

# BREAST

# CARE CENTER newsletter



SPRING ON-LINE!

**Laura J. Esserman, M.D., MBA**  
*Director, Carol Franc Buck Breast Care Center*

Welcome to our Summer 2000 Newsletter! As we move into a new millennium, we see that advances in the fight against cancer will come from better understanding the molecular and biological differences among tumors and among individuals. This understanding will allow us to tailor our treatment to each patient. We are moving towards that goal with our research in the molecular characterization of tumors, in MRI imaging, in vaccines, and in our research looking at micrometastases (see articles by Drs. John Park and Hope Rugo on page 3). New agents will eventually allow us to deliver chemotherapy only to cancer cells.

Our goal is to take these scientific discoveries out of the laboratories and into our clinical practice as soon as possible, so we can change the lives of women (and men) with breast cancer and make real progress in the quest for a cure. In our next issue, we will begin to feature the work of our basic science researchers who are conducting laboratory research focused on breast cancer. These men and women are working with us to find new and better ways to treat breast cancer. We will start the feature with renowned "gene hunter" Dr. Joe Gray and with our vaccine expert, Dr. Michael Campbell.

On a lighter note: We are happy to announce some exciting social events. On May 16, the *Smuin Ballet* will be honoring Carol Franc Buck with a special performance. The proceeds will exclusively benefit our center, so please join us for this fabulous evening! And mark your calendars: On September 23 we will be holding our second *Taste For The Cure* annual fundraiser, which features low-fat cooking lessons from the great chefs of San Francisco and yummy samples of healthy food. Also keep in mind that October is Breast Cancer Awareness Month- *Race For The Cure* will be held October 15.

Finally, we are thrilled to invite you to visit our brand-new website, now open for browsing! Please come check us out at <http://breastcarecenter.his.ucsf.edu>. The website will grow and evolve over time and hopefully allow us to communicate better. Your feedback is important to us. Please send your comments about the website or this newsletter to [sarah.paris@ucsfmedctr.org](mailto:sarah.paris@ucsfmedctr.org) or call Sarah at (415) 885-7323. We hope you enjoy the information presented on these pages and find it useful. ■



## THE SOUTH AFRICAN TRIAL

by Laura J. Esserman, M.D., MBA

This story about scientific fraud in a high-dose chemotherapy and bone marrow transplant trial from South Africa was on the front page of newspapers around the globe.

Background: Only one of five studies at last year's ASCO meeting reported a net benefit from bone marrow transplant. Discussions centered around the design of a clinical study that would compare the one supposedly successful study, the "Bezwoda" regimen, to what is considered standard therapy for women with node positive breast cancer (adriamycin, cytoxan, and taxol). But before starting the study, the National Cancer Institute (NCI) and clinical leaders in the U.S. insisted on an audit to make sure that the data reported were correct, before subjecting hundreds of women to a treatment found to be successful only at one institution by only one investigator (most NCI-sponsored trials are audited). A six-person team went to South Africa to review the study and the patient records. What they found shocked the cancer research community. The majority of records were not available; those that were demonstrated such discrepancies as to discredit the whole trial and the reported results. The study protocol seemed to have been written after the fact for the reviewers. It is not clear that there was ever a true study, and there is no record that patients were given an informed choice about participation. Dr. Bezwoda has admitted to "scientific misconduct" and has resigned.

We can learn several things from this event:

1. Is bone marrow transplant (BMT) not a valid treatment? Given that no other study has shown a benefit, BMT cannot be considered a standard of care for any woman with breast cancer (not even for ten or more positive nodes or metastatic disease). There is NO evidence to show that it is better than what would now be considered standard chemotherapy with three drugs (ACT). The side effects are clearly worse, as is the quality of life in the first year. This is actually good news; it means that the less toxic approach is likely to be as good.
2. Was it wrong to test BMT? No of course not. Without testing new ideas, we will never be able to improve treatment. BMT is likely to be tested as shorter alternative (one month) to standard chemotherapy, which takes nine months. Is it reasonable to test this? As long as the toxicity is low and the trial well-designed and supervised, it is. Safety is crucial; regimens with any projected mortality are not acceptable. The old BMT regimens had a 5-7% death rate from the therapy. Current methods are much safer (0-2% mortality).
3. Why have clinical trials? Because all of us want better therapies. But we must resist the temptation to assume that what is new or more toxic or alternative is necessarily better. BMT became the standard of care before it was tested, driven by some physicians, advocates, and legislators, who felt it should be covered by insurance. Our attitude should not be to resist new therapies, but to rigorously test them and assess the results with an open mind.
4. When contemplating any treatment, always ask yourself the questions: What are my treatment choices, what are my alternatives, and what is likely to be the outcome even if I do nothing? Clinical trials are particularly useful, when you are in a position to decide on the kind of therapy you will get, and, on balance, either choice would be a good one. That is the way most trials are designed. You should never join a trial without being given an informed consent.

The answer to this debacle is NOT more oversight and regulation of clinical trials. It is already hard enough to conduct them, and we do not want more barriers. The answer is to change the way in which we practice. The routine collection of critical data during care should become the standard of care, so we can ask ourselves, how have we treated our patients this year, and what is the outcome. Then the clinical trials will be a subset of our routine practice, where data can be examined readily. Our goal at the Breast Care Center is to try to develop the systems that allow us to track all of our results. ■

## BISPHOSPHONATES IN THE TREATMENT OF BREAST CANCER

### *The Pursuit Of New, Less Toxic Treatments*

by Hope S. Rugo, M.D.



Originally, bisphosphonates were developed to treat high levels of calcium in the blood associated with advanced cancers. But they have been shown to also delay bone destruction, decrease bone pain, and reduce bone fractures in metastatic breast cancer, prostate cancer and multiple myeloma. Animal studies suggest that bisphosphonates may also suppress cancer cell growth in the bone marrow.

Currently, the only approved use of bisphosphonates in breast cancer is to delay progression of bone metastases in women with known metastatic disease. Pamidronate is the only approved bisphosphonate in the United States; it is usually administered intravenously once a month. Zoledronate should be available for the same indication in June of 2000; the main advantage is a significantly shorter infusion time. Bisphosphonates can be given by vein (IV) or by mouth (orally). When they are taken by mouth, they may not be absorbed well enough to be as powerful as intravenous bisphosphonates.

What if the drugs were given orally at the time of diagnosis? Three randomized trials have studied the use of the oral bisphosphonate Clodronate in women with newly diagnosed, node-positive breast cancer. One study was performed on women with microscopic metastases only. It found a reduction in both bone and visceral (liver, lung, etc) metastases at 3 years, as well as improved survival. Two other studies treated women without testing the bone marrow. Preliminary results from the largest study showed a reduction in bone metastases at 3 to 5 years. A much smaller study showed possibly an increased risk of recurrence in the treated group; these women received minimal adjuvant therapy and only preliminary results have been reported. A nationwide randomized trial in the United States is set to begin later this year comparing the rates of recurrent cancer in women with newly diagnosed breast cancer receiving the intravenous bisphosphonate Zoledronate, or a placebo, given once a month for 3 years.

At the Breast Care Center, we are testing bone marrow samples for microscopic metastases at diagnosis, using three very sensitive techniques to enhance detection (see article on this page). Beginning later this year, we hope to be able to open a trial investigating the use of bisphosphonates to prevent or delay recurrence in women with node-positive breast cancer who have evidence of microscopic metastases in their bone marrow after completing adjuvant chemotherapy. This might involve having women come in to have their bone marrow tested one or two years after they have finished their breast cancer treatment. We are interested to find out if women would be willing to participate in this kind of study.

Testing patients for micro-metastases and treating them with bisphosphonates might prove to be an effective and non-toxic therapy to reduce long-term recurrence risk, in addition to the benefits of adjuvant chemo- and hormonal therapies. We will let you know more about this as we develop our study. ■

## UPDATE ON MICROMETASTASES IN BREAST CANCER

by John Park, M.D.

