UCSF Helen Diller Family Comprehensive Cancer Center

Spring 2010

Carol Franc Buck BREAST CARE CENTER NEWSLETTER

Focus Forward

The last six months have been full of news and activity at the Breast Care Center, from controversy about mammographic screening, to the opening of the exciting I-SPY2 TRIAL (see **ISPY2.org**) and the planning of the ATHENA Breast Health Network. My colleague, Ian Thompson, and I published an article called "Rethinking Screening for Breast Cancer and Prostate Cancer" that appeared in *JAMA* in October of 2009.[1] We had spent two years on this project, and our goal was to lay out a strategy that would allow us to improve our current approach to screening and prevention (see page 2 for details). A lot of the controversy, spurred by coverage of the article in the *New York Times*, clouded the message we had intended to convey. Over the last decade we have learned a lot about breast cancer. What we want to do is to take those lessons forward to help us improve screening, prevention, and treatment. Recommendations for change and improvement should not be frightening or upsetting. They should be welcome and insisted upon, and should generate thoughtful dialogue with a goal of advancing the field. If you went out to the store to buy a computer and the models were ten years old, you would be very unhappy with your choices. All of us should demand change and continual improvement rather than be satisfied just to keep things the same. In fact, the goal of the ATHENA Breast Health Network is to constantly evaluate the impact of interventions in breast cancer screening and treatment, to evaluate new science, and make change and improvement a routine process of care. ATHENA is a collaboration among the scientists and clinicians across all five UC Medical Centers (and affiliates) – it is a commitment to integrate clinical care and research. Planning is well underway, and in the fall, we will tell you lots more!

We are excited about some other changes – new or returning faculty and staff (see page 11), and the highly anticipated arrival of Dr. Laura J. Van't Veer from the Netherlands, who will be joining the faculty in April! Stay tuned for her profile in the Fall newsletter.

Spring is a good time to focus on change and renewal. Our goal: make spring our frame of mind all year long!

– Laura J. Esserman, MD

[1] Esserman LE, Shieh Y, Thompson I. Rethinking screening for breast cancer and prostate cancer. JAMA. 2009;302(15):1685-1692.

INSIDE:

On Screening and Prevention

by Laura Esserman, MD, MBA, and Ian Thompson, MD

www.mammoscan.com

Screening is complex because cancer is complex. Not all breast cancers or prostate cancers behave the same, and as a result, some people benefit more than others from screening. For both breast and prostate cancer, we have substantially increased the chance of being diagnosed with a slow growing tumor that might never have come to attention in the absence of screening, leading people to think they have a killer cancer when they do not. In this situation, we may be doing harm and creating anxiety, which often leads to more aggressive treatment choices. Screening for cancer needs to be used wisely, and the results interpreted carefully.

We recently published an analysis (JAMA Oct. 21, 2009)[1] of the impact of current screening for breast and prostate cancer and found significant room for improvement.

Importantly, we propose a strategy for moving forward. We are saying that screening has to be improved and that we can and must do better. We are not proposing that we stop screening. Screening has led to an increase in cancers detected, many of which are not life threatening, and we haven't been as successful as we had hoped in preventing more advanced stage cancers. Screening is most effective for moderate to slow growing tumors or where removing a pre-cancerous condition prevents the disease, as in cervical cancer and colon cancer. For fast growing or very aggressive tumors, traditional screening may not be able to help, as these types of tumors pose significant risk even when they are small and seem curable. For very slow growing tumors, finding them early will not make much if any difference.

1. We must focus on determining who is at risk for developing the most aggressive cancers and test new drugs to improve treatment and prevention. We also must be aware that the most aggressive cancers can turn up as masses between normal screens. A new mass or symptoms should not be ignored just because there has been a recent normal screening test.
2. We need to use the tools available (and develop new ones) for determining the aggressiveness of cancers at the time of diagnosis. This will help patients and physicians have conversations weighing the risks and benefits of interventions, and lead to new trials designed to help some patients safely forego treatment.
3. We need to think more about prevention. Our concept of screening should include the use of tools that identify how much risk a person has for developing cancer. Risk assessment tools can be used to identify people unlikely to benefit from screening. Therefore, we should avoid screening them. In women over 70, for example, there is no evidence that mammographic screening saves lives, as such women most often develop less aggressive or IDLE (Indolent Lesions of Epithelial origin) tumors. Our advice to women in this age group is to continue to do breast exams, and to seek care if they find a lump.
4. Finally, we need a concerted national effort to invest in large scale long-term studies and demonstration projects that accelerate the pace of learning about screening and prevention.

We will all welcome the day when screening and treatment options are more tailored and effective, and fewer women and men have to face the phrase, "you may have cancer."

Dealing with the complexities of screening honestly will lead to more options for our patients and make care better tomorrow than it is today. ■

Dr. Esserman is the Director of the UCSF Breast Care Center, Co-Director of the UCSF Clinical Translational Informatics, Co-Leader of the Breast Oncology Program, Professor of Surgery and Radiology, and Affiliate Faculty, Institute for Health Policy Studies.

Dr. Thompson is Chairman and Professor of Urology, UT Health Science Center, San Antonio, Texas

[1]Esserman LE, Shieh Y, Thompson I. Rethinking screening for breast cancer and prostate cancer. JAMA. 2009;302(15):1685-1692.

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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 use the envelope provided in this issue. Thank you!

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News from the 32nd Annual San Antonio Breast Cancer Symposium (SABCS)

SABCS is an international scientific symposium where basic scientists and clinicians in breast cancer come together to share new information to improve the care of breast cancer patients. Three Breast Care Center physicians tell us some of the exciting developments below.

