VISION
COPING WITH CANCER
VISION, JUNE 2015

Immunotherapy - the talking point at ASCO 2015

The annual American Society of Clinical Oncology (ASCO) meeting brings together over 30,000 oncology professionals from around the world to discuss research into new treatments, practices and scientific insights.

Much of the excitement at the conference was about immunotherapy. Rather than targeting a tumour directly, immunotherapy works by recruiting immune cells to target the disease instead.

"The field of targeted immunotherapy gets more exciting every year," said ASCO expert Lynn Schuchter, MD, FASCO. "With these trials, we're rapidly moving past the era in which immunotherapies are seen as breakthroughs for melanoma alone. Remarkably, these drugs are proving effective in other cancers where practically no other treatments work. Just as important, it's possible that we'll be able to pinpoint, in advance, which patients are the best candidates for these therapies. Unfortunately, not every tumour responds to immunotherapy in the same way. So, while immunotherapy is often the best treatment option available, it isn't equally effective for everyone.."

One type of drug that received particular attention at the conference binds to a molecule on our immune cells called PD-1. This effectively stops one of the ways cancer cells avoid being destroyed by our immune cells. These drugs have been generating interest for some time. A study presented at this year's conference compared one of these 'anti-PD-1' drugs – nivolumab – to chemotherapy for patients with advanced lung cancer. Those receiving the immunotherapy treatment survived for several months longer than those on chemotherapy, and with fewer side effects.

Another study used a combination of different immunotherapy drugs to treat patients with advanced melanoma. In this case, nivolumab was combined with another drug known as ipilimumab , that works in a slightly different way: it releases the brakes on the immune system. This 'one-two punch' meant that well over half (57 per cent) of patients in the study responded to the treatment, as opposed to only a fifth (19 per cent) who were given ipilimumab alone. But, unfortunately, there were also far more severe side effects as a result of the combination of treatments.

Many more studies looked into various combinations of immunotherapy treatments in several cancer types – for example head and neck cancers, liver cancer, and certain types of bowel cancer.

What is immunotherapy?

The American Cancer Society describes it as a treatment that uses certain parts of a person's immune system to fight diseases such as cancer. This can be done in a couple of ways:

- Stimulating your own immune system to work harder or smarter to attack cancer cells
- Giving you immune system components, such as man-made immune system proteins

Some types of immunotherapy are also sometimes called biologic therapy or biotherapy.

For a long time doctors suspected that the immune system could affect certain cancers. Even before the immune system was well understood, William Coley, MD, a New York surgeon, first noted that getting an infection after surgery seemed to help some cancer patients. In the late 1800s, he began treating cancer patients by infecting them with certain kinds of bacteria, which came to be known as Coley toxins. Although he had some success, his technique was overshadowed when other forms of cancer treatment, such as radiation therapy, came into use.

Since then, doctors have learned a great deal about the immune system and how it might be used to treat cancer. In the last few decades immunotherapy has become an important part of treating some types of cancer. Newer types of immune treatments are now being studied for many other types, and they'll impact how we treat cancer in the future.

Immunotherapy includes treatments that work in different ways. Some boost the body's immune system in a very general way. Others help train the immune system to attack cancer cells specifically.It seems clear that immunotherapy will be playing a key role in the future of cancer treatment.

Contacting Reach for Recovery

CANSA offices in Houghton,Johannesburg, have been sold and Reach for Recovery need to vacate the premises by the 30th June. The Telephone No. (011) 487-2895 will then no longer be in use so please if you could call on the Cell No. 072-849-2901 should you need to get in touch with Val at Reach for Recovery.

Cancer.Vive Poker Run

Details and more pictures on page 5.

Cancer survivorship and what it means to me

My first battle with kidney cancer was with a 20 pound rascal that went metastatic back in 1995.After the best treatments of the day had failed and I was given up for dead, I managed to put together an effective programme of guided imagery to solve the problem. You can perhaps imagine all the feelings that went through my now aged brain as I tried to muster up another win, this time with an 81 year old body.

Against my better judgement, I started a Sutent (sunitinib) programme that worked well until it didn't. One year ago, side effects from sutent had put me in the hospital without the use of my legs. I am still learning to walk again. I pulled the plug on Sutent, after taking some time off and went for a low dose programme of Inlyta (axitinib), which is far more tolerable. I sometimes give myself holidays under the presumption that what the oncologist doesn't know won't hurt him.

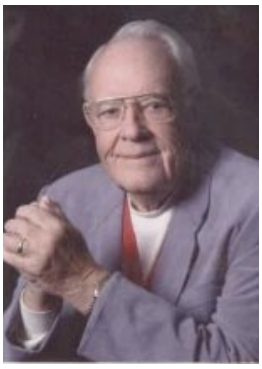
There are many things the additional 20 years of life that have brought me most involved personal happiness. But it has also afforded me the time to resume theoretical work on one of my research efforts that was interrupted by cancer back in 1993.

I made some new Guided Imagery CDs specific for the purpose and have used them several times a day, day after day. Some of you might be interested in the fact that for every pill taken during this ordeal, we have held it in our hands and all present have participated in a quiet time of prayer for healing as in James 5 in the New Testament.

Now for the good news. By every site scanned, the radiologist wrote "great" as the shrinkage was everywhere remarkable. So much so that my oncologist assured me that I would most likely die of something beside kidney cancer. He even pulled back on the ongoing dose and did not think it necessary to come back for three months which will give this poor old body a rest .

As terrifying as the first diagnosis of cancer can be, I think that recurrence after years of dormancy can in some respects be worse. Many people just give up rather than go back into that fierce battle.