One type of question that our patients very frequently ask is, "How do I know if I'm at risk for a recurrence? And, can we tell if my cancer has already spread elsewhere in my body?"

A new approach to this important problem is to detect so-called "micrometastases," breast cancer cells that have reached the blood stream and/or bone marrow. Recently, scientists in Germany reported that patients carrying such cells in their bone marrow at the time of their initial treatment

[ cont. on next page ]

for early breast cancer are indeed more likely to have a subsequent recurrence of metastatic breast cancer than those patients with negative bone marrows (Braun et al., New England Journal of Medicine, Vol. 342, Feb. 24, 2000). This test may improve our accuracy in assessing a patient's risk and allow us to tailor her treatment accordingly.

At the Breast Care Center, we have been conducting our own study of micrometastases using three different methods: immunocytochemistry, which is similar to the one used in the German study, and two newer technologies called reverse-transcription polymerase chain reaction (rt-pcr) and flow cytometry. We are trying to find out which method is most effective in detecting micrometastases in the bone marrow.

Every patient who has breast cancer surgery at UCSF has the opportunity to be in this study and have this test. For more information about this or any of our clinical trials, please contact Liz Wieland at (415) 353-7213. ■



## REPORT FROM THE SAN ANTONIO BREAST CANCER SYMPOSIUM

by Debu Tripathy, M.D.

The 22nd Annual San Antonio Breast Cancer Symposium held last December boasted the highest registration and most diverse participation ever. Among the highlights were: Breast cancer prevention - The approval of tamoxifen to lower the risk of breast cancer continues to generate controversy. In the short term (5 years), tamoxifen can cut the risk of getting breast cancer by about half (from 3% to 1.5% in a high risk population). This has to be balanced against the risks of uterine cancer, blood clots, and stroke. A model was presented to more accurately estimate a woman's risk of breast cancer and the amount by which it would be lowered by tamoxifen. These models can help doctors to make recommendations to individuals.

Herceptin therapy - One report suggested that gene-based assays of HER2/neu best predict response to Herceptin. Another study looked at a combination of vinorelbine (Navelbine) plus Herceptin for metastatic breast cancer and found that 71% of patients responded. This is promising and may be an option for patients who progress on Herceptin alone or on Herceptin plus paclitaxel (Taxol). We are looking forward to starting our own Herceptin trials for early-stage breast cancer patients with positive lymph nodes. This is in connection with two large national trials to determine if long-term improvements in recurrence and survival would outweigh the rare side effects on the heart.

New Drugs for Advanced Breast Cancer - There is much excitement over newer drugs that target cancer functions such as angiogenesis (tumor blood vessel formation necessary for tumor growth), estrogen receptors, and other growth factor receptors. Yet, no clear effects are being reported from early clinical trials of these drugs. Some interesting strategies include new vaccine antigens, new molecules that interfere with signaling via growth factor receptors like HER2/neu and EGFR, reversing tamoxifen resistance with retinoic acid receptor ligands, and agents that trigger cell death in cancer cells. ■

## FOCUS GROUPS

by Caryn Aviv, MA

The Program for Collaborative Care at the UCSF Breast Care Center and the Foundation for Informed Medical Decision Making have been developing tools to encourage shared decision making between patients and physicians. Two new tools, Consultation Planning and Consultation Recording, are currently available at the Breast Care Center for patients facing treatment option decisions.

We are in the process of developing a website and other patient support materials to help women with difficult decisions about breast cancer screening and treatment. To make sure we are meeting the needs of women facing these decisions, we are looking for breast cancer patients and family members who would be willing to help us evaluate early versions that we develop.