SABCS: Surgery/Local Treatment

by Michael Alvarado, MD

This year's conference devoted an entire mini-symposium to local recurrence following breast conservation surgery (lumpectomy) and radiation. This three-lecture symposium tied in nicely with an earlier presentation given by doctors from Memorial Sloan-Kettering Cancer Center (MSKCC). The presentation, "Clinical Management Factors Contribute to the Decision for Contralateral Prophylactic Mastectomy" (CPM), attempted to understand a national trend of increased CPM or bilateral mastectomy for one-sided breast cancer. This topic has created significant discussion not only in research journals, but also in the pubic media. The physicians at MSKCC reviewed their experience from 1997-2005. They identified the rate of bilateral mastectomy for unilateral breast cancer to be 13.8%. More interesting was that the rate increased from 6.7% in 1997 to 24% in 2005. The following factors were reviewed to try and identify a reason for this increase in prophylactic mastectomies: race, age, family history, MRI use, attempted lumpectomy and reconstruction. The authors found that use of MRI (and additional biopsies from this test), failed first attempt at lumpectomy (margin too close needing re-excision) and availability of reconstruction were strongly associated with choosing CPM. Family history was also associated with an increase rate of prophylactic surgery, but interestingly, the family history did not necessarily prove to be an indication for "risk reduction surgery." The conclusion stated: "Efforts to optimize BCT [lumpectomy and radiation] and minimize unnecessary tests may help curb this trend."

The mini-symposium was made up of three excellent presentations showing how well breast conserving surgery (lumpectomy) and radiation have improved over the past 20 years. The speakers gave evidence to show that historical results of local recurrence rates (10%) are more likely to be less than 5% after 5 years in contemporary studies with improved systemic (hormone therapy, chemotherapy) treatments, and in fact, this is what we have experienced here at the BCC ourselves. The presenters focused on the "biology" of the tumors as a predictor of local disease recurrence, which is a common theme in all of breast cancer therapy. Tumor biology is being studied extensively at the Breast Care Center and major efforts are going into this field of research, specifically, Dr. Laura Esserman's I-SPY trial.

Finally, Dr. Monica Morrow of MSKCC touched on two concepts regarding successful lumpectomy: margin status and MRI. She gave an elegant discussion that lends support to the idea that women are choosing mastectomy to avoid unnecessary procedures. It is uncommon (and usually unnecessary) for women to undergo MRI if they choose mastectomy. This decreases the chance of multiple biopsies from a possible false reading. Also, non-standardized pathology review may be a reason for re-excision following lumpectomy (margin-status). It is for these reasons that the Breast Care Center is dedicated to "individualizing" cancer treatment, not just for local therapy (surgery and radiation), but for systemic/whole body therapy as well. By treating the "patient" as opposed to the "population," we hope to avoid unnecessary tests and surgeries making treatment less "invasive," both physically and emotionally.

SABCS: Radiation Oncology

by Catherine Park, MD

At least two radiation oncology presentations sparked our interest at SABCS. One study, presented by Goyal and colleagues, asked whether patients with low-risk DCIS benefit from Accelerated Partial Breast Irradiation (APBI). While the authors concluded that there was a benefit, because recurrence was low, it was not clear that radiation was really necessary in the first place.

However, an article just recently published addressed the question of whether patients with low-risk DCIS

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SABCS: Radiation Oncology *from page 3*

need treatment beyond surgery alone. Performed by the Eastern Cooperative Oncology Group (ECOG), the trial enrolled patients with favorable DCIS (low-intermediate grade, <2.5 cm; or high grade, <1 cm) to undergo a wide-excision surgery alone with no radiotherapy. At 5 years of follow-up, patients in the low-intermediate grade group had 6% local recurrence (of DCIS or invasive cancer), while those with high-grade disease had a 15% risk (although most of the risk involves women under 45 years old).

Goyal et al. reported the results of treating DCIS with brachytherapy, (insertion of catheters across the lumpectomy site that are loaded with radioactive seeds) (Abstract # 951)[1]. This technique has been shown to effectively result in very low recurrence for patients with small invasive breast cancers. The authors reported outcomes on a small group of patients with identical pathologic criteria as the low-intermediate grade group in the ECOG trial, and showed that this group had 0% local recurrence. In addition, in the high-grade group, the local recurrence was 5.6%, but they used older patients, who would be expected to have low recurrence rates (<10%) without radiation. Another study (Abstract #952)[2] demonstrated similar results using balloon brachytherapy. These APBI techniques are popular in part because they require one week of twice daily treatment compared to conventional fractionation, which requires 5-6 weeks of daily treatment. Both authors caution that the use of these technologies is still experimental, and should be performed in the context of a clinical trial. The challenge still remains to select the most appropriate therapies tailored to individual risk. The use of APBI provides novel ways to provide effective radiotherapy in a significantly shorter time frame than conventional treatment. However, it now appears that many patients with low-grade DCIS can safely forego radiation.

Another promising form of APBI for breast cancer treatment is the Zeiss intraoperative "TARGIT" radiotherapy device. This technology allows for the direct delivery of radiation into the lumpectomy cavity at the time of surgery. Currently, UCSF is a leading U.S. participant in a large international trial that randomizes patients with early stage breast cancer to receive standard external beam radiotherapy versus a single intraoperative dose. The principal investigators of that trial presented their results using the intraoperative device to deliver the "BOOST" dose of radiation often applied to the tumor cavity using external beam methods. Vaidya and colleagues (Abstract # 4104) showed that the use of the intraoperative boost was feasible, safe, and achieved a local control rate that was superior to previously published trials using standard boost treatment.

SABCS: Advanced or Metastatic Breast Cancer

by Hope S. Rugo, MD

Metastatic or stage IV breast cancer often travels to bone, where it can cause pain and sometimes even fractures. Zometa (bisphosphonate zoledronate) is given intravenously once a month and has been shown to reduce pain, risk of fracture, and need for radiation. A new drug called Denosumab also blocks the growth and activity of the cells responsible for bone breakdown, called osteoclasts. Denosumab, like Zometa, prevents bone loss or osteoporosis. This drug is given as an injection under the skin once a month and was compared to Zometa in over 2000 women with metastatic breast cancer and bone metastases. Denosumab resulted in longer and better control of bone metastases, longer time before patients may need radiation, and less pain compared to Zometa. Zometa causes more muscle aching and fever with the first dose, and both agents rarely can cause osteonecrosis of the jaw (a part of the tooth or gum that does not heal). This improvement in quality of life is encouraging, although neither drug helped women to live longer. Denosumab is likely to be approved for the treatment of breast cancer metastatic to bone in the next year. Zometa is being tested in early stage breast cancer

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SABCS: Advanced or Metastatic Breast Cancer *from page 4*

to help prevent recurrence, along with other similar drugs.

