When a Parent Has Cancer: Taking Care of the Children

FROM THE DIRECTOR
ANNE COSCARELLI, PhD

“When I was 12 my mom was diagnosed with cancer. After several years of illness and treatment, she eventually died, leaving my sister and I with my dad. I’m not sure my dad ever really talked to me about his feelings or mine and life seemed to move on. I still have a very deep sense of loss and grief. I felt so alone. As I look back, I realize how much more could have been done to help me with this, but cancer seemed to be something that should never be discussed.”

- Adult with cancer reflecting on his experience as a child

The National Cancer Institute estimates that 24% of adults with cancer are parenting children younger than 18 years of age while about one third of women with breast cancer have children living at home. Cancer is a family disease; not only the patient but the entire family is affected, especially children and adolescents. These statistics underscore the importance of addressing the needs of parents and their children as they live with the consequences of cancer and its treatment.

Children whose parents are diagnosed with cancer are more likely to experience increases in general levels of distress and anxiety. They may experience other changes in mood as well as in their self-esteem. Children whose parents are ill may manifest their distress through changes in school performance, physical complaints of pain and discomfort, as well as changes in social and interpersonal relations. Children may have a tendency to act out their distress in their behavior with others. Adolescent girls may be the most vulnerable; they are more likely than adolescent boys to experience emotional distress after a parent is diagnosed with cancer. Girls have also been found to have more anxiety when their mothers rather than their fathers are diagnosed with cancer, more so than boys who had either parent diagnosed.

The developmental age of the child is also important as we try to understand what happens when a parent is diagnosed with cancer. While the research is limited, depending on the age of the child there are differences in how anxiety and emotional distress are expressed. Preschool-aged children are more likely to experience separation anxiety, depression and disruptions in their attachments in response to changes in caretaker responsibilities. It is harder for young children to adapt when there are substantial changes in who cares for them. School aged children and adolescents are more likely to have feelings of hopelessness. They are also more likely to feel burdened by guilt and/or anger over the diagnosis as well as emotional isolation. This research helps us begin to understand some of the ways that cancer can affect children. It is important, however, to recognize that each child is different and each family situation is unique. Any individual child may experience a myriad of emotions and feelings which can fluctuate over time depending on what is going on with the parent’s illness.

One of the challenges facing researchers is that parents’ reports of their children’s distress are not always congruent with the children’s self-reports. In one study, children and adolescents self-reported significant levels of distress after the diagnosis which declined when they were assessed four months later; their parents, however, reported that their children had little emotional distress. One reason why it may be harder for parents to perceive their children’s distress is because children do not always act maladjusted or exhibit behavioral signs of distress that come to the attention of the parents. Instead these children may internalize their anxiety and depression which may not be uncovered without substantially more parent-child interaction and discussion. In another study, children whose parents had been diagnosed with cancer reported higher levels of anxiety that was associated with an inability to discuss the illness with their parents. These children also spent less time in age-appropriate activities with their peer group and experienced ongoing worries about the parent’s health and illness.

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The role of both parents after a cancer diagnosis in helping children to adjust is very important. Families about the disease can be affected by the ill parent—who may be more absent—but also by the functioning of the well parent. The well parent is faced with many challenges that can include increased responsibilities at home, caregiving for the ill spouse, as well as managing the financial burdens of the family. They may experience their own feelings of depression, anxiety and distress. There may be an increase in marital tensions as the stress of the disease and treatment become more intense, chronic or overwhelming. The well parent may feel less capable of meeting their children’s emotional needs, responding appropriately to situations that arise and being able to set limits, boundaries and discipline. Parenting can be a consuming and difficult life role under the best of circumstances; when the family system is strained by the burdens of illness sometimes the caretaking parent is unable to provide time and consistent parenting.

Unfortunately, the medical environment does not offer much assistance in this area. Oncologists do not have the time, information and resources to help patients discuss their views about the diagnosis and the treatment. They may not know how to handle the questions their patients ask when the ill parent is not improving or is entering an acute phase. The well parent may feel less able to provide the information that their children need, especially when they are between 3 and 7, have a great capacity to see themselves as the center of the world. As such they think that they cause things around them. Children need to be reminded that cancer is not caused by anything that they did. It is important to reassure them with simple statements like, “Sometimes kids think that they might have caught it themselves.” Even school age children can think that their behavior, word, or stresses they created may be related to their parent developing cancer. Again, you need to reassure your child that they had nothing to do with the cancer affecting their parent. Children sometimes think that their cancer is contagious. You need to dispel this myth and make sure that the children, especially young children, understand that you cannot catch cancer.

School age children and adolescents are able to understand permanence. As a result, they are able to anticipate and understand the possibility of death and the permanence that it creates; they may have questions about the death that need to be addressed throughout the discussion. While these can be painful discussions for parents to engage in, they can be helpful in alleviating the immediate worries of their children.

Special Words and Information

Parents and family members should always assume that whatever is being talked about within the family is the overheard by the children. As a result, it is therefore, important to use appropriate words and terminology. It is better to name the specific cancer (e.g., breast cancer, lymphoma or leukemia) than to use alternative words (e.g., “boob-boob” or “lumps” all the time that are not serious and are not have the capacity to manage long time frames. It is important to know that you don’t have the answers to all questions and that you can come back to questions at a later time. If a child asks you something and you are not sure how to answer, they will tell their child, “I think that is a really good question, and I’m not sure how to answer it. I need to talk to your mom to see if she remembers if the doctor answered that for you before.” It is essential that children mostly need to know who will be taking care of their parents. The aspect of time may be less important as they may not have the capacity to manage long time frames. It is important to give children opportunities for questions. If your child does not ask questions, it can be helpful to anticipate some questions that might come up. When speaking to your children you can give them permission to ask questions by saying things like, “I have been told that many children your age want to know….” Is there something you might be interested in knowing?” If your child indicates they do not want to know something then you can explore with them what they are feeling and what they are thinking that might lead to this sort of response. It is important to know that you don’t have to have the answers to all the questions and that you can come back to questions at a later time. If a child asks you something and you are not sure how to answer, then tell your child, “I think that is a really good question, and I’m not sure how to answer it. I need to talk to your mom to see if she remembers if the doctor answered that for you before.” It is essential that children mostly need to know who will be taking care of their parents. The aspect of time may be less important as they may not have the capacity to manage long time frames. It is important to know that you don’t have to have the answers to all questions and that you can come back to questions at a later time. If a child asks you something and you are not sure how to answer, then tell your child, “I think that is a really good question, and I’m not sure how to answer it. I need to talk to your mom to see if she remembers if the doctor answered that for you before.” It is essential that children mostly need to know who will be taking care of their parents. The aspect of time may be less important as they may not have the capacity to manage long time frames.

Some children are better able to communicate when there is nothing else going on, e.g., no activity or disruptions. Other children do better talking about difficult things while doing a simple activity. For example, drawing pictures, coloring or playing an uncomplicated game of cards are good activities. It gives them another mechanism to help manage their anxiety and may allow them to talk more openly. Children, especially young children can benefit from being held while information is shared.

As a parent you may have to try some different approaches to see which seems to work best for your family. Sometimes sharing general information with the entire family at the same time is especially helpful and then tailoring more detailed messages for older children and adolescents can help ensure that attention can be paid to their needs. Remember that...
communication is about building and maintaining trust and the first communications are going to lay the groundwork for the future.

An inevitable part of this process is managing misinformation. Any child with a seriously ill parent is likely to hear information that is not correct. Well-intentioned friends may share information about someone else’s cancer experience which is irrelevant or frightening. Since you cannot filter what your children hear, you need to prepare them to bring the information to you. By continually this information and to clarify what applies to your family and what does not. Children need to be told that not everyone will have as much information as you have because only you are talking directly to the doctors. They need to help keep information channels clear by sharing with the family stories they hear, especially if they are worried, so that misinformation can be identified and corrected.

Older children are likely to go on the internet and explore information on their own. We know that not everything on the internet applies to everyone and that there is good and bad information on the internet. It is important to discuss with your child and to offer them reliable web sites to access. Explain to them that they should not read or believe everything on the web; sometimes it can give the wrong information or the information may not apply to you. Reassuring them that you get your information from your physicians who know the specific information relevant to you will help your child see you and your doctor as the best resources of information.

Caretaking of Children and Routines

It is very important to remind the children that they are loved and that the family will continue to work together to cope with this new family situation. It is important to reassure children that arrangements will be made for their care and to enlist a small number of reliable and caring caregivers to assist in the loving support of your children. One of the primary goals of these caregivers is to help maintain the children’s schedules. Children do much better when their basic schedules and routines are not disrupted. There is safety in their daily routines; reassure children that life will be as stable as possible. Schedules and routines are needed so that children regulate their emotions so it is helpful to keep these intact. Maintaining contact with peers, school and other activities help children and adolescents maintain the feeling that while parts of life are changing and in flux, there are other parts that are stable.

Another good way to help support your child is to keep their school informed of what is happening at home. Speak to the parent of each child’s best friend; ask them if they can help inform other families of your family’s situation to the degree that you want them informed. Encourage your child to maintain relationships with these other children. Do not want your child to feel that being close with other adults is distasteful to you as this may be a great source of support for them. You can also ask these other adults to direct your children back to you if they learn that your child has questions and concerns that may need to be addressed.

Children Who Don’t Want to Talk

While it is important that children receive the information they need, all children want to talk at length about their parent’s illness. Should they be forced to talk? No! One can really force someone to talk and we do not know if this would really help prevent problems down the line. The best stance is to continue to contact your child periodically. A safe, open-ended comment that you could make would be something like, “You know that if you want to talk about something (preferably not left) (the cancer) I seem to really like to hear about what it is like for you.” Provide some time for your child to share their thoughts. You can offer other prompts, such as, “Sometimes I think about (name child) and all the way it has affected me and I wonder how you think about it.” Some children may cope by keeping busy, seeing friends and not focusing on their parent’s illness.

Hospital Visits, Treatment and Doctor Visits

Visiting the hospital or treatment room can be a helpful experience for children as long as they are prepared in advance for these visits in order to not make them traumatic. Children need to be told what they can expect to see and their questions need to be addressed. When a parent is in the hospital, your child should be prepared for what they will see including whether there will be IV lines, blood, vomit, mattresses, doctors, nurses, oxygen and or any other machines. It is also helpful to describe benign things like TVS, a bed that goes up and down, a window or bathroom. Knowing there is a cafeteria where food can be purchased and even information about how the parent eats while in the hospital to help normalize some of the experience. It is easy for adults to assume that children understand these things when, in fact, they really do not. Even telling children the names of some of the nursing staff can help to humanize the experience.

When a child visits it is important to have a designated adult who can take them and will be sensitive to their needs if the child is scared, lonely or leave or who can answer their questions and be comforting. The visit should be arranged, if possible, at a time when the sick parent is more alert and not in an altered mental state, which could be frightening for the children. Having a friendly nurse greet the child and provide some reassuring remarks or even offer the child a juice or ice cream can make it friendlier. Communicating confidence and your own sense of being okay with the hospital environment helps children relate to the environment as another important aspect of life.

Separations can be difficult for young children. If possible, it is important to bridge these absences with visits, telephone calls, and messages. Having a child make a drawing for their ill parent can be nice for both the child and parent. Tell the child that their drawing is hung up in the room where their parent can look at it and think of them every day. These small things help maintain the parenthood attachment. Sometimes you can give the child something that belongs to their hospitalized parent to remind them that they are loved and connected during the hospitalization. I have seen parents get matching necklaces or bracelets or a special stuffed animal. These items are what we call transitional objects and they help children and adults maintain their attachments and negotiate their anxieties when separations are inevitable.

Inpatient visits are not the only situations that need managing. Some children are worried about their parents who get chemotherapy and may be gone for hours at a time, or their family doctor and when they are away. Meeting a warm and friendly nurse can help a child feel that their parent will be returned to them. For some children it may be helpful to come to a physician appointment accompanied by a safe supportive adult, like a family doctor or who is wise to connect with the child and reassure the child that

he or she is giving their mom or dad the best care he can also alleviate anxiety. These options need to be individually considered. If you are treated at an UCLA the clinicians at the Simms Mann Center can help you with decisions and arrangements.