If you have faced decisions about breast cancer screening or treatment at the Breast Care Center and are willing to share your experiences and evaluate some material for a web site, please contact Caryn Aviv by e-mail [Caryn.Aviv@ucsfmedctr.org](mailto:Caryn.Aviv@ucsfmedctr.org) or phone 415.353.7726. ■

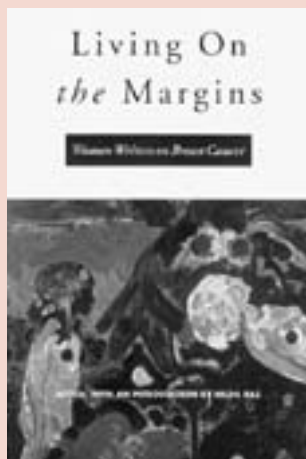
## THE HIGH RISK PROGRAM

by Leah Millheiser, MD

Our High Risk Program is one of the first multidisciplinary breast cancer prevention and screening programs in the Bay Area. The program provides services and education to women who have been identified as being at an elevated risk for the development of breast cancer. In addition to the physician-patient consultation, patients in our program may choose to participate in any of our comprehensive "boutique-style" services. These include: nutritional counseling, exercise physiology, alternative medicine and acupuncture, hormone replacement counseling, mammacare training (an individual breast self-exam tutorial), as well as a hereditary cancer risk assessment. Patients can also participate in our cutting-edge clinical research studies. Currently, we are testing the efficacy of certain drugs in the prevention of breast cancer, as well as new screening techniques. Monthly education sessions will be available to all patients enrolled in the High Risk Program. These interactive sessions take about an hour and will cover topics pertinent to women at high risk. They will also be attended by several of the leading Bay Area breast cancer clinicians. For further information regarding the High Risk Program, please call Dr. Leah Millheiser at (415) 353-7560. ■



[ PHOTO  
CAPTION  
HERE]



In *Living On the Margins*, Editor Hilda Raz presents the autobiographical accounts of well-known writers, such as Pulitzer Prize-winner Maxine Kumin, Alicia Ostriker, and Lucille Clifton. These diverse voices are united by their common need to speak and to transform suffering into art. The writing is brilliant, with sparkling, jagged poetry and prose as nourishing and honest as bread and jam. The stories in this book help one make sense of an overwhelming and alien experience. These writers use their cancer as creative fuel, bringing alive the fullness of an unknown and sometimes frightening world. Equally fine is the book's irreverent humor: Amy Ling choosing a wig, Carol Dine comparing herself and Marilyn Monroe. These lighter contributions make for delightful "bad girl" chat that reinforces the kinship that so many women with breast cancer feel for one another. This book shows us the many ways in which women, even under threat of death, can be strong, brave, and joyous. ■

Please note that the Breast Care Center is *closed* on **Monday May 29th for Memorial Day**. We will also be *closed* **June 7 to June 12**, when we move to our new location around the corner. **Our new address will be: 1600 Divisadero, 2nd Floor SE, CA 94115. Our phone numbers will change also:** For an oncology appointment of to get in touch with an oncologist, please call **415.353-7070**. To reach your surgeon or schedule an appointment with a surgeon, please call **415.353-7111**.

The **Bay Area Breast Cancer Forum** is a monthly gathering of health care providers, researchers, patients, patient advocates, friends and families. Topics are varied but the emphasis is on clinical trials and research. The meeting takes place on the **second Wednesday of the month at the 3rd floor of the Cancer Center**. At 6:00pm, there is a light dinner; 6:30-8:00pm a discussion led by Dr. Debu Tripathy. Please contact Fern Hassin at (415) 885-3738 for more information. ■

## FROM THE RESOURCE CENTER

### JOIN US FOR A FUNDRAISER AND CELEBRATION

Join the UCSF Cancer Resource Center and the Women's Philharmonic in an inspiring performance and fundraiser at 8pm on Friday, May 26th at the Herbst Theatre, 401 Van Ness Avenue in San Francisco.

The Women's Philharmonic is dedicating their season finale concert to help the Cancer Resource Center at UCSF raise funds needed to continue providing free supportive care and information services to cancer patients and their loved ones. For more information on purchasing tickets to this event to support the Cancer Resource Center, please contact us at 415.885.3693.

