

## African Oncology Round Table meeting

Linda Greeff director of PLWC/Cancer Buddies was invited by Pfizer Pharmaceutical to attend the African Oncology Round Table meeting in Dubai recently to present feedback on the Photovoice research project interim findings to representative across Asia and Africa. This talk was well received and the representatives received further training in strategic planning, management communication .

Linda reports that learning points from this meeting were :

1. One of the ideas that really stuck home for me was this comment "If you think you are too small to have an impact, try to go to bed with a mosquito". This really encouraged all attendees to think more innovatively about how important all stakeholders input is in changing the cancer landscape in South Africa but also in Africa and the world. The importance of collaboration and sharing of skills and know-how remains a core issue in our work going forward .
2. The importance for organisation to really sit down and apply their mind to determine the impact chain in their own organisations and then using this to drive your organisation forward more innovatively.
3. The following guideline was given to unpack and plan more measurable inputs and activities that are aligned with an organisation's strategic plan. The day of just doing things on the fly are gone and if organisations want to be taken seriously they have to apply their mind to working more proactively and in an accountable and measurable manner with the focus being on outcomes and deliverables and accountability. True leadership is required at all times.
4. Other challenges we face in the cancer landscape are :  
Cancer is not typically prioritised in countries where health services are generally set up to treat infectious diseases, rather than to manage chronic conditions. There is limited understanding of the nature and extent of the problem given that few LMICs maintain registers of cancer patients or have surveillance and epidemiological research programmes in place to guide decision-making.

Other challenges in responding to the cancer epidemic include:

- nsufficient health infrastructure
- Scarcity of specialist skills
- High cost of drugs and diagnostics
- Need for personalised treatment regimens and long-term follow-up
- Lack of general cancer awareness and education

All of the above are reasons why every single person that is concerned and touched by cancer should support cancer advocacy initiatives in their communities .

Please get involved and speak up when we ask for support. Cancer patients and caregivers have to become more vocal and active in the fight against cancer

Watch this space if we don't say "Enough is Enough" as the Aids lobbyists did, we will never reach our goals.

**#I can, We can**

## Misleading headlines could raise false hopes for cancer patients

When you read news issued by Yale University based on a study published in the prestigious New England Journal of Medicine, you might reasonably assume that the information you're receiving is reliable and devoid of hype. But you could be wrong in that assumption.

A PR news release issued on February 10, 2016 announced, "Yale researchers discover underlying cause of myeloma."

But the study is about a very specific patient population with a rare form of MGUS [monoclonal gammopathy of undetermined significance] associated with Gaucher's disease," says Michael A. Thompson, MD, PhD, a cancer researcher at the Aurora Research Institute and Aurora Health Care. "It may have some meaning for a few people per year, but it's not the cause of myeloma in the average patient." He adds, "It's an interesting observation but it's far from the Nobel prize-winning discovery that's suggested by the headline."

Thompson said he has contacted the YaleNews news release author and asked her to correct the news release, which also claims, incorrectly, that the Yale researchers "have identified what causes a third of all myelomas." He said he has yet to hear back from them.

Health News Review is gathering a growing number of stories about patients being misled and even harmed by inaccurate, imbalanced, incomplete media messages. Recently they profiled the roller coaster of emotion that a man with glioblastoma went through after hearing misleading news. Shortly they plan to bring you another similar story from a rare disease advocacy group.

NOTE - Although Yale has apparently changed the headline of the news release to "Researchers link lipids to one third of myelomas", the original headline still appears on a Google search.



## Carter High School - a heart for children with cancer!

Carter High School in Pietermaritzburg was buzzing with messages of hope for International Childhood Cancer Day in February. Showing their support for #CHOCPMB in full force as they came together as a community to showed that they have a heart!

## Running a marathon for a great reason

Dr Karin Baatjes, a member of the Reach for Recovery Board of Management, and a breast surgeon, has decided to run the West Coast Marathon to raise awareness of breast cancer and to raise some funds for the their Ditto Project. Within the first 2-3 days people donated R2 050, but more funds are needed, so please support Karin's project by sharing this with friends and family. Donations can be made online on the GivenGain website.

The Ditto project is an initiative run by Reach for Recovery to provide indigent women access to a silicone prosthesis to assist in restoring her self-image and confidence after the traumatic breast cancer diagnosis and surgery.

Surgery after a breast cancer diagnosis may involve part or all of a breast removed (mastectomy). Having a mastectomy leads to a tier of decision making regarding whether to have surgical reconstruction, wear an external breast prosthesis, or not wear anything at all to replace the amputated breast. External breast prosthesis may be the best option a woman has, especially if she cannot afford to undergo reconstructive surgery. However, not all patients can afford

kb for ditto

West coast marathon 23 April 2016



reach for recovery  
breast cancer support

ditto project

<https://www.givengain.com/activist/154630u/projects/12151>



Karin Baatjes with her mother who is a breast cancer survivor.

the cost of a permanent prosthesis. Although as much support as possible is given to the paying customer in terms of selection, affordability and even fitting a silicone prosthesis, Reach for Recovery believes that all women who have had breast cancer surgery should have access to appropriate breast prostheses, regardless of whether they can pay for it or not. The reality is that many breast cancer patients in South Africa cannot even afford a bra, let alone a breast prosthesis. Reach for Recovery wants to help these women who come from low income group to feel confident again after the traumatic diagnosis and surgery. We believe that a breast prosthesis is an important step in her recovery, especially to those women from communities where there is still a stigma attached to a cancer diagnosis. A more natural appearance with a breast prosthesis, together with the emotional support that she can continue to receive from Reach for Recovery volunteers through support groups, will help her to return to her place of employment and continue to provide for her family.

We are extremely thankful to our donors who help us to ensure the sustainability of this project!

## It's OK to talk about cancer!

Join us at a **CanSurvive Cancer Support Group** meeting for refreshments, a chat with other patients and survivors and listen to an interesting and informative talk.