About the author



In 1993 Gerald White survived a 20 pound kidney tumour that subsequently went metastatic to distant organs. After all medical treatments had failed and the dreadful "only three more months" death sentence had been delivered. He worked out a self-directed programme memes of guided imagery that induced a remission in three months. He has served a three year term as a Director of the National Kidney Cancer Association.

Through his web page he maintains an active world wide mentoring programme that has yielded many similar remissions of cases thought to be hopeless. Gerald has also produced a guided imagery CD plus one especially produced for children. Details can be found on his website http://cancerwarsmaarsjourney.com/

My purpose in making this post is to encourage those people who find themselves in this, the ultimate disappointment. First, I urge you to remember that you have beaten it once, you can do it again. You still have your personal and spiritual resources and medicine is making some progress, although at a slow pace. Never give up nor let any thing or anyone take your hope away. Your hope belongs to you and while you can choose to give it away, it cannot be taken without your consent.

It is a grand sight to see an oncologists face beaming like the morning sun and I took the opportunity to tell him how much I admired his determination and compassion in putting up with me. We then had a few minutes of beautiful conversation wherein my purpose was to give him something that I felt he needed, and there was cemented a beautiful friendship. The intervening years and wonderful people who have come into my life have taught me that I was, indeed, blessed by a 20 pound kidney tumour.

Should anyone ask, "Who wants to live to 84?", the answer is, a person who is 83.

IT IS POSSIBLE! YOU CAN DEFEAT CANCER!!

Introducing Cancer Dojo

Our aim is to empower people facing cancer by giving them a role in their own cancer. Traditionally cancer patients are not given a role in their own healing, which can lead to depression and an even more compromised immune system. These feelings of helplessness are hugely debilitating and lead to a higher cancer death rate.

Research shows that being empowered in a debilitating situation has fundamental and beneficial effects on your immune system; enabling one to be more resilient and bounce back from treatments and setbacks better than others facing the same conditions.

We, together with professors, medical doctors and cancer oncologists, believe this fact is underutilised in the context of cancer survival. So we're building a tool to change this: The Cancer Dojo mobile app is an application that enables people living with cancer to boost their immune systems, increase the efficacy of their treatments and bounce back more resiliently. It is a complimentary way to augment the traditional treatments of surgery, radiation, chemotherapy and many others. It is the one overarching layer that can positively enhance a potentially long and hard cancer experience.

Help us make this a reality, increase the cancer survival rate and save thousands upon thousands of lives.

Cancer Dojo is a space that brings the power of visual thought to life. We provide a platform where people can grow, learn and share skills and tools as active participants in their bout with cancer.

We aim to increase the survival rate one playful mind at a time.

We're crowd funding over at ThundaFund and have now reached the R 50 000 mark, but still need all the help we can get. Join us, let's see how we build this benevolent beast. https://thundafund.com/CancerDojo.

Cancer Dojo is social enterprise partner of People Living With Cancer, a registered Non Profit Organisation.

Compromise

How much therapeutic suffering would you endure to save your life? What if not to save your life, but to add five years? One year? Two months? The weekend of your daughter's wedding? What does quality mean to you, and how do you balance benefit, risk, life and death? This is not a theoretical, make believe question, this is real life, because the best and most compassionate doctor might advise, your family support and cajole, and the experts publish their "findings," but in the end it is up to you.

Friday, 10:00am: Lee is a 61-year-old-man with Chronic Myelogenous Leukemia (CML). His disease has responded to an oral "kinase inhibitor," which has put him into remission. Remission in CML is not cure, but is control. CML is often a fatal disease. The medication has given Lee mild side effects, the worse of which is occasional nausea and some swelling of his ankles. Therefore, even after exacerbated education by me, Lee has drastically reduced his dose of medicine. The side effects are less, but his risk for early relapse is substantial.

Friday, 2:15pm: Bill is a 66-year-old-man with CML. His disease has responded for several years to an oral kinase inhibitor, which has put him into remission. The side effects are severe. Bill has nausea with a 21-pound weight loss, a scaly, almost disfiguring facial rash, headaches and significant fatigue. Bill is house bound, withdrawn from an athletic lifestyle, which included tennis, boating and hiking. However, even after extensive discussions with me, Bill vehemently apposes any change in his treatment.

This is the nature of all medical decisions; Compromise. How much benefit for how much risk. Or loss. What are your goals and what are you prepared to sacrifice? What does suffering mean? How do you measure cost?

For now, I am not talking about money. Too often in our "modern" medical world, we confuse or combine cost in dollars, with cost in suffering or quality of life. Yes, that is an important conversation, just not here, right now. I am talking about how much a patient is willing to sacrifice of life itself, in order to gain the possibility of more time alive. For this moment, let us leave our checkbooks in the drawer.

If we take a medicine for blood pressure, which might protect us from stroke, the benefit is obvious. However, what if it gives us an occasional cough? Dizziness? Nightmares? Stiff joints?

A bone marrow transplant for lymphoma can cure, but is a very tough mountain to climb. Makes sense for a healthy 29-year-old with a 2-year-old son. For such a patient there is almost no amount of suffering which is not "worth it," even if the potential benefit is in the single digits. But, what about a 75-year-old with heart disease? A 29-year-old with a progressive neurologic disorder?

Healthcare decisions are compromise. Go out for a jog, twist your ankle. Vegan diet, miss that steak. Have a colonoscopy, enjoy the prep. Save your breast, undergo radiation. Treat an incurable, but just maybe, briefly, controllable cancer, lose your hair, deplete the strength in your legs, get fevers and maybe miss that last graduation or cancel that once-in-a-lifetime-the-thing-I-always-planned-to-do trip. "Do everything," and die on a ventilator surrounded by strangers, instead of in the home you love.