### CONFUSED ABOUT HEALTH INSURANCE?

Understanding your health insurance benefits, preexisting condition clauses, and disability benefits can be confusing. Speaking to an insurance expert can be very helpful in helping you maximize your options and maintain or obtain benefits. A health insurance expert can help to:

- Plan appropriately to maximize your health insurance benefits
- Maintain and access private and public benefits
- Sell your life insurance benefits, if appropriate
- Manage preexisting condition periods and limitations

Health benefits workshops and counseling are available at the Cancer Resource Center for patients and families on the second and fourth Thursday of each month, from 3-6pm. Please call to register, or for an individual appointment. ■

## WHAT MAKES DCIS SO DIFFICULT TO TREAT?

by Shelley Hwang, MD



Improved access to mammographic screening in the U.S. has resulted in the detection of a larger number of the earliest of breast cancers, called "ductal carcinoma in situ", or DCIS. Usually, the only sign of abnormality is the presence of small deposits of calcium, or micro-calcifications, on the mammogram. DCIS generally lacks metastatic potential, and the incidence of lymph node spread is only 1-2%. The focus of the treatment is to eradicate the cancer within the breast, usually with a surgical procedure. In some cases, mastectomy is recommended, but many cases of DCIS can be treated with lumpectomy and radiation.

Although the treatment of DCIS can be straightforward, there are some issues that complicate decision-making for both patient and physician. First, although mammography is an excellent diagnostic tool, it often underestimates the extent of DCIS. It may not be clear before surgery how much of an excision is required to completely eradicate the DCIS. Even during the operation, it is difficult to determine the extent of the spread, given that DCIS does not look or feel different from normal breast tissue. Another procedure may be necessary to completely excise the tumor. In fact, the "re-excision rate" for DCIS ranges from 25% to 75%.

Also, scientists are only beginning to understand the relationship between DCIS and "invasive" cancer. Studies in the past five years suggest that non-aggressive DCIS can turn into non-aggressive invasive cancer, but we have yet to determine how long this takes. Some reports indicate, that the time required for this progression may be 15 to 20 years. Nevertheless, since we currently have no way of knowing which patients will not develop invasive breast cancer, the treatment of DCIS is based on the assumption that all DCIS will turn into invasive cancer.

Finally, the issue of radiation adds another layer of complexity. Currently, all but the smallest and most favorable of breast cancers are treated by postoperative radiation following lumpectomy. Usually, this treatment is well tolerated, but there is a small chance of damage to the heart, lungs, and opposite breast, depending on how the treatments are administered. Rare incidents of secondary cancers have also been reported. Most importantly, approximately 10% of women treated for DCIS will eventually have a recurrence. They will not have the option of breast conserving surgery, since the breast cannot be radiated a second time.

These factors make it imperative that treatment decisions for DCIS be specifically tailored to individual patients, following a comprehensive discussion between the patient and her doctor. It is only through such dialogue that the treatment for this very complex group of cancers can be optimized. ■

# ANXIETY AFTER AN ABNORMAL MAMMOGRAM

by Jennifer Haas, MD

Mammography is an important tool to detect breast cancer at an early stage. It has been shown to reduce mortality from breast cancer among women who are between 50 and 69 years old. But mammography also carries the risk of a false-positive result. A false-positive result is like a false alarm: An area on the mammogram looks abnormal, but turns out to be benign after further evaluation. This further evaluation could include a physical examination by your doctor, an ultrasound of the breast, additional mammography, fine needle aspiration, or an excisional or core biopsy.

In a study from a large health maintenance organization over a 10-year period, one third of the women aged 40 - 69 who underwent mammography had at least one abnormal result that required further testing, even though no breast cancer was found. (For reasons which we don't fully understand yet, abnormal mammogram results are more common in the US than in other countries with similar standards of mammography.)

False-positive mammograms are not just costly, but often cause substantial anxiety to the patient. Therefore, we felt this was something which we needed to study. We examined the effects of abnormal mammogram results at two mammography facilities in San Francisco. We studied 488 women, who had received an abnormal mammogram report and who agreed to participate in two phone surveys, held one month and eight months after their mammogram. The average age of the women in our sample was 55. 63% of them were post-menopausal, 20% had a first-degree relative with a family history of breast cancer, and 23% of the women had a breast lump found by themselves or by their doctor at the time of the mammogram. Fifty-three women (11% of 448 total) were diagnosed with breast cancer within eight months of their initial mammogram.

