Dos and Don’ts When Someone You Know Tells You “I Have Cancer.”

Almost all of us will be touched by cancer during our lives. You might be the patient or it could be your parent, grandparent, cousin, sibling or friend. One of the things we know is that cancer is a family disease. When a patient is diagnosed, the entire family and social support network is affected. I often think that because cancer is so common everyone is adept at figuring out what to say and do when someone is diagnosed with cancer. With all of these opportunities to learn, we might expect that others would have just the right words of comfort. As it turns out, that is often not the case, in part because there are so many different experiences and everyone is individual.

Unfortunately, more often than not we hear patients report upsetting stories, communications and attempts to support that result in just the opposite experience. For some, the good intentioned remark can be as cutting as a sword, leading to increased distress and feelings of being overwhelmed. Many patients and family members that I have discussed this with recognize that the intentions are often well-meaning but, nevertheless, the outcome is painful. When offers to help are on the mark they can lead a person from feeling isolated and alone to feeling cared for, understood and strengthened. It is our goal to hear more stories from our patients about how their social support system has empowered and strengthened them. Why might this be important? As it turns out, having good social support is related to both better physical and mental quality of life and can serve as abuffer to intrusive thoughts and worries.

What should you say? What should you do? How do you respond? Unfortunately, there is no simple answer because patients with cancer are not generic. They are a diverse group of people with unique issues and concerns and each person brings his or her own needs to the experience.

There is probably only one universally accepted sentence that everyone with cancer might like to hear and that is, “Oh, it was a mistake, you don’t have cancer after all.” Short of that, responses must be tailored to the needs of the individual. Below is a list of ideas that may help after someone you love is diagnosed with cancer. I invite patients, family and friends to review the list together and use this list as an opportunity to think about what might be helpful and how to provide presence and support. We hope to make the cancer journey just a little less stressful and painful.

**Dos**

• Communicate interest in understanding what the patient is experiencing. Living with cancer can be an emotional roller coaster. This is a time when expressing your understanding is especially appreciated from those closest to the patient, but be mindful that not everyone wants to talk about the experience all of the time.

• Listen actively and without judgment. Be open to hearing what the patient has to say. Show understanding by nodding, making eye contact and acknowledging the meaning of their words.

• Recognize that intense emotions are appropriate responses to this experience and allow people to have them without shutting them down, cutting them off or withdrawing. Communicate your willingness to “hear” these emotions without judging them.

• Remember that this person is more than a patient with cancer. Some people want to talk about the cancer experience a lot, others less so. Recognize and respect the limits that a person sets regarding how much or how little to talk. Be cognizant that their comfort in talking will be bolstered by open and honest communication. If you don’t know what they need, ask!

• Allow room for their normal, non-medical life.

FROM THE DIRECTOR

ANNE COSCARELLI, PhD

in this issue

FROM THE DIRECTOR
1 Dos and Don’ts When Someone You Know Tells You “I Have Cancer.”

INSIGHTS INTO CANCER LECTURES
3 Cancer-Related Employment and Insurance Issues: What All Patients and Caregivers Need to Know
4 Pancreatic Cancer 2012: Surgical and Medical Treatment
6 Making Sense of Nutrition and Supplements in Cancer
9 Active Surveillance for Low-Risk Prostate Cancer (CaP)
10 Lung Cancer 2012: Traditional and Novel Approaches
12 Exercise and Cancer

IN AND AROUND THE CENTER
11 Groups for Education
14 Support Our Center
15 2013 Insights Into Cancer
16 Reflections

CONTINUED ON PAGE 2
There is no set time line for recovery and it is a mistake to assume that it will be anything other than on the patient’s terms.

Sometimes patients feel that their whole lives have been consumed by cancer. When a patient feels this way, it helps to be distracted by other things. Take cues from the patient about how much talk there should be about cancer and non-cancer topics.
• Bring humor if appropriate. Levity can change moods, lighten loads and help the patient and their family members to connect to those things in life that are not usually associated with cancer. Find ways to bring joy or meaning into the person’s life.
• Offer concrete assistance such as running errands, preparing a meal, driving to the doctor’s office, picking up prescriptions, dropping off the dry cleaning, making grocery runs and/or providing childcare. Be as specific as possible. Stay away from, “Call me if you need something.” Instead, ask if there is something specific and make suggestions of things you can realistically do.
• Organize! Create a “meal club” in which a group of families/friends makes home cooked meals and delivers them each night of the week. Create a “transportation team” by identifying key people who are available to drive to and from medical appointments. Create a phone/email tree to help communicate information that unburdens the patient and family from repeating updates of their status.
• Be honest when you feel nervous or unsure of what to say. Tell the patient, “I am scared of saying or doing the wrong thing, but I really care about you and I want to be here for you. I’m open to helping you in any way you need.”
• Recall pleasant memories. If there are favorite stories or shared experiences that have brought closeness, see if they continue to be comforting, helpful or uplifting.
• Recognize that the experience of living with cancer and its treatments can be isolating. Encourage the patient to join a support group, maintain social contacts and involve his or her faith community in the circle of healing.
• Bring joy into the patient and caregiver’s lives. Plan a special outing if the patient is up to it. Bring an old movie and offer to watch it together. Host a “Mad Hatter Tea Party,” in which the guests wear hats and bring a hat or scarf for the patient. Get creative and come up with ideas that are fun. Always remember that the patient and caregiver’s energy should be an important consideration. Also, learn to manage your disappointment if your ideas are not always well-received.
• Provide physical comfort. Offer to massage the patient’s hands, feet or neck and shoulders. Fluff pillows, offer to change the sheets or re-make the bed while visiting.
• Sometimes a person with cancer may want to protect friends and family and may censor communications. Invite them to share their fears as well as hopes and assure them of your continued presence.
• Be considerate. Call before you visit. Be aware of fatigue and notice if a patient becomes restless, seems anxious or shows signs of discomfort. If the person closes his or her eyes, this may be a cue to leave, but if uncertain, ask what the patient wants. It may not be a cue to leave and the patient might like company even if there is no interaction. Always stay mindful of the patient and caregiver’s needs. Make sure the caregiver is not taking care of you! What started out as a helpful visit could become a tiring and draining experience.
• Sit near the patient and greet him or her normally with a kiss on the cheek, a handshake or pat on the shoulder or leg, if appropriate. Touch can be an important soother and a powerful form of communication. If the patient is comfortable, offer a hand for holding. Be cognizant if the patient does not want touch because they may not want exposure to germs. Always wash your hands upon entering and only visit when you are feeling well. Also, be aware that different people feel differently about physical contact.

DON’Ts
• DO NOT burden the person with stories of people who have had cancer or died of cancer or tell them how to manage their disease, unless the patient actively requests such information. It can be overwhelming and irrelevant.
• DO NOT assume you know how a patient feels or what course their life should take. How one experiences cancer is individual and can only be defined by that person.
• DO NOT trivialize a person’s feelings. This can happen when attempts are made to reassure someone. For example, for a patient who has lost her hair it may not be comforting to be told that her hair will grow back. It does not acknowledge the current feeling of loss.
• DO NOT be afraid to talk about their religious faith, but do not push views or beliefs onto them. A cancer diagnosis draws people back to the basic issues of life and core questions of existence to which all religious traditions speak. Cancer has deep spiritual implications and can mark the beginning of a new chapter in one’s spiritual journey which may lead to a renewed and strengthened faith or even a departure from previous beliefs.
• DO NOT avoid the person because of personal feelings of helplessness, discomfort or lack of knowledge.
• DO NOT believe that having all the “right things to say” is what is most important. Communicating love and concern and a willingness to be present is one of the greatest gifts.
• DO NOT have a preconceived notion about how a person should respond to a cancer diagnosis. Expecting a patient to cry and share their deepest feelings may be inappropriate. Do not expect or insist that the patient feel optimistic and hopeful.
• DO NOT do more for the patient than he or she is comfortable having others do. Being treated like an invalid or a child when one is not can be degrading. Preservation of independence, at whatever level, is often important for one’s sense of self and personal mastery in the world.
• DO NOT offer the patient conclusions about the meaning of their experience unless they invite an opinion. Unsolicited opinions can be irrelevant or even hurtful and may serve to halt much-needed dialogue between patients, family and friends.
• DO NOT set preconceived timelines about a patient’s emotional recovery from cancer. There is no set time line for recovery and it is a mistake to assume that it will be anything other than on the patient’s terms. Sometimes, when treatment ends the person can feel the impact of the diagnosis and may be more distraught. Allow time for healing and a new normal. If there are concerns, it may be appropriate to suggest that the patient or family member seek professional consultation about their recovery from a mental health professional such as a psychologist, an oncology social worker or other therapist familiar with cancer treatment.
• DO NOT begin by asking questions that have a hidden agenda of blame. For example, many pa- tients who have been diagnosed with lung cancer frequently hear, “Did you smoke?” This is a way of distancing yourself from them and actually makes them feel more isolated and alone.
• DO NOT be afraid to talk about death, advance directives, quality of life and funerals. Many times patients want to have these discussions even though they are frightening for everyone. It can sometimes help to start with a difficult topic and lead to comfort and worst case scenarios. Discussing these issues is not a measure of hopelessness or giving up, but rather understanding.
• DO NOT make promises that cannot be kept. Trust is an important issue in all relationships. The need for it can be heightened when a patient is feeling vulnerable.
• DO NOT assume that little things do not mat- ter. When people have cancer they can feel less in control. One way this is managed is by organizing and orchestrating other issues that are in their control. They may have needs to have things in special places or for things to happen at special times. Sometimes this management may seem difficult for others and can lead to conflict. Communication becomes essential as well as an understanding of the importance of the loss of control. Whenever possible give the patient as much control as possible within the limits of the situation. If there are options, present them to the patient. Allow them to maintain as many roles as they can for as long as possible.
• DO NOT unknowingly create situations where the patient must take care of your needs or feelings. DO NOT tell them to have a “positive attitude” or tell them that they will get better with a posi- tive attitude. Attitude does not change the course of cancer.
• DO NOT provide too much information that is not wanted. This includes offering up the latest treat- ments, ideas about complementary or alternative approaches, food choices or other lifestyle issues. Patients can become burdened by too many ideas and suggestions. Always ask if your advice on a topic could be helpful and make certain that it is okay to say no to you.