Questions about Death and End of Life Preparation

Questions about death are not always about end of life preparation. Questions about death are expressions of anxiety that can come up even when the prognosis is extremely positive. Having hard questions can even be met with paying attention and even ask, “Are you going to die?” This is often one of the more frightening questions that parents have to address and many worry how to answer this question. Parents are worried about frightening their children and these questions raise anxiety in the parent and well spouse as well. Although different families handle this question in different ways such questions need to be addressed. Avoidance is not a healthy approach.

It is important to remember the goals of your communication. Parents want to reduce as much anxiety as possible in both the short and long term, but also to help families manage the cost of having the trust relationship which is ultimately at the heart of children feeling less anxious and more safe. Some parents will acknowledge the possibility of death, but will also provide reassurance that they will take the best care of themselves and that they are seeking the best medical care available which is often the case. Sometimes parents will answer based on their religious values that suggest that no one can know these things as they are in the hands of God. Giving children the comfort to understand the living with uncertainty is challenging for everyone and that living with uncertainty is about hoping for the best and having the best plans in place in case the worst arises. This requires that we, as parents and caregivers, explore our children’s worries and concerns and it may require asking the child about their worries if the parent were to die. For many children the issue is about how they will be taken care of if the parent dies and needing to know that there are plans in place that will sustain them. Some parents will tell children that they do not expect that they will die from this and that they will be living a long time. Sometimes parents will choose reassurance based on information that their physician has provided.

When the disease status is progressing and there is a greater likelihood that death will come from the cancer, despite all of medicine’s and the parents’ best efforts, it is important to realize that this ending phase is the beginning phase in processing grief for a child. There are many actions that can be taken to help facilitate an adaptive response to the loss. We may not be able to stop loss but we can exercise great influence over experience. It is very important that the children are told repeatedly that they are loved and that they have the opportunity to share their feelings of love with the ill parent. Children can participate in time at the bedside, even when a parent is not cognitively there and words can be said that may be experienced by the dying parent. It can be immensely helpful to have a trained clinician help facilitate discussion with the child and parent through these processes to uncover fears, address worries and plan and initiate final memories. Having children participate in hearing and telling stories about the parent—which may be humorous, joyful, or loving representations of the parent—can be incredibly important. They help facilitate the child’s internalization of a process of building an internalized representation of their parent. Grief is facilitated and adaptive when we are able to hold some image or space internally of the beloved parent with the attachments that have formed a secure and

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There are many different approaches to complementary medicine in the arena of cancer care. Some of these approaches come from a philosophical perspective that values the patient's therapists, many-modality, individualized techniques. Here we present three approaches which view similar symptoms from very different perspectives and offer different and complementary approaches for maintaining wellness.

**Integrative East-West Medicine Approach to Patients**

Traditional Chinese Medicine (TCM) presents a new and different philosophy of life and approach to health and disease. It is often used for a variety of cancer-related issues such as improvement of quality of life, symptom management, improving ability to tolerate conventional therapies, prevention of progression and maintenance of remission. TCM is also used as a prevention for cancer. In the Chinese medical model, all aspects of life are inter-related to one another – nature, social, environment and body-mind. There is a continuous interaction with flow and balance. Mind, body and spirit are never separated. TCM has a different model for understanding cancer as well as all other illnesses. In the TCM model pathogenic factors include external noxious stimuli, such as chemicals and the weather, psychological and emotional factors, lifestyle (e.g., smoking, impaired function and dysfunctions of organ network, Qi and blood). There is a constant process in which the body must balance the noxious stimuli and endogenous resistance. Any factor, no matter how seemingly indirect, that increases the amount of noxious stimuli and/or decreases the body's natural resistance can accelerate the cancerous process in the TCM model. The TCM model sees the local growth of cancer as a manifestation of a larger problem; it is often compared to the ‘fire’ and therefore, the patient needs to take a systemic approach in treatment.

The therapeutic goals for TCM are to restore the normal balance and flow including emotional, fluid, neurotransmitters and blood flow. It is a very individualized approach. It focuses on enhancing the body’s endogenous resistance to disease. There is less emphasis on specific causal factors. By doing this the body is able to build up its own resistance, by controlling symptoms it allows the body to heal itself.

TCM therapeutic modalities include acupuncture and its variants, such as acupressure and massage of specific points. Herbal combinations individualized to the person are also a significant part of TCM. Tai Chi and Qi Gong, and movement modalities which meld mind and body, help the body to heal itself and restore energy flow. TCM also includes health culturizing lifestyles and practices such as diet and sexual functioning.

TCM is not used instead of traditional Western medicine for cancer care but rather as an adjunctive therapy. It is believed that by combining these two different philosophies and treatment approaches patients are likely to have the greatest benefits. Neither lens is sufficient to address all aspects of the spectrum of health.

An integrative East-West approach has many goals. The first step is to educate the patient about the importance of balance and how the lack of it leads to depletion. The East-West model incorporates life style modifications, such as learning about appropriate types of exercise, nutritional advice and sleep management. Patients are taught self-massage techniques, sometimes on specific acupuncture pressure points, to help relieve symptoms and pain. Acupuncture and acupuncture are used along with trigger injection – a version of acupuncture (HVA) and low force. Herbal medicines may be used, but the diet approach is used first. Sometimes patients need their medication routine adjusted to improve their well-being. Finally, one of the most important aspects of this East-West approach is stress management with many different modalities available to achieve stress reduction. Some of you may be surprised to know that in the integrative TCM model, crying is seen as a good thing which helps create an appropriate emotional flow.

Acupuncture is a method of sending a signal to the body by using a needle or other means of stimulation, to help the body turn on its self-healing capacity. There are different ways to stimulate acupuncture points. It has been documented as useful for symptoms such as nausea, vomiting, dry mouth, chronic pain and myofascial pain symptoms. Systematic reviews show acupuncture to be helpful for several specific non-cancer pain conditions. There are only a small number of trials for cancer-specific pain, but the results are promising. Although complementary and alternative treatments are widely used by patients with cancer, the usage of acupuncture is relatively low with rates ranging from 1.7% to 31% depending on the study. Some of the barriers to acupuncture may be the small number of referrals from oncologist and the need to pay out of one’s own pocket for the services.

Tai Chi and Qi Gong have specific movements that move Qi (energy) in the body. These have many benefits including stress reduction, enhancing oxygen consumption, enhancing muscle strength, increasing flexibility, improving balance, lowering percentage of body fat, reducing mood disturbance, enhancing immunity and improving cardiovascular function.

Chinese herbal medicine is of plant, animal and mineral origin. It has been used for many years to treat patients and should be used under the guidance of a well-trained practitioner who knows and understands the theory of Traditional Chinese Medicine. It requires appropriate diagnosis within the TCM model. It is important that these modalities be properly integrated with Western medicine approaches for optimal cancer care. It is not just a matter of picking and choosing techniques, but applying the philosophy and art of TCM. “All forms of medicine aim to ease human suffering and improve quality of life; they differ only in their approaches to the realization of this goal. The blending of Eastern and Western approaches to health and healing can maximize the safety and effectiveness of care in an accessible and affordable manner.” The Center for East-West Medicine at UCLA can be contacted at 310 998-9118, cewm@mednet. ucla.edu or through the web at http://www.cewm. med.ucla.edu.

**Chiropractic Manipulative Therapy**

Chiropractic focuses on the relationship between the body’s structure – mainly the spine – and the body’s function. Doctors of chiropractic use manipulation (or adjustment) as their primary modality. Chiropractic is used most often to treat musculoskeletal conditions such as problems with the muscles, joints, bones, and connective tissue including cartilage, ligaments and tendons. It is important that these modalities be properly integrated with Western medicine approaches for optimal cancer care. It is not just a matter of picking and choosing techniques, but applying the philosophy and art of TCM. “All forms of medicine aim to ease human suffering and improve quality of life; they differ only in their approaches to the realization of this goal. The blending of Eastern and Western approaches to health and healing can maximize the safety and effectiveness of care in an accessible and affordable manner.” The Center for East-West Medicine at UCLA can be contacted at 310 998-9118, cewm@mednet. ucla.edu or through the web at http://www.cewm. med.ucla.edu.

Manipulation is used to restore proper movements to joints. There are many different techniques, but they fall into two general categories, high velocity low amplitude (HVLA) and low force. HVLA has over 300 named techniques, but there are about 10 core techniques. One low force technique called Activator uses a small spring loaded device to create the manipulation. Chiropractors also do myofascial work (reducing discomfort in tight muscles), physiotherapy, exercise recommendations, strength training, and teach balance and posture utilizing their expertise in analyzing gait. Chiropractors may also offer nutrition and supplement advice which is generally good for basic nutrition. There are no studies offered on nutrition and the debate in the field about the role in supplements. It is estimated that 4.8% to 8% of the US population uses chiropractors and that there are approximately 18,000,000 patients per year.

Individuals undergoing cancer care may benefit from chiropractic services. Many patients decrease their normal activity and lose movement over the course of their treatment. This can lead to increases in spinal and/or joint pain as well as soft tissue adhesions and contractures (shortening of muscles due to spasm); these can be relieved by the techniques used by chiropractors. Gait and balance can become disrupted and this can lead to less support in the rehabilitation and comfort care of patients with cancer. Being able to seek this type of care can provide a source of control and management in an otherwise very difficult experience.

There are some situations where chiropractic techniques are contraindicated (should not be used). For example, individuals with osteoporosis or weak bones should not the chiropractic although some of the low force techniques may be okay. Patients with bone metastases should also avoid chiropractic techniques that use force. Chiropractic is not a cure for any disease including cancer and should not be used instead of a primary care doctor or an oncologist for treatment of other disease and cancer. Chiropractors should also be willing to coordinate care with your regular physician. Any recommendations for vitamins and herbs related to your cancer care should be coordinated with your oncologist to avoid any problems with medications or treatments you are receiving.

Massage therapy is also something that may be beneficial. According to the American Cancer Society (ACS) massage is “thought almost universally to be beneficial.” Massage cannot cure cancer but it has been shown in several studies to improve quality of life and well-being. Massage decreases inflammation and swelling, improves circulation, and helps with muscle spasms. It also helps individuals with cancer to relax. It causes the release of chemicals in the body that help with pain and provides a distracting experience that helps take one’s mind off pain.

There is no state license for massage therapy; rather there are licenses issued by each municipality but they do not verify the individual’s competence. State certification can be used in any municipality. Typically massage therapists complete certificate programs of 250 or 500 hours of training. There are many advanced techniques and training that are available, especially here in California.

**COMPLEMENTARY MEDICINE IN CANCER: A PANEL OF EAST-WEST, MANIPULATIVE THERAPIES AND HERBALISM**

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This is a summary of a lecture presented on August 10, 2010.
If you have cancer you should consider that massage not be done over or near IV’s, catheters, or surgical wounds. Massage should not be done over known cancer sites, radiation burns or known tumor sites. Massage over areas where cancer has invaded the bones are also of concern. Circulatory ailments such as phlebitis or varicose veins should also avoid massage. Aggressiveness and strength are not indicators of quality care with people with cancer. There is no evidence to support the myth that massage will spread cancer. When having a massage, it is important to speak to your medical doctor and obtain clearance for this type of therapy.

Manual Lymphatic Drainage (MLD) massage is very different than other types of massage. This must be done by a trained MLD therapist and it is used to treat a condition called lymphedema – accumulation of lymphatic fluid in the tissues which often causes swelling, most often in the arm(s) and or leg(s). Lymphedema can develop when lymphatic vessels are missing or impaired, when lymph vessels are damaged or lymph nodes are removed. Radiation therapy and surgery often create the potential for lymphedema. MLD can include a special kind of massage and it is imperative to find someone who is trained and has experience working with people with cancer. MLD should be coordinated with your care from your medical doctor.

Modern Herbal Medicine

Many herbs can interfere with cancer therapies so it is essential that patients seek out information from knowledgeable practitioners who understand both the cancer treatment and the various herbal treatments. It is important to note that there is no one prescription that is tailored to the needs of the individual. The herbs described here are generally ones that do not interfere with chemotherapeutic regimens. However, developing an individualized approach is always the best plan.