As expected, many women underwent further evaluation after their mammogram: 65% of women received at least two more additional diagnostic tests. One month after their mammogram, 25% of women were "very" to "extremely" anxious about the results of their breast evaluation, regardless of the results of their evaluation. What concerned us even more was that the percentage of women with these levels of anxiety had only declined to 23% by the time of their eight-month evaluation, even among women with no evidence of cancer on further evaluation.

This study shows clearly that many women experience significant levels of stress because of abnormal mammograms. We will be conducting further research to find out how we can improve our care to minimize this type of anxiety for our patients. One such effort is our Same Day Assessment Program (see article opposite page). ■



## QUESTIONS FROM OUR PATIENTS

## SAME DAY ASSESSMENT PROGRAM

By Dulcy Wolverton, M.D.

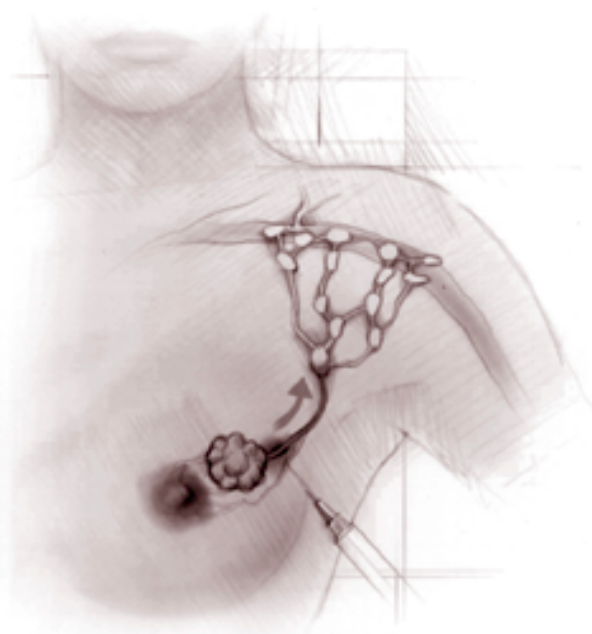
**Q:** What is Sentinel Lymph Node Dissection, and am I a candidate for it?

**A:** The sentinel lymph node received its name because it is the first in the chain of lymph nodes expected to be invaded by breast cancer cells if they have travelled outside the breast via the lymphatic system. Whether or not breast cancer cells are found in the lymph nodes under the arm tells us much about the risk of the cancer spreading. Most patients with invasive breast cancer have both their breast tumor and all or most lymph nodes removed. However, this procedure can result in complications such as lymphedema (swelling) of the arm and problems with arm mobility and pain.

Sentinel lymph node biopsy has been developed to decrease these potential complications by removing only one or just a few lymph nodes. If your tumor is 3 cm or less, and your health care providers cannot manually detect any cancer in your lymph glands, then you may be a candidate for this procedure.

There are several ways to locate the sentinel node during surgery: by utilizing blue dye or through a radiocolloid and a nuclear medicine scan called lymphoscintigraphy, or both. Generally, your physician will choose which procedure is best for you.

Scientific evaluation of the pros and cons of this procedure is ongoing. We have several clinical trials in process to improve how we use sentinel lymph node biopsy. ■



*The American College of Surgeons recommends that surgeons trained to perform Sentinel Node Dissection demonstrate their skill by performing 30 SND's followed each time by a complete axillary dissection. The need to be able to identify the sentinel node in at least 85% of patients, and to have at least a 95% accuracy in predicting node status using the sentinel node.*

One of the goals of this program is to minimize anxiety after an abnormal mammogram by providing patients, who come in for an evaluation of their breast problems, with results as soon as possible. We do this by coordinating our schedules, so the patient's clinical examination will take place on the same day as any required imaging procedures or any potentially necessary needle biopsy procedure.