Trastuzumab (Herceptin) is the standard treatment (in combination with chemotherapy) used to treat the type of breast cancers that have the receptor HER2 on their cells. A new drug, lapatinib (Tykerb) can also be used in combination with the chemotherapy drug capecitabine (Xeloda), for HER2 tumors that are metastatic. Each drug works on a different part of the HER2 receptor. We participated in a study which was reported at San Antonio; 300 women whose cancers had progressed on Herceptin were treated with either Herceptin and Tykerb, or the combination. Women who received the combination therapy had longer periods of time before the tumor grew and lived an average of 4.5 months longer compared to those who received Tykerb alone. This combination is being tested with chemotherapy in women with early stage breast cancer to try to further reduce the risk of recurrence. Dr. Mark Moasser, at the Breast Care Center, is also conducting a clinical trial with Tykerb, delivering it very differently with a goal of reversing resistance to this drug (see **www.ucsf.edu/science-cafe/articles/her2-breast-cancer-clinical-trial-based-on-research-advance**).

Another new drug, trastuzumab DM-1 (TDM1), links Herceptin to a chemotherapy agent, delivering the drug directly to HER2 positive cancer cells. We also participated in a study testing TDM1 in patients with metastatic cancer who had previously received multiple prior chemotherapy agents, Herceptin and Tykerb. The drug is well tolerated, with the main side effect being low blood platelets. About 30% of patients had substantial shrinkage of their tumors, and the shrinkage lasted an average of 7 months. This exciting new agent is being tested now in untreated metastatic HER2 positive breast cancer, and we hope that it will be available to treat patients outside of a clinical trial within the next year or two.

A number of studies testing antiangiogenic therapy (treatment that blocks new blood vessel growth to starve the cancer) combined with chemotherapy were presented. Bevacizumab (Avastin) is approved in combination with paclitaxel (Taxol) for the treatment of metastatic breast cancer as a previous trial showed more shrinkage and longer control of tumors compared to Taxol alone. New trials showed that adding Avastin to other chemotherapy agents also improved shrinkage and control. The main side effect of Avastin is high blood pressure, which is treatable. The addition of Avastin to chemotherapy has not been shown to help women live longer and it is quite expensive, so its routine use remains somewhat controversial. There was also a presentation about surgical complications from these drugs. Bevacizunab may cause more complications in women undergoing mastectomy and reconstructions with implants. Other oral antiangiogenic agents were tested in combination with chemotherapy; so far they appear to be more toxic or don't offer as much benefit as Avastin. More trials will be presented next year. What we really need is to find a marker in the cancer that tells us which patients will have the best result from this type of therapy.

Lastly, a new drug called a PARP inhibitor is being tested in cancers that lack receptors for estrogen, progesterone, and HER2 (triple negative) in combination with chemotherapy (gemcitabine and carboplatin). The PARP enzyme repairs damage to DNA caused by chemotherapy, allowing cancer cells to survive. Inhibiting PARP could help chemotherapy to work better. An update of a study of about 120 women with metastatic triple negative breast cancer showed that the addition of the PARP inhibitor BSI-201 improved response and survival (from about 8 months to a little over 12 months) with no additional side effects. A large trial aimed at trying to get this drug approved has just completed enrolling patients so we should see more information about this exciting drug in the next year. ■

[1] See: www.abstracts2view.com/sabcs09/viewp.php?nu=p951
[2] See: www.abstracts2view.com/sabcs09/viewp.php?nu=p952

Dr. Alvarado is a breast cancer surgeon at the Breast Care Center and an Assistant Professor in Residence at UCSF.

Dr. Park is an Associate Professor of Radiation Oncology at UCSF. She is especially interested in the treatment of lymphoma and breast cancer.

Dr. Rugo is a medical oncologist and hematologist specializing in breast cancer research and treatment. A member of the UCSF Breast Care Center team since 1999, she is Clinical Professor of Medicine and Director of the Breast Oncology Clinical Trials Program at UCSF.

BreastCancerTrials.org at California Women's Conference

By Elly Cohen, PhD

In October 2009, BreastCancerTrials.org was a proud exhibitor at the California Women's Conference, the nation's premier conference for women. Hosted by First Lady Maria Shriver and Governor Arnold Schwarzenegger, the two-day event in Long Beach drew over 25,000 attendees to listen and learn from 80 internationally-acclaimed leaders, visionaries and authors including Katie Couric, Jane Goodall, Elizabeth Edwards, Annie Leibowitz, Nicholas Kristof, Dr. Mehmet Oz, Valerie Jarrett and Capt. Chesley Sullenberger. The conference was also available to thousands more online, bringing its mission "to inspire, empower and educate women to be Architects of Change in their own lives and in the lives of others" to the widest possible audience.

BreastCancerTrials.org joined other vendors in the exhibit hall showcasing products and services for women. Being at the Women's Conference provided a wonderful opportunity to educate a large number of women in one setting about the importance of clinical trials. Laura Esserman, MD, MBA, Director of the UCSF Breast Care Center and UCSF BreastCancerTrials.org team members Susan Colen, Kathy Hajopoulos, Bethany Hornthal, Laurie Isenberg, and Meridithe Mendelsohn joined me at the Safeway Foundation-sponsored booth.

Video and audio broadcasts of the Women's Conference presentations are available online at **www.womensconference.org/the-womens-conference-2009/**.

BreastCancerTrials.org is the only clinical trial matching service dedicated to breast cancer. It has trials for breast cancer patients, those at risk, and individuals who have completed treatment. If someone you know has just been diagnosed with new or recurrent breast cancer, they can use BreastCancerTrials.org to help them learn about or find a clinical trial in which they can participate. There are also prevention trials on our site, or you can find them on the Love/Avon Army of Women web site **www.armyofwomen.org/current**. ■

Elly Cohen is the BreastCancerTrials.org Program Manager and a Senior Analyst with the UCSF Breast Care Center of Excellence. The web site address is **BreastCancerTrials.org**.