### Upcoming meetings:

**HEAD and NECK Group, Rehab Matters, Rivonia - 7 April 18:00**

**KRUGERSDORP Netcare Hospital Group -9 April 09:00**

**PARKTOWN GROUP, Hazeldene Hall, Parktown -9 April 09:00**

### Enquiries:

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[www.cansurvive.co.za](http://www.cansurvive.co.za)



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



## Not meant to survive

16,500 years ago in wind-driven snow on the massive Beringia land bridge between eastern Siberia and present-day Alaska, a Paleo-Indian hunting party of four men cornered their prey, the Arctodus or bulldog bear, at the edge of a cliff, as the ice laden steel sea crashed far below. The last of his kind, at nearly 2000 lbs, the furious mammal towered above his thin, frail, spear-armed attackers. Already wounded, it lashed out in a frenzy to survive. The massive paw caught the side of the nearest man, crushing his skull and somersaulting him into the air. But, even as his body flew over the edge, two flint-tipped points penetrated the bear's heart and it was dead before their brother's lifeless body hit the rocky shore. A great victory, the kill would feed the clan for weeks of winter and rap newborn infants in thick fur. They would miss and mourn their kinsman.

Such has been man's struggle of life and death for hundreds of thousands of years. Short, violent, painful, and absolute. Whether it was harsh weather, the battle for food, childbirth or brief disease, we lived or died. It did not require an understanding of possibility or prognosis. This was the world in which the human race evolved, conquered and, a few, survived.

In 2014, the control of our environment, sanitation, relatively stable governments and medical science has radically changed that world. While short death is possible, it is not the rule. In the United States, the average man will have his terminal disease for three years and a woman five. Medicine makes illness chronic and healthcare stretches time. No longer is dying about this moment. Dying is something we do slowly, perhaps for years.

This is victory. Most women with breast cancer are cured. Most men with prostate cancer are in remission. It is possible to live for years after lung cancer, bladder cancer and occasionally pancreatic neoplasm. This is good. This is wonderful. Nevertheless, this is a problem. We are not meant to survive.

Our minds are wired to fight the bear. Fight or flight. Live or die. Then, it is done. If we are dead, we are dead. If we are alive, then we have won and we are fine and we are healthy. The bear is not going to climb off the cooking spit and attack us again.

However, if we "survive" cancer, there seems always the chance, no matter how small, that the cancer will come back. What really is our prognosis? Did they get it all? What does that pain mean? Am I supposed to be this tired? What does the future hold? Our brains are designed for fighting a battle to survive which is a roar, not a haunting whisper. We understand that we are safe when we see no bear. How can we convince ourselves we are safe when we cannot see, barely comprehend the enemy, and there seems to be nothing we can do to really be safe again?

That nagging doubt, which seems to remind us too often that we are cancer patients, does not mean we are insane or weak. It means we are human. We do not survive well. It is normal and common to be reminded of the disease by nearly every pain, ache, fever and even the common cold. It is not crazy to worry that the soreness from your flu shot just might mean the cancer has spread to your arm. It is how we are designed. Listen for the bear. See the bear. Kill the bear. We are always alert, but we feel that battle should be brief, brutal and then complete. With cancer, how can we convince ourselves that the fight is won and we can truly rest?

First, recognise that these feelings are normal and will come and go, hopefully less, as time passes. Do not beat yourself up simply because your mind works like every person in the last million years.

### James C. Salwitz, MD

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



Learn your triggers. The next lab test? Breast cancer month? Aunt Millie's stories? The holidays? Body aches? Try to avoid or anticipate their effect. Put them in a broad perspective of feeling healthy.

Next, design, in coordination with your doctor, a surveillance strategy, whether it is exams, tests, or just the occasional discussion. Research that strategy; understand how it works, and how it will protect you. Invest the emotional burden, the anxiety, in that plan. Try to release your tendency to use worry as a blanket. Trust the plan.

Do things to gain control. Exercise? Anti-cancer diet? Reiki? Yoga? Teaching? Volunteering? Art? Work? Travel? Sex? Reading? Taking active command, organising your future, is not denial. The key to killing the bear is action and control. No hunter ever talked a bear to death.

Do not be embarrassed to share that you are frequently threatened by the possibility of relapse. Discuss it with family or friends, counselor or a support group. You are not nuts and definitely not alone. This is what they were talking about when they said, "misery loves company."

The world has changed. Our minds are alert, vigilant, and ready; but you are still a hunter on the harsh Bering Sea ice. But now, when you survive, the shadow of the bear remains. Thus, you must continue the fight. You are strong, you are able, and miraculously, you are alive. Flint arrowhead tipped spear at the ready.

## Care or no care

A simple slip of the tongue got me thinking. We were discussing how to guarantee that each patient who checks into our office has an Advanced Directive. Should the front desk ask or should it be part of the doctor's checklist? What is the RN's role? The nurse said, "Well, this is very important. Too often, our patients don't make decisions until it is too late. Planning for end-of-life is critical. She is right. It would be very important to make decisions if the doctors truly "give up on you," and end all care. I suspect the idea that their caregiver would abandon them, is a real fear for many patients. All that would remain would be fragments of life. Then, the prospect of death becomes even more terrifying, because it also means being alone.

This is why we say, when we get it right, "end-of-life **care**". Not only are we not going to desert you, there is a great deal of caring we can do. Pain control, ambulation, insurance and financial advise, spiritual guidance, durable medical equipment (bed, commode...), community involvement and the support a patient needs to go on ... to live. Hospice and palliative medicine is indeed about life....about coping and hope. The timing just happens to be near its end.

We must continue to emphasise this message. Hospice does not mean we are casting you out. Palliative medicine is not what we do, when we can do nothing. Good end-of-life care is not about being dead. It is about being alive. And, as long as there is breath in our bodies, that can be a very beautiful thing.

## A MORNING IN THE LIFE OF A Hospice Wits home care nursing sister

The first stop of the day is to visit \*Theresa, a woman in her mid-twenties who has an eight-month-old baby. The young woman is lying on a bed in the domestic living quarters of her aunt's place of work, dressed in a nightie, with her plump, happy baby sitting beside her. She noticed a small lump in her left breast when she was only a few months pregnant,

and in a very short space of time it had quadrupled in size. Today, Theresa struggles to walk and use her left hand, having received the diagnosis of an aggressive breast cancer (and the lump by then the size of a tennis ball). She had a mastectomy to remove the breast and soon thereafter the disease was found in her spine. Radiation treatment followed, and the brave woman will begin chemotherapy soon. \*Theresa's mother has come to Johannesburg to help take care of her daughter and granddaughter, and HospiceWits' Sister Ingrid visits weekly to monitor the patient, provide palliative care, words of comfort and advice, and to ensure that the young woman's pain is under control.