It is as important to obtain high quality products from known manufacturers as it is to have a skilled professional help you make selections. It is also important to prioritize what things to take. More is not always better, the body cannot handle too many supplements. Patients also need to be monitored for the unexpected when taking supplements. Always disclose your supplement regimen to your primary care doctors.

Herbal Preparations

Selecting safe herbal preparations is not always easy. They come in many different forms. It is not recommended to take cancer in a form for cancer. Herbs, if using retail or wholesale formulas patients must find manufacturers that are ethically responsible and self-policing their products. Remember, herbal supplementation can also come in the form of food. For example, garlic, ginger and soy are foods that can be eaten that have beneficial qualities. Garlic is simple to use, can be added to food and has a beneficial impact on the immune system and the flora in the colon. Onions are another way to prepare herbs. Green tea and nettle leaves can be added to soups and have positive qualities. Good quality green tea is pale and should not be astringent. Sometimes a weaker tea may be better. Peas have been helpful in preventing recurrent cancers but a green tea pill is not the same as having the tea. Tinctures are concentrated forms of an herb made with water, alcohol and glycerin as well as the herb. Standardized extracts are another method of herbal preparation and include milk thistle, turmeric and grape seed. Sometimes herbal preparations, such as reishi mushrooms, are powdered. Capsule and gel-caps are another form for ingesting herbal preparation and can include non-herbal things such as Omega-3 fatty acids. Finally, topical preparations – made from herbs such as camphor, aloe vera, and lavender may be useful for irritation, burns and wounds. Chamomile tea is good on burns and wounds, cucumber has a cooling effect and is an anti-inflammatory. Aloe vera gel is good for burns and skin irritation. Lavender is safe for most skin and it has some aromatherapy benefits.

Protective Foods and Herbs

Organic versions of food may be more protective or at least there is some evidence in the laboratory that organic foods and foods (non-cells). It is more protective against breast cancer cell lines. Below is a list of some foods or supplements that have beneficial effects, some of which have demonstrated protective effects in the cell lines in vitro (in the test tube). It is generally recommended that foods are used fresh before supplements. Adding a variety of foods to your diet can be the best prevention and protective model.

- Carrots, yams, squash and turnips are high in carotenoids which have anti-cancer and anti-inflammatory benefits.
- Foods rich in vitamins A, E, C, folic acid and flavonoids as well as fiber are also protective.
- The cabbage family, which includes foods such as brussels sprouts, cauliflower, and broccoli, has anti-oxidant effects. They can be steamed or added to soups and are easier to digest if less raw. Broccoli triggers glutathione S-transferase and may block carcinogens from interacting with cellular DNA.
- Grapes, figs, strawberries, berries and red wine have ellagic acid, which scavenges carcinogens.
- Grape seed extract contains resveratrol which is also found in red wine as well as other plants and foods (non-cellular). Resveratrol has anti-cancer properties. Grape seed extract seems to strengthen and protect blood vessels, support the immune system, may have cardiovascular benefits and is also an antioxidant that scavenges free radicals.
- Peas and beans have phytoestrogens which may slow the reproduction of cells in the large bowel to reduce colon cancer risk. Soy and legumes with protein, such as green beans and fava beans, are protease inhibitors which reduce enzymes in cancer cells.
- Isoflavone metabolites such as genistane, found in red clover, may block entry of estrogens to cells and genistein may have antiangiogenic effects.
- Real traditionally made sourdough rye bread, linseed/flaxseeds and sesame seeds have lignans and may have beneficial effects for hormone receptor types of cancers. Sesame seeds also have calcium. Flax oil is a rich source of cancer-preventative and hormone balancing lignans.
- Olive oil has squalene which has protective effects against breast cancer.
- Omega-3 fatty acids which are found in cold water wild caught fish (not the farm raised salmon and trout) may suppress growth of breast tumor cells and have anti-inflammatory benefit.
- Turmeric has curcumin which has anti-oxidant effects. Just a little goes a long way and so adding 200-400 milligrams per day to your diet is a good idea.
- Ginger has a number of benefits. Gingerol is the main pungent constituent of ginger and it has anti-emetic (anti-nausea) properties, improves appetite, is an anti-inflammatory and has anti-oxidant qualities. A cross-sectional study of 231 female breast cancer survivors who received cisplatin chemotherapy also received ginger in comparison to conventional antiemetic therapies. After the first day, ginger had as many positive effects as the anti-emetic drugs with fewer side effects.
- Garlic is also a powerful antimicrobial agent. It strengthens the immune system, helps lower blood pressure, normalizes blood lipid profiles and inhibits platelet aggregation. It is an antioxidant, anti-fungal, anti-carcinogenic and anti-inflammatory agent.
- Turmeric, ginger, garlic and the onion family all help the liver to filter out toxins. These may be especially helpful while getting chemotherapy.
- Echinacea appears to have anti-inflammatory effects and may also contribute to an immune modulation.
- Black cohosh has anti-estrogenic effects on human breast cancer cells. It is also an anti-spasmodic. Studies of postmenopausal women who had high intake of phytoestrogens corroborate earlier observations that phytoestrogens (Black Cohosh) improve heart health. With regard to hot flashes, different studies have shown different effects; however, the longer study (lasting one year) of 136 women with breast cancer survivors on tamoxifen showed a reduction in hot flashes and a reduction in severity of hot flashes in the group that took a specific black cohosh. There was no evidence of adverse events.
- Green tea, as noted above, has some health benefits. For cancer prevention it is generally recommended that 5-10 three ounce size cups are consumed daily. For patients with cancer, 10 cups per day may be more appropriate. Systematic reviews of case control studies and cohort studies show lower incidence and recurrence with highest use of green tea. There is no consistent dose response relationship, no control for preparation of the tea and no clinical trials. There may be some genetic factors that play a role in the positive effects associated with green tea.
- Milk Thistle contains lignans and there is some evidence to suggest that it has protective and antioxidant qualities for liver cell membranes. It may also inhibit breast cancer and prostate cancer based on some in vitro studies. It is also a mild diuretic.
- Rosemary and sage contain phenolic diterpene and are strong antioxidants. This may be good to add to the diet on non-chemotherapy days. They also have anti-inflammatory properties.

It is important to remember that these foods are not the “magic guns” against cancer; that is what Western medicine has to offer. However, diet can be a powerful adjunct tool. By eating a diet that is rich in these many different foods and herbs, there may be combined benefits that lead the body to being more cancer unfriendly which in turn may be helpful in both prevention of cancer and prevention of cancer recurrence.

Summary

There is no magic bullet to prevent cancer or prevent recurrence; however, there are activities in which an individual can engage to reduce the likelihood of recurrence or boost the body’s natural healing abilities. These approaches can come from different sources and while the research to date may be limited on many of these, there is a growing interest in understanding the complex relationship between these different approaches in their anti-cancer value and their ability to improve quality of life. Not all approaches will be compatible for all people; however, with guidance individuals may find some activities that help them to feel strong, live a more comfortable life and hopefully maintain wellness.

Editor’s Note: Choosing integrative approaches requires knowledge of both clinical and evidenced based literature. Becoming educated from reliable sources is a must. The Simms/Mann – UCLA Center for Integrative Oncology News, April 2011 provides an overview of how to make decisions about their complementary and integrative choices. Dr. Mary Hardy, an integrative medicine physician, does individual education sessions tailored to the needs of the individual taking into consideration a wide range of important factors. As part of the session a Body Mass Index analysis is done. These services are fee-for-service. In addition, dietary supplements selected by our Medical Director, Mary Hardy, MD, with attention to safety and quality are available at Reflections Boutique, 200 UCLA Medical Plaza, Suite 163 and online. For information and enrollment call 310 794-6644. The supplements are also on the web at www.SimmsMannCenter.ucla.edu.
Recent advances in radiation therapy are making it possible for us to move from two dimensional to four dimensional imaging and to provide more targeted treatment. As a radiation oncologist, my goal is to provide more accurate, more precise physical and biological targeting. This will allow for escalations in the radiation dose, potentially treating the cancer more effectively, reducing the amount of time that it takes to receive radiation therapy and, thereby, reducing toxicity. The ultimate goal is to improve tumor cure rates.

What is therapeutic radiation?
Therapeutic radiation can be thought of as using x-rays of higher frequency (therefore more energetic and potent) along a spectrum of different wavelengths of visible and invisible light. For example, low frequency radiation comes from things like the radio, microwave, infrared light, visible light, and ultra violet light. High frequency energy includes x-rays and gamma rays for treatment; the highest end of the spectrum appears at the cosmic level of the solar system. Therapeutic radiation kills cancer cells by either directly affecting the DNA or by indirectly oxidizing water (making free radicals) that diffuse towards the DNA and cause damage. If a critical double strand of the DNA breaks in the tumor cell, tumor cell death will occur. Cancer cells do not have the ability to repair themselves in the same way as normal cells. Radiation therapy has typically been given over longer periods of time with smaller amounts of radiation because traditional forms of radiation were less accurate and more normal tissue was in the radiation portals (fields). The slow daily doses of radiation are more likely to irreversibly damage cancer cells than normal cells because normal cells can repair sub-lethal damage. However, we now have better ways to completely exclude normal tissue in our radiation fields, and therefore, can now escalate the daily dose.

Stereotactic Body Radiation Therapy
Stereotactic body radiation therapy (SBRT) is a new approach that differs from more traditional therapies in a variety of ways. Previously, radiation would be mapped out as large areas around the tumor site because we did not have tools to verify if we were hitting the right target. The problem with this older approach with a large field is that a considerable amount of normal tissue may lie within the field while a portion of the actual tumor may still lie outside the field on any given day (due to lack of imaging daily to verify tumor location). SBRT differs from traditional therapy because it uses highly focused radiation concentrated on small tumors and only on doses to surrounding tissues. By using more focused, higher doses on the tumor site we can use fewer treatments. A single large dose or a few treatments is more biologically effective than 6 weeks of incremental doses of daily radiation, eliminating the longer period of radiation that has characterized more traditional approaches. In order for SBRT to be successful, it has to be done using very precise delivery techniques. This is accomplished by using image-guidance and using four-dimensional CT scanning prior to treatment. This technology allows the treatments to be mapped with very small margins around the tumors, thereby sparing the majority of normal tissue of high doses of radiation. A special belt is used to monitor a patient’s respiratory motion during the CT scan, so that the radiation oncologist can correlate internal tumor and organ motion with a patient’s breathing pattern. Once this is established it can be determined how the tumor moves with each breath. Potentially, we can use this information to turn the therapeutic radiation beams on and off as the tumor moves in and out of the field, to further reduce the field of radiation.

The next part of the treatment plan is to “map the tumor,” e.g., how and where the radiation will be entering the patient. The preferred mapping method is called 4D-conformal radiation therapy and uses multiple imaging modalities to characterize the treatment target such as PET-CT and MRI images. This method provides detailed information to define the specific target from multiple angles, thus making delivery even more precise and enabling the maximum amount of radiation to be aimed at the most active portion of the tumor. In addition, the beams come from multiple angles and the intensity can be modulated (called intensity modulated radiation therapy, or IMRT) which allows for the primary beam to give the most treatment while surrounding tissues receive less radiation, creating fewer side effects and less damage to normal tissue. The skin is also less damaged because the radiation treatments are coming from multiple angles.

Stage 1 lung cancer is, potentially, an operable and curable disease; however, many patients are not able to undergo a surgical procedure due to a variety of factors such as low pulmonary function, illness or other age-related variables. Here at UCLA, SBRT is being used for Stage 1 lung cancer patients ineligible for surgery because it allows for an increase in dosage with a lower side effect profile. In an article recently published in the Journal of the American Medical Association data was presented from the first North American cooperative group trial of SBRT. In this trial 55 patients with medically inoperable peripheral tumors (non-small cell lung cancer stages 1A and 1B) were given three treatments of SBRT. They had tumor control in 98% of the patients, 72% survival at two years and a median overall survival of 48 months. The question has been raised whether the SBRT treatments in these lung patients is equivalent to doing a non-surgical wedge resection; however, SBRT appears to have better local control and regional control at 4 years. We are continuing to follow these patients. This type of treatment has raised the control rates from 30% with traditional radiation therapy to 90% in lung cancer patients who receive SBRT. Likely, this is because the biological dosage of radiation has been significantly increased.