Keep in mind that communicating, which includes listening and talking, can be very helpful. It begins to be open and communicate that you want to be there and that you want to be helpful. Asking an open- ended question can be a way of starting that dialogue. Never assume you know the answer until the patient has responded. That is a really good beginning when someone you know is diagnosed with cancer.
INSIGHTS INTO CANCER

CANCER-RELATED EMPLOYMENT AND INSURANCE ISSUES: WHAT ALL PATIENTS AND CAREGIVERS NEED TO KNOW

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This is a summary of a lecture presented on December 4, 2012.

Most people don’t think about cancer and the law, but when you or someone you love is diagnosed with cancer, it becomes very important to understand how and if the law protects your employment and insurance-related issues. “What is a cancer-related legal issue?” These include, but are not limited to, health insurance, estate planning, landlord/tenant concerns, employment, life insurance, government benefits, family law, financial resources, custody/guardianship of minor children, real estate, disability insurance, immigration, toxic torts, genetic discrimination, and consumer law. The three most common issues with which patients have to deal are: health insurance, employment and disability insurance. A few of these topics are presented here with the understanding that health care reform, effective in 2014 and beyond, may drastically change some of these issues.

Health Insurance

Consolidated Omnibus Budget Reconciliation Act (COBRA)
COBRA gives workers and their families who lose their health benefits the right to choose to keep their same group health insurance plan for 18 to 36 months. COBRA requires that the person pay 102% of the premium, thus the individual must pick up the cost of what the employer was paying plus an additional 2% administrative fee. In order to qualify for COBRA an employer must have 20 or more employees. The qualifying events that allow someone to use COBRA for purchasing their health plan are: 1) Termination of employment, 2) primary person becomes the plan due to aging out to Medicare, divorce, or death of a spouse who was the worker carrying the insurance or 3) a child aging out because they turned 26 years of age (this was added as a result of the health care reform).
In the first event, a person is entitled for a period of 18 months. Each of the other qualifying events the coverage can be for up to 36 months.

California also has a CAL-COBRA which is a state law and it applies to employers of 2-19 and lasts 18 months. It also extends COBRA to 36 months for those who do not qualify for 36 months. The cost can be up to 110% of the applicable employee rate.

Health Insurance Portability and Accountability Act (HIPAA)
HIPAA gives workers and their families who lose their health insurance lapses. The health plan should give a “Certificate of Creditable Coverage” to the new insurance plan when a group plan is terminated.

Major Risk Medical Insurance Program (MRMIP)
This is a state run insurance program for people with pre-existing conditions. There is currently no waiting period for this. The cost is based on age and kind of coverage a person desires. The more coverage elected, the greater the cost of the insurance. This is appropriate for anyone who has been turned down for insurance.

Pre-Existing Condition Insurance Plan
New since the affordable care act, this is a plan to help individuals get insurance who have not had insurance for at least 6 months or more. It is for people who are uninsured and have a pre-existing condition. There are a variety of providers with a variety of options and costs. More information can be found at www.pcip.gov.

Pre-Existing Conditions: 2014
Starting in 2014, insurers cannot consider pre-existing conditions of a physical or mental nature, health status, medical history, genetic information or gender. What 2014 will bring regarding the price of insurance is still unclear as of this date. California is setting up health insurance exchanges for people to purchase health insurance. The costs are still unknown.

Low Income Resources

Medi-Cal is the California version of Medicaid. Individuals must be low income and fit another category as defined by the program, e.g., pregnant women with minor children or individuals with disabilities, etc. It is best to apply for the program and see if an individual qualifies. A person cannot have a lot of assets, although they can generally have a house and a car. Los Angeles has a program for individuals who cannot afford health care and do not fit the Medi-Cal categories called Healthy Way LA. This program will end in 2014 when it is combined with the regular Medi-Cal program.

Employment

Many people with cancer wonder about what kinds of protections are available to them in the workplace as they deal with a serious illness such as cancer. The Americans with Disabilities act (ADA) is a federal law that protects individuals from discrimination at all phases of employment. There are also many state laws which may vary from state to state. While someone with cancer may not want to be considered a disabled person, in the eyes of the federal law they are protected under these laws.

The ADA applies to employers that have 15 or more employees. It applies to employers who have a disability and to employees who are “qualified” for the job and can perform the essential functions of the job with or without accommodations. Disability is defined in this setting as a physical or mental impairment that substantially limits a major life activity. “Major Life Activity” is defined as walking, talking, breathing, eating, caring for oneself, activities of daily living, reproduction and sometimes working. A “Substantial Limitation” is defined as being unable to perform a major life activity and the factors that are evaluated include the nature and severity of the limitation, the expected or actual duration and the impact of the disability. The ADA protects people who have a disability, have a history of a disability, are regarded as having a disability and, in some cases, are caregivers. A caregiver could be discriminated against because they are perceived as someone who might not show up at work (an example of this is the parent of a disabled child); this could be the basis of their protection under the ADA.

Title I of the ADA requires an employer to provide reasonable accommodation to qualified individuals with disabilities who are employees or applicants for employment, except when such accommodation would cause undue hardship. This law sets forth an employer’s legal obligations regarding reasonable accommodations. Other employers may provide more than the law requires.

The Equal Employment Opportunity Commission has issued guidelines that determine what “reasonable accommodation” means and who is entitled to receive it. “Reasonable accommodations” can include a modification of the physical work environment, restructuring of the job and possibly an extended period of leave time. These can include things such as flexible scheduling, allowing someone to work at home, or creating a workspace that accommodates the disability. There is an organization, Job Assistance Network (www.askjan.org), which works with employers and employees to come up with reasonable accommodations. A medical provider must state what the needs of the disabled person are, what they can and cannot do, and certify that what the person needs is reasonable. Medical providers do not need to turn over medical records or reveal specific diagnoses.

California also provides protections through the Fair Employment and Housing Act. It is broader than the ADA because it applies to companies with five or more employees, it is a little more liberal than the ADA and they specifically define how cancer can be a “limitation on major life activity.”

Family Medical Leave Act (FMLA)
FMLA provides protection to employees who are ill or who have a covered family member who is ill. It insures that employers provide 12 weeks of protected leave per year so that employees can return to their job and maintain their health benefits. It is not guaranteed as paid leave; leave pay is up to an employer. A “covered individual” is self, parents, minor children or spouses. A covered employee must have worked for 12 or more months prior to the leave and must have worked at least 1,250 hours in the previous year. The 12 weeks can be taken intermittently or can be taken all at one time. A “covered employer” includes all public employers (local, state, and Federal) and some large private employers who have 50 or more employees located within a 75 mile radius.

The California Family Rights Act runs concurrently with FMLA. It is very much the same as FMLA but includes registered domestic partners as equivalent to a spouse.

Disability Insurance Programs

Disability insurance programs come in three forms: private insurance plans, state short-term insurance, and federal long-term insurance. Private insurance plans must be purchased privately which means some people have them while others do not.

State Disability Insurance (SDI)
SDI lasts for up to one year and provides 53% of a person’s wages. In order to qualify the person has to

CONTINUED ON PAGE 5
neuroendocrine tumors make up about 5% of pancreatic adenocarcinoma is from the exocrine cells and makes two types: exocrine and endocrine. Pancreatic ductal secretions affect several different hormones in absorption of nutrients and digestion. The neuroendocrine secretes enzymes into the digestive tract that aid in the absorption of nutrients and digestion. The neuroendocrine cancer is divided into two types: exocrine and endocrine. Pancreatic ductal adenocarcinoma is from the exocrine cells and makes up about 85-90% of all pancreatic cancers. Pancreatic neuroendocrine cancers account for about 5% of pancreatic cancers and emerge from the endocrine cells in the gland. The majority of this write-up is dedicated to the most common, exocrine pancreatic cancer.

The pancreas is divided into three major sections, the head, the neck/body and the tail. Pancreatic ductal adenocarcinoma, the most common pancreatic cancer, occurs 60-70% of the time in the head of the pancreas, approximately 10-15% in the tail and about 5-10% in the neck/body. About 20% of the time there is a more diffuse presentation of the tumor that goes through the entire gland.

There are approximately 43,770 new cases of pancreatic cancer per year; as of 2011 there have been 35,240 deaths. In California alone there are 3,700 new cases per year. Unlike some of the other more common cancers, the epidemiology of this disease has shown little improvement in the overall statistics regarding mortality from this disease since 1930. However, these data do not take into consideration some important new treatment approaches; there is hope that these treatments will begin to change the overall survival rate. Pancreatic cancer has been hard to treat because it is usually quite advanced by the time it is diagnosed. The biology of the tumor is often quite aggressive and, overall, there has been poorer response to available therapies if the disease is not surgically resectable. The survival rates go up substantially when it is diagnosed early and is resectable.

Pancreatic cancer appears to take a long time to develop into an advanced cancer; it is estimated that the pancreatic ductal adenocarcinoma has been developing for approximately 12 years by the time it is diagnosed. The first changes occur as genetic changes in the cellular architecture of the organ. This research has also begun to identify how different these cancers are; thus, single treatment approaches are less likely to be successful, and more individualized, personal care is the target of research. Several mutations have been identified (which have also been identified in other tumors) including KRA5, BRCA, and P53 gene mutations.

There are several known risk factors for pancreatic cancer and some debated issues. Hereditary factors account for a small number of patients with pancreatic cancer. However, patients with a family history of breast and ovarian cancer who have the BRCA1 or BRCA2 genetic mutation are at an increased risk for pancreatic cancer. Patients with family histories of breast cancer, ovarian cancer and pancreatic cancer may need to see a genetic counselor and receive appropriate counseling and testing if indicated. Patients who have one of the genetic mutations that cause colon cancer such as APC (adenomatous polyposis coli) and HNPCC (hereditary nonpolyposis colorectal cancer) are also at an increased risk for pancreatic cancer. Finally, patients who have hereditary pancreatitis have 40 times the risk of developing pancreatic cancer than someone without this known hereditary risk.

Chronic pancreatitis increases the likelihood of developing pancreatic cancer because it can cause chronic damage to the organ over time. Environmental factors include both cigarette smoking and alcohol use. Obesity and a high fat diet also seem to play a role. There is some correlation between diabetes and metabolic syndrome, obesity and alcoholic pancreatitis, and alcohol consumption may be contributing factors. There is no definitive link, but there are circumstantial data to suggest that patients with diabetes and metabolic syndrome may be more likely to develop pancreatic cancer. These risk factors suggest that eating a healthy diet that does not promote high glucose, e.g., one that is low in fat, low in sugar, low in simple carbohydrates, high in fruits and vegetables and high in whole grains may affect risk for pancreatic cancer. Diet, along with a lifestyle that includes not smoking and low and moderate alcohol consumption, may be preventative factors that individuals can independently embrace to reduce the likelihood of developing pancreatic cancer.