For example, a woman may have had a recent mammogram which was considered abnormal. She may have been recommended a biopsy or magnification views, or has come to the Breast Care Center for a second opinion. If appropriate, she may be scheduled for evaluation in the Same Day Assessment Program. Her mammograms are reviewed by one of our radiologists, who determines the need for any additional imaging, such as specialized mammograms or an ultrasound, which would be done on the same day. The patient is also examined by one of our breast surgeons. Occasionally, we can show that the abnormality seen on the outside mammograms is almost certainly benign or normal, and the patient will not require a biopsy procedure. If there appears to be an abnormality that requires a biopsy, the type of biopsy is determined that day, based on the patient's physical examination and on the imaging results. A Fine Needle Aspiration (FNA) or core needle biopsy or ultrasound can be performed the same day, while a surgical biopsy would be scheduled for another date.

By streamlining a patient's examinations and appointments in this way, we can find out more quickly whether or not there is a serious breast problem. We can minimize the chance of "false positive", and the patient can either receive reassurance or treatment faster than would ordinarily be possible. ■



**PLEASE JOIN US**

*or an evening of great entertainment for a great cause*

**A TRIBUTE TO CAROL FRANC BUCK**

TUESDAY, MAY 16 AT 8 pm at the Yerba Buena Theater

FEATURING PERFORMANCES by SMUIN BALLET AND SAN FRANCISCO OPERA

*All proceeds will benefit the Carol Franc Buck Breast Care Center at the UCSF Comprehensive Cancer Center.*

Smuin will perform their acclaimed ballet underwritten by Ms. Buck, Pinocchio. San Francisco Opera Adler Fellows will perform excerpts from: L'Africaine by Meyerbeer, Rusalka by Dvorák, Hamlet by Thomas, and A Streetcar Named Desire by Previn.

Tickets: \$30, \$50 or \$100

(\$100 ticket holders receive preferred seating and a reception following the performances)

How to purchase: call 415-978-2787 (11 am- 6 pm) or in person, Tuesday - Sunday (11 am - 6 pm)  
Yerba Buena Center Ticket Office: 701 Mission Street, San Francisco, CA 94103

## WELCOME

---



**Dulcy Wolverton, MD**, has joined our center as a radiologist specializing in breast imaging. She joined the UCSF faculty as Associate Professor of Clinical Radiology in June 1999, working with Dr. Edward Sickles in the Mt. Zion mammography unit. Previously, Dr. Wolverton was Chief of Mammography at the University of Chicago.

Her research interests include digital mammography and computer-aided diagnosis. She is also involved in the breast MRI research programs being conducted here at UCSF. Her clinical interests include the correlation of ultrasound with breast MRI, and streamlining patient care through programs such as our Same Day Assessment Program (see article on page 9).

**Dr. Catherine Park** will be joining our Center as a radiation oncologist in July. She received her medical degree from UCLA School of Medicine and is currently a resident at the Joint Center for Radiation Therapy, Harvard Medical School.

Dr. Park is interested in the clinical aspects of breast cancer treatment as well as in basic science research. Her research will focus on the role of the microenvironment in the development of breast cancer, in collaboration with Drs. Joe Gray at UCSF and Mina Bissell of Lawrence Berkeley National Laboratory. ■

## THANKS FOR YOUR SUPPORT!

The benefactors, listed at right, have sent us contributions since our last newsletter appeared. We are most grateful for their generosity, which helps us to continue to expand our programs and services, as well as to produce this newsletter.

Contributions received after the date this newsletter went to print (April) will be acknowledged in the next newsletter.

We are touched by each and every contribution we receive; however, the stories behind some of them are particularly inspiring. We just wanted to share the story of Kali Hamano, a high school junior, who sponsored a coin drive at Monte Vista High school in Danville and collected \$230 on behalf of the Carol Franc Buck Breast Care Center. Kali Hamano, who lost her mother to breast cancer, sent us the check saying "this disease touches the lives of everyone in our community, and the students of Monte Vista are honored to aid in the fight and provide hope for all." ■



Our patient, Susan Voight, sent us this picture taken 3 weeks after her surgery with a note: "Dr. Esserman, you and Dr. Anthony are brilliant! I bet you would not be able to tell which breast is really an abdomen in disguise!"