Any doctor will tell you that decisions around compromise, balancing real life goals with real medical facts, is at the core of the physician – patient relationship. Skilled clinicians first listen in order to understand how a patient sees the world, in order to phrase education and advice within the context of that person's "zeitgeist."

Dr. Salwitz is a Clinical Professor at Robert Wood Johnson Medical School.

He lectures frequently in the community on topics related to Hospice and Palliative Care and has received numerous honours and awards, including the Physicians Leadership Award in Palliative Care.

His blog, Sunrise Rounds, can be found at http://sunriserounds.com

Despite the best attempts to communicate, personal medical realities have limits. Sometimes the "truth" is inflexible. A fact is a fact. A broken bone is a broken bone. One the other side, there are many unknowns, especially for specific patients. "How long will I live" or "how well will the treatment work," may have only a vague answer. Finally, "reality" changes. Cancers spread, coronary arteries close, sudden pneumonias invade. Doctors see the medical future through a haze, and even the most empathetic cannot read your soul.

Therefore, the final burden for each decision, for setting goals, for balancing personal benefit and cost, comes back to the patient. It requires forethought, discussion, and education. It demands introspection; what are your dreams, priorities and limits? Who are you? What do you want? It requires planning, now, today, when you are still hopefully healthy, well before the moment of critical decision.

If you, because of ignorance, trust or fear, abdicate that responsibility, step back and just "goes with the flow," let the "experts" or your family decide, the result may not be healthy compromise. It may compromise life itself.

Choosing your words wisely: imagery, metaphors, and cancer

by Diane Blum, MSW, FASCO

I sat down to write about how we use language to describe cancer and its treatment shortly after I watched the six-hour PBS series, The Emperor of All Maladies. This three-part programme, adapted from the award-winning book by Siddhartha Mukherjee, traces the story of cancer from ancient times to the present by telling compelling stories of patients and families affected by cancer and by interviewing several generations of experts dedicated to understanding and controlling this complex constellation of diseases.

But I watched this fascinating programme with another focus: to pay attention to how cancer was described and the words chosen to communicate its impact. This has been an interest of mine throughout my career, starting with my early days as a social worker at the Dana-Farber Cancer Institute when I was struck by all the language of war and battle that was used to describe treatment.

The "war on cancer" has been a dominant theme since the early 1970s when President Nixon announced a national commitment to vanquish cancer at the same time as the Vietnam War was being fought. This imagery was so pervasive that in 1978, Susan Sontag wrote the book, Illness as a Metaphor, which challenged descriptions of cancer as an "evil, invincible predator" with "cells that invade the body," patients who are "bombarded" with radiation, and chemotherapy that is "chemical warfare that destroys to save."

Although times have changed dramatically since this book was written, with an increased commitment to patient autonomy and engagement, the language surrounding cancer has not changed. Cancer continues to be the enemy.

In 2015, HBO aired a documentary called Killing Cancer. The narration in The Emperor of All Maladies talked about "God's curse," "an enemy that lies within us," and the need for a "massive force in the ongoing struggle to achieve a final victory." Many advocacy organizations still focus their communications on the "fight against cancer." We also continue to hear that a patient "failed treatment" far too often, as if the patient and cancer were in a battle and the patient lost.

So what do we make of this? Is this language helpful to people? Does it help with resilience and determination, or does the concept of an "enemy" lead to anxiety about feeling weak or fatigued? Like so many issues concerning cancer, this comes down to the individual.

Age, gender, and cultural background all influence how we talk about cancer and how people manage their disease day-to-day. Many will tell you that "fighting the battle, waging the valiant war, and deploying all weapons" is crucial for them to manage their treatment and keep them and their loved ones going. For some, military metaphors give them common terminology to approach talking with their health care team about their treatment and care.

However, Lisa Bonchek Adams, who wrote an influential blog about her life with metastatic breast cancer, penned a widely distributed poem that says the opposite: "When I die don't say I 'fought a battle.' Or 'lost a battle.'" To Lisa, these metaphors meant that she didn't try hard enough or just gave up. Thirty-five years after Susan Sontag wrote Illness as a Metaphor, Lisa issued an eloquent call to relinquish the use of metaphors and talk directly about her and her cancer diagnosis.

For better or for worse, the war on cancer is still with us. Experts express optimism that we are closer to winning it, which will be a great victory for many people. However, in the meantime, we all need to think about our words, be sensitive to the use of military language, and consider how it affects the people experiencing the challenges of a cancer diagnosis.

Diane Blum, MSW, FASCO, began her career as an oncology social worker before serving as the Executive Director of CancerCare and the Chief Executive Officer of the Lymphoma Research Foundation. Ms. Blum has been a member of the American Society of Clinical Oncology (ASCO) since 1992 and served as the Editor in Chief of Cancer.Net from 2001 to 2013.

This post originally was published on http://www.cancer.net/blog/2015-05/choosing-your-words-wisely-imagery-metaphors-and-cancer and is reprinted with permission of Cancer.Net.

LET'S TALK ABOUT CANCER!

Join us at a CanSurvive Cancer Support Group meeting

- have a cup of tea/coffee, a chat with other patients and survivors and listen to an interesting and informative talk.

