

Counterfeit medication epidemic

According to UNICEF, 438,000 people died from malaria in 2015; 80% of whom were under five years old. That's more than 800 children a day. According to a BBC news article, however, one-third of anti-malaria drugs in sub-Saharan Africa are counterfeit, unnecessarily causing more than 120,000 annual deaths.

Fake malaria drugs are just a fraction of the counterfeit medication problem. Other popular counterfeit drugs include chronic medicines for illnesses like diabetes and hypertension, antibiotics, corticosteroids, drugs for erectile dysfunction, cancer medicines, and even anti-retroviral medications for HIV/AIDS.

The Executive Director at Self-Medication Manufacturers Association of South Africa (SMSA), Nicola Brink, explains the dangers of counterfeit medication and what consumers can do to identify them.

It's difficult to distinguish authentic medicines from inauthentic ones – especially if you buy them online. However, the WHO says that some fake medicines can be identified by:

- ❑ The packaging – this should be clean, in good condition, and free of spelling mistakes or grammar errors.

PinkDrive hits the R1million mark at Comrades

The Comrades Marathon Association handed over the funds raised from the 2017 Comrades Marathon to its six official charities on August 2. PinkDrive received an astounding amount of R1,024,395.79 from this year's fundraising efforts.

Runners have the opportunity to choose their charity of choice and raise funds to aid their charity of choice. During this year's marathon, 107 runners took up the challenge to raise R5000 or more for PinkDrive. The top donor for PinkDrive during this year, was breast cancer survivor, Teresa Wilson. Teresa's 2017 journey assisted the cause with an amazing contribution of more than R53 000.00.

Noelene Kotschan, CEO and Founder of PinkDrive expressed her gratitude by saying: "I am in awe what can be achieved through collaboration. I thank each and every runner and sponsor for assisting us to keep our mobile units on the road. Your support will touch lives!"



Noelene Kotschan and Sifiso Nzuza, Comrades Marathon Chairman.



The launch of Netcare's new Pinehaven Oncology unit

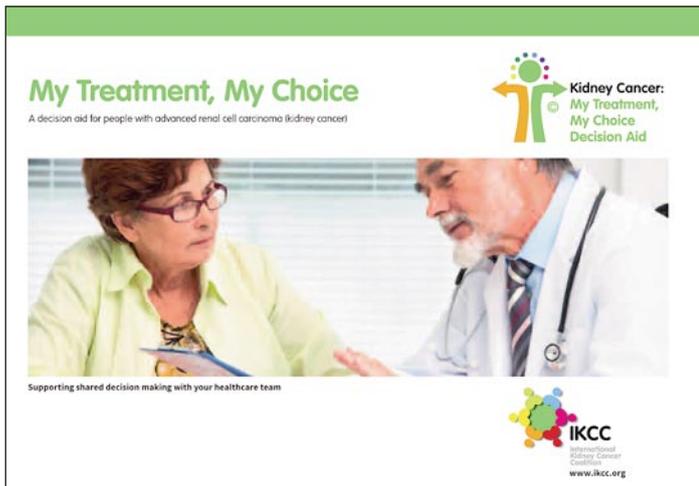
The new unit was launched on 21 July with displays from various cancer-related organisations. The 100-bed Netcare Pinehaven Hospital is a partnership between Netcare, empowerment companies Phelang Bonolo Healthcare and Rubispan (Pty) Ltd, and offers a comprehensive range of private healthcare services. **(More photos on page 7)**

- ❑ The expiry date – the manufacturing and expiry dates should be valid and the details on the outer packaging should match that on the inner packaging.
- ❑ Patient information leaflets – the information leaflet should be in the language it was advertised.
- ❑ Medicine condition – the medicine should look correct (a description will be available in the info leaflet), it shouldn't be discoloured or degraded (e.g. chipped or cracked tablets), and it shouldn't have an unusual taste or smell.
- ❑ The dosage – this shouldn't be different to another unit of the same brand, or from your doctor's prescription.
- ❑ Security seals – these should be intact, with no signs of tampering.

If you've taken a medication that you suspect isn't working properly or you've suffered an adverse reaction, discuss your situation with your pharmacist or doctor as soon as possible.