Effects of SBRT in HCC:

This type of treatment is also being used in certain types of liver cancers as well. While surgery is possible in less than 15% of patients with hepatobiliary cancer, SBRT appears to be an effective non-surgical alternative. Further, it can be used to treat the tumor without creating some of the side effects of traditional radiation therapy creates in the liver such as radiation-induced hepatitis. SBRT is also being used to help control the cancer so that patients are able to get on the liver transplant list. Some patients who are not surgical candidates may become surgical candidates after such treatment. There is preliminary evidence to suggest that patients treated before liver transplant have a lower rate of recurrence and potentially some patients are cured, whereas this disease was previously thought to be highly incurable.

While lung and liver are only two examples of cancers where SBRT seems to be improving treatment strategies, there are other cancers that are also being considered and will likely be addressed in this manner in the future.

Patients sometimes hear about these treatments through advertisement by treatment centers indicating that they have a particular state of the art machine. There are many manufacturers of these machines that offer this type of treatment, such as the Novalis TX and Cyberknife. They have different names, like luxury cars such as BMW and Mercedes Benz. UCLA has the Novalis TX machine. The most important consideration is, as with driving a car, having someone who really knows the technology. Just as with driving a car, having someone who really knows how to use the machine. Just because a treatment center has a special machine does not insulate that they have well-trained and experienced physicians using them. It is an important part of the equation to have improved technology but the human variable is critical. Mistakes often happen when technology is not being appropriately used by individuals and human judgment is not emphasized.

Safety is an important consideration in any radiation environment. Just as airline pilots go through a safety checklist with another pilot before take-off, similarly safety checklists are needed when using advanced radiation procedures. Data suggests that the use of these checklists helps reduce the number of mistakes that happen that are sometimes reported in the news.

We are making significant advances in radiation oncology and are now able to use increasingly more precise and safe treatments to map and treat cancer. And, we are expanding our understanding and application of SBRT and other radiation therapy approaches in radiation oncology every day. As Atul Gawande, MD, from Brigham and Women’s Hospital – Harvard Medical School has written in his books, “Better is possible. It does not take genius. It takes diligence. It takes moral clarity. It takes ingenuity. And above all, it takes a willingness to try.”
loving bond. As the children move past the death, helping them to hold these attachments and memories will be important.

Children who go through a parent’s cancer experience and ultimately lose their parent actually know loss because they are managing it throughout the process. It can be helpful to remind them of the strength and coping skills that they have developed that will serve them as they move forward. Parents have a lot of responsibilities during difficult and challenging times but they also provide opportunities. It can be helpful for ill parents to write letters to their children to have as representations of their love and concern for them. These legacies are often incredibly helpful to children as they mature in the absence of a parent. They serve as transitional objects and representations of attachments. In these legacies children can be told that the ill parent wanted them to enjoy life and to live fully which can help alleviate their guilt over re-engaging in life for fear of being disloyal to their parent. It can also be a communication about values. See my article in the previous newsletter which is about legacies and ethical wills. Engaging in this process can be so important for children after the loss of a parent.

Professional Assistance
Parents and children often benefit from a consultation with a well-trained psychologist or social worker with knowledge of cancer and child development. The psychologist can help parents make decisions about how and what to say to children, problem-solve any special needs of the children in a particular family, and help evolve a resolution that makes the most sense. In these consultations, the parents’ knowledge of their family and their children is combined with the experience of the professional.

The Simms Mann Center is currently piloting a program and seeking additional funding to offer education to parents as well as help children process their experiences dealing with a parent who has cancer. We arrange meetings for parents and children to meet with a psychologist followed by individual meetings with each of the children and another meeting with the entire family. This often sheds light on the needs and questions of the children that the parents may not have been able to discern or that the children were not able to verbalize. These meetings do not have to become ongoing therapy meetings but may be important at transition times or even to just assess where things are in a particular family. Sometimes drawings are made during these sessions.

Professional assistance can lead to the identification of issues that need to be addressed within a family, but it can also help identify when a child might need some extra evaluation or therapeutic contact to help them manage the unique difficulties that they are facing. I want to encourage parents to bring their concerns forward as only through this process can the needs of everyone in the family be accurately identified and solutions found. Children are often very resilient; with small amounts of assistance along the way their resilience can be fortified. Our families who have made the choice to come in have inevitably shared with us that it was valuable and helpful to them. It is not stigmatizing. Children often see it as part of being included in the overall care of the family by the comprehensive medical team that is treating their parent.

Many years ago, I was interviewed on television about these types of services. As it turned out the father of one of my children’s friends happened to see the show. He had lost his mother as a child. He called me in tears and told me about his loss, about which I had never known. He expressed such gratitude for the services that we are offering, that nothing like that had been available when he was a child and how immensely helpful it would have been for him and for his mother. The cancer experience is powerful in families but so, too, can be support and assistance. We would be happy to help your family navigate the best course possible through this extraordinarily challenging time.

Anne Coscarelli, Ph.D.

When you are dealing with cancer and the effects of cancer treatment, the last thing you or your family needs to worry about is if you can afford the services that you need. Almost all of our services are offered without fees and insurance companies would not cover them, yet we know care for the whole person is essential. In order to maintain our programs we need voluntary donations from you, your friends, and your family. Voluntary donations of any and every size are meaningful and necessary.

Fortunately, we survived the downturn in the economy thanks to some estate gifts! However, we need your ongoing assistance, now more than ever, to keep this program available to the next patient who enters our doors. It costs approximately $1,000 per patient or family member that we see each year. We have initiated the One-to-One Club; members make annual donations of $1,000 or more depending on how many individuals they wish to sponsor for the next year. Please consider joining this important group of donors!

If you cannot make as substantial a gift as you would like, please give what you can; other donors like to know that everyone values and gives back to the Center. There may be people within your network who might be able to help support us. You could be an important conduit to company giving, foundations or even a collection of caring and compassionate individuals who want to help support you through this experience and others like you. We are asking you to look at people you know and ask them to contribute with you or contribute on your behalf. The Simms/Mann Center is not endowed and we depend on your generosity.

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You may designate your gift for general operational support; to help underwrite the costs of any of our programs: support groups, Insights Into Cancer lectures, newsletter production and mailing, and/or Reflections.

WHAT FORMS MAY MY GIFT TAKE?
Gifts and pledges may come in the form of cash, checks, and securities. We also accept Visa, MasterCard and American Express as forms of payment. We gladly accept matching gifts from your place of employment. Gifts can be given in honor and in memory and we encourage people to do this. Estate planning is also essential to our existence, now and in the future. Please talk to us about incorporating us into your long term estate plans and become part of UCLA’s Second Century Society.

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SKIN CHANGES AND CANCER TREATMENTS: TIPS FOR HEALTHY SKIN AND HAIR

CAROLYN GOH, MD, CLINICAL INSTRUCTOR, DEPARTMENT OF MEDICINE, DIVISION OF DERMATOLOGY, DAVID GEFFEN SCHOOL OF MEDICINE AT UCLA, AND JENNY KIM, MD, PHD, ASSOCIATE PROFESSOR OF MEDICINE DEPARTMENT OF MEDICINE, DIVISION OF DERMATOLOGY, DAVID GEFFEN SCHOOL OF MEDICINE AT UCLA

This is a summary of a lecture presented on September 14, 2010.

INSIGHTS INTO CANCER

Why address issues of the skin?

It may seem obvious, but both patients and physicians often do not address the issue of skin care as part of regular cancer care. Cancer and its treatments often impact skin quality, especially when there are appearance changes and discomforts such as pain and itching. Most important- ly, skin changes that cannot be controlled might lead to a dose adjustment of medication, which may alter the likelihood of optimal response to therapy.

There are many causes of skin changes in patients with cancer. For some patients the skin changes are related to the malignancy itself including metastases, primary cancers and some immune disorders. They can also be related to cancer therapy as well as non-cancer therapy conditions. For instance, they can be related to cancer therapy as the skin changes are related to the malig- nancy. For example, the skin may change color, texture, or thickness. It can also be related to non-cancer therapy as the skin changes might lead to a dose adjustment of medication.

Why address issues of the skin?

It is important to have an accurate diagnosis and to understand what may be causing the skin changes.

Cancer Therapy and the Skin, Hair, and Nails – Dr. Carolyn Goh

There are 52 distinct skin toxicities that have been reported as a result of 41 unique chemotherapies. This includes chemotherapy, radiation therapy and newer targeted agents. The two agents that cause the most skin toxicities include cetuximab (Erbitux) and sorafenib (Nexavar). Both traditional chemotherapies and the newer targeted treatments can affect skin, though the profile of side effects may be different. Skin, hair and nails are affected by therapy because they have rapidly dividing cells; cancer tends to also have rapidly divid- ing cells so chemotherapy can target these cells. The skin, hair and nails be- come innocent bystanders. Radiation can have direct toxic effects on the skin as can chemotherapy that leaks out of the IV and has contact with the skin. The newer targeted therapies that block the epidermal growth factor receptor (EGFR) to inhibit cancer cells from growing also affect the skin because EGFR is crucial for the normal development and physiology of the skin (epidermis). Blocking EGFR receptors can affect the cells of the epi- dermis (skin), causing inflammation and sensitization of the epidermis to ultravo- let (UV) radiation.

Changes in Hair

Alopecia (hair loss) is a common side ef- fect for many but not all chemotherapy agents. Hair has a natural cycle that in- volves three phases of growing, resting and falling out. Not all hair is synchro- nized on the same cycles, which is why hair is maintained. Usually about 90% of hair is in the active growing phase and these are the ones that are affected by chemotherapies that affect rapidly divid- ing cells. Hair usually starts to fall out about 4 weeks after stopping therapy and completely in 1-2 months. It mostly affects the scalp, but can also affect eye- lashes, eyebrows and beards. It is usually reversible and hair re-grows 3-6 months after stopping therapy. Hair may be dif- ferent in color, structure and or texture. Sometimes the density of the hair may re- main low after chemotherapy. There are only a few cases of permanent hair loss reported. When permanent hair loss oc- curs it may be due to some other process that is unrelated from the treatment.

Combination therapy is more toxic and the duration and intensity of the treat- ment are also factors in hair loss. Anti- microtubule agents, such as paclitaxel, cause hair loss 80% of the time. Topoi- somerase inhibitors, such as doxorubicin (Adriamycin), cause hair loss 60-100% of the time. Alkylators, such as cyclo- phosphamide (Cytoxan), cause hair loss in 60% of the patients who receive it. Antimetabolite chemotherapy, such as 5-fluorouracil (5-FU), causes hair loss about 10-50% of the time. Epidermal growth factor receptor inhibitors, such as cetuximab, can only cause hair loss 5-6% of the time.

Radiation therapy can also cause alopecia in the area that is irradiated. Sometimes radiation causes scarring and, therefore, the hair loss in a particular area can be- come permanent. Some patients have experienced a delayed response 4-6 months later in which the stress of the treatment causes the phases to become synchronized for all hair and their hair all falls out. It is usually temporary. Many patients facing hair loss want to know if any treatments prevent or lessen the severity of hair loss. Scalp cooling caps have been used, but are not recom- mended in leukemia or lymphoma and there is some concern about the possi- bility of scalp metastases. These cooling caps may induce headaches, claustro- phobia and discomfort due to the cold. Microcool (Proxima) can also be helpful and it comes in 2% or 5% solutions or 5% foam. The 2% solution was found to decrease the severity and/or shortened the duration of hair loss in some patients. There are more side effects for women than for men. Other coping strategies in- clude hats, scarves, wigs and hairpieces.

Hypertrichosis/eyelash trichomegaly is a condition in which the eyelashes enlarg- e to grow. They do not stop and tend to grow quite long and often become a bit unwieldy and out of control. It appears 100 days after starting EGFR inhibitors. Patients who develop this should have an ophthalmology evaluation because they are at an increased risk for corneal ulcerations, which is also increased by contact lens use. It may persist through treatment and may not stabilize, thus the eyelashes continue to grow.