Upcoming meetings: starting at 09:00 at

MIDRAND - 23 May - in the Boardroom (follow the signs) at Netcare Waterfall City Hospital

HEAD and NECK Group - 4 June at Rehab Matters, Rivonia

PARKTOWN - 13 June, Hazeldene Hall (opp. Netcare Park Lane Hospital)

Enquiries:

Bernice 083 444 5182 or bernicelass@gmail.com

Chris 083 640 4949 or cansurvive@icon.co.za

www.cansurvive.co.za

The Groups are run in association with the Johannesburg Branch of Cancer Buddies and is hosted by Netcare. The Group is open to any survivor, patient or caregiver. No charge is made.

You're in safe hands

CONTRIBUTIONS FOR PUBLICATION IN "*VISION*" NEWSLETTER

Comments, articles, letters and events submitted for publication in VISION are welcomed and can be sent to: cansurvive@icon.co.za.

Let us know what items you would like to see more of in VISION.

Cancer.Vive Poker Run

The annual Cancer.vive Poker Run was held in March and was a great success. Maria Muller and her father, Frans, hosted it and they are just dynamite!

This is one of many events held countrywide to raise funds for cancer patients and cancer awareness.

This event is a lot of fun because people collect a card at different collection points and then the person with the best hand at the end, wins. There is a breakfast to round up the morning.

The generosity of the bikers is legendary and is quite humbling. One very generous gentleman made a donation of R25 000 on the spur of the moment.

Service to the community

In order to take part in the annual Cancer.vive Ride, team members need to raise money or do a certain amount of education or awareness community event to qualify.

One of our new team members Nolwandle Mbele arranged this event during May at the Kwa-thema Methodist church.

Above: A special ceremony for a cancer survivor.

Below: The Cancer.vive team at the church

Kidney cancer charter

Amsterdam Patient Charter for Global Kidney Cancer Care (April 2014)

The International Kidney Cancer Patient Charter was created by the International Kidney Cancer Coalition (IKCC) to ensure that the more than one million people living with kidney cancer worldwide (338 000 diagnoses in 2012 alone, (http://www.wcrf.org/cancer_statistics/data_specific_cancers/kidney_cancer_statistics.php) have access to the best available treatment, care, information, and support.

It is our aim to assist national kidney cancer patient organisations in helping patients and their families worldwide to obtain the information necessary to play an active role in the management of their kidney cancer and to gain a better awareness of what they can expect from their treatment and care.

This charter was developed in April 2014 in Amsterdam, The Netherlands, at a meeting of kidney cancer patient advocates from diverse geographic regions convened by the IKCC. For a period of four years, the IKCC has used web-based search engines and personal networks to contact all patient organisations globally with a stated interest in kidney cancer. In several countries, general cancer or kidney organisations only have a kidney cancer chapter or contact person; however, many countries have independent organisations dedicated specifically to kidney cancer patient support, including Canada, the USA, the UK, The Netherlands, Germany and Ghana. More than 40 organisations have been contacted by the IKCC and invited to attend annual meetings. The 34 patient group representatives present at the Amsterdam meeting, coming from 20 countries spread over six continents, identified the hurdles met by kidney cancer patients worldwide and outlined the universal standards of care that patients should expect, with the goal of enabling patients to become active, informed and empowered participants at every stage of their treatment. The charter contends that the current situation could be improved if those involved in the care and treatment of patients adopted the principles outlined in the charter on a global scale. This charter is entirely driven by patient organisations and is intended to underscore the global need for equity of care and access to expertise.

Collectively, the global kidney cancer community declares that patients have the following rights:

1. Timely investigation and accurate diagnosis by medical experts with experience in treating kidney cancer;
2. Patient-oriented information and education concerning all treatments including quality of life, side-effect management, pain control, and palliative care;
3. Access to optimal, current evidence-based treatment as suggested by a multidisciplinary team of medical professionals possessing specialist knowledge about kidney cancer;
4. Regular follow-up care concordant with national and/or international guidelines including appropriate and culturally sensitive psychosocial support;
5. Access to medical records, including pathology and imaging reports, if requested;
6. Provision of information on all available support systems, including patient support tools and local patient support and advocacy organisations;
7. An active role in decision-making concerning the management of their kidney cancer (e.g. patients should be offered a choice, whenever possible, in the surgical and medical management of their kidney cancer);
8. Information regarding the availability of clinical trials in their country/region;
9. Recognition that kidney cancer can have long-term effects, including heart disease and kidney function insufficiency. Patients should be provided with survivorship information, including medical and lifestyle recommendations; and
10. Recognition that up to 10% of all kidney cancer tumours are hereditary in nature as part of familial syndromes, and that these patients require specialised and coordinated care over their entire lifetime.

The charter was signed by the participants of the 4th IKCC Annual Conference EXPANDING CIRCLES in Amsterdam.

Kidney cancer in South Africa

At the present time there is no kidney cancer specific support group in South Africa despite the fact that it is estimated that a growing number of people are diagnosed with this cancer in this country each year.

Would an on-line group be the answer? If you, a family member or acquaintance have kidney cancer, please email us and let us know whether you would like such a group - or what alternatives you can suggest.

We look forward to hearing from you - cansurvive@icon.co.za

Wings of Hope Cancer Support

Buddy Training Course 2015

R1 000 000 raised for PinkDrive at Comrades

With the "Ultimate Human Race", the Comrades Marathon done and dusted for 2015, PinkDrive was proud to be actively part of this iconic event.

PinkDrive was one of the six official charities of the Amabeadibeadi Charity Drive. At this event, athletes had the opportunity and choice to "Race4Charity" and in doing so, raising much needed funds for the charities. This year PinkDrive had a total of 122 runners of which 91 runners formed part of the "Race4Charity" batch. These athletes have raised R5000.00 or more to fight breast cancer. To date, R1 023 659.50 has been raised for PinkDrive with Carel Nolte being the top donor in the "Race4Charity" campaign - raising more than R150 000.00.