We're now on our way to visit a new, elderly patient, \*Mrs Patel. Her family is very concerned about her – she's bedridden and has several health and joint problems including severe rheumatoid arthritis. A domestic worker takes care of the 84-year-old, but one of her daughters lives close by and spends a large part of every day with her. \*Sister Ingrid takes a careful and detailed history, after which she addresses the patient, speaking slowly and clearly to the hard-of-hearing little lady tucked up in bed. After first checking her vital signs, and then inspecting her body for bedsores, Sister recommends they employ an experienced day nurse to assist in turning the patient more frequently, and to give the family some respite from the physically demanding aspect of caring for their mother. There are six siblings, and they will share the cost of employing a nurse. A phone call is made, and Sister tells the family the nurse will arrive at 08h00 the following day. \*Sister Ingrid also suspects the old lady has had a few small minor strokes, and tells the family she will arrange for the HospiceWits doctor to do a home visit. One of Mrs Patel's sons arrives before we leave, and the siblings seem so grateful and relieved that HospiceWits will visit frequently and advise on the best treatment for their much-loved mother.

By this time it is late morning and there are two more patients to see. We drive to Auckland Park to visit a lady with advanced lung cancer. \*Betty's home-care assistant greets us with a huge welcome, and soon Betty appears and hugs both Sister and I. Still mobile, this tiny woman chose not to have the conventional chemotherapy treatment, and she has been in our home-care program for a couple of years now, and is getting very frail. She orders coffee and biscuits for us, and Sister starts asking how she's managing her pain and other symptoms. They discuss various aspects of the prescribed medication, and Sister advises Betty that she should see her home doctor about an issue unrelated to her cancer. Of concern to Sister Ingrid is the fact that when the nurse is off-duty



*The Houghton Hospice exudes a lovely calmness and offers patients a soothing place to rest.*

on a Saturday, the old lady prefers to be on her own, and to have the house to herself. Although Betty says she carries a panic button around her neck, Sister makes it clear to her that she could have a fall and be immobile on the floor injured, without any help. Betty is quite unperturbed, and relishes her Saturday solitude. We finish our coffee, exchange hugs and positive wishes, and slowly make our way to visit our last patient of the morning.

\*Jonathan, a retired medical specialist with advanced prostate and bladder cancer, lives with his elderly wife, Molly. He is bedridden and looks terribly ill. Molly suffers from severe back and joint pain, so the two of them are permanently side-by-side in adjacent twin beds. They have a live-in lady nurse/assistant who does their shopping, cooks and cleans for them. In fact, she does absolutely everything for them. Sister Ingrid pops in regularly to see how they are doing, takes their vital signs, checks their medication and advises on any other issues that are concerning them. As this is a particularly tough caring role, they work through an agency that provides suitably qualified individuals to help the couple from time-to-time. I find it particularly disturbing that the couple does not have any children to help care for them. The house needs a coat of paint, lots of maintenance work, and is very untidy. After we say our goodbyes I remind myself that when you have a terminal illness and are confined to bed, there's probably no point in being concerned about something as trivial as painting the house.

\*All names have been changed to protect the identities of the patients and Nursing Sisters.

### Palliative care training

Throughout the year Hospice Wits host various short courses: the 5-day Introduction to Palliative Care, 2,5-Day Grief, Loss and Bereavement Workshop, 5-day Introduction to Paediatric Palliative Care, 3-day Non-Clinical Palliative Care, 3-Day Physical Assessment Workshop, as well as other client specific courses which they present on request.

**For further details phone 011 483 9100 or email [training@hospicewits.co.za](mailto:training@hospicewits.co.za).**



# Brute

## *We do not remember days, we remember moments - Cesare Pavese*

It is the middle of a long night in the Emergency Room. The surgeon — tired, angry, and frustrated — must repair the drunken prisoner's long, deep forehead laceration. Although the man is shackled to the emergency room cart, he thrashes his head back and forth.

After several attempts to get the man to cooperate, the surgeon stands and retrieves two heavy sutures and a large needle from the supply cabinet. He places the stitches through the drunk's earlobes and then through the mattress, tying them tightly. "I have sewn your ears to the stretcher," the surgeon tells the man. "Move, and you'll rip 'em off." The surgeon clears the blood from the man's eyes to make certain his patient can see, grins down at him, and sets to work.

The scene, from "Brute," a short story by surgeon-author Richard Selzer, is told for the benefit of a young doctor as an older surgeon recalls his distant past. The reader "hears" the surgeon's thoughts - a stream of fury and judgment - even as the sutures are carefully placed and the cut repaired. "Brute" concludes with the wound closed, the patient heading off to jail, and the surgeon reflecting back on what he regrets.

On a couple of occasions, I have brought "Brute" and other physician-written short stories to our trainees and students. Many of the young doctors have been in the Emergency Department in the middle of the night repairing facial lacerations for people who were very uncooperative. Most of the students have yet to have that experience.

Around a conference table early in the morning, we take turns reading aloud. When we reach the end, I look around the room. "What do you think of this story?" I ask. "How does the surgeon make you feel?"

The discussion takes a moment to coalesce. Those who have faced the situation might wonder what the young medical students must think. Eventually, someone speaks up.

"Well, the surgeon was wrong to be so angry. Sewing the man's ears to the table was out of line. It's hard, though."

"Well," says another, "it's a tough problem but I will admit that I

Dr Bruce Campbell is a Head and Neck Cancer Surgeon. He has been a leader of the MCW Multidisciplinary Head and Neck Cancer Programme of the Froedtert Cancer Centre. He evaluates patients with tumours of the oral cavity, throat, sinuses, voice box, thyroid, and neck.

He coordinates cancer care and performs any necessary surgery. Read his blog at <http://www.froedtert.com/HealthResources/ReadingRoom/HealthBlogs/Reflections.htm>



sympathise a bit with the doctor. He had to get the cut closed. He probably had ten other things to do that night."

The discussion becomes lively. Someone notices that, for the most part, what the surgeon says aloud is appropriate. His thoughts, however, reveal the depths of his anger and contempt. He characterises the large patient as an animal.

The lay public - and, by extension, the trainees in the room a few short years ago - sometimes view the story with horror, often assuming that it is autobiographical. Selzer, however, frames it as a cautionary tale, opening the piece with a preamble that begins, "You must never again set your anger against a patient."