UCSF BCC team at the 2009 Women's Conference BreastCancerTrials.org booth. L to R: Susan Colen, Meridithe Mendelsohn, Laurie Isenberg, Kathy Hajopoulos, Elly Cohen, Laura Esserman and Bethany Hornthal.

UCSF Breast Care Center in Marin?

It is true! Our new satellite office thrives in Greenbrae at 1100 South Eliseo, Suite 107. Doctors Cheryl Ewing and Jennifer Zakhireh have clinic hours on Tuesdays and Fridays. Both Dr. Ewing and Dr. Zakhireh have been part of the Breast Care Center surgical team for many years and are Marin residents. Bridget Hogue, one of our Breast Care Center nurse practitioners, also sees patients there.

We are looking forward to expanding the services available at this site within the next year. If you decide to have your care in Marin, be sure to ask to see pictures of Dr. Zakhireh's 17-month old daughter Lilia Belle, of Dr. Ewing's gorgeous dogs, her Rottweiler Forrest, and German Shepherds Ronin and Teyla, the Warrior Princess. To schedule an appointment in the Marin office, call our main line at (415) 353-7070. Our schedulers will be happy to help you. ■

Super Charged Smoothies:
More Than 60 Recipes for Energizing Smoothies

Mary Corpening Barber and Sara Corpening Whiteford with Alison Eastwood, RD, Chronicle Books, 2010. Reviewed by Meridithe Mendelsohn

Rated "G", approved for General audiences and Good for you as well, this newest recipe collection from the San Francisco food writing twins promotes healthy food choices with a focus on "superfoods." Not familiar with superfoods? These delicacies are chock full of phytochemicals, omegas, and probiotic and antioxidant qualities. Mary and Sara's recommendations for the well stocked superfood pantry include: acai berries, chia seeds, flax seeds and oil, goji berries, matcha powder and raw nuts, among other nutrient packed items. There is a resource section that lists places to pick up these good-for-you additions to your larder. The recipes include kid-friendly drinkables such as "Pinkalicious," featuring raspberries and strawberries. Their "Smoothie Revival Program" outlines an easy way to incorporate these wellness promoting drinks into your everyday diet.

"Smoothies are a quick and convenient way to get essential elements into your diet without cooking, using easily accessible ingredients," says Alison Eastwood, RD. Alison is a co-author, former Breast Care Center dietitian and busy mom. The book is available at the Friend to Friend store on the first floor of the UCSF Cancer Center or check with your local bookseller. Find out what Mary and Sara are up to at **www.maryandsara.com**. Here's to drinking your way to better health in 2010! ■

Kale, Apple and Carrot Smoothie

Serves 2.

1 ½ cups fresh pressed carrot juice
½ cup filtered water
1 cup firmly packed kale, stems removed
1 small apple, cored and diced
2 tablespoons raw sunflower seeds
1 tablespoon fresh pressed lemon juice
1 tablespoon flax seed oil

Combine all ingredients in a blender. Blend until smooth.

Swimming for Cancer *By Meridithe Mendelsohn*

On a sunny Sunday this past October, Breast Care Center staff members joined a group of patients to support the Oakland-based Women's Cancer Resource Center (WCRC) in their 14th annual Swim-A-Mile fundraising event. The WCRC provides direct services to Bay Area women with breast cancer and advocates for broad changes in the health care system through grassroots efforts. The UCSF team was led by Michelle Melisko, MD, and raised over $2,400 for the Center. All who attended agreed that the event was a great way to stay fit while helping others! For information about the 2010 Swim-A-Mile, visit **www.wcrc.org**. ■

Jonathon Park (Dr. Melisko's son), Michelle Melisko MD and Eunha Jung

Some of our Breast Care Center swim team: Bridget Hogue, Amy DeLuca, Maria Lena Horta, Julia Lyandres, Eva Mihalis, Michelle Melisko MD, Angelo Lamola, and Amalia Lane

Left: Laura Esserman, MD and Bethany Hornthal

FACES: Living Better with Cancer

Part 2 of an Interview with David Spiegel, MD

Our interview with David Spiegel, Professor and Associate Chair of the Department of Psychiatry & Behavioral Sciences, Member of the Stanford Cancer Center and Medical Director of the Stanford Center for Integrative Medicine continues. Dr. Spiegel discusses his research on breast cancer support groups and how a person can live better with cancer through the coping strategy FACES: F, Facing cancer; A, Altering perception; C, Coping actively; E, Expressing emotion; and S, Social support. *– Catherine Metzger*

David Spiegel, MD

CM: From your experience facilitating support groups for women and your research on sleep, sex, and coping with cancer, could you speak about self-image, self-worth and the sex life of women undergoing breast cancer treatment?

DS: There's no question that women with breast cancer feel damaged, and some of them are damaged. It ranges from mastectomies, which there are less of than there used to be, to radiation, chemotherapy, hormonal treatments and early menopause. At the very least, you feel like you're aging quicker. You feel much older than you did two months ago, and that's not easy for anybody. You may have physical symptoms that range from nausea to fatigue. Fatigue can last a year after radiation therapy is over. People think that the day after treatment, they'll feel better, which is like thinking you're going to fit in to your blue jeans the day after you give birth. The body doesn't work that way. So part of it is just coming to terms with the physical changes.

Cancer is experienced by many women as a kind of betrayal by their bodies. Cancer is an especially weird disease. It's one thing if your heart or your kidneys don't work as well. But in cancer, part of your body has become the enemy. It's invading other parts of the body. So you feel betrayed by your body and there's a certain amount of emotional work you have to do to get back on terms with your own body. It's sort of like you had a fight with a good friend – you have to work on it to be able to talk to them again. That's a hard thing for you to do. So if you're not accepting of your own body, it's hard to imagine your own lover accepting your own body. I think here, charity begins at home. Many husbands/partners are afraid they are going to hurt their wives. Plus their membranes may be drier as they have less hormones flowing around. There are things you can do locally to try to make sexual function comfortable, but you literally have more trouble engaging in sexual activity.