Stay vigilant, informed, and don't take chances. The risks associated with taking, or giving someone in your family, counterfeit medications are just too high.

<http://ehealthnews.co.za/counterfeit-medication-epidemic/>



New IKCC kidney cancer treatment decision aid

A decision aid for people with advanced renal cell carcinoma (kidney cancer)

The principle that patients should be involved in the decisions made about their own health and care, has been talked about for many years. Shared decision making starts with a conversation between the person who is receiving care and the person delivering care and develops into a process in which healthcare professionals and patients work together to make the best possible decisions based on clinical evidence and the patient's own preferences.

As patients and patient advocates for the kidney cancer community, the International Kidney Cancer Coalition (IKCC) believes that patients and their families have an essential role to play in healthcare decisions that affect their lives. This decision aid booklet for people with advanced kidney cancer, was written by a collaborative team of patients, patient advocates and medical professionals who between them, have supported thousands of kidney cancer patients worldwide.

You may find that this booklet contains a lot of medical information and new terms. If you find it difficult to read all at once it may be helpful to read it in sections or to reread it again at another time. The "My kidney cancer dictionary" is included to help you understand the medical terms that are used throughout the booklet.

We hope you will find this booklet helpful as you navigate the decisions ahead in partnership with your healthcare team.

Download the booklet now from:
<http://tinyurl.com/yaw882dm>

"One of the first duties of the physician is to educate the masses not to take medicine."

- Sir William Osler

Support for cancer kids in Namibia

Mr Jan-Christo Coetzer (2nd from left) of GEKA Pharma recently handed over N\$120 000 to the Cancer Association of Namibia's CHICA Interim Home in support for children fighting cancer in Namibia. Pictured are the GEKA Pharma and CAN staff at the recently opened CHICA Interim Home for childhood cancer patients' support in Windhoek West.



Randburg Bowls Club is proud to present their **Annual Cancer Challenge Bowls Day**

Friday 3 November 2017

Start: 12:00 for 12:30

Venue: Randburg Bowling Club, Tinktinkie Road, Randburg

**24 Teams of 4 players per team
 (1 being a cancer survivor or cancer fighter)**

NO EXPERIENCE NECESSARY

Entry Fee: R1000.00 per team
 (Includes afternoon tea and snacks after the game)

Prizes, Raffles, Live Music, Cash Bar and loads of Fun

To book or for more information contact:
 Wendy: 082-469-3874 or email: wendylobz@gmail.co.za

For those who do not want to play, why not sponsor a team or donate some money to this worthy cause

All proceeds given to CanSurvive who support people who are living with Cancer. CanSurvive is a registered Non-profit company No. 2016/111301/08

CanSurvive
 CANCER SUPPORT

RECOVERING FROM PROSTATE SURGERY

The role of your Men's Health Physio

by Lorraine Jacobs MSc (Physio)

The path to recovery after prostate surgery can take some unexpected twists and turns. Surgery is a routine event for doctors, and they may lose sight of the impact of the diagnosis on patients and their families. Preparation can help you manage the uncertainties, and smooth your path to recovery.

The anatomy and function of prostate gland, or how enlargement or cancer happens, or the surgical options available is not discussed here - the aim is rather to give you lots of information to make your recovery as easy as possible.

Think back to when you last bought a new car, or TV or prepared for a cycling or running event, or even wrote an exam. I am sure you put in many hours of preparation, to be quite sure that you were making the right choices, or that you were in peak physical condition. Preparing for a prostate surgery requires just as much dedication - a successful outcome relies on having sufficient knowledge, acquiring