Recently the Comrades Marathon Race Directors announced that PinkDrive will be part of the Amabeadibeadi Charities for the next three years.

Noelene Kotschan, CEO and Founder of PinkDrive expressed her excitement about Comrades by saying that PinkDrive was honoured to be part of this iconic race, especially this year. "PinkDrive is ecstatic and we are privileged to be part of the 90th Comrades Marathon this year. We are thankful to all athletes who raise awareness and funds for our worthy cause. You are helping PinkDrive to 'outpace' cancer" said Kotschan.

PinkDrive had an official water point activation on route at Polly Shortts, and encouraged the runners to make it up the last hill of the race.

The money raised through this campaign will be used to keep our current mobile mammography and educational units on the road, but also to build more mobile units. The mobile units are taken to communities across South Africa, and do free mammograms for individuals who are medically uninsured. PinkDrive also educate on breast cancer and spread the message that 'early detection saves lives'.

"Bamba Iqhaza" - PinkDrive is part of it!

LIVESTRONG Leaders in Africa

CanSurvive & Cancer Buddies
SUPPORTING
LIVESTRONG FOUNDATION

South Africa
Cameron Green — green.cameron@gmail.com
Chris Olivier — cansurvive@icon.co.za
Elvis Munatswa — elmunat@gmail.com

Egypt
Ali Louay — louay@runforyellow.org
Amr Magdi — amrmagdi00@gmail.com
Esraa Elsayed — journey.by.night@gmail.com

Rwanda
Daniel Turikurwe — turidani05@yahoo.fr

Sierra Leone
Alpha bedoh Kamara — rowacacancers@gmail.com

Tanzania
Juma Mwesigwa — huhesofoundation@yahoo.com

Zimbabwe
Champion Kudiwa — championkudiwa@gmail.com
Dave Rauzhi Mahlangu — davemahlangu@gmail.com
Banele Mahlangu — banele.mahlangu@yahoo.com

Dates to diarise

June 2015

23 CHOC Pamper day at Mowana Spa. Contact Sophie Ndhlovu on 073 469 6289 or 011 486 1212

27 CanSurvive Cancer Support Group, Netcare Waterfall City Hospital, Midrand, 09:00

27 Bosom Buddies, Hazeldene Hall, Parktown, 09:30 for 10h00

July 2015

2 CanSurvive Head and Neck Support Group, at Rehab Matters, 1 De la Rey Rd. Rivonia at 18h00

11 CanSurvive Cancer Support Group, Hazeldene Hall, Parktown 9:00

14 Reach for Recovery, Roodepoort Centre for the Aged, Robinson Street, Horizon14h00

15 Reach For Recovery, Johannesburg, 19 St John Road, Houghton 13:30

18 Wings of Hope, German International School, Parktown, 09:30 for 10:00 - birthday.

21 Prostate & Male Cancer Support Group, Auditorium, Constantiaberg MediClinic, 18:00

25 CanSurvive Cancer Support Group, Netcare Waterfall City Hospital, Midrand, 09:00

25 Metastatic Breast Cancer brunch, Cape Town 08:00 to 12:30. contact 021 565 0039, admin@plwc.org.za.

30 Reach for Recovery, Cape Peninsula 10:00. Psychology and breast cancer

August 2015

1 Bosom Buddies, Hazeldene Hall, Parktown, 09:30 for 10h00

6 CanSurvive Head and Neck Support Group, at Rehab Matters, 1 De la Rey Rd. Rivonia at 18h00

8 CanSurvive Cancer Support Group, Hazeldene Hall, Parktown 9:00

18 Prostate & Male Cancer Support Group, Auditorium, Constantiaberg MediClinic, 18:00

22 CanSurvive Cancer Support Group, Netcare Waterfall City Hospital, Midrand, 09:00

27 Reach for Recovery, Cape Peninsula 10:00. Does deodorant cause breast cancer?

September 2015

3 CanSurvive Head and Neck Support Group, at Rehab Matters, 1 De la Rey Rd. Rivonia at 18h00

5 Bosom Buddies, Hazeldene Hall, Parktown, 09:30 for 10h00

5 Can-Sir & Can-Sir malecare, Prostate Awareness Breakfast 9:30 (Venue TBA)

8 Reach for Recovery, Roodepoort Centre for the Aged, Robinson Street, Horizon14h00

12 CanSurvive Cancer Support Group, Hazeldene Hall, Parktown 9:00

CONTACT DETAILS

Cancer Buddies Johannesburg branch, and CanSurvive Cancer Support Groups - Parktown and Waterfall : Chris Olivier 083 640 4949, cansurvive@icon.co.za

CanSurvive Head and Neck Support Group, Rivonia, Johannesburg. Contact Kim Lucas 0828801218 or lct@global.co.za

Cancer Buddies/People Living with Cancer, Cape Town: 076 775 6099, info@plwc.org.za, www.plwc.org.za

GVI Oncology /Cancer Buddies, Rondebosch Medical Centre Support Group. Contact: Linda Greeff 0825513310 linda.greeff@cancerbuddies.org.za

GVI Cape Gate Support group: 10h00-12h00 in the Boardroom, Cape Gate Oncology Centre.| Contact: Caron Caron Majewski, 021 9443800

GVI Oncology Somerset West Group for advanced and metastatic cancers. Contact person: Nicolene Andrews 0218512255

Cancer.vive, Frieda Henning 082 335 49912, info@cancervive.co.za

Can-Sir, 021 761 6070, Ismail-Ian Fife, ismailianf@can-sir.org.za Support Group: 076 775 6099.