Common Side EFFECTs of the Skin

A rash known by a variety of names, including papulopustular eruption, can develop with some treatments. It is most notably associated with epidermal growth factor receptor inhibitors (EGFRi) and occurs in 60-80% of patients. It can also occur in monoclonal antibody thera- peutics (treatments in which the name ends in “ab”) and in tyrosine inhibitors (treat- ments in which the name ends in “ib”). It can be associated with taxanes and steroids. When it appears in conjunction with EGFRi, the severity of the rash is ironically associated with better tumor response. It is usually, bumpy, red and the bumps can be filled. It tends to develop on the face, chest, back, scalp, palms and soles. It may or may not be itchy and/or tender. It is often dose de- pendent; the higher the dose, the greater the rash. Lesions occur within 1-3 weeks of the initiation of the EGFRi therapy. The maximal skin toxicity occurs by 3 to 5 weeks. Lesions tend to resolve within 4 weeks of EGFRi cessation. Spontaneous improvement or stabilization of lesions can occur with continued EGFRi therapy.

There are a variety of treatments depend- ing on the severity of the rash. Topical applications of hydrocortisone and clin- damycin are often used for mild forms. More significant forms may require the use of systemic antibiotics and very se- vere forms may need a short course of steroids. Make-up is often used to cover it when it occurs on the face. Collodial oatmeal lotion is also helpful as are topi- cal steroids. Pre-emptive treatment has also been shown to be beneficial. For ex- ample, patients on cetuximab who also took 100 mg of minocycline once a day experienced less severe rash during their first month of treatment. For patients on panitumumab there was a 50% risk redu- ction in developing more severe (grade 2 or worse) rash by following specific steps that included the following steps:

• Using a skin moisturizer and applying it to face, hands, feet, neck, back and chest each day in the morning upon arising.
• Sunscreen that is PABA free with an SPF greater than or equal to 15 with both UVa and UVb protection should be applied to exposed skin areas before going outdoors.
• Topical steroid (1% hydrocortisone cream) can be applied to the face, hands, feet, neck, and back at bedtime.

Topical steroids can be used for mild forms of rash and will usually take effect within 24 hours. Topical steroids can be used for mild forms of rash and will usually take effect within 24 hours. Fortisil (5-fluo- rouracil), doxorubicin, and methotrexate) can cause hand-foot syndrome, another significant skin effect. It occurs in 6-42% of patients and is characterized by red, burning, tender lesions on the palms and soles. Blisters may develop and the risk increases with higher dose chemotherapy, cumulative doses, in- creased age and when used in women. It happens due to secretion of the medi- cation in eccrine glands. Eccrine glands (or merocrine glands) are the major sweat glands of the human body, found in virtually all skin. Hand-foot syndrome is treated with regional cooling topical moisturizers, urea, corticosteroids, and dose modification.

There is a slightly different hand-foot syn- drome associated with targeted therapies such as sorafenib (Nexavar) and sunthinb

• Doxycycline (100 mg) can be taken twice a day.

When a dermatologist sees a patient with these rashes they are categorized into 4 levels of severity which include:

• Grade I: Pustules covering less than 10% of body surface area which may or may not be associated with symptoms of pruritus (itch) or tenderness.
• Grade II: Pustules covering 10-20% of body surface area which may or may not be associated with symptoms of pruritus or tender- ness; associated with psychosocial impact limiting instrumental activities of daily living.
• Grade III: Pustules and/or pustules covering greater than 30% of body surface area which may or may not be associated with symptoms of pruritus or tenderness; which may or may not be associated with symptoms of pruritus or tenderness; limiting self-care and activities of daily living; associated with local super-infection with oral antibiotics indicated.
• Grade IV: Pustules and/or pustules cov- ering any % of the body surface area which may or may not be associated with symptoms of pruritus or tenderness and are associated with extensive super-infection with IV antibiotics indi- cated; life threatening consequences.

In summary, treatments include counsel- ing about the condition and self-care of the skin, doxycycline or minocycline twice per day at 100 mg, mometasone cream (topical steroids) twice per day for 2-3 weeks, a transition to topical pimecli- mucus or tacrolimus (steroid sparing cream) for the face, higher potency topical ste- roids for non-facial skin, and a wash for the face that is used as an acne treatment called sodium sulfacetamide wash.

Some chemotherapies (cytarabine, 5-flu- orouracil, doxorubicin, and methotrexate) can cause hand-foot syndrome, another significant skin effect. It occurs in 6-42% of patients and is characterized by red, burning, tender lesions on the palms and soles. Blisters may develop and the risk increases with higher dose chemotherapy, cumulative doses, in- creased age and when used in women. It happens due to secretion of the medi- cation in eccrine glands. Eccrine glands (or merocrine glands) are the major sweat glands of the human body, found in virtually all skin. Hand-foot syndrome is treated with regional cooling topical moisturizers, urea, corticosteroids, and dose modification.

There is a slightly different hand-foot syn- drome associated with targeted therapies such as sorafenib (Nexavar) and sunthinb
Paronychia is inflammation of the areas around the nails, which have darkening under their nails from destruction result from acute stress on the nail such as Beau’s lines and hyperpigmentation in the nail, brittle nails, loss of nails, and eczema. Common nail changes in cancers, capecitabine, bleomycin, hydroxyurea (Sutent). In this condition, the inhibition of growth factor receptor proteins may prevent the development of skin in high-pressure areas which are often exposed to a low level subclinical trauma. It develops 2-4 weeks after the onset of therapy and is more likely to occur when there is a combination therapy. Before treatment with these agents it is important the patient have a consult with a podiatrist and a dermatologist. If there is abnormal weight bearing on certain parts of the feet it may be a good idea to get orthotics. Also reduce exposure to hot water (i.e., dishwashing and baths). Reducing calluses may reduce potential risk. During the first month of therapy it is a good idea to prevent trauma by resting and wearing thick cotton socks and gloves to minimize trauma. Once symptoms start, urea cream and salicylic acid can be helpful. In addition, topical corticosteroids, topical analgesics, and non-steroidal anti-inflammatories, such as Advil and Motrin, are also beneficial. Patients may need a podiatrist consult for treatment management. This syndrome has not been found to be related to the efficacy of the treatment. Fissures can develop in localized areas such as the tips of the fingers and heels. It usually starts around the third week with EGFRIs. It is important to use thick moisturizers (creams rather than lotions) at least twice daily. Liquid bandage, Krazy Glue or Dermabond are sometimes used to fill the fissures and reduce discomfort.

Nail Changes
Nail changes are common with the taxanes, capetitabine, bleomycin, hydroxur-ea and EGFRIs. Common nail changes include Beau’s lines which create a groove in the nail, brittle nails, loss of nails, and hyperpigmentation. Non-specific changes such as Beau’s lines and hyperpigmentation result from acute stress on the nail matrix where the nail grows. Approximate half of all individuals who have dactylitis and pedalxite lose their nails or have darkening under their nails from debris, blood and pus under the nails. Paronychia is inflammation of the areas around the nails. It develops in 12-58% of patients on EGFRIs. It usually occurs after 4-8 weeks of therapy, is associated with dryness of the skin, and it usually impairs daily activities.

Taxane-induced nail changes are sometime -times prevented or reduced with frozen gloves worn 15 minutes before adminis-tration of taxane, during the one hour infusion, and for 15 minutes after. Moisturize and gentle hand and foot care are important.

EGFR nail changes benefit from moisturiz-er and many oncologists recommend that you refrain from manicures and pedicures as well as any "wet" work such as dishwashing, vinegar soaks (1 part water to 1 part white vinegar) for about 5-10 minutes daily can be helpful for both taxane-based and EGFR-based nail conditions. Beau’s lines usually resolve with time.

In sum, there are many cancer therapies that affect the skin, hair and nails. Common treatments are associated with a higher risk of developing most reactions. Preventative measures can be taken and treatments are available. Studies are cur-rently ongoing, particularly for hand-foot syndrome and papulopustular eruption, in order to improve treatment options.

Tips for Healthy Skin

What are the basic issues of normal aging and skincare? There are two major factors of associated with aging skin. The first are the intrinsic ones which are genetically programmed, occur with time and differ significantly by individual. There is nothing to be done about these. The extrinsic factors include environment-al factors such as ultraviolet radiation, pollution, harsh weather and smoking as well as medical factors such as surgery, chemotherapy, radiation and medication. Aging in the face can come from surface damage such as brown spots, broken vessels and lines. Soft tissue changes in-clude thinning of the skin, less collagen, loss of elasticity, and the loss or gain of fat. Muscle changes can lead to wasting and atrophy. Winter and seasonal changes include coarsening of bony prominences or loss of bone such as in the jaw.

Dry skin care is very important. Skin can be protected by not showering too fre-quently as this washes away the body’s natural good oils. Warm showers are better than hot water showers because fewer oils are washed away. Skin cleansers should be used rather than soap because cause soap has drying effects. When dry ing off after a shower it is better to pat the skin dry lightly rather than rubbing it vigorously. Applying emollients on the skin helps to maintain moisture. Creams are better than lotion because they are thicker and hold in more moisture. Con-sider using extra treatment at night. Use with tenderness and high dry areas overnight such as on the lips, feet and hands. Wearing cotton gloves or socks over the ointments help to keep them on the skin, providing more protection.

Skin has a circadian rhythm. Oil produc-tion is highest at noon. The temperature of the skin is higher at night and, therefore, there is more washing off at night. Thus, it makes sense to replenish mois-ture more in the evening.

Sunsans may look nice but they are not good for your skin. They are the single most aging event that affects your skin. Sun tanning became popular in 1923 when Gabrielle “Coco” Chanel was seen sitting on Duluth’s yacht, “Le Jour”, from Paris to Cannes. Ultraviolet B rays (UVB) cause immediate sunburn. Ultra violet A rays can cause chronic aging. Our skin is like a grape; when put in the sun it becomes wrinkled and old looking like raisins. There are many harmful ef-fects of the sun plus it down regulates the immune response. Sun ages the skin titanium, uneven complexion or pigmentation and can give the skin a leathery texture. It can also cause eye damage such as cataracts. Sun exposure causes skin cancers such as melanoma, basal cell and squamous. Higher-dose sun is important. It is important to note that not all melano-mas are related to sun exposure and there is a growing interest in the genet-ics associated with BRCA genes and their association to melanoma.

It is very important to protect your skin from the sun. To do this, avoid direct sun especially between 9 am and 4 pm. Wear protective clothing including hats, covers and sun glasses. Sunscreens should include protection for UVA and UVB rays. They now make clothes that are tightly woven to reduce sun exposure and there is soap that can be put into clothes that increases its SPF factor. The best sun protection comes from physical blockers that contain micronized zinc and titanium. Better, Parsol 1789 and Mexoryl are also important. Always use an SPF of 15 or greater. Apply sunscreen every 2 hours when outdoors and use sunscreen daily. Do not ever use sunlamps or tanning beds. No matter what you have heard, no tan is safe. In addition, examine your skin regularly and see your dermatologist for skin checks.

Many people wonder whether topical applied to the skin can help with reduc-ing the impact of already damaged skin. There are a variety of these including retinoids, hydroxy acids, growth factors, peptides, and antioxidents. The retinoids are the most superior products.

Does Eating Healthy Help the Skin? There are no studies that suggest that eating specific foods will help to reduce damage caused by the skin, but healthy eating helps your organs and body be healthy. Your skin is important and is the largest organ of your body. Yes, your skin is an organ! Vitamin A, found in foods such as liver, milk and eggs is the most biologically active. Carotenoids (provita-min A) are found in foods such as carrots and other colorful vegetables and fruits. All of these foods are part of a healthy diet. Vitamin A helps with reversing photo damage, increases collagen and the anti-oxidant effects it helps to reduce wrinkling, but these benefits are most likely found when it is applied directly to the skin.

Vitamin C (ascorbic acid) is found in citrus fruits and dark leafy vegetables. Vitamin C is a co-factor for collagen and elastin synthesis. It is also an anti-oxidant and increases collagen I and III. No clinical research to date has established that Vi-tamin C is good for the skin, but it is impor-tant in an overall healthy diet.