Symptoms and Diagnosis

The symptoms of pancreatic cancer often depend on the location of the tumor. For patients in which the tumor is in the head of the pancreas, common symptoms include weight loss, jaundice, itching, clay colored stools, diarrhea and fatty stools. When the tumor is located in the body/tail of the pancreas, weight loss and pain are common. The pain is often due to the tumor putting pressure on the many nerves that run through the pancreas and behind it.

One of the single best tools for diagnosing pancreatic cancer is a helical (spiral) CT scan. When someone presents with symptoms, they may receive a CT scan that will only show a mass. A helical or spiral CT scan is needed because this type of scan displays more detail of the pancreas, other organs and the relationship of the tumor to the veins, all of which is crucial in determining if it is resectable. Endoscopic ultrasonography (EUS) and endoscopic retrograde cholangiopancreatography (ERCP) are also important in the initial work-up. An MRI/MRCP is a magnetic resonance cholangiopancreatography which allows the biliary and pancreatic ducts to be imaged and helps to determine the exact location of the tumor and how it might be interfering with the ducts. A PET scan is typically done to determine if the tumor has spread outside the pancreas and is necessary before surgery can be done. Sometimes a FNA (Fine Needle Aspiration) is done using endoscopic ultrasonography to obtain cells to review in pathology. Tumor markers for CA 19-9 are also done; if these markers are elevated at diagnosis they can be a good way to follow the tumor as well. If it looks like surgery is likely, they always begin with a laparoscopy before a major surgery is initiated to try to determine if the full surgery is indicated. All of these tests are done to gather as much information as possible and to try to assess whether the disease is contained and resectable, a tumor not likely to spread outside the pancreas which could become more contained with treatment such as chemotherapy prior to surgery, thus increasing the likelihood of longer term survival.

Having a team that is experienced in making a pancreatic cancer diagnosis is essential. It increases the probability of having a successful surgery and reducing the possibility of putting someone through an invasive surgery when the disease is too extensive to be resectable. Once the disease is confirmed and a dual phase scan of the pancreas and the liver to determine whether the veins that are close to the pancreatic cancer are involved. If the veins are involved then surgery could delay beginning to be considered. Treatment approaches are less likely to be successful if the disease is extensive. The involvement of the tumor around or into the veins/arteries is a crucial determination because the veins/arteries cannot be removed.

Surgical Treatment of Local Disease

The best candidates for surgery are patients whose disease is confined to the pancreas with no distant metastasis to other organs, especially to the liver. Regional lymph node involvement is okay. There needs to be no vascular involvement. A vein can be reconstructed, but an artery cannot. It is also important to consider other medical conditions to make sure it is safe to perform the surgery.

There are three types of surgeries that are performed. If the tumor is in the head/neck of the pancreas, the pancreatic head is removed, leaving clear tissue (margins) around the edges. This is often called the Whipple procedure, named after the doctor who began performing this procedure in 1935 in the United States. In the standard Whipple procedure, the distal stomach, intestine, gallbladder, bile duct and head of the pancreas are removed. Once these are removed there is reconstruction with the remaining pancreas being reconnected to the jejenum along with the liver and the intestine. More recently this procedure has been revised so that the pylorus, the juncture at the duodenum which permits normal emptying of the stomach, is preserved. This procedure has better recovery and prevents weight loss. This type of procedure requires about 7-10 days in the hospital following the surgery.

If the disease is in the body/tail of the pancreas, a dissection or pancreatic surgery is done. In this procedure the body and tail of the pancreas is removed and the bottom of the pancreas is sewn together to prevent leaking of the juices from the pancreas. Sometimes this involves removing the spleen as well, but not always.

If the disease is in multiple areas of the pancreas, the whole pancreas can be removed, called a total pancreatectomy. This is now seldom used to treat exocrine cancers of the pancreas.

The best survival outcomes are for patients who have resectable disease, no lymph nodes involved with disease, a small tumor size (<3 cm), clear margins (meaning a margin of healthy tissue around the diseased tissue),...
Cancer-related Employment and Insurance Issues: What All Patients and Caregivers Need to Know (Continued from Page 3)

have been unable to perform regular/customary work for at least eight calendar days and have a loss of wages. They also must have earned at least $300 from which SDI taxes were withheld during the previous 12 months. Claims must be filed within 49 days of the disability date. This is run through the Employment Development Department (EDD) of the State of California.

Family Temporary Disability Insurance (FTDI) FTDI provides six weeks of wage replacement benefits for employees who take time off to care for a seriously ill child, spouse, parent, or domestic partner. It has the same requirements as SDI. It only allows for six weeks of paid leave per any 12 month period.

Federal Disability Insurance There are two types of Federal Disability Insurance, Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI). In order to qualify for either of these, a person cannot perform any “substantial gainful activity” due to a physical or mental impairment. There is an expectation that this impairment will last for one or more years or result in death. There are a list of diseases and conditions known as compassionate allowances. Compassionate Allowances (CAL) are a way of quickly identifying diseases and other medical conditions that invariably qualify under the “Listing of Impairments” based on minimal objective medical information. Cancer that has metastasized or is inoperable is included in this list. More information can be found at ssa.gov/compassionateallowances. Medical evidence of disability comes from medical records. It is important that the physician actually writes down what is wrong and what a person is able to do/not do in the medical record in order to qualify for this disability insurance. These records may need to be produced. If the disabilities are discussed but not appropriately documented then the disability benefit could be denied.

SSDI is based on prior work history, whether a person has paid into Social Security and whether they are unable to continue working due to a disability. SSDI payments are not made immediately; there is a waiting period of at least six months from the date of disability; however retroactive payments are possible. Once someone has been on SSDI for 2 years, they also become eligible for Medicare health insurance. As an example:

- Disability began May 1, 2010, the person applied for SSDI on January 1, 2011.
- The first SSDI check came in June, 2011.
- The check will be for 8 months which excludes the 6 month waiting period.

Supplemental Security Income (SSI) is based on whether or not a person has assets and income. It is not related to work history. People eligible for SSI are automatically eligible for Medi-Cal.

Conclusion While the law is not perfect, there are a variety of programs through which persons with cancer can access health and disability insurance, and people with cancer or a history of cancer should not be discriminated against in the workplace. People who need more specific information about which laws apply to their particular situation are encouraged to contact the Cancer Legal Resource Center at 866-THETL-CLRC (866-843-2572) or visit our website www.cancerlegresourcecenter.org

Resources
- EEOC (800)669-4000 or www.eeoc.gov
- Department of Fair Employment & Housing www.ca.desh.gov
- Job Accommodation Network www.askjan.org
- Pre-Existing Condition Insurance Plan www.pcip.gov
- Social Security Administration – Compassionate Allowances www.ssa.gov/compassionateallowances
- CLRC (866-THETL-CLRC) www.cancerlegresourcecenter.org

The mission of the Cancer Legal Resource Center is to provide information and resources on cancer-related legal issues to cancer patients, survivors, caregivers, health care professionals, employers and others coping with cancer. It is a joint program of the Disability Rights Legal Center and the Loyola Law School of Los Angeles. It provides confidential services which are primarily educational in nature.
MAKING SENSE OF NUTRITION AND SUPPLEMENTS IN CANCER

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This is a summary of a lecture presented on August 15, 2012.

Contrary to popular belief, most cancers are caused by factors that are not inherited. Pure genetic risk accounts for only 5-10% of cancers in the United States. Two thirds of all cancer deaths are related to lifestyle choices — one-third from tobacco exposure and another third from poor diet and physical inactivity. Thus, your lifestyle is a critically important factor in your health. Approximately 38% of breast cancer, 45% of colorectal cancer and 36% of lung cancer are believed to be preventable if three lifestyle goals are attained: staying lean, eating smart and moving more.

Despite the clear associations between diet and disease, conducting research on nutrition is one of the more challenging areas of research. It is hard to capture the importance of timing, dose, and duration of exposure to any particular dietary choice. Most research in nutrition provides a snapshot of these factors at best. In addition, research into nutrition is constantly evolving, which is positive, but can be frustrating for those who want definitive, consistent answers NOW. Because nutrition provides a snapshot of these factors at best, conducting research on nutrition is one of the more challenging areas of research. It is hard to capture the importance of timing, dose, and duration of exposure to any particular dietary choice. Most research in nutrition provides a snapshot of these factors at best.

What is a healthy weight? Healthy weight can be determined in several ways, usually by calculating your body mass index (BMI), which is a measure of weight and height. There are many websites that will calculate this for you. A BMI of less than 18 is considered too low, normal BMI is 18-24, Overweight is a BMI of 25-29 and over 30 is considered “obese.” However, another calculation that is important and being utilized is waist circumference, because this is an indicator of abdominal fat which has negative implications for health in many arenas. The American Heart Association has suggested that a waist circumference should not be greater than 40 for males and 35 for females, but the American Cancer Society has taken a stricter view suggesting a waist circumference no greater than 35 for males and 30 for females. Even if a BMI is less than 25, if waist circumference is elevated there may be an increased risk for some cancers.

Achieving/Maintaining a Healthy Weight
Achieving and maintaining a healthy weight takes knowledge of what determines a healthy choice and meal planning to implement these choices. Food literacy consists of understanding that portions make a difference, and that eating a plant-based diet is preferred. Such a diet should include at least 3 cups of fruits and vegetables per day and would limit the amount of processed foods, red meat and refined carbohydrates.

To find healthier choices, it is important to learn to read labels on food packaging, minimizing simple sugars, maximizing fiber and limiting unhealthy fats such as saturated fats. It helps to understand that % Daily Value is based on a 2,000 calorie diet and each number on the label is based on the percentage of the 100% of the recommended amounts for that nutrient per day. For example, 18% fat means that one serving would furnish 18% of the total maximum amount of fat that you could eat in a day and stay within public health recommendations. However, if you are trying to eat less than a 2,000 calorie a day diet, then these numbers would be high. As a quick reference, a Daily Value of 5% is considered a low number and 20% or more is considered a high number. So, if you want to eat a food that is a source of protein, then foods with higher % daily value would be good. If you want to eat a food that is a source of fat, you would want to stay on the low side. It is also important to read the label to determine the serving size and how many portions there are in the container. You would be surprised to find out that many boxed or canned foods are based on very small serving sizes!

