or there isn't a good match through UCSF's program, referrals are made to local, regional and national peer support matching around the country. These programs, like UCSF's, are made up of volunteers trained to assist anyone regardless of where care is received. Peer support is especially helpful to those who live in rural or isolated areas where attending support groups or finding someone who has gone through a similar experience is tough. Speaking with a veteran survivor is often an opportunity to find resources and other methods of coping. Peer support can be utilized at different points along the way, for example when you are newly diagnosed. Speaking with someone who dealt with specific issues, such as breast reconstruction can be especially important. If you are facing a recurrence, speaking with a veteran survivor who is living with metastatic disease can provide reassurance and hope.

To receive peer support or find out how to become a volunteer, please contact Idonah Molina at (415) 885-7801 or Mimi Roth at (415) 885-7604. You can also drop into the Cancer Resource Center or go online to **cancer.ucsf.edu/crc** to read more about the program. If you're not sure if this is the right program for you, please contact us anyway and we can provide all types of information and support which you might find incredibly helpful as you navigate the complexities and challenges cancer may bring to you, your family and friends.

The Ida & Joseph Friend Cancer Resource Center (CRC) is a place to find help for many of the unanswered questions that might come up. Patient education and supportive care services are available to anyone diagnosed with cancer and their family/friends, regardless of where care is received. Caring staff and volunteers are ready to assist in-person and on the phone from the moment of diagnosis through treatment and beyond for assistance navigating the complexities and stresses of a cancer diagnosis. The CRC is located just past the gift shop on the first floor of the Helen Diller Family Comprehensive Cancer Center at 1600 Divisadero St in San Francisco, CA. ■

Mimi Roth is the Manager of the Joseph and Ida Friend Cancer Resource Center at UCSF.

Belkora to Receive CBCRP Award

Jeff Belkora, PhD, Assistant Professor, in the Department of Surgery and Institute for Health Policy Studies (IHPS), and Director of Decision Services at the UCSF Breast Care Center, has been selected to receive the 2010 Faith Fancher Research award from the California Breast Cancer Research Program (CBCRP) for an outstanding research proposal focused on underserved communities. His co-recipient and community partner is Sara O'Donnell of the Mendocino County Cancer Resource Center. Their work, "Recording Medical Visits for People with Breast Cancer," explores the adaptation and implementation of the UCSF Decisions Services model in rural Mendocino, and seeks to find ways of expanding the reach and effectiveness of decision services.

The Faith Fancher award is given to a researcher, institution or community-based organization whose work reflects the values that Faith Fancher portrayed in her own work for women facing breast cancer. Fancher, a Bay Area news anchor who passed away in October, 2003, was a founding member of the CBCRP Executive Team.

Belkora appreciates the attention the award will draw to the Breast Care Center, where patients are actively encouraged to be informed and involved participants in their own health care decisions. ■

Dear Beth *from page 5*

What does current research show about cancer susceptibility?

As we learn more about the precise biological features of inherited cancers, we are also learning that people with cancers caused by in inherited mutation may respond differently to certain cancer treatments. Early cancer detection and cancer prevention are the main options provided to people who learn that they have an inherited susceptibility to cancer. In the future, knowledge about the inherited causes of cancer may allow doctors to treat patients with more targeted therapies. We have also learned that prophylactic surgery really does remove almost all of the risk of developing breast or ovarian cancer and the procedures have improved dramatically. So, it is important to know your options. ■

Calendar

Spotlight on Survivorship

The 2010 Spotlight on Cancer Survivorship series is made possible by Mount Zion Health Fund, a supporting foundation of the Jewish Community Endowment Fund, in memory of Laurence Myers.

Wellness Sojourn Retreat

Greta MacCaire, RD, Jane Clark, and Dianne Shumay, PhD
Saturday, October 9, 8:30 am to 12:30 pm

Learn how to balance your health with exercise, diet and skills for emotional coping. There will be demonstrations and chances for participation throughout this informative session.

Taste for the Cure: A Celebration of Breast Cancer Survivorship

Saturday, November 7, 12:30 pm – 4:30 pm

- Two panel presentations by Breast Care Center practitioners that include discussions about the latest research updates and clinical trials
- Personal chefs from all over the Bay Area sampling their wares
- Cooking demonstrations
- Live music
- Resource information

The above events take place at the
JCCSF, 3200 California St., San Francisco.
Space is limited. For reservations call (415) 476-0272.

There is no cost for these programs.

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, (415) 885-7213 or lauren.metzroth@ucsfmedctr.org. All sessions take place in room H3805 on the 3rd floor of the Cancer Center.

Wednesday, November 3rd
Topic To Be Determined

Wednesday, January 5th
San Antonio Update

Breast Care Center Honor Roll

Your Support Keeps Us Going!

We want to thank these generous benefactors for contributions received during the period between January 27, 2010 – August 15, 2010.

$2,000,000+

Safeway Foundation Northern California Division

$500,000-$1,999,999

The Susan G. Komen Breast Cancer Foundation

$50,000-99,999

Ginn Family Charitable Foundation
Pepper & Michael Jackson
in honor of Laura J. Esserman, MD, MBA
The Laszlo N. Tauber Family Foundation, Inc.