"So," I ask, "What did the surgeon regret? Why did this story stay with him for twenty-five years?"

Someone rechecks the story. "It's interesting that the thing he regrets later is not the anger or the contempt. It wasn't even sewing the man's ears to the mattress. It is the way he made certain that the patient could see that he was grinning at him." The surgeon had intentionally tried to humiliate the man.

I am the oldest in the room by a couple of decades. The first encounters I had with emotions and experiences in my earliest days of training come back to me more clearly now than things that happened more recently. Those moments changed me.

Selzer reminds us that surgeons are human and that we make mistakes. I believe he is telling us that we must learn from each encounter, being mindful as we evolve through our stages of training. Pausing to reflect along the way helps each of us find better ways to care for patients now and leads to fewer regrets later. I remind myself to schedule more conferences like this one.

## Medication adherence

As more and more oral anti-cancer drugs become available, the importance of medication adherence becomes increasingly apparent. Nearly 25 percent of all cancer patients now take one or more oral medications as a part of their comprehensive cancer care, but fewer than half of those patients take their medication as prescribed by their doctor.

Taking your medication exactly as prescribed by your doctor is important in the fight against your cancer and in determining the effectiveness of your medication throughout treatment. Most anti-cancer drug regimens are designed to maintain a specific level of drugs in your system for a specific duration of time, based on your cancer type, stage, previous treatments and several other factors.

Non-adherence can lead to cancer progression, unnecessary side effects, hospitalisations and physician visits.

Six factors for medication adherence

1. The right drug
2. At the right dose
3. At the right time
4. On the right schedule
5. Under the right conditions
6. With the right precautions

Download their free PDF of the full booklet from:

[http://www.patientresource.com/Medication\\_Adherence\\_Overview.aspx?utm\\_source=71615&utm\\_campaign=71615&utm\\_medium=email](http://www.patientresource.com/Medication_Adherence_Overview.aspx?utm_source=71615&utm_campaign=71615&utm_medium=email)

# Faces vs data: protecting ourselves to death

by Howard (Jack) West MD

I just heard an excellent talk by Juan Enriquez at the TEDMED meeting I attended, on the subject of "What is the missing measure in medicine?" Specifically, his central point was that we focus on the risk of harm from treatments: the baby victims of thalidomide are etched on our collective memories, with a mandate that the FDA protect consumers from dangers so that we can say "never again". However, our extreme caution against the risks of approving potentially risky treatments leads us to sacrifice the benefit to all of the potential beneficiaries. We have no way to see and capture the time, quality of life, and even lives lost by NOT having treatments be available to people who miss that opportunity from our extreme fear of harm.

This is reflective of our "predictably irrational" behavior described and popularised by behavioural economist Dan Ariely, who notes that people consistently value avoiding harm or loss more than gaining equivalent benefit. We are irrationally risk-averse to the point that we make poor choices for our long-term outcomes because of it. At the same time, in a world in which the FDA or individual physicians are vilified for harming a patient, the negative consequences are truly far, far greater for harming one person by an error of commission (even if it was an appropriate judgment of risk but an improbable outcome) than by failing to offer a treatment that could help someone significantly. Nobody gets sued for failing to cure a challenging cancer.

What makes it even harder is that our brains are programmed to gravitate to stories and individuals. Strong evidence with data from hundreds or thousands of people is all good and well, but patients are unduly swayed by the story of a treatment that happened to work for their friend's cousin, or hearing a story on the news of a mother who is certain that a vaccine caused her child's autism. Cancer care institutions also market this to good effect by portraying romantic, non-representative anecdotal reports of remarkable results in individual patients. So do lawyers or politicians, who highlight a sympathetic patient who has had a bad outcome, or the sweet face of someone who they contend would be subject to a "death panel". A compelling, data-driven argument doesn't stand a chance.

Sadly, even doctors trained in evidence-based medicine are still often convinced by the before/after images in the "case study" of an indi-

## Thank you to Netcare !

Cancer Buddies and the CanSurvive Cancer Support Groups, Johannesburg, wish to thank Netcare for their assistance and encouragement.

We value the support and generosity of Netcare and their staff and their commitment to helping us to improve support for cancer patients and their families by providing a comfortable and accessible venue and refreshments for our meetings.

## ConCourt dismisses Genesis application

The Constitutional Court on 17 February dismissed, without a hearing, the application for leave to appeal by Genesis Medical Scheme against a judgment of the Supreme Court of Appeal, obliging the scheme to pay PMB benefits in full in the private sector. The application was dismissed for lack of prospects of success with costs awarded against Genesis.

According to Mr Daniel Lehutjo, Acting Chief Executive and Registrar of the Council for Medical Schemes (CMS), this now marks the end of the debate on the extent to which medical schemes may in their rules seek to limit payment for treatment of prescribed minimum benefits (PMBs) as envisaged by the regulations under the Medical Schemes Act 131 of 1998 (the Act), for expenses incurred at a public or state institution.

"Medical schemes are obliged to appoint a designated service provider (DSP) to limit their exposure to the cost of funding PMB treatment and cannot in their rules seek to limit their obligation to pay for these benefits outside of this dispensation. The Constitutional Court accordingly endorses the CMS' stance that a medical scheme may not, in the absence of a duly appointed DSP in its rules, seek to avoid the obligation to pay the costs of treatment for PMBs in full, regardless of whether these services were obtained in a public or private institution," states Lehutjo.

"This is undoubtedly a momentous judgment in that it settles once and for all the ongoing speculation by medical schemes on limiting PMBs outside of what the Act and Regulations prescribe," Lehutjo emphasised.

vidual patient doing well on a particular new treatment or the relay of a colleague's great result from a particular strategy than from the strength of the best evidence from a broader but faceless population.

But failure to recognise our predictably irrational behavior of avoiding harm by an act of commission but allowing 10 or 100 times as much harm by an act of omission, and by falling prey to the seductive appeal of an anecdotal report to outweigh all of the best evidence. But having 10 people die from progressing cancer to ensure that one never dies from the treatment isn't a noble or wise decision. In the end, what we have is a system that reflects the incentives acting on it. We could help ourselves by recognising that our current system of extreme protectionism is killing us with kindness.