Next it is important that you look at the calories per serving size, as this is important for your goals of losing weight, gaining weight or maintaining weight. The left side will show how many calories are in one serving while the calories from fat will be listed on the right. It is important to remember that a product that is labeled fat-free is not necessarily calorie-free and it is important to balance portion and your calorie intake per day, depending on your goal. It is always a good idea to limit your intake of fat. However, we Americans often don’t get enough dietary fiber, vitamin A, vitamin C, calcium or iron in our diets, so reading labels for these and tracking your intake of these components can help improve your health.

The New American Plate: Remember the food pyramids? It’s been replaced by the new American plate. If you look at the diagram below, you will see that ⅓ of your plate should be filled with fruits and vegetables, ⅓ with a lean or plant based protein source, and ⅓ with whole grains or other complex carbohydrate.

There are no magical super foods; however, a well-balanced diet will provide you with the micronutrients you need. It is important to make sure you consume nu-
trients from a wide variety of whole foods which contain several different healthy compounds. Remember, variety is good! You need Vitamin C, so you eat your orange, but most people don’t realize that a single serving of a red bell pepper has twice the vitamin C as a daisy. Remember that not all the many food sources that provide various micronutrients. Foods that can reduce your risk of cancer because they are high in micronutrients include cruciferous vegetables (e.g., Brussels sprouts, Napa cabbage, bok choy, broccoli, cauliflower), berries (strawberry, raspberry, blueberry, cranberry, lingonberry), Omega 3 fatty acids (cold water wild fish such as halibut and salmon), mushrooms, garlic, onions, whole grains, spices (turmeric and ginger) and green tea.

Serving Size: Serving sizes can be hard to determine with fruits and vegetables; what exactly is a serving size for a piece of fruit? A small apple is about the same size of a tennis ball and it represents one serving size (approximately 60 calories). Other serving single sizes are: one small banana, one medium orange, 15 cherries, 16 grapes, four large strawberries, 4 ounces of applesauce, one large plum.

Organics: Many people question whether or not to buy organic foods. The Environmental Working Group (EWG) is an American environmental organization that specializes in research and advocacy regarding toxic chemicals, agricultural subsidies, public lands, and corporate accountability. Annually, the EWG publishes its “Dirty Dozen” list of foods with the highest pesticide residue. The EWG recommends that consumers look for organically produced varieties of these products. The EWG also publishes the “Clean 15” list of foods with the least pesticide residue that you can feel safe eating. There is no study linking organic food usage to reductions in cancer, but these studies are very hard to perform because of confounding factors. Remember that not all US families purchase some kind of organic foods. It is a huge industry with 28 billion dollars being spent in 2010 on organic products, both food and non-food products.

Omega-3 Fatty Acids: Omega-3 fatty acids (DHA) are important in decreasing the formation of inflammatory cytokines and chronic inflammatory states. Omega-3 fatty acids (DHA) are important in decreasing the formation of inflammatory cytokines and chronic inflammatory states. The Institute of Medicine (IOM) recommends that people eat 1-2 grams per day of DHA although this amount may not be sufficient for optimal cardiovascular health.

Omega-3 fatty acids may be important; it is difficult to get the appropriate high dosage levels from food alone.

Whole Grains: Whole grains are also good; however, it is important to read the labels because if it is not the first ingredient listed, it is probably not a high fiber food. Whole grains or foods made from them contain all the essential parts and naturally-occurring nutrients of the entire grain seed: the bran (high in fiber), the germ (protein) and the endosperm (carbohydrate and protein). If the grain has been processed (e.g., cracked, crushed, rolled, extruded, and/or cooked), the food product should deliver approximately the same rich balance of nutrients that are found in the original grain seed. Whole wheat flour, bread, crackers, brown and wild rice and popcorn are all whole grain foods. A recent popular addition to this category is Quinoa which has 4 grams of protein and is a gluten free product. Whole white grains are far, wheat berry, barley, whole wheat cereal, whole rye and oatmeal.

Soy: People often wonder about the value of soy. There has been some controversy regarding its potential estrogenic effect and what influence that might have on women with breast cancers. A 2009 study published in the Journal of the American Medical Association indicated that soy foods when eaten as whole foods were safe for breast cancer survivors. The American Cancer Society acknowledges soy as an excellent source of protein and suggests that it may reduce the risk of a variety of cancers. It is generally recommended that people should not exceed 1-2 servings per day and only eat it as a whole food, not in supplement form. A serving is 1 cup of soy milk, ½ cup of tofu, 2 table spoons of soy nuts, ½ cup of shelled edamame.

Alcohol: Alcohol has been also been a controversial subject. There are no studies that say that if you abstain from alcohol, you will decrease your risk of cancer. Alcohol may be more detrimental for women than for men because alcohol does have an effect on circulating levels of estrogen. In the Nurse’s Health Study cohort, a study that has followed 75,000 participants since 1988, the cumulative amount consumed over a lifetime was the best predictor of risk. Risk goes up with increasing consumption over the lifetime. Women who consumed 2 or more alcoholic beverages per day had a 1.5 higher risk of getting cancer over women who never drank; the 10 year risk increased 1.3%. Women who drank 1 alcoholic beverage a day had a lifetime risk that was 1.2 times higher and their 10 year risk increased by 0.7%. The American Cancer Center recommends that women who choose to limit their consumption to no more than one alcoholic beverage per day. It is important to note that one beverage is considered one five-ounce serving, so make sure you check how much you are pouring into your glass.

Physical Activity: Physical activity is critically important as a cancer prevention strategy and as a strategy for maintaining a healthy body weight. You need 150 minutes of moderate intensity or 75 minutes of vigorous intensity activity spread throughout the week. The activity above your usual activities will provide some benefit; going from nothing to something is beneficial. For example, a 30 minute relaxed swim burns about 204 calories while 25 minutes of yoga burns about 200 calories.

Appropriate Goals for Wellness Plan with Supplements

Developing a wellness plan involves optimizing your diet as discussed above, exercising regularly, maintaining a healthy weight, practicing regular stress management, and following through on conventional medicine recommendations.

Supplement-Vitamin D: Everyone needs vitamin D for healthy bones and overall health. Vitamin D needs to be assessed on an individual basis from a blood test to determine whether you are in the normal range or not. It is sometimes difficult to get solely from sun exposure because it requires being in the sun with 40% of your body exposed for 30 minutes per day during peak hours in order for your body to create enough vitamin D. There may be a situation where supplementation may be preferred or needed in addition to food. Some foods are higher in vitamin D, such as sockeye salmon (687 IU), halibut tuncare (544 IU), silver salmon (430 IU), king salmon (236 IU), sardines (222 IU), and halibut (162 IU). Other sources of vitamin D include plain yogurt, which also contains calcium. Beef liver, cheese, and egg yolks provide small amounts. Milk is fortified with 400 IU of vitamin D. Some breakfast cereals, orange juice, margarine, and soy beverages might also be fortified and thus it is important to read the labels.

Vitamin D has been studied with regard to some cancers and cancer treatments. While the data are not overwhelming, there is a growing body that supports the value of having at least vitamin D levels beyond good bone health. Vitamin D is important and there have been incidence rates of higher breast cancer and prostate cancer in populations that live at latitudes farther from the equator with lower vitamin D levels. One study looked at women who were cancer free at one year after intervention who received one of three treatments: 1) calcium plus D, 2) calcium only, or 3) a placebo. These women were then followed for five years and the survival curves demonstrated that patients whether the dose that you are trying to achieve can be done by food alone. Presented below is a discussion of some common supplements that may not be as easily met by food alone.

Supplement-Fish Oil: There have been two recent studies on small groups of patients randomized to receive fish oil (300 mg EPA and 400 mg DHA) for 8 weeks. In one study the control group had decreases in the number of neutrophils and functions while the fish oil group showed no decrease, preserved function and gained weight. In another study, those in a group of non-small cell lung cancer patients receiving fish oil maintained their weight, while the other group lost the value of 5 lbs. Lower intake of DHA has also been associated with higher fatigue and greater inflammation in breast cancer survivors. For cancer patients and people with health issues, a high quality fish oil supplement may be important; it is difficult to get the appropriately high dosage levels from food alone.
Supplement-black cohosh: There have been several studies that have looked at whether Black Cohosh helps women with hot flashes who are receiving tamoxifen, in both women who were at risk for breast cancer and those who were breast cancer survivors. The results indicated that preparations made from the American black cohosh reduced hot flashes; the American black cohosh was not estrogenic as it binds to the hypothalamus and there were no negative effects. When the preparation was substituted for the Chinese black cohosh, the same effects were not found. What does this mean? It means not all black cohosh preparations are equal or beneficial. There are only two preparations that have been tested; both are made in Germany but only one is currently available in the states. In order to assure safety and benefit you need to use one of the two preparations that was used in the trial. That preparation is carried in the Reflections Boutique at UCLA (310 794-9090).

Supplement-Mushroom Extracts: Mushrooms are good sources of vitamins and minerals and they have less than 100 calories per serving. If you choose a sun-exposed mushroom, they are also high in vitamin D. Mushrooms provide the best benefit when eaten as a whole food and there are benefits to heating/cooking them. There are many different kinds of mushrooms. Some of the mushrooms that have been studied include cordyceps or Trametes versicolor, basidiomycotina, griffola or poropus umbellate, griffola frondosa, lentinides, agaricus, and ganoderma. Most of the studies have been done in Japan. Some of these have been studied for their medicinal properties and used in supplement preparations. One of the problems that exist is that not all mushroom preparations have the actual mushroom in the bottle. So when they are studied and controlled there may be one outcome, but what a patient thinks he or she is getting when they buy them as a supplement may be something different. There is a growing body of literature to suggest that some of these mushrooms may have benefits to patients, but this needs to be evaluated on an individual basis by someone who knows the mushrooms, the disease and the preparations.

Traditional Foods as Supplements: Ginger, turmeric and licorice have traditionally been used as healing herbs and roots. They have often been used for treating pain in “poorer” cultures. These same supplements may have anti-inflammatory properties as well. Anti-inflammatory is good because there is growing evidence that inflammation is a factor in many health conditions and in the carcinogenesis process; foods and supplements that reduce inflammation may help to slow the carcinogenesis process.