$20,000-$49,999

Barbara and Gerson Bakar
Georges Harik
Salesforce Foundation

$10,000-$19,999

Pierre Nallet

$1,000-$9,999

AstraZeneca
Kathleen & William Banaka
in honor of Laura J. Esserman, MD, MBA
Josefina & Arnold Baptiste
Marilyn Cantlay
Stephanie & Richard Fredericks
Cheryl & Philip Genet
Harrington Family Foundation
Bethany & Jim Hornthal
Suzanne M. Lewis-Frankl & Andrew Frankl
In memory of Mrs. Mary Laugharn Buster
Garrett Lambert
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Helen & Charles Schwab
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Laura & Gregory Spivy

$500-$999

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Beatrice & Don Cherry
Margaret & Raymond De Gennaro
in memory of Mr. Jim Ingram, Mr. Ray Goddard, Sr. and Pastor Millie Wilson
David W. Kim, MD
Michele Florian
in memory of Ms. Marlene Grodin and in honor of Mrs. Jeanne S. Eber
Irene & Alfred Lunardi
Lena H. Shao

$100-499

In memory of Mrs. Mary Laugharn Buster
Debbie Abono
J.C. & K.L. Barens
Janice & Steve Barlow
Bay Area Council, Inc.
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San Francisco Fly Casting Club
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Saxon-Hamilton
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Kirsten Weisser & Joseph Tuman
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Patricia & John L. Winther
Sylvia & Peter Dworkin
Helena Holthuis-Catalano & Anthony Catalano
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Sylvia and Peter Dworkin
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Robyn & Thomas E. Geissler
In memory of Ms. Suzanne Griffith
Sheila & John Buchwald
Doris & Micheal DeSantis
Shelton Park Sunshine Company
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in honor of Laura J. Esserman, MD, MBA
Laurie Hunter & Jonathan J. MacQuitty
Melissa Moore
Ragni & Marc Pasturel
Renee & Miles Rubin
in memory of Ms. Jane Moriarty and Mr. Leonard Eiebe
Roberta & Charles Saunders
Johann Schroettner
in memory of Mrs. Helen Schroettner
Alyce N. Shikano
in memory of Ms. Rhea Wilson
Patricia M. Stone-Hokenson & Earl Hokenson
in honor of Mrs. Pamela Hirsch
Susan & C. Henry Veit
Miha Wang & Anthony Chao
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Kirsten E. Weisser & Joseph S. Tuman
Patricia & John L. Winther

$5-$99

Gael A. Beresford & Owen M. Raven
in honor of Mindy E. Goldman, MD
Esfir & Yakov Bernshteyn
Holly & Brian D. Burgess
in memory of Mr. Ray Blakemore
In memory of Mrs. Mary Laugharn Buster
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Barbara D. Treadwell
United Way of the Bay Area
Ellen G. Wong
in honor of Ms. Genevieve N. Leitner
Carolyn & Bill L. Lee

We sincerely regret any errors or omissions. Please contact Meridithe Mendelsohn at (415) 476-3793 or mendelsohnm@cc.ucsf.edu with your concerns.

First row: *Juanita Clemena (manager), Vanessa Valera, Erlyn Balanag, Maria Purganan, Stephanie Sare, Rocio Hernandez* **Second row:** *Jose Bermudez, Rafael Garcia, Salvador Luna, Anastasia Vazheva, Anna Nemesio, Grace Njane, Tamiko Hayes, Natalie Bailey* **Not pictured:** *Miracle Austria*

BCC Call Center Staff

It is always good to know who is on the other end of the phone when you call! Our wonderful Call Center staff is available to help you from 8 am to 5 pm, Monday through Friday, at (415) 353-7070.

UCSF Helen Diller Family Comprehensive Cancer Center

The Carol Franc Buck Breast Care Center
UCSF Comprehensive Cancer Center
San Francisco, CA 94143-1710

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www.ucsfbreastcarecenter.org

Carol Franc Buck
BREAST CARE CENTER
NEWSLETTER

Taste for the Cure

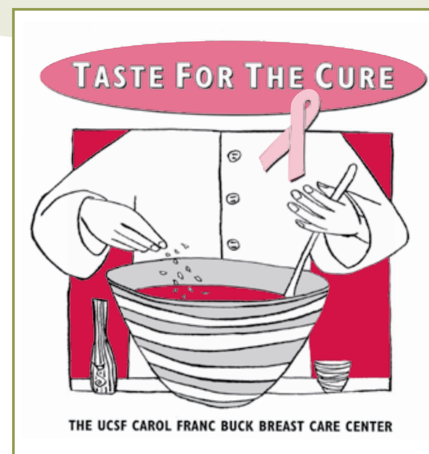
A Celebration of Breast Cancer Survivorship

Saturday, October 30, 12:30 – 4:30 pm

Jewish Community Center • 3200 California Street, San Francisco

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

- Panel presentations by UCSF Breast Care Center practitioners that include discussions about issues specific to those who have finished their active breast cancer treatment, other updates and clinical trials
- Healthy food vendors and personal chefs from all over the Bay Area sampling their wares
- Live music
- Valuable resource information from the Center of Excellence in Women's Health, Cancer Resource Center, Friend to Friend Shop, Art for Recovery, and local health related organizations



To reserve your place, call (415) 476-0276

Saturday, October 30
12:30 – 4:30 pm

Jewish Community Center San Francisco
3200 California Street