Vitamin D is found in liver, beef, and egg yolks. Large amounts are found in oily fish such as wild caught salmon. Vitamin D3 can be synthesized from 7-dehydrocho-lerol in skin melanocytes and UVB exposure; however this also creates the risk of sun damage. Many people are vita-min D deficient and it is needed for good bone health. Research indicates that indi-viduals who have sufficient vitamin D levels have fewer falls. Vitamin D3 is being given in higher doses than ever to elevate and sustain people’s levels because of the many health benefits that good vitamin D levels are associated with, including re-ductions in cancer and osteoporosis. Vita-min D appears to have benefits for bones, heart, cancer risk and the immune system. Vitamin D levels are affected by skin color (darker skin is equated with lower D levels in the blood serum), latitude, diet and sun exposure. The US government is currently recommending significant lower levels of Vitamin D than America’s population need. There is a growing consensus that individuals need between 2000 and 4000 IUs per day. It would require drinking 40 glasses of milk per day to get 2000 IUs of vitamin D. There are no large controlled studies to demonstrate clinical efficacy of oral vitamins and antioxidants in skin rejuvenation or reversal of photo aging of the skin. However, your skin reflects your health and well-being; vitamins (often found in a rich and healthy diet) are im-portant for your health.

There are a variety of age-related skin problems and skin disease that can de velop including actinic keratosis (scaly or crusty bump), melanoma, non-melanoma skin cancers (such as cherry angiomas (small red bumps, vascu lar in nature), seborrhea keratosis (raised growth), lentigines (sun spots or liver spots), pruritus (itching), bullous pemphigoid (chronic blistering of the skin), herpes zoster (shingles), xerosis (abnormal dryness), purpura (red or purple spots) and rhhytides (wrinkles). There are many common non-surgical and aesthetic treat-ments that are used including botulinum toxin, fillers, laser hair removals, micro-debmareation and laser skin rejuvena-tion. Approximately 10 million of these treatments are performed each year. Bro ken blood vessels in the face are treated with pulsed dye laser or an intense pulse light (IPL). Freckles are treated with lasers, IPL, liquid nitrogen and chemical peels. Botulinum toxin is injected into the bunny lines on the nose, lip lines, the chin, the lower mouth, neck and fine lines in the forehead. Fillers can be used to improve the shape and size of lips. Col-
MAKING THE TRANSITION FROM CANCER PATIENT TO CANCER SURVIVOR

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This is a summary of a lecture presented on June 15, 2010.

There are currently approximately 12 million Americans who have a previous history of cancer, equivalent to approximately 3.7% of the United States population. Each year approximately 1.5 million people are diagnosed with cancer, 1 million of those will be treated with intent to cure. Many of these people will go on to have cancer free survivals, with some being managed as a chronic disease or having intermittent episodes of disease recurrence. We anticipate the number of cancer survivors will increase sharply during the next 25 years as baby boomers live past 65 years old, the peak years when cancer is diagnosed. These individuals are the ones towards whom survivorship care needs to be most pointedly directed.

Cancer treatment is particularly complex, expensive and often involves using multiple modalities, e.g., surgery, radiation therapy, chemotherapy and now more novel targeted therapies. Each of these treatments has its own unique late effects and toxicities. Because treatment is multimodal there are many specialists involved in the care of patients with cancer; on average at least three specialists per patient. The outcome of having such a large multi-disciplinary team is that care is not always well coordinated among the specialists. Treatments are often given across time and in a variety of settings that will be reflected in the medical record. All of this may have had relatively simple treatment but survivorship care needs to be more refined and updated.

One potential solution is to make certain that every patient has a survivorship care plan. The purpose of a such a plan is to (1) summarize and communicate what transpired during cancer treatment, (2) to describe known and potential late effects of cancer treatments and the expected time course, (3) to communicate to the survivor and other health care providers what has been done, (4) determine what actions to be taken in the future, and (5) promote a healthy lifestyle to prevent recurrence and reduce the risk of other co-morbid conditions.

The key elements included in a high quality survivorship care plan are:

- Specific tissue diagnosis and stage
- Initial treatment plan and dates of treatment
- Description of specific treatments completed
- Toxicities during treatment
- Expected short- and long-term effects of treatment
- Monitoring that is needed for the detection and treatment of late toxicities
- Surveillance for recurrence or second cancer
- Who will take responsibility for survivorship care such as mammograms, bone density scans, etc.
- Psychosocial needs that often do not arise until after treatment is over or changes as the individual begins to return to their previous life
- Vocational needs
- Recommended preventive behaviors/interventions

In 2006, the Institute of Medicine (IOM) issued a report related to cancer survivorship entitled From Cancer Patient to Cancer Survivor: Lost in Transition. The importance of continuity of care and these survivorship care plans were an emphasis of the report. This creates a customized, post-treatment care plan for cancer survivors in five quick steps. There is also a patient toolkit. The Survivorship Care Plan can be printed, saved, edited or emailed.

A survivorship care plan is important for all cancer patients, even those who may have had relatively simple treatment because it provides information about follow-up care as well. It is especially helpful for those patients who may have temporarily left their primary care physician for their oncologic care and it helps re-establish care with the primary care physician.

At UCLA, the UCLA-LIVESTRONG™ Survivorship Center of Excellence is testing models of survivorship care at the UCLA Medical Center and three community collaborators (Tonrance Memorial Medical Center, Health Care Partners Medical Group, and UCLA-Olive View Medical Center). The focus is on the development and evaluation of diverse models of cancer survivorship health care delivery. At UCLA, one program available to cancer survivors is the VITA program, which stands for “Virtual Information and Tailored Assessment.” This program is usually a one-time visit during which the patient meets with a psychologist or oncology social worker (from the Simms/Mann UCLA Center for Integrative Oncology), a nurse practitioner and a medical or pediatric oncologist. The key activities during the evaluation include:

- Survivorship consultations and the development of care plans for adult survivors of cancer. This includes obtaining the medical records and summarizing treatments and making recommendations for care, surveillance and follow-up.
- A long-term follow-up clinic for child-hood cancer survivors in which the pediatric oncologist works to provide ongoing care and follow-up along with other members of the team.
- Consultations and coordination of care for adult survivors of childhood cancer including care plans and recommendations for follow-up care.
- Symptom management for cancer survivors.

The goal of these consultations is to help coordinate care with the primary care physician by using the treatment summary and survivorship care plan as a focus. Because patients also get a copy of the treatment summary and care plan they can become empowered to advocate for their needs and initiating communication with their physicians as well.

Determining when long-term survivorship begins is a bit of a definitional problem, but survivorship planning should begin at the moment of diagnosis when treatment decisions are being made. Treatment summaries should be done when treatment ends with the idea that they can be updated should there be a recurrence or additional treatment. Dr. Ganz has three P’s of survivor care that should be the primary goals:

- Palliation
- Prevention
- Health Promotion

Unfortunately, palliative care is often a focus only when cancer is progressing and is often thought of as part of a progression toward end of life care. Palliative care, however, is symptom management and should be an integral part of survivorship care regardless of the presence of disease. Palliative care is medical care or treatment that concentrates on reducing the severity of disease symptoms. The goal is to prevent and relieve suffering and improve quality of life for people facing complex illness. The most common palliative care concerns that face survivors are:
• Pain
• Fatigue
• Depression
• Physical limitations
• Cognitive Changes
• Lymphedema
• Sexual dysfunction
• Menopause related symptoms
• Body Image

Depending on the kinds of symptoms and difficulties that are ongoing, it is often helpful to get consultation from a variety of specialties. Some of the common specialties that are utilized include mental health, pain management, physical medicine/vocational rehabilitation, endocrinology, cardiology, gynecology/fertility, pulmonary and neurology/neuropsychology.

Prevention and health promotion are also important areas to consider. The goal is to screen where appropriate and to detect, as early as possible, any serious or late-onset complications along with initiating early interventions for such illnesses as cataracts, osteoporosis, and cardiac disease. Chemoprevention may be relevant for prevention of second cancers when available. Life style modification is important to prevent second cancers. The goal of health promotion counseling is to reduce risk for health problems that commonly present during adulthood, especially for childhood cancer survivors.

The most important health promotion activities include avoiding weight gain and maintenance of a healthy body weight, increases in physical activity, avoiding harmful exposures and decreasing your risk of other chronic diseases such as diabetes and heart disease. The ultimate goal is to improve medical outcomes and help survivors get appropriate health care.

The mission of the UCLA-LIVESTRONG™ Survivorship Center of Excellence is to facilitate improvements in the quality of life and quality of care of cancer survivors, in the Los Angeles region and beyond.

One of the keys to good care is being able to effectively navigate the medical follow-up care that is provided. Each survivor’s journey is different and these differences need to be respected. Each survivor’s medical needs are also different and these differences call for individual planning of care. What may work best for one person may be different for another. For example, patients who have a particularly complex cancer with a high likelihood of recurrence might be better served by follow-up from a particular specialist. However, someone with a more common cancer, or someone who has many other medical problems with difficulty getting to multiple specialists, may benefit from having a primary care physician coordinate their care and refer out only as needed for specialized care that the primary care physician cannot provide.

It used to be that patients were either seen by their many cancer doctors on a regular basis forever after diagnosis or the patients were lost to follow-up. The newer approach allows patients and their doctors to work together to develop an individualized approach to their cancer follow-up care. Which is the more appropriate care scenario?

On the one hand, cancer specialty care provides continuity with cancer treatment, expertise with cancer and experience caring for many patients with similar issues or problems. On the other hand, primary or geriatric care provides continuity with overall treatment, health care and expertise and experience with medical issues unrelated to cancer. Primary care doctors are skilled at managing patients who also have multiple medical issues. Scientific studies have shown that well trained primary care physicians and/or a nurse practitioner/physician assistant can provide equivalent care to cancer specialists for follow-up care of cancer survivors. This is especially true for the most common types of cancer.

Unfortunately, in the real world not all patients get the recommended care they need, even when seeing specialists, but they are more likely to get recommended care from cancer specialists than primary care doctors. It is also true that in the real world many cancer survivors get essentially no cancer follow-up care. One study found that 30% of elderly breast cancer survivors were not getting routine mammograms, despite being insured.

There needs to be a balance within cancer follow-up care. To achieve the best care, having a team approach might be the best plan.

Surveillance is an important part of follow-up care to identify potential recurrence, second cancers and late effects both medical and psychosocial. Let’s consider three of the most commonly occurring cancers and the kinds of evaluations and tracking that should be done on a regular basis by a good primary care doctor:

**Breast Cancer**
- Regular mammograms and breast exams to identify second primary breast cancers and recurrences.
- For patients who were diagnosed before genetic tests were actively being used, a review of whether tests for breast and ovarian cancer (BRCA) genes should be done. Patients found to have a breast and ovarian cancer gene require specialized care for themselves and their families.
- Monitoring and treating related side effects such as:
  - Osteoporosis
  - Uterine cancer
  - Lymphedema
  - Cardiovascular disease
  - Cognitive dysfunction
  - Depression
  - Fatigue
  - Weight gain

**Colon Cancer**
- Serial colonoscopy to identify second primary colon cancers and recurrences
- CT scans for high risk patients to detect potentially curable recurrences earlier
- For patients who were diagnosed before genetic tests were actively being used, a review of whether tests for colon cancer genes should be done.
- Patients found to have a colon cancer gene (for example, genes associated with Lynch Syndrome) require specialized care for themselves and their families.
- Monitoring and treating related side effects such as:
  - Neuropathy
  - Diarrhea
  - Fatigue
  - Depression

**Prostate Cancer**
- PSA testing and potentially digital rectal exam to identify recurrences
- Monitoring and treating related side effects such as:
  - Erectile dysfunction
  - Urinary incontinence
  - Depression

When considering surveillance one issue that comes up for debate among different groups of physicians is how much testing should be done to look for recurrence. Using breast cancer as an example, some argue that every possible test should be done at regular intervals. Some even suggest that this creates greater peace of mind for the patients; however, this is not always the case. For some patients the stresses of monitoring increase worry about fear of recurrence as well as creating greater exposure to the various aspects of medical testing and the medical environment. A 1999 study looked at two different monitoring modalities in 1,263 breast cancer patients who were randomized to two groups. One group received intensive testing (essentially everything anyone could think of) while the other group received routine clinical follow-up. The survival curves were identical; intensive testing did not lead to increased longevity. Thus, more is not always better.