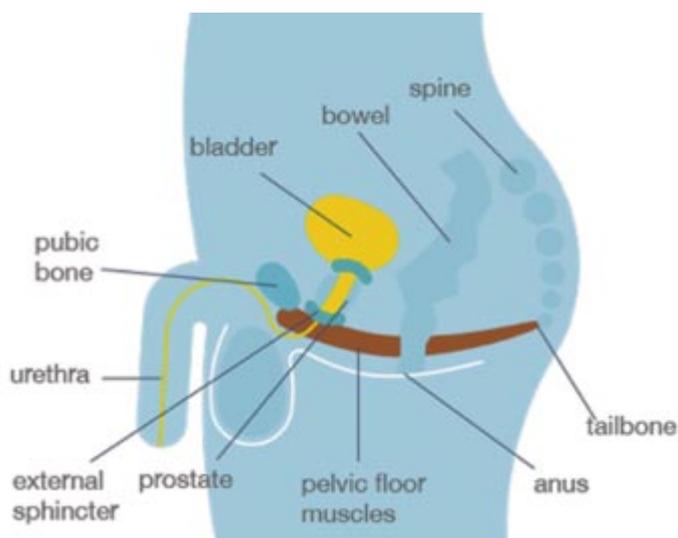


Image – coloplast.com

the right skills beforehand and having access to the best tools for the job, as well as focused hard work.

Knowledge

Question your healthcare provider about the procedure and what you can expect post-operatively. You will get lots of advice from friends and family, and I am sure you (or your partner) will have googled it! Always check back with your healthcare provider if something concerns you.

A prostatectomy removes the entire prostate, and can damage the internal (or involuntary) sphincter of the bladder. The most common problems after surgery are urinary incontinence, erectile function and ejaculation, and are usually temporary, as a result of bruising of the nerves around the prostate gland during surgery. These nerves supply the muscles of the pelvic floor that play a role in control of urination, erectile function and ejaculation.

The prostate gland is a mix of muscle and gland tissue which is wrapped around the urethra. The urethra carries urine from the bladder to the penis. Any enlargement of the prostate can put pressure on the urethra, causing you to need to urinate more frequently. The muscles of the pelvic floor muscles line the floor of the pelvis and add support to the bladder. The pelvic floor muscles are a mix of slow twitch muscles (for support) and fast twitch muscles (for action). You can see from the diagram that these muscles act as a sling to support the bladder, urethra and the anus.

When these muscles contract they pinch the urethra closed, allowing the bladder to contain any urine, until such time as you choose to empty the bladder - when you voluntarily relax the muscle urine flows out of the bladder.

There is a muscle ring around the urethra called the external urethral sphincter that can be trained to take over control of the emptying of the bladder. It is part of the pelvic floor muscle and is often weak. It takes approximately three months for the pelvic floor muscles to strengthen enough to sustain continence.

Skills

Preparation should begin as long as possible before surgery. We call this pre-operative preparation "pre-habilitation". Try to ensure that you are in peak condition, both physically and emotionally. If you can lose extra weight beforehand as this reduces the load of the abdomen on the pelvic floor. Stopping smoking assists recovery, as

CanSurvive

CANCER SUPPORT

Let's talk about cancer!

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

Upcoming meetings:

PARKTOWN Hazeldene Hall (opposite Netcare Parklane Hospital) - 12 August 09:00

SOWETO, HapyD, 1432 Buthelezi St. Jabulani - 19 August 09:00

CHARLOTTE MAXEKE Radiation Department, Level P4 - 23 August

KRUGERSDORP Netcare Krugersdorp Hospital - 2 September

CHARLOTTE MAXEKE Radiation Department, Level P4 - 6 September

PARKTOWN Hazeldene Hall (opposite Netcare Parklane Hospital) - 9 September 09:00

Enquiries: **062 275 6193**

or email cansurvive@icon.co.za

www.cansurvive.co.za

www.facebook.com/cansurviveSA

The Groups are free and open to any survivor, patient or caregiver.

(continued on page 4)

RECOVERING FROM PROSTATE SURGERY

(continued from page3)

nicotine reduces the flow of blood and oxygen to the tissues that are healing. Improving your cardiovascular fitness also helps with recovery. Ideally, mastering pelvic floor training can hasten recovery after surgery. A Physiotherapist trained in the field of Pelvic Health or Men's Health can be of great help on your journey.

Learning how to activate the pelvic floor correctly is probably the most challenging step of the rehabilitation process, which is why it makes sense to learn this skill beforehand. Don't worry if you haven't been able to do this - you will still be able to catch up. Normally the pelvic floor works constantly all day to control the flow of urine, without you even being aware of it. You may only become aware of its activity when your bladder is full and you have to control it, for example during a cough or sneeze, or lifting a heavy load, or when you stop a wind.