<http://jackwestmd.com/west-points-blog/>

*The article was first published by the Global Resource for Advancing Cancer Education (GRACE) a nonprofit organization that was developed as a means of improving the overall medical care for cancer patients by democratising cutting edge information on optimal cancer management and providing it directly to patients. Their website is [www.cancergrace.org](http://www.cancergrace.org).*

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# How does cancer affect you in terms of nutrition - part 2

Written by Megan Lee for FutureLife

## MANAGING SYMPTOMS

### POOR APPETITE

- When unable to eat then rather drink something that provides energy, protein and nutrients such as a meal replacement, energy/protein supplement such as FUTURELIFE® Smart Food or High protein, milk, juice, soup, milkshake etc.
  - Eat 5-6 smaller meals instead of 3 big meals
  - Always keep snacks nearby for when you do feel like eating
  - Eat when your appetite is most normal
  - Exercise with approval of your doctor which will increase appetite
  - Try a bedtime snack
  - Add extra protein and energy to your diet by following the steps given earlier
  - Avoid drinking liquids with meals which will fill you up quicker
- ### CONSTIPATION
- Increase physical activity which increases gastrointestinal activity and will help to alleviate symptoms of constipation
  - Drink at least 8 glasses of fluid per day and replace lost fluids if vomiting
  - Drink hot liquids such as coffee or tea
  - Eat high fibre foods if you are allowed to, as with some cancers you need to avoid fibre

### DIARRHOEA

- Replace all fluids and electrolytes lost
- Eat foods that contain electrolytes such as bananas, potatoes and FUTURELIFE® High energy SmartBar.
- Avoid high fibre foods that may worsen diarrhoea.
- Eat grated apple which has been left to go slightly brown which is high in "soluble fibre" which helps to prevent diarrhoea by soaking up liquid and creating a gel thus thickening stools.
- Avoid foods which worsen diarrhoea (fatty food, very high sugar drinks and food, alcohol, sugar-free products containing xylitol or sorbitol, including apple juice)

### NAUSEA

- Try easily digestible foods (yogurt, clear liquids, carbonated drinks, canned bland fruit and vegetables)
- Avoid foods that are fatty, very sweet, spicy or have a strong smell
- Eat small but regular meals
- Eat before getting hungry
- Drink liquids in between meals but not with meals
- Eat dry crackers or toast
- Avoid drinking if vomiting, wait until vomiting is under control and then drink small amounts of clear liquids

### SMELL AND TASTE CHANGES

- Avoid foods which smell and taste bothers you. You can reduce the smell by using a straw, drinking through a travel mug, put a fan on when cooking or serve foods at room temperature.
- Focus on foods which smell and taste good to you
- Try tart foods such as citrus fruit, sherbet or lemon custard
- Add sweetness to foods if they have a salty, bitter taste to you
- Marinate food to enhance flavour

### SWALLOWING - DIFFICULTY AND MOUTH OR THROAT SORES

- Choose foods that are easy to chew and swallow (custard, yogurt, milkshake, scrambled eggs, soup, FUTURELIFE® Smart Food, High Protein or Smart Oats)
- Cook food very well, cut into small pieces and you can even liquidise foods
- Drink through a straw
- Suck on ice chips to soothe painful sores and inflammation
- Eat food that is cold or at room temperature.
- Avoid foods that cause pain (spicy, hot, raw, salty or acidic foods)

## GOOD FOOD HANDLING PRACTICES

It is important to ensure that you use hygienic food handling practices to ensure that you do not get sick because often cancer patients on treatment have weakened immune systems and will therefore struggle to fight off food-borne infections. Below are hygienic food-handling practices:

- Wash your hands thoroughly before and after cooking and before eating
- Keep hot foods hot (>60°C) and cold foods cold (<4°C) so refrigerate leftovers as soon as possible.
- Do not defrost food at room temperature but rather allow them to defrost in the refrigerator or in the microwave. Once defrosted, use straight away and do not re-freeze
- Wash fruit and vegetables well before peeling or cutting.
- Look at the expiry date of foods and consume within that date.
- Do not lick a utensil and then put it back in the dish.
- Avoid cross-contamination of foods by using a clean knife to cut different foods and use a separate cutting board for raw meat, chicken and fish. Also do not use the same plates or utensils for raw and cooked meat.
- Avoid eggs with cracked shells.
- Ensure food is well packaged and that cans aren't dented, swollen or rusted.

## FutureLife® mango high protein smoothie and peanut butter blitz

1/2 cup frozen mango juice, 1/2 cup fat free vanilla yogurt

1/2 cup cold water, 1 small handful of ice, 50g (5 heaped tablespoons) of Original flavour FUTURELIFE® HIGH PROTEIN Smart food, 1 cup fat free milk, 1 tablespoon smooth Peanut Butter, 50g (5 heaped tablespoons) of Original flavour FUTURELIFE® HIGH PROTEIN Smart food, 1 handful ice cubes

Add all the ingredients to your blender and blend together on full power until smooth. Serve and enjoy.

Serves 1 – meal, serves 2 – snack

For more information and recipes using FUTURELIFE® Health Products, go visit the website [www.futurelife.co.za](http://www.futurelife.co.za).

## Dates to diarise

### March 2016

- 8 Netcare/CANSA Support Group 10:00 Clinton Oncology Centre, 62 Clinton Rd. New Redruth. Alberton. Contact Penny: 0832642216
- 12 CanSurvive Cancer Support Parktown Group, Hazeldene Hall, Parktown 9:00
- 12 Wings of Hope, Netcare Head Office Auditorium, Sandton, 9:30 for 10:00.
- 15 Prostate and MaleCare Support Group, Constantiaberg, Medi-Clinic 17:45. Speaker: Linda Greeff
- 16 Cancer Buddies@Centurion, 4th floor Lecture Room at Netcare's Unitas Hospital in Centurion at 18h00
- 17 Cape Gate Oncology Centre support group 10:00 - 12:00. Survivors stories
- 29 GVI Oncology Unit support Group, 4th Floor Rondebosch Medical centre from 6:00 to 7:30. Topic: Psychoneuroimmunology
- 30 Advanced Breast Cancer Support Group, GVI Oncology, Panorama, Cape Town. Contact 021-9443850, emerentia.esterhuyse@cancercare.co.za