It is important not to be so focused on detecting a cancer recurrence that other preventive health care is skipped. Routine health care for non-cancer related conditions needs to be continued. It is also important that your health care team understand your values about end-of-life care (whether or not cancer is active) and that there is a shared understanding and values. Finally, good health care should be flexible and change if the situation changes.

The keys to making successful transitions in care and beyond include the following:

- Identify a team of healthcare providers with roles that provide sufficient:
  - Expertise
  - Accessibility
  - Affordability
  - Coordination of care

- Communication is essential both with the patient and with other specialists.
- Develop and carry out a survivorship care plan. It is very important that all doctors involved in a patient care understand the patient’s cancer history, including the treatments that were used. Having a survivorship care plan can really facilitate this communication.
  - Include all elements of recommend-ed surveillance, if appropriate.
  - All patients need to be educated and monitored for symptoms of recurrence, as well as late effects (both medical and psychological) of treatment so that symptoms can be treated appropriately.
  - Stay flexible to address needs as they change.
LUNG CANCER 2010: ADVANCES IN TREATMENT

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This is a summary of a lecture that was presented on October 12, 2010.

Lung cancer is the most common cancer in the world. There are approximately 1.3 million new lung cancer cases per year worldwide. Lung cancer accounts for about 15% of all new cancer diagnoses in the United States. Men have a 1 in 13 lifetime risk for developing cancer of the lung and bronchus; women have a 1 in 16 risk of developing cancer of the lungs. It is estimated that in 2010, 215,020 people will diagnosed with lung cancer in the United States. Lung cancer occurs when normal cells in the lung grow out of control and form a mass or tumor, no longer functioning as normal lung tissue cells anymore. There are two main types of lung cancer, non-small cell lung cancer and small cell lung cancer. The one-year relative survival for lung cancer was 41% in all stages during 2000-2004. The five year survival rate for all stages combined was 15% during 1996-2004. When the disease is detected early (still localized) the overall survival rate is 50%. Unfortunately, only 16% of lung cancers are diagnosed at this early stage. Lung cancer is the leading cause of cancer death in every ethnic group. The five year survival rates for breast, prostate and colon cancers which have widely accepted screening tests (mammogram, PSA blood test, colonoscopy) have gone up significantly.

Tobacco and second hand smoke are primary risk factors for lung cancer. In addition, exposure to asbestos and radon are also risk factors. Most people who develop lung cancer today have either stopped smoking years earlier or have never smoked. Nearly 80% of new lung cancer cases are former and never smokers. The concern for women and lung cancer has recently emerged from out of the shadows. Lung cancer kills more women than any other cancer — nearly 200 women each day. Most die within a year of diagnosis. Yet lung cancer remains the "hidden" women’s cancer with little known about it and rarely discussed. It is the least funded cancer in terms of research dollars per death of all of the major cancers and one of the only cancers where patients are routinely blamed as responsible for their condition. Lung cancer overtook breast cancer as the leading cause of cancer death among women in the United States in 1987 and now claims the lives of more women each year than breast, ovarian and cervical cancers combined.

Lung cancer continues to be one of the most underfunded cancers overall. Comparing the amount of research dollars by disease in 2005 and in 2010 shows how shockingly underfunded lung cancer research is in the United States. The graph illustrates the number of federal research funding by disease per cancer death.

Diagnosis and Staging

There are different types of lung cancer with regard to what they look like under the microscope, also known as the histology of the cancer. About 40% are adenocarcinomas which are characterized by malignant epithelial tumors with glandular differentiation or mucin production, showing acinar, papillary, bronchoalveolar, or solid with mucin growth patterns or a mixture of these patterns. Approximately 30% are squamous carcinoma which is a malignant epithelial tumor showing keratinization and/or intercellular bridges that arise from the bronchial epithelium. Another 15% are large cell carcinomas which is an undifferentiated non-small cell carcinoma that lacks the features of small cell carcinoma and glandular or squamous differentiation. There are an additional 15% which are classified as other. There are slightly different patterns of these tumors by gender with women having a substantial rise in adenocarcinomas beginning in the mid-1980s. Squamous cell tumors have been rising for women and are on the decline for men.

Currently there are no screening tests recommended for the general population although a low-dose helical computed tomography (CT or CAT) scan is currently being studied for this purpose. The symptoms of lung cancer include fatigue (tiredness), cough, shortness of breath, chest pain, loss of appetite, coughing up phlegm, and coughing up blood (hemoptysis). If the cancer has spread symptoms...
include bone pain, difficulty breathing, abdominal or back pain, headache, weakness and speech difficulties. The diagnosis of lung cancer often involves a chest X-ray or a CT scan of the chest. To determine whether a tumor is cancer, a biopsy of the tissue must be done. The patient is worked up and other CT scans are often done as well as PET scans (positron emission tomography) and MRI (magnetic resonance imaging). These scans help to determine all of the locations of the cancer as it is important to know if the cancer has started to grow somewhere else in the body. These processes are used to stage the cancer which is a standardized way of characterizing the size of a tumor and where it has spread. Staging is the most important tool doctors have to determine a patient’s prognosis. Staging is different for non-small cell lung cancer and small cell lung cancer. When a cancer comes back after treatment it is a recurrent cancer and may need to be re-staged.

Stage I cancer is found only in the lung and surgical removal is recommended as the first line treatment. Radiation therapy and/or chemotherapy may also be used. In Stage II the cancer has spread to lymph nodes in the lung. Treatment still involves surgery to remove the tumor and nearby lymph nodes. Chemotherapy is also recommended and radiation therapy is sometimes given after chemotherapy. In Stage III lung cancer the cancer has spread to the lymph nodes located in the center of the chest, outside of the lung. Stage IIIA lung cancer has lymph nodes in the chest on the same side where the cancer originated, but in Stage IIIB the cancer has spread to lymph nodes on the opposite side of the chest, under the collarbone, or the pleura which is the lining of the chest cavity. Surgery or radiation therapy with chemotherapy is recommended for Stage IIIIA non-small cell lung cancer. In Stage IIIB, the cancer has spread to different lobes of the lung or to other organs such as the liver, brain, bones, and lymph nodes in the chest. Stage IV non-small cell lung cancer is treated with chemotherapy. There are a variety of factors that affect the survival including stage of disease, how healthy and well the person is at diagnosis (performance status), gender, recent weight loss, how the tumor looks under the microscope, smoking history and ethnicity.

**Treatment**

Surgery is the best option for early stage lung cancer in which the tumor and nearby lymph nodes in the chest are typically removed to offer the best chance for cure. For some small cell lung cancer, a lung transplant of all of the entire lobe where the tumor is located—has been shown to be the most effective surgical strategy. Not all patients are able to have surgery and these patients need other options. Even when surgery is done, many patients need adjuvant therapy which is treatment given to lower the risk of the cancer returning. It can include chemotherapy, radiation therapy and targeted therapy. Radiation therapy is the use of high-energy X-rays to destroy cancer cells. It has some side effects which can include fatigue, malaise (feeling unwell), loss of appetite, and skin irritation at the treatment site. Radiation pneumonitis is an irritation and inflammation of the lung and occurs in about 15% of patients. Radiation treatments try to target the diseased area and to avoid the healthy parts of the lung. Like surgery, radiation is a focused approach. Chemotherapy, on the other hand, is a more systemic approach because it uses drugs to kill cancer cells which can reach cells in all parts of the body. Cisplatin is often combined with other drugs in the treatment of non-small cell lung cancer. Chemotherapy can be used before or after surgery, or before, during, or after radiation therapy. It can improve survival and lessen lung cancer symptoms in all groups of patients, even those with widespread disease.

In addition to the above approaches, newer treatments have evolved called targeted treatments. Targeted treatments stop the action of abnormal proteins that cause cells to grow and divide out of control and thereby stop the cancer from growing. Bevacizumab (Avastin) targets the processes that allow the cancer to form new blood vessels (angiogenesis) which help feed the growth and spread of tumors. It is typically given in combination with chemotherapy. Erlotinib (Tarceva) is another targeted treatment that is approved for locally advanced and metastatic non-small cell lung cancer. Erlotinib blocks the activity of a specific protein called epidermal growth factor receptor 1 (HER1/EGFR) which is needed for the cancer cells to grow and divide.

Lung cancer treatments have had some recent advances, but the progress in lung cancer has been slow. As a result, there is an important need for clinical trials to advance research in this area. A clinical trial is a research study that involves people to test new treatment approaches. New treatments and prevention methods are tested to determine whether they are safe, effective and better than the standard treatments. The purpose of a clinical trial is to answer a specific medical question in a highly structured and controlled environment. Clinical trials can evaluate methods of cancer prevention, screening, diagnosis, treatment, and or quality of life. Clinical trials are described as “phases.” A phase I trial determines the safety and dose of a new drug or treatment in a small group of people. A phase II trial provides more detail about the safety for the new treatment and determines how well it works for treating a specific type of cancer. Phase III trials are needed before a drug is made available to the public. A phase III trial takes a new treatment that has been promising in the phase I or II trial with a small number of patients and compares it against the current standard treatment for a particular disease. Phase III trials involve a large number of patients to more accurately define efficacy.

Patient safety is a big concern in clinical trials. No one can participate in a clinical trial without giving informed consent. Participants should understand why they are being offered entry into a clinical trial and the potential benefits and risks associated with it. Informed consent is an ongoing process. Patients can leave the trial at any time and, most importantly, participation is always voluntary. Safeguards exist to ensure that patient safety is protected on an ongoing basis.

There are a number of clinical trial resources available where patients can find information including:

- Coalition of Cancer Cooperative Groups (www.CancerTrialsHelp.org)
- CenterWatch (www.centerwatch.com)
- National Cancer Institute (www.cancer.gov/clinical_trials)
- EmergingMed (www.emergingmed.com)

Making sure you understand your diagnosis and treatment options is important, as well as the resources that may be available to you where you are getting your care. Having good psychosocial support is also essential. Some patients fear that they may not get as much support or the help that they need because they are worried about judgments from others that they may have contributed to their disease (e.g., by smoking). Doctors and other members of the health care team, including mental health professionals, can be good resources and help both patients and families cope with their diagnosis and treatment. Below is a list of questions that every patient should ask to maximize your knowledge and available resources.

**Questions About Diagnosis**
- What type of lung cancer do I have and what is the stage?
- Has the cancer spread to other parts of my body?
- What type of surgical procedures do I need?
- When do I start treatment? How long will it last? How often will I get it?
- Do I qualify for any clinical trials? If so, how do I enroll?
- Which treatments are covered by my insurance?

**Questions About Treatments**
- What are my treatment options?
- What type of treatment do you recommend for me? Why?
- What are the side effects from my treatments?
- What can I do to help prevent or manage side effects?
- Do I need to change my diet or lifestyle while undergoing treatment?
- Are there any support groups available for me and/or my family and friends?
- Where can I get more information about lung cancer?
- What type of treatment do you recommend for me?
- Where can I get financial assistance?
- Where can I get treatment related assistance? Treatment to appointments?
- Do you have oncology social workers or psychologists available for me to talk to?

Side effects are often a concern for patients and many are treatable. It is important to talk with your doctors and nurses to get help with your side effects. Fatigue is the most common side effect. Pain is treatable through a variety of non-narcotic pain relievers as well as different types of narcotics. Antiemetic drugs are used to reduce or prevent nausea and vomiting associated with treatments. There are also a variety of medications and extra oxygen that can improve breathing. Radiation therapy or surgery can be used to treat metastases that are causing pain or other symptoms. A good resource for information about side effects is the cancer.net web site, www.cancer.net/sideeffects.

**After Treatment**

There are several behaviors that cancer survivors can engage in to help promote their ongoing wellness. For example, walking 15 to 30 minutes each day can improve lung and heart functioning. Many survivors are at high risk for heart disease, stroke, emphysema, and chronic bronchitis. Some treatments can increase these risks and, thus, good follow-up medical care is essential. In addition, quitting smoking helps recovery and health. Patients with lung cancer who are smoking at the time of diagnosis and stop, live longer than those that continue to smoke. It is never too late to stop smoking. Patients with lung cancer face other risks including developing a second new cancer as well as having a recurrence. Follow-up with their doctors for regular X-rays, scans and check-ups are necessary.