More Balls than Most: febe@pinkdrive.co.za, www.pinkdrive.co.za, 011 998 8022

Prostate & Male Cancer Support Action Group, MediClinic Constantiaberg. Contact Can-Sir: 079 315 8627 or Linda Greeff 0825513310 linda.greeff@cancerbuddies.org.za

Wings of Hope Breast Cancer Support Group 011 432 8891, info@wingsofhope.co.za

PinkDrive: www.pinkdrive.co.za, Johannesburg: febe@pinkdrive.co.za, 011 998 8022 Cape Town: Adeliah Jacobs 021 697 5650 Durban: Liz Book 074 837 7836, Janice Benecke 082 557 3079

Bosom Buddies: 011 482 9492 or 0860 283 343, Netcare Rehab Hospital, Milpark. www.bosombuddies.org.za.

CHOC: Childhood Cancer Foundation SA; Head Office: 086 111 3500; headoffice@choc.org.za; www.choc.org.za

CANSA National Office: Toll-free 0800 226622

CANSA Johannesburg Central: 011 648 0990, 19 St John Road, Houghton, www.cansa.org.za

CANSA Pretoria: Contact Miemie du Plessis 012 361 4132 or 082 468 1521; Sr Ros Lorentz 012 329 3036 or 082 578 0578

Reach for Recovery (R4R) : Johannesburg Group, 011 487 2895.

Reach for Recovery (R4R) : West Rand Group. Contact Sandra on 011 953 3188 or 078 848 7343.

Reach for Recovery (R4R) Pretoria Group: 082 212 9933

Reach for recovery, Cape Peninsula, 021 689 5347 or 0833061941 CANSA offices at 37A Main Road, MOWBRAY starting at 10:00

Reach for Recovery: Durban, Marika Wade, 072 248 0008, swade@telkomsa.net

Reach for Recovery: Harare, Zimbabwe contact 707659.

Breast Best Friend Zimbabwe, e-mail bbfzim@gmailcom

Cancer Centre - Harare: 60 Livingstone Avenue, Harare Tel: 707673 / 705522 / 707444 Fax: 732676 E-mail: cancer@mweb.co.zw www.cancerhre.co.zw

News in brief

Study adds diabetes drug with anti-cancer effect to ovarian cancer treatment

Several recent studies have suggested that metformin, an established drug developed to treat patients with type II diabetes, may provide significant benefits, including increased survival, to patients being treated for advanced cancers. An analysis of combined results from these earlier studies found that metformin use was associated with a significant decrease in cancer risk, tumour burden and cancer mortality.

The University of Chicago Medicine is leading, with two other centres, a clinical trial that will compare the most effective current therapy for patients with stage 3 or stage 4 ovarian cancer against that same therapy plus metformin. To enroll in the trial, volunteers must have a presumed or confirmed diagnosis of ovarian, fallopian tube, or primary peritoneal carcinoma, but not diabetes.

http://tinyurl.com/q6bhrkj

Cancer survivors have evolving information needs

Judging by the nature and topics of their information seeking, cancer patients' information needs appear to differ depending on the type of cancer they have and where they are in their survivorship. Clinicians caring for cancer survivors may need to understand these needs in order to better address survivors' concerns about cancer recurrence, late effects, and family members' risks.

A three-year study of over 2,000 cancer survivors by the University of Pennsylvania's Annenberg School for Communication discovered that, across survivors, the most frequently sought information was about cancer recurrence. However, interest in other topics varied by cancer type: breast cancer survivors were more likely to seek information about topics related to late effects and family members' risks than prostate and colon cancer survivors. The patterns of seeking for these topics also changed over time. For instance, breast cancer survivors were less likely to seek information about their risks of cancer recurrence in later years than during the first year after their diagnosis. These findings are reported in the journal Cancer Epidemiology, Biomarkers & Prevention.

The findings from the study are important because understanding how people seek cancer information during their cancer survivorship is an important component as clinicians help to address the physical and emotional issues their patients may be experiencing. Clinicians may need to intervene at distinct points during the cancer survivorship period with timely information to address their patients' concerns about cancer recurrence, late effects, and family members' risks.

http://www.medicalnewstoday.com/releases/294028.php?tw

Tollfree service for cancer patients

PLWC Cancer Buddies now has a tollfree number - it is

0800 033 337

All cancer patients now have access to free cancer support and can ask any questions about cancer and treatment of cancer; the emotional issues related to the cancer journey; questions about side effects of treatment; assistance with accessing resources like wigs, prosthesis, home nursing and hospice. Problems relating to access to treatment or services delivery issues can also be reported .

Flinders vortex device makes for better cancer treatments

South Australian invention, responsible for unboiling an egg, has been used to produce a four-fold increase in efficacy of carboplatin, a commonly used drug for ovarian, lung and other cancer.

The latest research, published today in the journal Scientific Reports, is just one in a growing number of important applications for the vortex fluidic device (VFD) invented by the South Australian Premier's Professorial Research Fellow in Clean Technology, Flinders University Professor Colin Raston. The ground-breaking device is being manufactured at Flinders University and will soon be available to research organisations around the world. Professor Raston said the high-tech, yet simple device can be used in medical and pharmaceutical research along with a range of industries – all with a focus on cleaner, greener and cheaper production.

"This device creates a unique way to develop more sustainable and cost-effective products, services and technologies which can accelerate innovation in a range of industries, from drug manufacturing to food and biodiesel production," he said.

The device's unique ability to control chemical processes already has enabled scientists to 'unfold' proteins to their natural state, in a process likened to 'unboiling an egg', which could be used in protein-based drug research. The machine has the potential to revolutionise the delivery and manufacture of a wide range of pharmaceutical processes and products by "streamlining the loading of drugs into nano-packages" for better results and less waste, Professor Raston said.