Turmeric comes from a plant and is used as a major component in curry, has been used as a dye because of its deep yellow color, and has been recognized as a medicinal source since ancient Greece. It is very prominently used in Ayurvedic medicine. The active ingredient in Turmeric is Curcumin. Curcumin, which has been used as a general tonic and blood purifier, contains an ingredient called pheylpropanoids. It has been used in some small cancer prevention studies in patients with high risk lesions or premalignant lesions. These studies have 5-41 patients per study so it is difficult to judge its universal value based on these findings, but they suggest benefits. The doses used in these studies were higher than people can achieve just by using Turmeric in foods. To achieve potential benefits, you need to take a Curcumin supplement. Consumer alert regarding this supplement—not all Curcumin supplements are bio-available, which means able to be processed, absorbed and used by the body! You need to use a high quality supplement which, when a capsule is opened, is oily and a very deep yellow color. Not all supplements will deliver the same benefit—many have lower quality and are not bio available. The one that is oilier and a very deep yellow color is beneficial.

Ginger, another traditional root, has been used in clini-
cal trials for nausea experienced by women receiving Cisplatin chemotherapy. While the study was small (N=48) they found that ginger root at 1 gram per day for 5 days was not as good as conventional anti-naus-
ea medications on the first day, but the ginger was as good in subsequent days plus there were fewer side effects for those on ginger.

Green Tea is also much talked about for its medicinal anti-cancer qualities. Previous studies in Japan showed that drinking 10 cups of green tea reduced polyf orma-
mation in 136 patients with previous polyps who con-
tinued drinking green tea. These patients were random-
ized to take 1.5 grams of green tea extract and after 1 year 31% in the control group versus 15 % in the green tea extract group had new polyps.

Safety of Dietary Supplements and Herbs -- Choosing Wisely

Healthy body weight for your height and frame. If you want to use supplements, choose carefully, get assistance from a trained professional who does not benefit financially from the sale of the supplements and be aware of what you read on the internet. Choose simple formulations and remember less may actually be better depending on your situation.

• Liquid forms may be easier during active treatment because they are easier to swallow and may be absorbed more easily. Consider taste and ease of swallowing when choosing a supplement.

Conclusion

Choose healthy foods first, get exercise and maintain a healthy body weight for your height and frame. If you want to use supplements, choose carefully, get assistance from a trained professional who does not benefit financially from the sale of the supplements and be aware of what you read on the internet. Choose simple formulations and remember less may actually be better depending on your situation.

[Editor’s Note: Our Integrative Practitioners have selected a variety of supplements that are researched and found to be of higher quality; they are available in the Simms/Mann – UCLA Center for Integrative Oncology, Reflections Boutique, a non-profit store located in the 200 UCLA Medical Plaza Building, Suite 163, 310 794-9090 and can be purchased in-person or by phone and sent via priority mail. For patients who are interested in an individual education session, please contact the Simms/Mann Center at 310 794-6644.]

Who received the calcium and D had the best survival results.

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Making Sense of Nutrition and Supplements in Cancer CONTINUED FROM PAGE 7
Active Surveillance for Low-Risk Prostate Cancer (CAP)

Leonard S. Marks, MD, Professor of Urology, David Geffen School of Medicine at UCLA

This is a summary of a lecture presented on July 10, 2012.

Treatment for prostate cancer has significantly changed over the past few decades. At one time it would have been considered heresy to actively watch a prostate cancer instead of immediately performing treatments of surgery, radiation or chemotherapy; however, we now know that active surveillance is the right course of action in approximately 50% of all prostate cancer cases. Active surveillance is not a “do nothing approach.” Quite the contrary, active surveillance is a structured management strategy of monitoring men who have localized low-risk cancer of the prostate or for men who choose to defer conventional treatment. There are three main compelling reasons for this approach. First, many cancers of the prostate (CaP) are benign in nature; they will not progress in a way that is life threatening or harmful. Second, there is limited benefit from treatment for many men who have these types of lesions. Thirdly, there are many potential adverse effects of treatment.

In 2012 there were 241,740 new diagnoses of prostate cancer, but there were only 28,170 deaths from this disease. This significant discrepancy between frequency and mortality speaks to this issue that many of these cancers have very little impact on life expectancy. While the lifetime chance of developing prostate cancer is about 50%, only 16% will be diagnosed and only 3% will die from this disease. This underscores that not all prostate cancers are “terrible” cancers. In 1996 Dr. Wael Sakr did a study in Detroit, MI where he removed the prostates of all men that had died due to all causes unrelated to prostate cancer. He conducted over 500 autopsies and found that, as the age increased from 20 to 70 in this population, the number of prostate cancers in incremental decades also increased steadily. In the 70-79 year old group, 80% of both Caucasian and African American men had prostate cancer, but it was NOT the cause of their deaths. This indicates that while prostate cancer is a disease that many men die with; it may not be a cause of their death.

In a study published in the New England Journal of Medicine, Daniel M.gesk, who is a member of UCLA’s faculty, Dr. Bill Aronson, a group of men were studied at the Veterans Administration who agreed to be randomized to radical prostatectomy or observation. The study showed that there was less than a 3% decrease in mortality seen in this trial for those that were treated. This study, while open to certain criticisms, underscores that there may be little benefit to treatment for some men.

In 2008, a study published in the New England Journal of Medicine by Sandra and co-authored by one of UCLA’s faculty, Dr. Bill Aronson, a group of men were studied at the Veterans Administration who agreed to be randomized to radical prostatectomy or observation. The study showed that there was less than a 3% decrease in mortality seen in this trial for those that were treated. This study, while open to certain criticisms, underscores that there may be little benefit to treatment for some men.

In 48 men who underwent active surveillance but later had a radical prostatectomy they found that on average there was a 30 month delay from the original diagnostic biopsy to treatment. More importantly, the outcome for the men regarding well-being and disease status was the same as if they were treated at the time of the original diagnosis. In all 10 men with a tumor greater than 1 cm volume, the location of the tumor was in the anterior region of the prostate. The volume of the disease is important and difficult to assess with traditional ultrasound and systematic biopsy procedures. UCLA Active Surveillance Program (ASCAP)

An estimated 500 men per month become candidates for active surveillance in Southern California. UCLA designed a protocol to follow these men and to study them as well, thus creating opportunities to advance the field of prostate cancer diagnosis, surveillance, and treatment. To date, 250 men have been enrolled in the ASCAP project. When they agree to be followed in this way, they also sign informed consent that outlines how the information that is gathered will be used to learn more about the disease and, hopefully, improve quality of life and outcomes.

For men electing active surveillance, they receive a confirmatory biopsy 6 months after the original biopsy and then periodically thereafter. They are screened with a digital rectal exam and PSA every 6 months and they complete questionnaires on their quality of life and anxiety. To date, a 17% progression rate has been found in this study, which is below that of the nationwide average of 30%. The reason for the low progression rate at UCLA may relate to the sophisticated biopsy method employed at UCLA, which is described below.

One of the other aspects of the program has been a new focus on prostate imaging. Because we have one of the most up-to-date MRI facilities as well as a highly trained and skilled multi-disciplinary team, we are able to guide the patient together with ultrasound and MRI to view the actual prostate organ. This is called ULTRASOUND AND MRI FUSION and it is combined with biopsy site tracking. All of this is done with a device called the Artemis (Artemis was the “Greek Goddess of the hunt”). This device was FDA approved in 2008 and creates digitized images that can be constructed in 3D that allow us to identify the exact location of the biopsy and to return to this same site in future biopsies. UCLA prefers no longer to perform biopsies; since 2012 we are performing targeted MRI-guided biopsies. In some patients this has led to an ability to get to the anterior region and to find aggressive cancers that were otherwise being missed through the traditional blind systematic approach, wherein the prostate is divided into 6 sections. Pretreatment results from fusions-guided biopsy program are extremely encouraging. Many men with persistently elevated PSA, even after having undergone a negative biopsy by the conventional method previously, are now being found to have treatable prostate cancer upon targeted biopsy.

All of this speaks to the value of not only doing active surveillance, but doing it as part of a study where additional aspects of prostate cancer can be addressed and research can further the field. This can only be done in an academic institution where there is a multi-disciplinary team that includes a dedicated pathologist, surgical oncology urologist, a biomedical engineer, specially trained technicians and radiologists with specialization in the newest imaging techniques. Working together, this team is synthesizing their wide range of knowledge to move the field of prostate cancer diagnosis and treatment forward.

Summary and Conclusions

It should be noted that active surveillance programs have challenges. First, from a physician’s perspective, it requires that physicians change established practice and, sometimes, it may require them to manage patients for an extended period of time as well as loss of income from surgical procedures. For patients, the anxiety of living with cancer may be a barrier along with repeated medical procedures. For both physicians and patients there may be fears associated with a “lost opportunity” for cure. The research is addressing some of these challenges. However, the advantages of active surveillance programs may allow for the detection of tumors that otherwise would not have been detected, identifying which tumors are serious cancers, decreasing the overall number of biopsies, decreasing confusion over the biomarker such as PSA, and, finally, providing reassurance that active surveillance is appropriate for men with insignificant tumors. Active surveillance is an excellent management strategy for low-risk prostate cancer. Careful follow-up is absolutely mandatory and, thus, there needs to be high compliance on the part of the patient. Targeted prostate biopsy using advanced imaging technology is more accurate than blind systematic biopsy. Targeted biopsy is improving patient selection for surveillance versus immediate curative therapy of prostate cancer.