Plus, you're worried about all these big issues, so there are a whole bunch of things that get in the way of sexual intimacy. I think it takes real effort and desire to get beyond that. One can do it, but one has to work at it. I think there are also husbands that can't deal with it. In most cases though, the women feel more badly about their bodies than the men do. I have also known women in a group that have laughed and said something like, 'My husband's a leg man anyway."

I think that after surgery, it can be helpful to get reacquainted physically; when the woman feels comfortable, have her lover touch her scar, if it's a mastectomy or even a lumpectomy, and reacquaint him with her body. Communicate more than you ordinarily would about what feels good and what doesn't. Find alternatives to full intercourse for a while if that's not comfortable, and make it a joint project to find a way to give pleasure to one another after the acute disruption of the diagnosis and treatment. We tend to think that it will just naturally come back, and for some people it does, but for some it doesn't. What I've been sad to see is that some women are so convinced that they are now ugly that they just don't let their husbands near them. Then, of course, the husband gets more and more awkward because he doesn't know what to do. She interprets that as further rejection: "He can't stand me." He doesn't actually feel that way, but he doesn't know what to do. So I think there are times when rebuilding the relationship is doable but it takes real efforts and real risks. That again is where learning to be more open emotionally, to not be judgmental of others, but to just say what you feel is good training for rebuilding intimacy.

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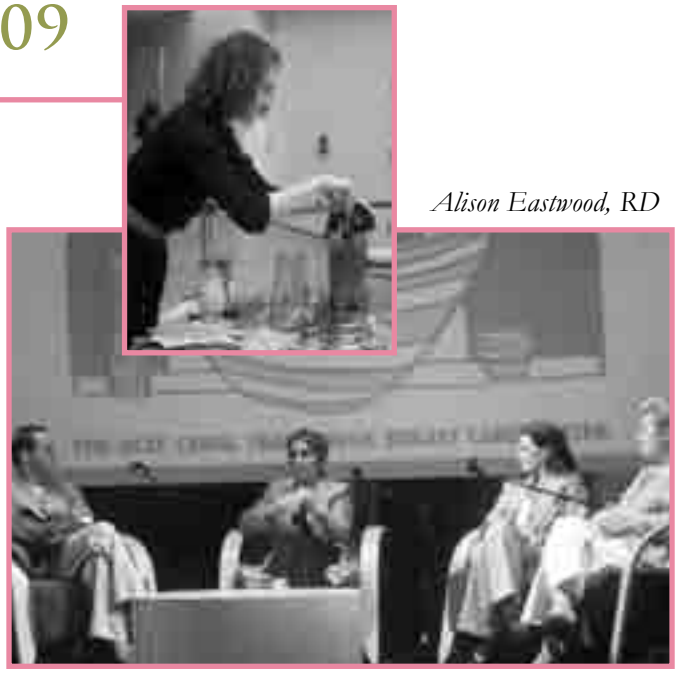
Taste for the Cure, 2009



Alison Eastwood, RD

Taste for the Cure panel: (L to R) Mitch Rosen, MD, Debby Hamolsky, RN, MS, Pamela Munster, MD, and Mindy Goldman, MD

A great crowd convened on November 7 at the Jewish Community Center in San Francisco (JCC) for the Breast Care Center's "Living Well Beyond Breast Cancer" event. Our center teamed with the JCC to co-sponsor an activity-packed afternoon of terrific tastes, informative panels and cooking demonstrations to a crowd of over 200 attendees. In Kanbar Hall, expert panels composed of doctors Michelle Melisko, John Park, Mindy Goldman, Pamela Munster, Mitch Rosen, Laura Esserman and the BCC's nurse specialist, Debby Hamolsky, responded to audience questions on current breast cancer research, genetic risk, hormonal changes, fertility following treatment and other diverse subjects.

The tasty part of the afternoon was provided by several personal chefs including Elizabeth Baldridge from *Sprig of Thyme*, Jesse Miner, a vegan personal chef, *Tip Top Tapas* chefs Raul and Candido, Alison Mountford from *Square Meals*, Kara Forman and Jennifer Rudd from *Fine Foods at Home*, and the JCC's Joanna Karlinsky from their own *Sweet Jo's Café*.

Chefs provided delicious and varied samples of their wares produced from fresh, wholesome ingredients. Dietitian Alison Eastwood demonstrated two smoothie recipes that include "superfoods" such as hemp seeds, acai berries, and matcha, as well as fresh fruits and vegetables. Our favorite singer, Director Laura Esserman, and her band, Vic Sher and Louis Blumberg, wound up the afternoon with musical entertainment. We were very glad that so many of you were able to join us and hope to see you all at this year's event on November 6, 2010. ■

FACES *from page 8*

In one of my groups, a woman complained endlessly about her husband – "He just doesn't help... He doesn't do this... He doesn't do that..." I didn't know her husband but she was a little extreme. So I said to her, "I'm sitting here thinking 'If I were your husband, I wouldn't know what you wanted." What do you want right now?" And she complained for a little while longer and then said. "I want somebody to understand how much I need help." But it was also clear that she didn't want to be needy. Many cancer patients want to be able to do everything they did before. They are conflicted themselves, and they give mixed messages. They say they don't get help, but when someone offers, they say they don't want help. So in the groups, you would help them get clear: If you want help, you ask for it. If you don't ask for it, you'll probably get a confused response.

CM: What are you studying now?

DS: It looks as though we will get our Challenge Grant from the National Center for Complementary and Alternative Medicine to study which parts of the brain work together to produce states of hypnosis and mindfulness. We hope to better learn how the mind controls itself and the body beneath it.

CM: How does hope play a role in facing cancer?