An additional resource is www.cancer.net/lung. It provides comprehensive and oncologist-approved cancer information. There are guides for more than 120 types of cancers and cancer related syndromes. It also has information on coping resources, survivorship information, information in Spanish, and the latest cancer news including a weekly feature article.

[Editor’s Note: The Simms/Mann – UCLA Center for Integrative Oncology has many resources for patients including a weekly support group for patients with lung cancer and family member or caregiver. Please call the Center for more information.]
Many people find great value in being part of a group led by an experienced professional. Since each person has somewhat different needs, we offer a variety of groups. Some groups are like a class while others provide greater opportunity for self-expression, feedback and providing and receiving support.

The groups listed below are available without cost to patients and family members. Priority is given to UCLA patients. Enrollment requires an interview with the facilitator. For more information about our groups or to enroll, please call (310) 794-6644.

FOR PATIENTS:

Ethical Wills
Ethical wills are an age old custom for preserving and passing on your values, beliefs, life lessons, hopes for the future, love, and forgiveness to your family and community.

Healing Through Art
A weekly art therapy group to explore the issues faced by individuals with cancer. No art skill required.

Living Beyond Limits
A weekly support group for women with recurrent or metastatic disease.

Look Good; Feel Better
A 3-yr program for women, co-sponsored with the American Cancer Society. Participants receive complimentary cosmetics and learn skin care, make-up application & the use of wigs and head-coverings.

Prostate Cancer Group
A group for men dealing with prostate cancer.

Women Together
A weekly, ongoing support group for women being treated for early stage breast cancer.

Young Adult
A group for young adults facing the challenges of coping with life and medical issues.

FOR PATIENTS AND THEIR FAMILY MEMBERS

Acupressure
A program that teaches helpful protocols and acupressure techniques for yourself and your loved ones.

Circle of Reflections
An exploration of spiritual journey that cancer creates for each of us. Each month reflects on a different theme.

Lung Cancer Group
A weekly support group for lung cancer patients and their caregivers.

Meditation: Guided Imagery for Inner Healing
A group designed to optimize emotional, physical and spiritual well-being through meditation & guided imagery.

Mindfulness Meditation
A weekly group to enhance well-being in the present moment.

QiGong
A weekly group practicing an ancient Chinese movement for restoring health and prolonging life.

GROUPS FOR EDUCATION AND SUPPORT

FOR FAMILY MEMBERS & FRIENDS

Husbands (Partners) of Women with Cancer
An evening group for men who live with women diagnosed with cancer.

INTEGRATIVE ONCOLOGY PROGRAM:
The following fee-based groups/assessments are conducted by a physician. These programs help you maintain or restore health and wellness, improve quality of life and live as fully as possible.

Individual Integrative Medicine Assessment
Most one-on-one to formulate a plan to maximize your overall health and wellness, based on an in-depth review of your current lifestyle. Topics covered include nutrition, exercise, herbs & supplements, and alternative medicine treatments. Cost is $350.

Small Group Workshops
Dr. Hardy is able to offer workshops to small groups based on a specific diagnosis or issue, e.g. esophageal cancer, post-treatment menopausal symptoms, etc. Please call Marcia at 310-794-1923 to get information on offering a small group workshop.
INSIGHTS INTO CANCER

2011 SPEAKERS & TOPICS

SEE OUR LECTURES ON THE WEB
No matter where you are in the world you can see and listen to the leading professionals who participate in our monthly lecture series to help patients and their families live with and learn about cancer—providing up-to-date information, practical advice and answers.

To access our video archive,

- Select the Information Resource & Current Newsletter link on the left hand side of the screen
- Select Archives: Insights Into Cancer Videos & Article Summaries
- From there, choose the lecture you wish to view and the type of video player you have on your computer. If you do not have a video player we have a link for you to download Windows Media Player or QuickTime.

Encourage your friends and family to logon each month and see our lecture. Of course, we hope you will join us because then you get to ask your questions and we love seeing you there!

March 8, 2011
CHINESE MEDICINE AS A SUPPORT SYSTEM IN CARE OF THE CANCER PATIENT – Lucy Postlot, LAc, licensed acupuncturist and herbalist, discusses Chinese Medicine as a complementary therapy in the treatment and aftercare of individuals diagnosed with cancer. The discussion includes information on how acupuncture works, clinical applications of acupuncture for patients with cancer, what oncology patients should know when seeking an acupuncturist, how Chinese herbal medicine is used to support patients going through chemotherapy and radiation, an analysis of individual herbs for support while receiving chemotherapy, and more.

April 12, 2011
CANCER-PREVENTION STRATEGIES, EARLY RECOGNITION, AND TREATMENT – Teresa Soriano, MD, UCLA Associate Clinical Professor and dermatologic surgeon, discusses the risk factors, signs, and treatments of skin cancers, the most common type of cancer in the United States. There are three main types of skin cancer: basal cell carcinoma, squamous cell carcinoma, and melanoma. More than 2 million cases of non-melanoma skin cancers are diagnosed yearly in the United States. Most skin cancers are highly curable when detected and treated early. Knowing and understanding risk factors and early detection are essential to protect oneself from skin cancer.

May 10, 2011
EVOLVING INSIGHTS INTO THE RATIONAL TREATMENT OF BREAST CANCER 2011 – Sara Hurvitz, MD, UCLA Assistant Professor, medical oncologist and leader of the UCLA breast cancer clinical research program, discusses important changes in our understanding of breast cancer subtypes and reviews current standards of care for breast cancer throughout the continuum: from diagnosis through treatment of early disease and management of metastatic breast cancer. Breast cancer is a disease that is best treated with systemic interventions that prevent the recurrence of cancer after surgery and/or treatment recurrence when it metastasizes to other organs. Traditional treatments such as chemotherapy and hormonal agents: are discussed and the role of biological agents that are being tested in clinical trials and emerging in clinics.

June 14, 2011
BLADDER CANCER 2011: THE SURGEON’S AND MEDICAL ONCOLOGIST’S PERSPECTIVE – Mark S. Litwin, MD, UCLA Professor of Urology and Public Health, urologic oncologist and surgeon, and Steven G. Wong, MD, UCLA Associate Professor of Medicine, medical oncologist and researcher, discuss bladder cancer from two different medical specialties. Bladder cancer, often associated with smoking, is a disease that is found in both men and women. When caught early it is curable. Treatments include surgery, radiation, chemotherapy and novel agents. New approaches to treatment are available and discussed.

July 12, 2011
COLORECTAL CANCER 2011: UPDATES IN THE BIOLOGY AND TREATMENT – Zev Wainberg, MD, UCLA Assistant Professor, medical oncologist and Assistant Director of the GI Oncology program, discusses care of patients with colorectal cancer from initial diagnosis through treatment of early disease, and management of metastatic cancer. Colorectal cancer is best treated with systemic (drug) interventions that prevent the redevelopment of colon cancer after surgery or treat recurrence when it metastasizes to other organs. Traditional treatments such as chemotherapy and biological therapy are described along with ground-breaking targeted biological agents that are being tested in clinical trials and emerging in the clinic.

August 9, 2011
CANCER AND THE IMPORTANCE OF VITAMIN D – Mary L. Hardy, MD, integrative medicine physician and Medical Director of the Simms/Mann-UCLA Center for Integrative Oncology, discusses the latest thinking and controversies over the importance of Vitamin D in the prevention of cancer and its role in overall health. Experts have discovered an “epidemic” of Vitamin D deficiency and linked low Vitamin D levels to higher rates of many common cancers including colon, breast, prostate, pancreatic, ovarian and bladder cancer. Clear benefits for bone health and fracture prevention are described along with positive effects in cardiac health, immune function and mood. Optimum levels of Vitamin D and sun exposure versus supplements are discussed.

September 13, 2011
SYMPTOM MANAGEMENT DURING CANCER TREATMENT: 2011 UPDATE – Thomas Stroutte, MD, UCLA Professor of Clinical Psychiatry, pain management and palliative care physician, and Medical Director of the UCLA Neuropsychiatric Hospital, outlines optimal, evidence-based approaches to managing pain, fatigue, nausea, dry mouth, depression, anxiety, and other symptoms commonly experienced during cancer treatments. Participants are introduced to existing published treatment guidelines and to the guiding concept of symptom relief during all phases of cancer treatment, regardless of whether the expected outcome is cure or chronic illness. Novel and emerging techniques and treatments are also addressed. The goal of this lecture is to help patients and families expand their knowledge of symptom management in order to work effectively with their treatment teams towards the goal of optimal well-being during treatment.

October 11, 2011
RIDING THE CANCER WAVE—SPIRITUALLY SPEAKING – Michael Exelern, Chaplain, Simms/Mann – UCLA Center for Integrative Oncology, shares some of what he has observed and learned walking beside those touched by cancer. Cancer not only invades the physical body but can also invade our spirit, our soul, our very identities, and the relationships that keep us connected to life, even to our sense of higher power or God. It can confound our deeper sense of what’s true and meaningful but also lead us into deep spiritual growth and discovery. The journey through cancer is not unlike riding a wave—peaks, valleys, wipeouts, and even sublime thrills. The qualities that help patients and families meet the challenge of cancer—for the religious and secular alike—are discussed.

November 15, 2011
LUNG CANCER PROGRESS: 2011 – Edward Garon, MD, UCLA Assistant Professor, Director of Medical Oncology Program in Thoracic Malignancies, medical oncologist and researcher, discusses treatment of lung cancer focusing on the role of chemotherapy and targeted therapy. Treatments are currently available for patients with all stages of disease. In addition to the traditional “cytotoxic” chemotherapy, FDA approved targeted therapy approaches are discussed along with promising approaches that are currently in clinical trials and may be available to patients.

December 6, 2011
PROSTATE CANCER: WHAT HAPPENS NEXT? – Steven G. Wong, MD, UCLA Assistant Professor, medical oncologist and researcher, provides an understanding of prostate cancer treatment from diagnosis, to monitoring, to addressing roles of various modalities at all stages of disease. Surgery, radiation, and systemic therapies—hormonal therapy, chemotherapy—are discussed in addition to the latest treatment advances, including novel treatments such as vaccine therapy and biologic treatments. Approved targeted therapy approaches are discussed along with promising approaches that are currently in clinical trials and may be available to patients.

Our lectures are free of charge, open to the public, first-come, first-served, Tuesday nights 7:00 – 9:00 p.m. For information, call (210) 794-6464. This year our lectures are held in the new Ronald Reagan UCLA Medical Center (BRMC) Auditorium, B Level, Room B130, 757 Westwood Plaza, Los Angeles, CA 90095; UCLA parking is $11; wheelchair accessible. Attendees can park in the medical plaza or there is valet parking at the front of BRMC.
**Reflections**

Our products include:

- Hair alternatives, including wigs, for complete or partial hair loss.
- Hats, head wraps, sleep caps and scarves.
- Breast prostheses.
- Mastectomy and post surgical bras and camisoles.
- Special garments prescribed for lymphedema treatment.
- Gift items, jewelry, frames.
- High quality vitamins, herbs, supplements and nutraceuticals.

**Reflections Online Store**

In addition to buying in our Reflections® store you can order ALL of the supplements recommended to patients by Dr. Mary Hardy online and have them mailed to you, wherever you are in the United States and some international locations.

Reflections® has partnered with a proprietary fulfillment center to handle your nutraceutical needs—vitamins, supplements, herbs. Go to [http://www.simmsmanncenter.ucla.edu/Reflections/section/supplement-list.asp](http://www.simmsmanncenter.ucla.edu/Reflections/section/supplement-list.asp) to get information on how to order those products and manufacturers that Dr. Hardy has selected from our customized virtual dispensary.

We are excited to make it easier and more convenient for you to order the high quality supplements so important to supporting your immune system, managing treatment symptoms, and taking care of health after treatment. If you have any questions or want to find out more about our online store, please call the Center. If you want to review your supplements or have new questions, please contact us at 310-794-6644 to set-up an appointment with Dr. Mary Hardy.

**PLEASE KEEP IN MIND, YOUR PURCHASES AT REFLECTIONS HELP TO FUND FREE SERVICES TO PATIENTS WITH CANCER AND THEIR FAMILIES OFFERED IN THE SIMMS/MANN – UCLA CENTER FOR INTEGRATIVE ONCOLOGY!**

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