For more information on this technology and to see a video: Go to YouTube: Targeted Prostate Biopsy using MR-Ultrasound Fusion http://www.youtube.com/watch?v=LcU1t2dcK5o

Simms/Mann – UCLA Center for Integrative Oncology News, Spring 2013

INSIGHTS INTO CANCER
Lung cancer continues to be the leading cause of death from cancer, causing approximately the same number of deaths as breast, colon, prostate, and pancreas cancers combined. Smoking has a strong relationship to lung cancer—approximately 85% of the 200,000 cases per year are linked to a smoking history—but this does not tell the whole story. Approximately 15% of individuals who develop lung cancer NSCLC have never smoked. All patients who develop lung cancer are typically divided into two categories: (1) small cell lung cancer, which accounts for about 15% of diagnoses or (2) non-small cell lung cancer (NSCLC), which includes about 85% of the diagnoses. Within NSCLC there are three primary types: squamous cell (25-30%), adenocarcinoma (35-40%) and large cell carcinoma (10-15%). When you are diagnosed with lung cancer, the first thing that needs to be done is to determine the stage of your tumor. Treatment decisions are based on the stage. Staging is based on the size and characteristics of the tumor, the presence or absence of lymph node involvement and their location in the chest, and whether disease has spread to distant sites. Early stage NSCLC is treated most often with surgery. If the patient is not a good candidate for surgery, we will treat with radiation or we might consider radiofrequency ablation. In early stage disease where there are no nodes present, there is no data to support chemotherapy after surgery. In early stage disease where there is lymph node involvement, the risk of recurrence can be decreased with cisplatin-based chemotherapy. Unfortunately, many patients can be discussed with patients to tolerate and we do not really know which patients will benefit most from this treatment. From a statistical standpoint, 15-20 patients must be treated in order to prevent recurrence in one patient with chemotherapy treatment after surgery. As a physician, having this conversation with patients is very difficult because time is needed for healing after the surgery. These targeted therapies have been developed for small cell lung cancer to date. Stage IV disease is any lung cancer that has spread to other organs, such as to the brain or the bone. In addition, when there are lung cancer cells in the pleura (lining of the lung) or a condition called pleural effusion (increased fluid between the lung and the chest wall) or pericardial effusion (cells found in fluid around the heart), this is considered Stage IV disease and thus lung cancer must be treated systemically. Stage IV disease is almost exclusively treated with chemotherapy, although some symptomatic areas may also receive more focused treatment such as surgery or radiation. This might occur in situations where it has spread in an isolated way to the brain or bone and focal treatment may help with control. It is often difficult for patients to understand why the primary lesion cannot be removed from the lung when it is widespread, since they often see it as isolated masses of the disease. For the physician, it is seen as a systemic disease, such as diabetes, needing treatment that will encompass the body. Although lung cancer has spread to other organs, surgery may compromise or delay the necessary systemic treatments needed to get the disease under better control because time is needed for healing after the surgery. If there are surgical complications, it can further delay chemotherapy. All of these issues need to be considered and your doctor will make a decision based on what will lead to the best outcome for the patient.

Small Cell Lung Cancer Treatment

Only 2% of patients with small cell lung cancer are eligible for surgery since this disease is generally found after more extensive spread. This disease is treated as a systemic disease and treatment usually involves chemotherapy. It is standard practice that non-small cell lung cancer is staged, but it is further categorized as limited or extensive. The disease is “limited” when all of the disease can be encompassed completely within one radiation port and in these circumstances radiotherapy may be used. All other disease is thought of as “extensive” and, thus, must be treated with chemotherapy as a systemic treatment. The best most effective treatment is cisplatin or carboplatin and etoposide, although some patients have an absolute inability for etoposide. If the disease is limited, chemotherapy is still combined with radiation starting in cycle 1 or 2. Some patients also receive prophylactic whole brain radiotherapy, which has been demonstrated to increase survival in patients who respond to chemotherapy. Unfortunately, there have not been many advances in the treatment of this disease, most likely because so few patients go through surgery and there are very limited tissue samples to research and better understand the molecular nature of this disease. As a result, no targeted therapies have been developed for small cell lung cancer to date.

Non-Small Cell Lung Cancer Treatment

In NSCLC, cisplatin-based chemotherapy has been combined with other chemotherapies. The survival curves with each of these treatments look exactly the same. Research in the treatment of lung cancer as with other cancers, has been oriented toward understanding more about the molecular structure of the tumor itself and then searching for specific treatments. These treatments hopefully target some aspect of the tumor that promotes its growth or inhibits its demise. One of the first targeted treatments was an anti-angiogenesis drug. This class of drugs targets the tumor’s ability to generate blood vessels to help feed the cancer. As a tumor grows, it needs its own supply of blood and as a result must send signals to the body to create more blood vessels that directly support the tumor. An anti-angiogenesis drug stops the tumor from creating this blood supply. As a result, it limits tumor growth and the ability to spread to other areas. In a trial in which paclitaxel and carboplatin were compared to paclitaxel and bevacizumab (Avastin), significant improvement was found when the anti-angiogenesis drug bevacizumab was added to the 6 cycles of chemotherapy. One big question has been whether we should continue therapy after four to six cycles of initial chemotherapy. This practice is called “maintenance therapy.” In one trial, Erlotinib (Tarceva) was used as a maintenance treatment after 4 cycles of chemotherapy in Stage IIIb or Stage IV patients. This trial showed that the disease could be stabilized and was less likely to progress after response to the chemotherapy. In a study looking at maintenance therapy after Stage IIIB patients, the best supportive care versus a placebo after initial chemotherapy, pemtrexed and best supportive care was found to improve overall survival and progression free survival in patients with advanced disease. In addition, patients with a non-squamous tumor did better, thus confirming the importance of looking at the histology or type of tumor. Other chemotherapies can be helpful if the disease progresses after the initial treatment. For example, we have found that when docetaxel was given to patients who had been previously treated, their tumor stability and survival rate were improved. However, the actual tumor did not shrink very often, but at least it remained stable and stable is good.

Molecular Profiling of Lung Cancer Tumors and Novel Treatments

One of the exciting new areas of research in lung cancer involves molecular profiles of tumors in individual patients. The Lung Cancer Mutational Consortium was started by a grant that was funded through the 2009 Recovery Act. The goal of this grant was to molecularly profile 1000 different lung cancers. The objective was to test 1000 tumor specimens from patients with lung adenocarcinoma for KRAS, EGFR, BRAF, HER2, PIK3CA, AKT1, NRAS, MEK1, EML4-ALK and MET amplification. These mutations exist in the DNA of the tumor; they are not in the genes that a person is given from birth. Further, part of the goal is to try to identify which are driver mutations, meaning the mutations drive the growth of the tumor. Some of these may be bystander genes, meaning that they may promote or help with growth, but may not be essential for the survival of the cancer. We are still working to identify which elements of the tumor are true driver mutations. Another goal was to use the information in real time to either select one of 1000 different targeted therapies with EGFR mutations or recommend a lung cancer consortium clinical trial for patients who had a specific mutation identified. The consortium was successful in this process and found mutations in 54% of the samples that were analyzed. Since the start of this study, additional mutations have been identified and researchers hope to have a Lung Cancer Mutational Consortium II in the near future. For nearly half of the patients who were found to have a specific mutation in their tumor, these results could be used to guide the choice of the drug. We are still working to identify which elements of the tumor are true driver mutations. These targeted clinical trials have been exciting, informative and in many cases successful. We were able to have trials with fewer patients but had an increased likelihood of success because their treatment was specifically targeted to their tumor’s specific mutation. One problem that arises when unselected patients are enrolled in a targeted therapy is that all the patients that one would not expect to benefit are included in the analysis of the data. This can dilute the findings such that a drug may not appear to be effective when it is in fact effective but for only a particular population.

INSIGHTS INTO CANCER

LUNG CANCER 2012: TRADITIONAL AND NOVEL APPROACHES

EDWARD GARON, MD, DIRECTOR OF THORACIC ONCOLOGY PROGRAM, ASSISTANT PROFESSOR OF MEDICINE, DIVISION OF HEMATOLOGY/ONCOLOGY

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This is a summary of a lecture presented on September 11, 2012.

10 Simms/Mann – UCLA Center for Integrative Oncology News, Spring 2013
This occurred with a drug called gefitinib (Iressa), where many patients were put on the drug because the initial trials looked promising, but the actual trial did not respond as well with Tarceva as patients who do have the mutation. There are clear benefits to identifying the mutation and having a drug that targets the mutation.

A significant shift is occurring in research and in the scientific paradigms for understanding cancer and clinical trials. For example, new studies are being done where a group of patients with a particular mutation is tried on a targeted therapy that may already be approved. The goal is to try it in a small number of patients, a Phase I trial, to see if there is any benefit. If there appears to be none, then research dollars are saved because a huge randomized trial can be avoided. In addition, trying to develop therapies for the known mutations, progress can be made in subsets of lung cancer as research continues on understanding the mutations that are not currently known. There are old drugs that were shelved because they showed some promise in a few patients, but when tested more globally, did not work. The hypothesis is that previously, we lacked the ability to identify who would benefit from the drug and thus washed out the advantage of the drug by using it on people for whom it would never work. This is a significantly different way of approaching lung cancer and, in fact, many cancers.

EGFR mutations have been responsive to Tarceva, yet that drug sometimes does not work or stops working for some patients. One key is to figure out the next drug that may be able to target that same mutation in a different way. AUY922 is an example of some of that work.

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 old tradition for expressing your wishes, 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 — Two weekly support groups, one for only women with recurrent or metastatic disease and one open to all patients with recurrent or metastatic disease.

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

#### Looking Ahead — A monthly group for women who have finished treatment and have no evidence of disease.

#### Breast Cancer — 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.

#### Iranians Touched by Cancer — A bi-weekly support group held in Farsi for Iranian cancer patients and their family members.

#### 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.

### FOR FAMILY MEMBERS & FRIENDS

#### Bereavement Group for Spouses/ Partners — A bi-weekly group for men and women who have lost a spouse/partner to cancer.

### Conclusion

Over the last 10 years there have been significant improvements in the treatment of lung cancer, with more improvement for patients with tumors having some specific molecular changes. One of the biggest limiting factors is the amount of funding available for this disease. Even with this limitation, researchers here at UCLA and around the world are making significant strides forward. The goal at UCLA is to look at the evidence, pick the best trials that have supporting theory and data and to bring these to the clinic for patient participation. While chemotherapy will likely play a significant role in the future, newer treatments are adding benefit and changing care. For now, a goal in metastatic disease might be to have treatments that evolve such that as one treatment reaches its limit, there is another treatment that extends that limit. In so doing, patients are able to live for longer period of time and, hopefully, enjoy a life with meaning.
EXERCISE AND CANCER

MARY L. HARDY, MD, MEDICAL DIRECTOR, SIMMS/MANN – UCLA CENTER FOR INTEGRATIVE ONCOLOGY, INTERNIST, INTEGRATIVE MEDICINE PHYSICIAN, ASSOCIATE PHYSICIAN, DEPARTMENT OF MEDICINE, DIVISION OF HEMATOLOGY-ONCOLOGY, DAVID GEFFEN SCHOOL OF MEDICINE AND AUDREY CHERNOFSKY, BS, PT, KAREN HUNT, BS, DT AND ANNETTE SWEZEY MSHP, FROM THE OSTEOPOROSIS PREVENTION AND TREATMENT CENTER.
This is a summary of a lecture presented on May 8, 2012.

Exercise has a helpful role throughout the cancer journey, from prevention and risk reduction, during active treatment, through the transition to recovery and as risk reduction for a new cancer or recurrence of a previous cancer. Not only is exercise critical in cancer survivorship, it is also important for the health of caregivers as well.