"With ovarian cancer, we found that this technology can increase the loading of second generation anti-cancer carboplatin drugs into delivery vehicles from 17 per cent to 75 per cent," he said. "This not only would have a direct benefit of reducing the negative side-effects which affect patient health, but of being able to use less of the drug."

Using more effective drugs would also reduce manufacturing waste, with up to half a tonne of waste generated from the production of just 1kg of anti-cancer and other drugs. "Much of the drugs end up in sewerage systems and possibly create superbugs in our environment," Professor Raston added.

"Our VFD will enable the pharmaceutical and many other industries to innovate – including further improvements in the chemical delivery of a range of existing approved drugs, as well as development of new improved drugs."

http://tinyurl.com/otnqcxc

Successful study of virus attack on cancer

A new weapon in the arsenal of cancer fighting treatments utilises genetically modified viruses to invade cancer cells and destroy them from the inside.

University of Louisville researcher Jason Chesney, M.D., Ph.D., deputy director of the James Graham Brown Cancer Centre (JGBCC), and a

team of international scientists found that stage IIIb to IV melanoma patients treated with a modified cold sore (herpes) virus had improved survival. The results of the findings were published recently in the Journal of Clinical Oncology.

The University was one of the major sites for the phase III clinical trial involving 436 patients who received the viral immunotherapy, talimogene laherparepvec (T-VEC). Scientists genetically engineered the herpes simplex I virus to be non-pathogenic, cancer-killing and immune-stimulating. The modified herpes virus does not harm healthy cells, but replicates when injected into lesions or tumours, and then stimulates the body's immune system to fight the cancer.

"The results from this study are amazing," Chesney said. "Patients given T-VEC at an early stage survived about 20 months longer than patients given a different type of treatment. For some, the therapy has lengthened their survival by years. "

Shari Wells from Ashland, Kentucky is one of those patients. She entered the trial in 2010 with stage IV, or metastatic, melanoma. Before entering the T-VEC trial, she had been through numerous procedures and major surgeries. According to Wells, nothing worked and she was facing a death sentence.

"When you hear that you may only have three to six months to live, it is very scary," Wells said. "I would not be alive today if I had not been accepted into the T-VEC trial. Dr. Chesney and the James Graham Brown Cancer Centre saved my life."

Wells drove to Louisville every two weeks for about two and a half years to receive injections in each of the more than 60 lesions on her leg. The lesions eventually began to fade and finally disappeared. She has been in remission for almost three years.

"I want everyone to know they should never give up hope. With research there will always be something new tomorrow that wasn't here today," she said.

The U.S. Food and Drug Administration (FDA) and the European Medicines Agency (EMA) are considering findings from the trial to make the treatments available to more patients with advanced melanoma.

http://tinyurl.com/o85ayom

Treating gum disease might help prostate symptoms

Treating gum disease may help reduce symptoms of prostate inflammation, which can make urination difficult, a small study suggests.

The study included 27 men, age 21 and older, who had prostatitis and moderate to severe gum disease. The men underwent treatment for gum disease and showed significant improvement in their gums within four to eight weeks, the study authors said.

The men received no treatment for their prostatitis, but symptoms of the condition improved in 21 of 27 of them after their gum disease was treated, according to the study published recently in the journal Dentistry.

"This study shows that if we treat the gum disease, it can improve the symptoms of prostatitis and the quality of life for those who have the disease," corresponding author Dr. Nabil Bissada, chair of periodontics at Case Western Reserve University in Cleveland, said in a university news release.

Gum disease affects more than the mouth. It also can cause inflammation in other parts of the body, Bissada said. Previous research at Case Western had found a link between gum disease and fetal deaths, heart disease and rheumatoid arthritis, the researchers said.

Bissada said he wants to make gum disease treatment a standard part of treatment for prostate disease, much like dental checkups are advised before heart surgery or for women who are pregnant or considering pregnancy.

http://tinyurl.com/o85ayom

Could the herpes virus help the spread of skin cancer?

A genetically engineered herpes virus has been shown to halt the spread of skin cancer, killing diseased cells and kick-starting the immune system into action against tumours.

That is the conclusion of a landmark clinical trial of a brand new drug carried out at 64 research centres across the world.

It could be available within a year but there are fears it may be too expensive for the NHS after it refused to buy a number of high-profile new cancer drugs on the basis of cost.

The new treatment has been hailed as a potential cure to skin cancer, known as malignant melanoma, which is the most deadly form of cancer killing 2,000 people a year in Britain, with 13,000 cases.

Scientists believe the newest study is the first of its kind to definitively show viral immunotherapy is beneficial to cancer patients.It was led by researchers at The Institute of Cancer Research and The Royal Marsden Hospital.

In 40 per cent of cases in which it worked, the tumours vanished or shrunk by more than half. And the new drug doesn't harm healthy cells which means the side effects are minimal compared to aggressive cancer treatments such as chemotherapy.

http://tinyurl.com/pdh5jtz

Study finds that proton therapy has fewer side effects in esophageal cancer patients

New research by scientists at the University of Maryland School of Medicine has found that esophageal cancer patients treated with proton therapy experienced significantly less toxic side effects than patients treated with older radiation therapies.

Working with colleagues at the Mayo Clinic in Rochester, Minnesota and the MD Anderson Cancer Centre in Dallas, Texas, Michael Chuong, MD, an assistant professor of radiation oncology at the school, compared two kinds of X-ray radiation with proton therapy, an innovative, precise approach that targets tumours while minimising harm to surrounding tissues.