Carol Franc Buck

BREAST

CARE CENTER  
newsletter

Editor: Sarah Paris Design: Greta Berger Photos: Janet Bram (Resource Center); Ramona Lipske (Dulcy Wolverton). Printed by UCSF Reprographics This newsletter is funded by DOD Grant DAMD 17-96-1-6260 "A New Vision For Integrated Breast Care"

30,000+  
Herb & Susen Grossman

10,000+  
Aaron Braun  
& Joan de Hovitz

5,000+  
Crow Canyon Women's  
Golf Association  
Elizabeth McGee

2,000+  
Britex Fabrics  
(donation of fabrics)  
Wendy Jonah  
The Women's Foundation/  
The Patricia Chang Fund

100+  
Delia Crawford  
Jane Dickerson  
Kali Hamano & the Students  
of Monte Vista High school  
Deborah and Bill Harlan  
Ken & Karen Harley  
Terri Howard  
Linda Lachelt & L. Dean Jones  
Alex & Valentina Lakovetsky  
Patricia D Lorentzen  
Bonnie J. Moss  
Meridithe Mendelsohn  
Mrs. Melvin Shaw  
In Memory of Nancie Goldstein  
Agnes T. Waters

25 - 99  
Jenny Aquino  
Estela Becerra  
William and Andrea Conneally  
Gary & Jodi Horsman  
Setsuko Hunter  
Rita Kravets  
Louwanda & Reece Miller  
In Memory of Judi Goltz  
Debra Nelson  
Roger & Cynthia Parks  
Joanna Robinson  
Robert & Donna Shives

In-Kind Donation:  
Discount Fabrics

Franking Code #2096

The Carol Franc Buck Breast Care Center  
UCSF Stanford Health Care  
2356 Sutter Street, Box 1710  
San Francisco, CA 94143-1710



Nonprofit Org.  
U.S. Postage  
**PAID**  
University of California  
San Francisco

### *A Major Breast Cancer Prevention Study*

The Carol Franc Buck Breast Care Center is enrolling volunteers in one of the nation's largest breast cancer prevention clinical trials. Called the STAR trial (Study of Tamoxifen and Raloxifene for the Prevention of Breast Cancer), this five-year study will determine if the osteoporosis prevention drug raloxifene is as effective as tamoxifen in reducing the incidence of breast cancer in postmenopausal, high-risk women. The National Cancer Institute is funding the study.

The trial is open to postmenopausal women who are 35 years of age or older and who are considered to be at a high risk for the development of breast cancer. Factors used to determine risk include age, family history of breast cancer, having children later in life, and a diagnosis of lobular carcinoma in situ--a condition that indicates a higher chance of developing invasive breast cancer.

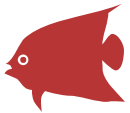
**For more information on enrollment, please contact Karin Morris at 415/353-7319.**

### *Clinical Trial For Women With Stage III Breast Cancer*

Standard treatment for Stage III breast cancer (breast cancer in which the tumor is large or has spread to lymph nodes in the underarm) is to give one or more phases of preoperative (neoadjuvant) chemotherapy prior to surgery and radiation. We are planning a CALGB clinical trial for women with Stage III breast cancer which involves the use of imaging (both MRI and mammography) in the course of their treatment. The goal of the trial is to help us predict how a patient will respond to treatment and to find out more about the behavior of Stage III tumors. This will help us identify patients who may respond poorly to standard treatment and may be more appropriately treated with novel therapeutic interventions.

**For more information, please contact Liz Wieland at 353-7213.**

WOMEN | NEEDED  
TO PARTICIPATE IN OUR INNOVATIVE RESEARCH



We are looking for an angel to gift us with a SALTWATER AQUARIUM for the waiting room; this would include contents and maintenance. Please call Meridthe at (415) 885-7558 for details.