Exercise can impact cancer in both direct and indirect ways:

• Exercise can decrease the risk of getting a cancer.
• Exercise can help decrease some of the symptoms caused by treatment for cancer.
• Exercise can increase longevity after a cancer diagnosis.
• Exercise helps to maintain normal body weight.
• Exercise improves quality of life.
• Exercise is useful in reducing fatigue, and breathlessness.
• Exercise improves cardiac fitness and, thus, will improve performance status which is a general measure of overall wellness and functional ability.
• Exercise helps with stress management.
• Finally, for individuals who are cancer survivors, exercise reduces the risk of other illness such as heart disease, hypertension, stroke and osteoporosis.

It is important to aim to have a healthy weight throughout life. To help achieve this and reduce cancer risk, be physically active for 20 minutes or more most days and choose a mostly plant based diet, limiting red and processed meat. The American Institute of Cancer Research in 2007-2012 published papers integrating weight, diet and physical activity to increase cancer prevention. On their website, you can find good resources and tools to help you assess your personal status and address these issues as well. (http://www.aicr.org/reduce-your-cancer-risk) We estimate that approximately one third of the most common cancers could be prevented by healthy lifestyle changes that include staying lean, eating smart and moving more. Approximately 38% of breast cancers, 45% of colorectal cancers, 36% of lung cancers and 70% of endometrial cancers are believed to be preventable based on lifestyle!

Exercise affects the characteristics of cancer development, especially in hormone driven cancers such as breast, prostate and endometrial cancer. Exercise modifies hormones and the binding qualities of hormones as well as influencing the glycemic index of the diet. Exercise increases the insulin sensitivity of skeletal muscle and, therefore, decreases the amount of insulin and glucose circulating in the body after eating food. High insulin levels and insulin insensitivity are components of metabolic syndrome. Metabolic syndrome can develop into diabetes, a very negative metabolic state in the body that is associated with increased cancer risk. Individuals with metabolic syndrome accumulate fat around their waist (also called central obesity), have impaired glucose intolerance, hypertension, and high blood cholesterol.

Metabolic and endocrine changes arising from obesity affects hormones, insulin and glucose stores—all of which can lead to increased risks for many different types of cancer. According to a recent study, a 200% increased rate of breast cancer recurrence occurred in women with metabolic syndrome and higher serum testosterone levels.

Excessive weight is also associated with a greater risk of developing many types of cancer, especially pancreatic cancer, esophageal cancer, colon cancer, breast cancer and endometrial cancer. Not only does excess weight affect insulin and glucose metabolism, but central obesity promotes inflammation, a final common pathway for cancer and many other chronic diseases. It is essential to maintain a healthy weight, in part by increasing lean muscle mass rather than fat. The information in this article is empowering because it provides us with recommendations and activities within our own control that we can implement to reduce our risk and make our body less cancer friendly.

The importance of exercise to breast cancer development has been shown in a number of recent studies. Breast cancer risk was substantially lower in athletes versus non-athletes. Exercise appears to be most protective for women who develop their breast cancer after menopause. For post-menopausal women, staying fit and maintaining weight may reduce the risk of death by 40% from breast cancer. The amount of physical activity after a breast cancer diagnosis also seems to influence breast cancer mortality. Women with the highest activity levels had substantially lower mortality than their sedentary cohorts.

Recommendations have been made for people to exercise 150 min per week of moderate exercise or 75 minutes per week of vigorous exercise. So, how do we measure activity levels? With METs. MET stands for metabolic equivalent task. One MET is the amount of energy expenditure and caloric requirement when a person is at rest and just breathing. Walking at a leisurely pace increases energy expenditure to about 2.5 METs per hour of walking while vigorous activity can increase METs to much higher ranges of 6-12. Walking at a very brisk pace for an hour, 1 mile every 17-18 minutes is 3.5 METs. The desirable level is at least 8 METs per week. This measurement allows a more precise exercise goal to be set for an individual but an easier rule of thumb states that moderate exercise allows you to be able talk while you are doing it and vigorous exercise does not allow you enough breath to talk.

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In a very important study called “Women’s Healthy Eating and Activity (WHEAL), survival was evaluated over a 9 year period for four groups of women. The four groups were assigned to eat a diet that was either high or low fruit and vegetable intake combined with high or low levels of physical activity, i.e., women who had both low fruit and vegetable intake and low physical activity, those with high fruit and vegetable intake and low physical activity, those with low fruits and vegetable intake and high physical activity and the women who had both high fruit and vegetable intake and high physical activity. The greatest survival rates were those who had high fruits and vegetable intake and were high in physical activity and this group had significantly fewer recurrences than the other three groups. Obesity is an independent risk factor for recurrence. The obese subjects who were in high fruits and vegetable group plus high physical activity group had the same recurrence risk as their non-obese cohort. Thus, it appears that high physical activity coupled with a diet high in fruits and vegetables, and high physical activity has benefits in longevity and longer disease-free time for colon cancer patients in active treatment, there were no correlation. All studies showed that high occupational activity was highly significant. It means that you can modify risk even before you lose weight or change all of your lifestyle habits.

There are more than 20 studies demonstrating the positive effect of physical activity on colon cancer. As the rate of activity goes up the rate of colon cancer goes down. This does not, however, appear to be the case for rectal cancers, where there seems to be no correlation. All studies showed that high occupational activity that is engaged in all day long, was also a preventive factor in colon cancer risk. For stage III colon cancer patients in active treatment, there were benefits in longevity and longer disease-free time for patients who walked 45 minutes per day. Modest benefits in longevity and longer disease-free time for colon cancer patients in active treatment, there were no correlation. All studies showed that high occupational activity was highly significant. It means that you can modify risk even before you lose weight or change all of your lifestyle habits.

Summary

The American Cancer Society has developed physical activity recommendations. They include:

• Adults should get at least 150 minutes of moderate intensity or 75 minutes of vigorous intensity activity each week (or a combination of these), preferably spread throughout the week. We suggest that you try to exercise most days as this increases the likelihood that you will develop this as a regular habit and actually achieve the goal.

• Children and teens should get at least 1 hour of moderate or vigorous intensity activity each day, with vigorous activity on at least 3 days each week. We have a serious problem with our youth no longer getting enough exercise and becoming more obese and less healthy than ever before. There are benefits to doing exercise in your early years and carrying it throughout your life time.

• Limit sedentary behavior such as sitting, lying down, watching TV and other forms of screen-based entertainment. Do not sit in front of the TV, your computer, or other device all day. Being a couch potato is unhealthy for you!

• Doing some physical activity above usual activities, no matter what one’s level of activity, can have many health benefits.

Exercising is not an excuse to eat more and needs to be done in addition to a healthy diet. Exercise does help to burn calories; however, it takes a lot of exercise to burn off something that is unhealthy and highly calorific. For example, to burn off one large order of French fries (400 calories), it will require 95 minutes of moderate walking, scrubbing floors for 89 minutes, dancing for 75 minutes, bicycling for 25 minutes or running for 28 minutes. IT REALLY MAKES THOSE FRENCH FRIES LOOK A LOT LESS ATTRACTIVE!

There are many different ways to get exercise and to increase METs. Some of these include aerobic activities that increase your cardiac fitness by increasing your pulse and cardiac output (walking, swimming, running, dancing, biking, spinning or aerobic exercise classes), strength training (lifting weights, doing isotonic exercise or using high intensity stretchy bands), balance training, stretching, household activities (weeping in the garden, mowing the lawn, scrubbing floors), transpor- tation (walking, running, roller skating, biking), leisure activities (golfing without a cart), tennis, basketball and finally recreational activity (construction, getting up and down and walking in a workplace, digging, landscap- ing, heavy manual labor). Some aerobic exercise is weight-bearing which has additional benefits. However, keep in mind that joint protection should always be considered; especially for individuals with osteoarthritis, metastatic bone disease and/or those who are at high risk of injury.

Getting Started with Exercise

Motivation is an important part of exercising and hav- ing a reason to exercise is important in terms of setting a goal. You have to make time in your schedule and commit to doing it in the same way that you approach your day—you need to include exercise as part of your day in the same manner as eating meals, brushing your teeth, or going to work. Set a goal that you can succeed at by making it reasonable and increasing your goals over time as you reach them. Setting too high of a goal can be a good way to keep yourself from succeeding be- cause it may lead to feeling of defeat and self-criticism which reinforces the wrong choice. Choose the easiest thing first. Make a regular time to exercise, and find a partner or participate in group activities to increase the likelihood of success. You have a back-up plan in case the first time does not work. Do not give up!

Here are some ideas to get started:

• Limit the time spent watching TV and using other forms of screen-based entertainment.

• Use a stationary bicycle/treadmill when you do watch TV.

• Use stairs rather than an elevator.

• If you can, walk or bike to your destination.

• Exercise at lunch with your coworkers, family, or friends.

• Take an exercise break at work to stretch or take a 15-20 minute walk at lunch.

• Walk to visit coworkers instead of phoning or send- ing an e-mail.

• Go dancing with your spouse or friends or take a dance class.

• Plan active vacations rather than only driving trips.

• Park farther away and walk a little extra to your office, to the grocery store, to your doctor’s appoint- ment.

• Wear a pedometer every day and increase your number of daily steps.

• Join a sports team.

• Get an exercise partner to help you.

When getting started, it is important to remember that safety comes first. See your doctor if you have not exer- cised in a long time or if you have any heart problems. Start slowly. Gradually increase the duration, intensity and frequency of your exercise. On the first day, do less rather than more to see how this affects you, if you get too sore the first time out you will not want to exercise again. Take your pulse several times during exercise to check to make sure that you are not exceeding your maximal heart rate. Remember to warm up properly and cool down with stretching. Rehydrate frequently in hot weather and protect your skin if exercising outside with a hat and sun block.

To take your pulse, find one of the pulse points on your wrist or neck. Place a finger firmly, but do not press if you are using the pulse in your neck. Count the number of beats during a 30 second period and multiply that number by two. To determine your maximal heart rate, subtract your age from the number 200 and that is your maximal heart rate. For example, if you are 50, then 200-50=150. Keep your heart rate in the range of 50-70% of your maximal rate for moderate intensity activ- ity. Vigorous intensity activity is defined by keeping your heart rate in the range of 70-85% of your maximal rate.

Below are some lists of activities that fall into moder- ate intensity and vigorous intensity although there can be differences even within these categories depending upon the intensity of effort that is invested:

Moderate Intensity Activity

• Jogging or running, fast bicycling, circuit weight training, aerobic dance, martial arts, jumping rope, swimming.

• Soccer, field or ice hockey, lacrosse, singles tennis, racquetball, basketball, cross-country skiing.