### April 2016

- 2 CanSurvive Cancer Support West Rand Group, Netcare Krugersdorp Hospital, 09:00
- 7 CanSurvive Head and Neck Support Group, at Rehab Matters, 1 De la Rey Rd. Rivonia at 18h00
- 8 Netcare/CANSA Support Group 10:00 Clinton Oncology Centre, 62 Clinton Rd. New Redruth. Alberton. Contact Penny: 0832642216
- 9 CanSurvive Cancer Support Parktown Group, Hazeldene Hall, Parktown 9:00
- 13 Reach for Recovery Group meeting 13:45 Lifeline offices, 2 The Avenue, Cnr Henrietta Street, Norwood
- 14 Cape Gate Oncology Centre support group 10:00 - 12:00. Love your nuts
- 19 Prostate and MaleCare Support Group, Constantiaberg, Medi-Clinic 17:45. Speaker: Kate Squires-Howe
- 20 Cancer Buddies@Centurion, 4th floor Lecture Room at Netcare's Unitas Hospital in Centurion at 18h00
- 23 Wings of Hope, Netcare Head Office Auditorium, Sandton, 9:30 for 10:00.
- 30 GVI Oncology Unit support Group, 4th Floor Rondebosch Medical centre from 6:00 to 7:30. Topic: Pilates

### May 2016

- 5 CanSurvive Head and Neck Support Group, at Rehab Matters, 1 De la Rey Rd. Rivonia at 18h00
- 7 CanSurvive Cancer Support West Rand Group, Netcare Krugersdorp Hospital, 09:00
- 12 Cape Gate Oncology Centre support group 10:00 - 12:00. Stress management
- 13 Netcare/CANSA Support Group 10:00 Clinton Oncology Centre, 62 Clinton Rd. New Redruth. Alberton. Contact

### CONTACT DETAILS

CanSurvive Cancer Support Groups - Parktown and West Rand :  
 CanSurvive Head and Neck Support Group, Rivonia, Johannesburg  
 Cancer Buddies Johannesburg branch  
 Chris Olivier 083 640 4949, cansurvive@icon.co.za  
 Contacts: Kim Lucas 0828801218 or lct@global.co.za  
 Bernice Lass 083 444 5182 or bernicelass@outlook.com

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/Netcare Support Group 10:00 Clinton Oncology Centre, 62 Clinton Rd. New Redruth. Alberton. Second Friday each month.

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, 011 869 1499 or 072 849 2901. Meetings: Lifeline offices, 2 The Avenue, Cnr Henrietta Street, Norwood

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 bbzfim@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

### Could a lung cancer drug work better with Coke?

Patients with the leading form of lung cancer may be able to look to Coca-Cola Classic to solve a common medicinal challenge, new research suggests.

As the Dutch scientists explain it, the effectiveness of the powerful lung cancer drug Tarceva (erlotinib) depends on the pH level of the stomach. But many people on Tarceva must also take a proton pump inhibitor heartburn medication - such as Nexium or Prilosec - which raises stomach pH to more alkaline levels. That higher pH can lower the absorption rate for Tarceva, cutting its effectiveness in fighting non-small-cell lung cancer, research suggests.

What to do? In the new study, researchers led by Dr. Roelof van Leeuwen, of Erasmus MC Cancer Institute in Rotterdam, the Netherlands, wondered if the solution might be to reverse stomach pH "by taking Tarceva with the acidic beverage cola," namely Coca-Cola Classic. The study focused on 28 people with non-small-cell lung cancer who were taking Nexium plus Tarceva. For two weeks, half of the patients took about 8 ounces of water with their meds for the first seven days, and then the same amount of Coca-Cola Classic for the next seven days. The following two weeks, the patients took the beverages in the reverse order.

The result? "Cola intake led to a clinically relevant and statistically significant increase" in the absorption of Tarceva for patients taking Nexium, van Leeuwen's team reported online in the *Journal of Clinical Oncology*.

The study authors believe that asking patients to drink less than a can of cola may be an "easy-to-implement" way to maximise the effectiveness of Tarceva when a heartburn medicine must also be taken by the patient.

### Cancer patients in remission after T-cell therapy

A revolutionary cancer therapy that uses the body's own immune cells to attack metastatic tumours that have spread is being hailed as a "paradigm shift" in treatment of the disease. Patients with advanced blood cancers who were not expected to live beyond five

## HELP CAN SURVIVE TO PROVIDE SUPPORT FOR CANCER PATIENTS



months have shown complete remission after 18 months of follow-up checks with no signs of the disease returning, scientists have revealed.

In one trial of a patient's own T-cells - a type of white blood cell - that were engineered in the laboratory to identify and attack tumour cells, more than 90% of the 35 patients with acute lymphoblastic leukaemia went into complete remission. In two other clinical trials involving about 40 patients with either non-Hodgkin's lymphoma or chronic lymphocyte leukaemia, more than 80% of patients responded to the treatment.

Detailed findings of the clinical trials are to be published later this year, but summary results were discussed at the American Association for the Advancement of Science, whose annual meeting in Washington DC ended on Monday. Cancer specialists urged caution over the early trials of T-cell therapy, saying that it did not work for everyone and some patients experienced toxic side-reactions and died. However, they said the improvements seen in some patients who had failed every other course of treatment were unprecedented.

"In the laboratory and in clinical trials, we are seeing dramatic responses in patients with tumours that are resistant to conventional high-dose chemotherapy," said Dr Stanley Riddell, of the Fred Hutchinson Cancer Research Centre in Seattle.

"These are in patients who have failed everything. Most of the patients in our trial would be projected to have two to five months to live. This is extraordinary. This is unprecedented in medicine, to be honest - to get response rates in this range in these very advanced patients," Riddell added. T-cells help to identify invading viruses and bacteria and can keep a "memory" of previous infections in order to launch a rapid immune response. T-cell therapy works best on the "liquid" tumours of the blood and bone marrow. the independent

<http://tinyurl.com/gneg7yx>

### Study examines link between HPV in the mouth and risk of head and neck cancers

Researchers, led by Ilir Agalliu, MD, and Robert Burk, MD, at Albert Einstein College of Medicine have found that when human papillomavirus (HPV)-16 is detected in peoples' mouths, they are 22 times more likely than those without HPV-16 to develop a common type

## PSA and male cancer support group

15 MARCH 17:45 – 19:30

The venue is the Boardroom at  
MediClinic, Constantiaberg, Plumstead

Joining a support group is an important part of your emotional healing during your journey with cancer. Come and meet with this special group of people to share and care for each other in a unique manner !