The researchers looked at nearly 600 patients and found that proton therapy resulted in a significantly lower number of side effects, including nausea, blood abnormalities and loss of appetite. The results were presented at the annual conference of the Particle Therapy Cooperative Group, held in San Diego.

"This evidence underscores the precision of proton therapy, and how it can really make a difference in cancer patients' lives," said Dr. Chuong.

Patients with esophageal cancer can suffer a range of side effects, including nausea, fatigue, lack of appetite, blood abnormalities and lung and heart problems. Proton therapy did not make a difference in all of these side effects, but had significant effects on several.

The results have particular relevance for the University of Maryland School of Medicine; this fall the school will open the Maryland Proton Treatment Centre (MPTC). The centre will provide one of the

newest and highly precise forms of radiation therapy available, pencil beam scanning (PBS), which targets tumours while significantly decreasing radiation doses to healthy tissue. This technique can precisely direct radiation to the most difficult-to-reach tumours.

http://www.medicalnewstoday.com/releases/294367.php?tw

Noninvasive, early detection of stomach cancer

A potentially quick, simple, inexpensive and non-invasive method for identifying people at risk of stomach (gastric) cancer and finding tumours at an earlier stage has been announced by Prof. Hossam Haick at the Technion-Israel Institute of Technology.

Haick, a professor of chemical engineering at the Technion's Russell Berrie Nanotechnology Institute, developed the nanotech breath-analysis system Na-Nose to detect a range of illnesses. The latest study proved its effectiveness in predicting and diagnosing gastric cancer.

Writing in the prestigious journal Gut, Haick and his lab team describe how they took 968 breath samples from 484 patients, including 99 known to have gastric cancer.

They analysed each sample twice – once using a standard gas chromatography-mass spectrometry method (GCMS) and again with Haick's nanoarray technology combined with a pattern-recognition algorithm — for Helicobacter pylori, a bacterium known to increase the risk for stomach cancer.

The tests showed that patients with cancer as well as those at high risk had distinctive "breath prints."

http://tinyurl.com/qajvmvj

Prostate cancer treatment with new injectable gel

A device to lower side effects of radiation treatment (RT) for prostate cancer received FDA clearance on recently. The device injects a temporary gel to create a space between the prostate and the rectum. Named the SpaceOAR System ("OAR" stands for "organ at risk"), FDA granted clearance after a US clinical trial showing that SpaceOAR hydrogel achieved a significant reduction in rectal radiation dose and late rectal toxicity.

Despite advancements in RT for prostate cancer, a common side effect is damage to the rectum, which is located just below the prostate. Unintended RT exposure to the rectum often results in complications including diarrhea, bleeding and pain.

SpaceOAR, developed by Augmenix, Inc., temporarily positions the front portion of the rectum away from the prostate during RT, creating space for protection. The device uses hydrogel. The gel is injected in liquid form through a needle and quickly solidifies into a soft gel to separate the two organs. Evidence suggests that by reducing RT side effects, this method will bring two additional benefits: it opens the way to dose escalation (more RT for improved cancer kill rates) and hypofractionation (fewer RT sessions). All around, these potential benefits should improve patient experience, improve therapy outcomes, and help reduce healthcare costs.

"Shielding the rectum from radiation allows us to increase the RT dose used to kill cancerous cells in the prostate," said Rodney Ellis, MD, radiation oncologist at UH Seidman Cancer Centre.

The gel maintains this space for "about three months." After six months, all the gel has been absorbed and the space returns to normal.

PSA Rising

Removing neck nodes before the spread of oral cancer saves more lives

Removing lymph nodes in the neck before they are affected by oral squamous cell cancer is a life-saving measure and should be adopted as a new standard in treating the disease, according to the results of a phase 3 study.

The randomised phase 3 study showed an improvement in overall survival and a reduction in the risk of death and recurrence when the nodes were removed during patients' initial surgery for early-stage, node-negative, oral squamous cell cancer (SCC), rather than in a separate operation after a recurrence of the disease.

The findings were presented by lead author Anil D'Cruz during the 2015 annual meeting of the American Society of Clinical Oncology , a gathering of nearly 30,000 oncology professionals in Chicago.

"Our study is the first to conclusively prove that more lives can be saved with elective neck dissection," said D'Cruz, adding that the results resolve a question doctors have been asking for more than five decades. There is currently wide variation in this setting regarding whether nodes are removed before or after a relapse.

Oral cancer is a global problem affecting more than 300,000 individuals in both developed and developing countries, D'Cruz stressed. "It is seen anywhere where there is an excessive consumption of alcohol and tobacco," which is responsible for 90 percent of oral cancer diagnoses, according to ASCO.

The findings reported at ASCO are drawn from an interim analysis involving 500 patients who, after excision of their primary tumours, were randomly assigned to therapeutic neck dissection (TND; n = 255), also known as "watch and wait," or elective neck dissection (END; n = 245).

Study authors acknowledged in an ASCO statement that the only drawback to neck dissection is that the procedure can be linked to shoulder problems, which affect 5 percent to 40 percent of patients because the nerve that supplies the large muscles associated with shoulder movement crosses the surgical dissection field. Future research should focus on techniques that could minimise this complication, they said.

Jyoti D. Patel, ASCO spokesperson and moderator of the press briefing at which the results were reported, said the findings were particularly important in countries and in populations where there are multiple barriers to healthcare:

"This one-and-done approach, we know now, definitively improves survival. Armed with the results of this study," said D'Cruz, "doctors will be able to confidently counsel patients that adding neck surgery to their initial treatment is worthwhile."