DS: The issue is hope for what – one can be very hopeful with a short time frame – match your hopes to your realistic prospects and find something enriching to hope for – hope for the best but prepare for the worst. So much of what makes us hopeful is the world of family and friends around us, and our ability to feel their support and influence them. As one cancer patient told me, "Since I got cancer, my life has not been the same. But in many ways, it's better." She trivializes the trivial, and lives more fully. ■

Dear Greta

Our guest editor this spring is Greta Macaire, RD, CSO, a Registered Dietitian and Board Certified Specialist in Oncology Nutrition at the UCSF Helen Diller Family Comprehensive Cancer Center. Greta develops personalized nutrition plans for patients, offers special classes and sessions through the Cancer Resource Center, and contributes to the Survivorship Program's special events (see the Calendar, p. 11).

During treatment, are there any foods I should eat or avoid?

Eat a well-balanced diet to maintain your strength, energy and immunity during treatment. Build meals and snacks around minimally processed, low-fat foods such as vegetables, fruits, whole grains, and small quantities of good quality protein like fish, lean chicken, legumes, soy, eggs, and nonfat dairy. Eat small amounts of healthy fat in foods like avocadoes, olive oil, nuts, seeds, salmon and sardines.

Drink plenty of fluids during the day to avoid dehydration which can occur with certain drugs or side effects such as nausea or diarrhea. If you need to gain weight, choose higher calorie liquids (in addition to water) such as fruit smoothies or 100% vegetable or fruit juices.

Limit your intake of caffeine, sugar, sodium, and alcohol especially if you struggle with treatment-related weight gain.

Practice food safety as chemotherapy and other cancer treatments can weaken the immune system and increase your risk for infection. Food safety prevents you from eating something containing unsafe levels of germs: wash your hands before eating, wash vegetables and fruits well, thoroughly clean items that come in contact with raw meats, poultry, fish and eggs, and keep foods at proper temperatures. When eating out, avoid foods that may have bacterial contamination, such as sushi, salad bars, buffets, unpasteurized beverages or foods, and raw or undercooked meat, poultry, fish, and eggs.

Be flexible, listen to your body and respond to how your body responds to treatment. Learn more at: **ucsfhealth.org/adult/edu/cancerSymptoms/index.html**

Tell your health care team about your symptoms so they can be treated. Inadequate fluid intake and poor nutrition can contribute to fatigue, decrease your tolerance of treatment, and generally affect your quality of life.

Editor's Advice:

If you want to have half a glass of wine with dinner every night, choose 4 nights a week to have wine. If you like having 2 glasses when you drink wine, choose 1 night a week to have wine. Filling a wine glass with mineral water and a twist of lime can be a good alternative to alcohol.

– Laura Esserman, MD

What is a common sense approach to my diet after I finish my cancer treatment?

Good question. Increasingly, studies show that diet may reduce the risk of cancer recurrence. This may be especially true for women who have had hormone receptor negative (estrogen negative) breast cancer. After treatment:

Maintain a healthy weight. Treatment-related weight gain and obesity increase the risk of recurrence and other diseases.

Limit calorie-dense foods and drinks. Limit portion sizes of foods and aim for having 20% of your calories come from fat from healthy sources such as cold water fatty fish, nuts, seeds, olive oil, canola oil, avocados, and flaxseeds.

Eat a predominantly plant-based diet and avoid foods made from refined grains and flours. Vegetables, fruits, beans, and whole grains are high in nutrients, cancer inhibiting phytochemicals and fiber, and low in calories. Fill 3/4 of your plate with plant foods, and limit animal products to 1/4 or less. Research suggests that moderate intake (1-3 daily servings) of whole soy foods (soybeans, tofu, tempeh, soymilk, and soy nuts) appear to not have negative effects on postmenopausal ER+ breast cancer though soy supplements or isoflavone extracts are not recommended.

Limit or avoid alcohol. In a recent study, breast cancer survivors who drank were 30 percent more likely to have a recurrence than those who didn't.

Protect your bones. Breast cancer survivors are at high risk for osteoporosis. To maximize bone health, obtain adequate calcium (1000-1200 mg/day) and vitamin D (400 – 2000 IU/day) from your diet and include a supplement, if needed.

Aim for 30 minutes or more of moderate physical activity daily. For more information go to **cancer.ucsf.edu/crc/nutrition_breast.pdf** ■

Introducing...

Brigid Miralda, FNP *Nurse Practitioner*

Brigid Miralda is back seeing patients after serving a 12-month stint in Fort Belvoir, VA, just outside Washington, DC. She is in the 7234th Medical Service Unit of the Army Reserves out of Vallejo, and was called to duty in late 2008.

As a native San Franciscan, Brigid is happy to return to her family, friends, and job as nurse practitioner in our clinic at the end of her assignment! She says that working on an active base near the nation's capitol had its perks. Brigid served in a Family Practice Clinic and did everything from well-baby checks to evaluating troops with post-traumatic stress disorder. She said that while she'll miss holding the babies, she has been struck by the similarities in the stress experienced by her patients here as they deal physically and emotionally with the rigors of breast cancer treatment, and the stress troops undergo after returning from combat.

Brigid returned with a new extracurricular interest – boxing. While in Virginia, she took up the sport and now practices her punches in addition to running as a fun way to keep fit.

Gina Pietras, B.S. *Medical Assistant*

Gina Pietras joined the BCC team as a medical assistant. She started in May 2009 after deciding that working in a clinical setting in a great research institution like UCSF would be aligned with her long-term goal of attending medical school. For the previous three years, she had advised health professionals on retirement planning. While working in accounting by day, she completed pre-medical studies at UC Berkeley on nights and weekends.

Gina grew up in Tacoma, Washington, where she particularly excelled at synchronized swimming. After earning a B.S. in Mathematics with Honors at Ohio State University where she'd been recruited to swim for their synchronized swimming team, she considered graduate school to prepare for a career teaching math at the university level. Instead, she accepted a more exciting offer: a place on the U.S. National Synchronized Swim team. For the next ten years, she swam year around, for synchronized swim clubs from August to April and for the U.S. team from April to Aug, supplementing her income with substitute teaching and coaching. After leading the Swiss National Synchronized Swimming team to the Junior World Olympics in Moscow, coaching full time for a year, Gina returned to the States where she settled in the Bay area.