For more information contact:  
079 315 8627 PSA Support Line  
[info@can-sir.org.za](mailto:info@can-sir.org.za) or call Liesl: 021 565 0039

## CancerBuddies@Centurion

Netcare's Unitas Hospital, home of the new Cancer Buddies Support Group in Centurion, has a record of caring for its patients. On World Cancer Day, 4 February, they contributed to all their patients' nutrition – and for Children's Cancer Month they had fun with the young patients admitted on the Oncology wards and gave each of them a "Smile"

Another cancer project that runs right through the year is for each patient to knit a block with wool provided and then they are all crocheted together to form blankets which are given to patients in need.



of head and neck cancer. The study was published in JAMA Oncology. A rising proportion of these cancers are oropharyngeal cancers (cancers of the middle part of the throat including the soft palate, the base of the tongue and the tonsils). This study is the first to demonstrate conclusively that HPV-16's presence in the oral cavity precedes the development of oropharyngeal cancers. (HPV-16 is also responsible for the majority of cervical cancers.) Other studies indicate that detection of HPV in the oral cavity is related to sexual behavior.

The Einstein study involved nearly 97,000 people taking part in two large, national prospective studies. At the start of the studies, participants provided mouthwash samples and were cancer-free. A total of 132 cases of head and neck cancer were identified during an average of nearly four years of follow-up. The study also included a comparison group of 396 healthy subjects (controls), i.e., three controls for each case. Mouthwash samples for head-and-neck cancer cases and for the controls were analysed for the presence of several types of oral HPVs.

### Clear view of nanoparticles helps researchers evaluate new cancer treatment

Clear images of minute packages meant to shield healthy cells from potent anti-cancer drugs have helped researchers evaluate a promising of new approach to chemotherapy.

The drug cabozantinib, also known as XL184, effectively combats several kinds of cancer but like many chemotherapies causes so much damage in healthy tissues that doctors must limit doses or even suspend treatment periodically to allow patients to recover.

To allow a more sustained attack on tumours, a team led by Tayyaba Hasan at Massachusetts General Hospital wrapped drug particles in membranes meant to protect non-cancerous tissues from their effects. They spiked the membranes with molecules that react to infrared light, which penetrates quite deeply into the body, by releasing the drug at the site of a tumour.

The approach seemed to work in a mouse model of pancreatic cancer. But the scientists needed to know how well their wrapping procedure really worked. For a better view of their particles, they turned to a team at UC San Diego led by Elizabeth Villa, a professor of chemistry and biochemistry.

A new, sharp camera provided exceptionally clear images of the protective packaging. Although the researchers intended to wrap each drug particle in a double-layered membrane like the ones that enclose cells, a surprising percentage were not, yet they caused less collateral damage than the unprotected form of the drug. Instead, many drug particles seemed to be wrapped in a single layered membrane, a form called a micelle, which gives the researchers an additional strategy to pursue.

## Talc powder, ovarian cancer link: what evidence?

A US jury recently ordered Johnson & Johnson to pay \$72 million in damages to the family of a woman who died from ovarian cancer at age 62 and was a long-time user of the company's talc powder products, reported Medscape Medical News .

The jury found Johnson & Johnson guilty of negligence, failure to warn, and conspiracy to conceal the potential risks of its talcum powder products, according to news reports.

But what do studies and researchers say about the possible risk of developing ovarian cancer from using talc powder in the genital/rectal area for "feminine hygiene"? Medscape Medical News found that the literature has mixed results, and that experts have conflicting interpretations of that evidence.

Talc is a cause of ovarian cancer, says Dr Cramer, who was the lead author of the first study ever to link talc use with ovarian cancer in 1982 and who also testified at the Johnson & Johnson trial as a paid expert witness. He cited 20 well-executed, case-control studies that support the association over the last 30 years, including a recent study he coauthored, which was published just a few months ago in *Epidemiology*. There is about 30% increased risk for ovarian cancer with talc usage in the case-control studies, on average, and there is evidence of a dose-response relationship in some studies, he said.

Karin Rosenblatt, PhD, a professor of public health at the University of Illinois at Urbana-Champaign, also estimates the increased risk to be roughly 30% and agrees about the dose-response evidence, which is part of the basis of causal relationships. However, Dr Rosenblatt, who was also the lead author of a case-control study

## Downloads for you

A caregiver is any person who offers support to a patient through their cancer journey. To help navigate this role, ASCO has released the ASCO Answers Guide to Caregiving, offering practical tools and tips for caregiving, from near and far. Download the document here: <http://bit.ly/1M5P4IO>

### "The Conversation" project

Talking about dying isn't easy, but it's vitally important. It's not easy to talk about how you want the end of your life to be. But it's one of the most important conversations you can have with your loved ones.

This Starter Kit will help you get your thoughts together and then have the conversation.

This isn't about filling out Advance Directives or other medical forms. It's about talking to your loved ones about what you or they want for end-of-life care.

<http://theconversationproject.org/starter-kit/intro/>

### Children with Cancer: A Guide for Parents

This guide is for parents who have a child with cancer. It has information about childhood cancer, together with tips to help you and your family to cope during this challenging time.

The guide can be downloaded as a PDF from:

[http://www.cancer.gov/publications/patient-education/guide-for-parents?cid=eb\\_govdel](http://www.cancer.gov/publications/patient-education/guide-for-parents?cid=eb_govdel)

## Valentines Day with Wings



On the 12 February Olivedale Clinic held an early Valentine's day for their cancer patients. And as always, Wings of Hope contributed to the fun with support and goodies.

that found a positive association, is uncertain of the data's meaning. "I can't say for sure if [talc] is a definite risk," said Dr Rosenblatt, who has no ties to industry.

Likewise, major cancer organizations are not definite.

The American Cancer Society says anyone concerned about using talc could instead use cornstarch-based powder products.

<http://tinyurl.com/hz8vyao>

## Queen's University in world's first trial of new treatment for prostate cancer

Queen's University, in partnership with the Belfast Trust, is leading the world's first ever trial of a new combination of cancer therapies for patients with advanced prostate cancer, with the hope of prolonging their lives.

Thirty patients will participate in the trial over the next 18 months. It is aimed at men with advanced prostate cancer, where the cancer has spread to the bones at the time of diagnosis. This accounts for around 10 per cent of prostate cancer patients.