• Digging, carrying and hauling, masonry, carpentry.

• Heavy manual labor

It is very important that you start slowly if you do not exercise regularly. Even experienced athletes need to warm up to prevent muscle injury. Stretching loosens muscles and tendons and prevents injury. Stretching during the day can also relieve muscle strain and aches associated with tension, repetitive movement and poor body mechanics.

Summary

Our goal is to improve your health, prevent cancer or recurrences, or get through your cancer treatment with minimal symptoms. Exercise combined with diet will help lead to improved health, both physical and mental. Try to pick activities that you like and can stay with. Having an overall wellness plan is good for everyone, whether you have cancer, you are trying to prevent it or prevent a recurrence, or you just want good quality of life.
“My experience at the Simms/Mann Center continues to be invaluable for me and my partner. Everything we have experienced here has helped us to cope, manage, survive, live, laugh, become more resourceful and vocal.”

“I deeply appreciate the vast array of resources that were offered to me gratis at the lowest point in my life. The help I received enabled me to continue functioning in my daily life. Without it I wouldn’t have been able to work or take care of my family. Many thanks!”

We are grateful to be able to provide the kind of care reflected in these patient comments because we do understand that medicine alone is not enough and cancer affects more than just one’s physical condition.

We are able to do this only because of the generosity of many. We need your generosity in order to be here for the next patient or family member who is diagnosed with cancer. We hope that, as you read through our newsletter and think about what we offer, you will help us continue to provide so many services without fees to patients and families touched by cancer. 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.

We hope that every patient and family member who has contact with the Center will make at least one donation each year to the extent of their ability! If you have benefited from our services you could write an email to your network of family and friends asking them to donate to the Center. The son of one of our patients wrote a compelling email to his friends about his mother’s breast cancer that led to multiple donations. We know not everyone can make substantial donations, but every donation helps. 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 and others like you through this experience.

It costs approximately $1,000 to provide the range of services that we offer to each patient or family member who receives our services without charges. You can become a member of the “One-to-One Club” by making an annual donation of $1,000 (just $84 per month) or more depending on how many individuals you wish to sponsor for the next year. One-to-One members are included in some of our special events and may reserve seating at our Insights Into Cancer lectures. We hope you will consider joining this important group of donors!

Members of our Advisory Board make annual donations of a minimum of $10,000 for at least three years. This is an excellent opportunity to be involved with a wonderful group of individuals who are highly motivated to help the Center maintain its leadership in the field of integrative oncology. You or someone you know may be able to make such a commitment. Please contact the Center Director for more information.

For those who may not be able to make gifts at this time, an estate gift is another way to continue our free services into the future. The Simms/Mann Center is not endowed and is not funded by the University or the State—we depend on your generosity.

“I give because I want to make certain that the next patient or family who hears, ‘It’s cancer,’ will have the Simms/Mann Center as their partner in this journey.”

HOW WILL WE USE YOUR GIFT?
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. 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.

PROCEDURE FOR MAKING A GIFT TO THE RESOURCE CENTER
To make a gift to the Center, complete one of the gift envelopes available in the Center’s lobby or in Reflections, or send us a brief note stating the purpose of your gift, your name and address. You can pay by credit card or check payable to the JCCF/Simms/Mann Center. You will receive a letter of acknowledgement from the Center and tax acknowledgement from the Foundation.

You can also make a donation online at our website: www.simmsmanncenter.ucla.edu/support/section/donate_now.asp

If your gift is in memory or in honor of another person, please include the name and address of the person who should be notified. We will send a letter to that person stating that a gift has been received. The amount of the gift will not be disclosed. Our website and newsletter includes lists of the names of those who have made a donation to our Center during the past fiscal year. The exact amount of the gift is not publicized although we publish ranges.

Please send your donation envelopes or letters to:
SIMMS/MANN - UCLA CENTER FOR INTEGRATIVE ONCOLOGY
200 UCLA Medical Plaza, Suite 502
Los Angeles, CA 90095-6934

If you have any questions or would like more information, call us at 310-794-6644. Thank you for your support!
INSIGHTS INTO CANCER

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,
• Log on to our webpage, www.SimmsMannCenter.ucla.edu.
• On the left hand side of the home page select Articles, Videos and More
• Select Lecture Summaries and Videos
• From there, choose the lecture you wish to view and click the arrow to begin the video.

Encourage your friends and family to log on 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!

2013 SPEAKERS & TOPICS

PETICT CANCER IMAGING: CANCERS EAT A LOT OF SUGAR  – Johannes Czernin, MD, Professor, Vice Chairman, Department of Molecular and Medical Pharmacology, Chief, Ahmanson Translational Imaging Division at UCLA provides a multi-media presentation on the most exciting and novel imaging tools in oncology today, the PETICT scans. These scans play vital roles in determining the stage of cancer, what areas are involved and the impact of treatment. Through presentation and pictures, patient and families member see the importance of these new technologies in their overall cancer care and as a result may be better prepared to talk to their physician about the results and uses of scans.

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LIVING AND THRIVING IN NOT-KNOWING: ZEN BUDHISM AND CANCER  – Rev. Wendy Egyoku Nakao, Abbot of the Zen Center of Los Angeles discusses how a cancer diagnosis throws us into the unknown and forces us to bear witness to the changing nature of life by challenging our belief systems, personal conditioning, spiritual beliefs, and shaking up our hopes and dreams. She explores how Zen Buddhism uses these very elements of upheaval as a skillful means for living with the sense of groundlessness that accompanies major illness and how the practices of Not-Knowing, Bearing Witness and Healing Actions provide a means to address and overcome the challenge of cancer and illness.

MELANOMA 2013: UPDATE ON ANTI-CANCER THERAPIES  – John A. Glaspig, MD, MPH, UCLA Professor of Medicine, oncologist and researcher presents the latest information about melanoma, the most serious kind of skin cancer. Small localized lesions can be treated with surgery; however, when melanoma spreads to other organs it can be a difficult disease to stop and traditional chemotherapies have been less than effective. Promise lies in novel targeted approaches including those that utilize the body’s own immune system. The latest treatments used in the clinic and in research trials are discussed with their promise for now and the future.

SLEEP DISTURBANCE AND FATIGUE IN CANCER SURVIVORSHIP  – Michael Irwin, MD, Norman Cousins Professor and Director Cousins Center for Psychoneuroimmunology Semel Institute, psychiatrist and researcher, describes the inter-relationships between cancer, sleep disturbance, and fatigue. Problems with sleep and fatigue often arise during cancer treatment and can persist long-term, complicating survival and reducing quality of life. New research links alterations in inflammatory biology dynamics to these long-term effects which are discussed along with effective strategies to identify those at greatest risk as well as strategies for prevention and treatment of sleep disturbance and fatigue in cancer survivors.

CANCER AND LGBT PATIENTS AND FAMILIES  – Allison L. Diamant, MD, MHS, UCLA Associate Professor, researcher and internist, and Thomas J. Pier, MSW, LCSW, Clinical Oncology Social Worker at the Simms/Mann – UCLA Center for Integrative Oncology and Field Instructor for UCLA’s Department of Social Welfare, discuss cancer risk factors unique to the LGBT community highlight the importance of specialized screening and early detection for LGBT patients and those at risk and the importance of coming out to the treatment team. Unique needs of LGBT patients diagnosed with cancer and its impact on their non-traditional family structures are also addressed with consideration for ways of reducing barriers for LGBT patients and families so they can maximize medical treatments and receive appropriate psychosocial support and spiritual care throughout the continuum of cancer – treatment, survivorship and end of life care.

MAINTAINING A HEALTHY IMMUNE SYSTEM THROUGH CANCER TREATMENT AND BEYOND  – Mary Hardy, MD, integrative medicine physician and Medical Director of Simms/Mann – UCLA Center for Integrative Oncology, discusses a topic of great interest to patients diagnosed with cancer as they seek to find ways to participate in optimizing their own health. Supporting the immune system is one of the most common reasons patients take dietary supplements with or without a cancer diagnosis. The latest research on the effects of immune nutrition and supplements for immune health are discussed as well as how to review and interpret labels of dietary supplements.

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SLEEP DISTURBANCE AND FATIGUE IN CANCER SURVIVORSHIP  – Michael Irwin, MD, Norman Cousins Professor and Director Cousins Center for Psychoneuroimmunology Semel Institute, psychiatrist and researcher, describes the inter-relationships between cancer, sleep disturbance, and fatigue. Problems with sleep and fatigue often arise during cancer treatment and can persist long-term, complicating survival and reducing quality of life. New research links alterations in inflammatory biology dynamics to these long-term effects which are discussed along with effective strategies to identify those at greatest risk as well as strategies for prevention and treatment of sleep disturbance and fatigue in cancer survivors.

CANCER AND LGBT PATIENTS AND FAMILIES  – Allison L. Diamant, MD, MHS, UCLA Associate Professor, researcher and internist, and Thomas J. Pier, MSW, LCSW, Clinical Oncology Social Worker at the Simms/Mann – UCLA Center for Integrative Oncology and Field Instructor for UCLA’s Department of Social Welfare, discuss cancer risk factors unique to the LGBT community highlight the importance of specialized screening and early detection for LGBT patients and those at risk and the importance of coming out to the treatment team. Unique needs of LGBT patients diagnosed with cancer and its impact on their non-traditional family structures are also addressed with consideration for ways of reducing barriers for LGBT patients and families so they can maximize medical treatments and receive appropriate psychosocial support and spiritual care throughout the continuum of cancer – treatment, survivorship and end of life care.

MAINTAINING A HEALTHY IMMUNE SYSTEM THROUGH CANCER TREATMENT AND BEYOND  – Mary Hardy, MD, integrative medicine physician and Medical Director of Simms/Mann – UCLA Center for Integrative Oncology, discusses a topic of great interest to patients diagnosed with cancer as they seek to find ways to participate in optimizing their own health. Supporting the immune system is one of the most common reasons patients take dietary supplements with or without a cancer diagnosis. The latest research on the effects of immune nutrition and supplements for immune health are discussed as well as how to review and interpret labels of dietary supplements.

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 (310) 794-6644. Our lectures are held in the Ronald Reagan UCLA Medical Center (RRMC) 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 RRMC.

Simms/Mann – UCLA Center for Integrative Oncology News, Spring 2013 15
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Reflections® is a boutique that provides information, resources and products to help men, women and children manage the physical appearance changes caused by cancers and their treatments. Our staff are certified fitters of mastectomy bras, prostheses and lymphedema garments and have many solutions for hair loss.

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