Now she is happy to find that working in the Breast Care Center is even more personally satisfying, challenging, and educational than she had hoped. What she likes best about the Breast Care Center are the people she gets to serve and the members of her team. She feels like an amazingly good twist of fate brought her to work on the second floor. And we do too!

A. Jo Chien, MD *Assistant Clinical Professor*

We are very pleased to introduce Jo Chien to the Breast Care Center. She joined our faculty in September 2009, after two years as a Fellow in Hematology/Oncology at UCSF. She sees patients in the clinic, and continues to pursue several areas of research. She works with Dr. Mark Moasser in his ongoing study of HER2 using Lapatinib in early stage breast cancer, and with Dr. Mitch Rosen, a UCSF reproductive endocrinologist investigating how breast cancer diagnosis and treatment affects fertility. Dr. Chien is also interested in new agents for identifying high risk, early stage breast cancer.

Originally from the Bay Area, Dr. Chien took her BS with Honors in Biology from Stanford University. After completing medical school and an Internal Medicine residency at Harvard and Mass General, respectively, she returned to the San Francisco area to study hematology and oncology at UCSF.

When Dr. Chien is not working, she loves the outdoors. She hikes and runs to relax, and lights up when she talks of traveling. She was able to take a long break recently to visit friends and travel through several Southeast Asian countries. Dr. Chien is engaged to be married this spring. Many well wishes for continued success in all your new paths, Dr. Chien!

Calendar

Spotlight on Survivorship Lecture Series

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.

Stress Reduction

Kristie Home

Thursday, May 13, 6 pm to 7:30 pm

Kristie Home, a Specialist at the Osher Center for Integrative Medicine, teaches stress reduction techniques accessible to people in all states of health.

Pilates

Jane Clark,Cancer Exercise Specialist, Certified Personal Fitness Trainer

Tuesday, July 13, 6 pm to 7:30 pm

Jane Clark, the UCSF Specialist in exercise for cancer patients, will teach and demonstrate Pilates activities that will improve your range of motion and balance, and strengthen your body. Learn takeaway techniques to practice at home.

The Yogic Art of Joyful Living

Kristie Home

Thursday, August 12, 6 pm to 7:30 pm

Kristie Home, a Specialist at the Osher Center for Integrative Medicine, makes yoga interesting, appropriately challenging, and accessible to people in all states of health.

Author Reading

Author To Be Determined

September 14, 6 pm to 7:30 pm

Taste for the Cure

Saturday, November 6, 12:30 pm to 4:30 pm

The Breast Care Center presents a full afternoon of lectures, good food and educational information.

All events take place at the JCCSF, 3200 California St., San Francisco. There is no cost for these programs. Space is limited. For reservations call (415) 476-0272.

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 by 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.

American Society of Clinical Oncology Update

Wednesday, June 16, 6 pm to 7:30 pm

Fall Fashion Frenzy

A UCSF Friend to Friend Shop Benefit

Saturday, October 9, 11:30 am to 2 pm

Join us for an afternoon of fashion, food and frolic benefitting the Friend to Friend Fund. The Fund provides cancer treatment related items such as wigs, scarves, mastectomy bras and swimsuits, breast prostheses, and books to patients who can't afford them. This year's event will honor Ms. Ruth Ann Rosenberg, celebrating her 50th year as a UCSF volunteer. Tickets are $75. For reservations call (415) 353-1366.

Lake Merced Golf Club, 2300 Junipero Serra Blvd., Daly City

Breast Care Center Decision Services: An Intern's View

by Alexandra Teng

Alexandra Teng

On the first day of our internship, Dr. Esserman stood before us and laid out what to expect. More than anything else, she said, we would learn to listen, and we would learn through listening.

I am one of 10 premedical interns employed by Breast Care Center faculty members to spend four days a week working on research projects ranging from intraoperative radiation therapy studies to clinical trial online databases. I extended my internship by a year to help coordinate the Decision Services consultation planning staff in facilitating a shared decision-making between patients and doctors. One day a week, each intern works for Decision Services as a consultation planner, helping newly diagnosed breast cancer patients develop a list of questions for their doctors, and then accompanying them to their appointments to take notes and make an audio-recording. Most of us entered this internship to get a sense of what it would be like to be a physician, and whether we should choose that career path. Last year, after several months in the Breast Care Center's internship program, I made the decision to apply to medical school.

Recently, in one of my medical school interviews, the dean of admissions told me that the point of medical school was to train physicians who would make an impact in every way a physician can. Now, in my second year of the internship, it has been exactly as Dr. Esserman had predicted. Through learning to listen to doctors, coworkers, and most importantly, patients, I have seen all the ways in which a doctor can make an impact. That has made me not only sure that I want to become a doctor, but has taught me exactly what kind of doctor I hope to become.

Listening to Patients

We may not have medical degrees, but that is part of what makes it possible for us to be effective for patients and to gain true insight into the patient side. The sole reason we accompany a patient into her appointment is to listen to her questions and concerns. We are not biased; we are not there as experts or to offer our opinion on what we think is "best" for the patient. Rather, we are there to help the patient realize what is important to them and what *they* think is "best." Premedical students are always looking for opportunities for patient exposure. We get more than that. It is not the doctors we are shadowing, but the patients. And because of this perspective, I will forever be committed to making patients informed and involved in their treatment decisions.

Listening to Doctors

Through various UCSF projects, interns also get to see how physicians incorporate the individualized patient information gained from consultation planning into recommendations specific to each patient. Getting the chance to attend weekly tumor boards, I have seen a physician struggle between their expert opinion and his or her respect for a patient's preferences. Although these tensions are difficult to reconcile, I have come to realize how elegant the decision-making process is when there is a partnership between doctor and patient.

Taking notes at appointments, I have heard doctors face patients who question the status quo. One patient particularly struck me during our phone consultation when she asked, "It's always surgery, radiation, chemotherapy, and maybe hormone therapy. With so many different types of cancers and women, how can they always all be given the same choices? If you don't question the standards, how can you make advances?" Patients come to UCSF because of its reputation for leading specialists who pursue innovative treatment and research. As an insider, I see how it is really the patients that drive physicians to pursue cutting edge research.