Men with advanced prostate cancer are normally treated with hormone therapy, which aims to shrink a tumour by limiting the amount of testosterone reaching the cancer cells. The new approach being trialled by Queen's researchers is the first to combine two existing forms of radiotherapy - Volumetric Modulated Arc Therapy (VMAT) to target prostate cancer cells in the pelvis, along with Radium 223 to target the disease in the bones. If successful, it has the potential to completely change the way in which the disease is treated and potentially extend the life expectancy of patients with the advanced stages of the disease.

VMAT is an advanced type of radiation therapy which manipulates radiation beams to conform to the shape of a tumour, delivering precise radiation doses to a tumour, while minimising the dose to surrounding normal tissue. It is delivered externally, using a radiotherapy machine called a linear accelerator

Radium 223 is a relatively new 'bone-seeker' drug. It is a type of internal radiotherapy, which is given intravenously. Once it is in the bones, Radium 223 releases radiation which travels a very short distance - between 2 and 10 cells deep, which is less than a millimetre. This means it delivers a high dose of radiation close to the tumour deposits in the bone, killing the cancer cells and minimising damage to the healthy cells.

<http://tinyurl.com/zyuxmkz>

## New hope for untreatable cancers

Life Healthcare Group has announced that it plans to extend its investment in Novalis Tx Radiosurgery system, which offers South African cancer patients access to cutting-edge radiation technology, to two more of its hospitals this year.

Stereotactic radiosurgery (SRS) is a highly precise form of radiation therapy initially developed to treat small brain tumours and now being applied to the treatment of body tumours with a procedure known as stereotactic body radiotherapy (SBRT).

The group initially installed the system in the Life Vincent Pallotti Hospital's oncology centre in Cape Town and another system will be available at Life Hilton Private Hospital, Midlands (KwaZulu-Natal) in May 2016 and later in the year at Life Eugene Marais Hospital, Pretoria (Gauteng).

Advances in radiation physics and computer technology means that advanced stereotactic radiosurgery, delivered by the system, can shape the radiation beam precisely to patient's tumours, ensuring that the best possible treatment dose is delivered while healthy tissue is protected.

"The term stereotactic radiosurgery may be confusing because there is no surgery involved. No cutting is actually done. This is a highly precise form of radiation therapy initially developed to treat small brain tumours and now being applied to the treatment of body tumours. Generally, patients return home immediately after treatment with limited discomfort," said Dr Rainer Fröhling, resident radiation oncologist at Life Vincent Pallotti Hospital.

The radiation beam adapts to the patient's breathing and other body movements to continuously maintain safe, complete and accurate treatment. The unit rotates around the patient to deliver treatment beams anywhere in the body from virtually any angle. It offers fast treatment session and gives new hope to patients with tumours once considered untreatable.

Using a range of innovative imaging methods and tools such as 3D rotational angiography, magnetic resonance imaging (MRI) and digitally subtracted angiography provides oncologists with improved, comprehensive and accurate target volume definition and visualisation. "This gives me the ability to offer the best treatment available to our patients," concludes Fröhling.

For more information, go to [www.lifehealthcare.co.za](http://www.lifehealthcare.co.za).

## Depressed patients at higher risk for complications and hospital readmission

Cancer patients who report significant symptoms of depression before undergoing a complex abdominal surgery are at increased risk of postoperative complications and unplanned hospital readmissions, according to a University of Pittsburgh Cancer Institute (UPCI) study published in the *Journal of Clinical Oncology*.

"Postoperative complications and readmissions can be very stressful for cancer patients and their families, not to mention very costly," said Carissa Low, Ph.D., assistant professor of medicine and psychology at UPCI's Biobehavioral Oncology Program and the study's lead author. "We wanted to look at patients who reported significant symptoms of depression before complex cancer surgery to see if depression predicts poorer postoperative outcomes."

Researchers had 98 patients scheduled for HIPEC+CS complete a measure of depressive symptoms prior to surgery. Of those patients, 28 percent had scores that indicated they were suffering from significant symptoms of depression. Within 30 days of leaving

## Tollfree service for cancer patients

All cancer patients 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 Cancer Buddies toll-free number is

**0800 033 337.**

the hospital after their surgeries, 22 percent of those patients were readmitted to the hospital and 31 percent had suffered from a complication such as infection.

"What this study tells us is that those patients going into this surgery with symptoms of depression are at risk for poorer short-term outcomes," Dr. Low said. "We don't yet know if these effects also will be seen in patients getting less complex surgery for other cancers. We also don't yet know the mechanisms responsible for these effects. In addition to psychological sources of depressed symptoms, there is evidence that the cancer itself may release factors that trigger some types of depressive symptoms, such as fatigue".

<http://www.medicalnewstoday.com/releases/306988.php?tw>

## Kuruman Hospital introduces patient transport overnight accommodation

For some rural patients, hundreds of kilometres and long nights spent sleeping in the cold can stand between them and care for complicated illnesses like cancer and drug-resistant tuberculosis (DR-TB). One Northern Cape hospital is making the journey a little easier.

In many places, care for complicated illnesses such as cancer and even DR-TB remain centralised at provincial or specialist hospitals.

To reach these services, many rural patients must travel to their nearest local hospital to catch patient transport buses that will ferry them to the larger specialist or provincial hospitals farther afield for treatment.

In areas of the Northern Cape, patients seeking treatment including chemotherapy and hysterectomies must travel about 230 km from Kuruman to Kimberley for such care. These patients must arrive at Kuruman Hospital the afternoon before their bus patient transport shuttle leaves for Kimberley Provincial Hospital the next morning at 3 am. For those already suffering from debilitating illnesses, this meant spending a cold night sleeping on the floor until now.

The John Taolo Gaetsewe Developmental Trust recently donated two park homes equipped with beds, showers and toilets to Kuruman Hospital.

"The hospital had cases where patients slept on floors and benches," said the trust's communications officer Modiri Gabaathole in a statement. "These desperate patients are now using the park homes."

Patients can now sleep in the park homes before departing early from Kuruman Hospital or returning late from the provincial hospital to ensure they do not have to travel in the middle of the night or sleep on the floor. More than 165 villages surround Kuruman and the farthest villages among these can be hundreds of kilometres away from the town and only accessible via poor roads.

<http://www.health-e.org.za/2016/02/29/21599/>