Listening to the Team

So as I wrap up applying to medical school and begin to think about my career in medicine, my perspective is forever changed. Early on in my professional development, because of the patients I have listened to, the doctors I have observed, and the colleagues I have worked with, I have formed an expectation for teamwork. There are too many challenges to face and too much at stake to not take every player into consideration. I will carry with me always the lesson of listening, and hopefully it will make me able to have an impact in every way a physician can. ■

General Breast Cancer Screening Information

Recommendations regarding screening with mammography in the U.S. range from having annual mammograms starting at age 40, to having mammograms every 2 years from ages 50-75. Importantly, for women 40-49, the US Preventive Task Force Guidelines call for patients and their physicians to make an individual decision, taking into account family and personal history of cancer as well as factors like a history of previous biopsies, age at menarche, age of child bearing, intake of alcohol, smoking habits, diet, weight, prior radiation therapy and/or hormone replacement therapy. Of course, paramount to good decision making is understanding the benefits and risks of screening. Screening has benefits, but it also has some limitations. It is important for clinicians and patients to be aware of these so that we make the most of the information we get from screening.

Paramount to good decision making is understanding the benefits and risks of screening.

For Women Aged 50 to 75

Evidence from clinical trials has shown that women age 50-75 receive the greatest benefits of early detection through screening. As women get older, breast cancer is more common. Breast cancer is made up of several types, some that are aggressive and grow quickly, and some that grow less quickly. Mammography is makes the biggest impact on women with slow and moderate growth tumor, which are most common for women in this age group. As you get older, you are more likely to develop very slow growing tumors, which may not benefit from early detection. Therefore, you are less likely to benefit from screening, especially if you have other serious medical conditions such as heart disease or diabetes which are more likely to cause mortality. Additionally, the U.S. Preventive Task Force Guidelines showed that, screening every other year has just about as much benefit as screening annually since many tumors found in women in this age range are slower growing and finding them early doesn't make a difference in terms of treatment. Since screening more frequently would not result in a better outcome, it is all right to stretch the interval between mammograms to 1.5-2 years. This is consistent with how mammographic screening is conducted in Europe.

For Women Aged 50 and Under

Women in their 40's need to be informed that the chance of being called back for additional studies or a biopsy is pretty high while the chance of actually having a cancer is relatively low. If 2000 women are screened every year for 10 years, 1100 will have a call back and possibly a biopsy, but probably only 10 cancers will be found, and screening would have saved the life of 1 of the 10. If there is a family history or other risk factors, women should be screened annually in their 40's, but should discuss their risk with their health care practitioner as they might also consider prevention options such as chemoprevention, surgical prophylaxis and/or lifestyle changes. Screening does have some benefit in this age group, but it is small. Women should weigh the pros and cons and make an informed decision. How often to screen is controversial. Women in this age group are more likely to have faster growing tumors so it may make sense to screen annually if you are going to screen.

Women in their 40's need to be informed that the chance of being called back for additional studies or a biopsy is pretty high while the chance of actually having a cancer is relatively low.

Women of All Ages

If you develop a new mass in your breast, make sure to bring it to the attention of your provider, even if you have had a recent mammogram that is normal. Rapidly growing tumors are more common in young women, but can arise at any age. Women should be familiar with how their own breasts feel and be able to recognize a change. The fastest growing tumors can arise quickly and women themselves are in the best position to find them and bring them to medical attention. ■

Director's Circle 2009

We want to thank these generous benefactors for contributions received during the period between July 1, 2009 – January 27, 2010.

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Friends of the BCC Fifth Annual Director's Circle Event

The fifth annual Director's Circle Reception was held November 20 at the magnificent home of the Honorable Dianne Feinstein and Richard C. Blum. With over 100 guests in attendance, the evening was a wonderful success, raising over $400,000 in unrestricted funding for the UCSF Carol Franc Buck Breast Care Center (BCC). Over the past five years, the Director's Circle campaign has raised well over $2,000,000 for the BCC. We thank each and every donor who has made a gift. Contributions enable BCC Director Laura Esserman, faculty, and staff to further the BCC's mission: customizing breast cancer treatment and prevention to individual women's biology, preference and clinical performance. Presenters included Friends of the BCC Chair, Janet Hunter; Vice Dean of the UCSF School of Medicine and Director of the UCSF National Center of Excellence in Women's Health, Dr. Nancy Milliken; Friends of the BCC committee member, Jan Laret; and UCSF Chancellor Susan Desmond-Hellmann, MD. Please plan on joining us next fall for our sixth annual Director's Circle reception. Your support advances the science and art of breast care from prevention to advanced treatments. ■

(L to R) Back row: Diana Moy, Jeanne Eber, Kathleen Volkmann, Sue Foley, Lauri Isenberg; Middle row: Laura Esserman, MD, Claudia Edwards Perlow, Marcia Forman, Janet Hunter (Chair of the Friends of the BCC), Jan Laret; Front row: Trisha Pillsbury, Vicki Fleishhacker, Gail Stern, Julie Wong

Breast Care Center Honor Roll

Your Support Keeps Us Going!

We would like to thank the Friends of the UCSF Carol Franc Buck Breast Care Center for their ongoing development work in support of breast cancer research and programs. The Friends of the BCC started the Director's Circle program which provides a source of unrestricted funding for expanding existing programs and pursuing new opportunities in breast cancer treatment.

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Director's Circle *from page 14*

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in honor of The Honorable Dianne Feinstein
Genelle Relfe
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Linda Williams
in honor of Doris Betts

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in honor of Diana Moy
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We sincerely regret any errors or omissions. Please contact Katherine Tick at (415) 476-2278 or ktick@support.ucsf.edu with your concerns.

Carol Franc Buck
BREAST CARE CENTER
NEWSLETTER

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Call Eva Mihalis at
(415) 476-0276
for more information