The muscles we have to find are the ones at the front of the pelvic floor - these are the muscles that prevent the bladder emptying uncontrollably, as well as assisting with erections and ejaculation.

- Step 1 is to find the muscle and train its ability to hold a contraction. Once you can do this we tackle the retraining of the pelvic floor muscles just like training for any other endurance event by adding progressive load (volume of urine and time) and more challenging activities:
- Step 2 is training to control leaking while the bladder fills normally, during lying, sitting and standing. A mix of long slow sustained contractions and quick contractions are advised, up to a hundred repetitions a day are advised.
- Step 3 trains the bladder to accommodate more urine, and to increase the periods between emptying.
- Step 4 integrates pelvic floor control into all your normal daily activities, as well as more challenging aerobic activities. Training is started with contracting the abdominal muscles, adding walking on flat surfaces, progressing on to uneven surfaces and running.
- Step 5 is the final step - coping with unexpected loads or high load training, such as lifting weights, squats, planks, Turkish get-ups. This includes selective retraining of the slow twitch muscle fibres (to maintain an erection) and fast twitch muscle fibres (for ejaculation).

How do we find this important muscle? When the correct muscle is activated the testicles lift towards the belly, and the penis pulls in or shortens slightly. This can be seen in a mirror. The exercise is best done in standing, so that the muscle can contract against gravity.

We can use verbal cues such as:

- "Lift your testicles" (such as walking in to freezing water)
- "Shorten your penis" (most men don't find this appealing at all!)
- or a more basic command "Lift your nuts to your guts"
- Stopping the flow of urine may also be a useful cue, especially during the pre-rehabilitation stage.
- We can also use visual cues such as standing in front of a mirror and seeing the testicles lift and the penis shorten as the muscles contract.
- Or you can touch the area between the scrotum and the anus (the perineum) and feel it tightening as you contract the muscles.

Your Men's Health Physio will advise you on an individualised programme, and progress it according to your needs.

ONCOLOGY AWARD

Do you have a non-medical, non-treatment idea for changing cancer care? The Astellas Oncology C3 Prize® is encouraging applicants from all over the world and from all backgrounds to submit innovative ideas to change cancer care. Now in its second year, the C3 Prize will award \$100,000 in unrestricted grants and access to mentorship to bring the brightest ideas to life. Applications are being accepted until 11:59 p.m. CST on August 21st. Visit www.C3Prize.com for all of the details.

Sometimes additional assistance is needed to get the correct activation, and your physio will help you with comfortable electrical stimulation to contract the muscle. Similar muscle stimulators can be purchased for personal use, if necessary. Your physio may also have access to real time ultrasound imaging to visualise the bladder and the muscle action lifting it.

Tools

For approximately two weeks after surgery a catheter will be inserted while the tissue is healing, and once it is removed rehabilitation can be started. Initially the flow of urine may be constant, and you will need incontinence shields, kept in place with well-fitting underpants (rather than boxer shorts). These are much more convenient than pull-ups. As your continence function improves your Physiotherapist can assist you with a practical programme to wean you from the shields. You are also advised to keep yourself hydrated, with water or herbal teas, but avoid drinks that can irritate your bladder such as alcohol, especially beer, caffeine (in tea, coffee and cola drinks) and fizzy drinks.

The tissues of the penis require a regular supply of oxygen and nutrients to keep them healthy. Normal spontaneous nocturnal erections that occur prior to surgery are disrupted due to bruising of the nerves and trauma to the tissues. Post-operative penile rehabilitation can be started about four weeks after surgery. The simplest method is a vacuum pump which applies suction to the tissues of the penis, drawing in oxygen and nutrients. Once again your Men's Health physio will be able to advise you.

On a personal note, I am also a survivor of cancer and surgery. As a Physiotherapist and Life Coach I understand the importance of setting yourself realistic goals during recovery, that are aligned with what gives your life meaning. SMART goals – Specific, Measurable, Achievable, Realistic and Time-based goals helped to move me from focusing on my illness to focusing on my recovery. My SMART goal (as a previous non-runner!) was to train for, and complete a 10km race with friends and family - which I did, 10 months after my surgery.

The path to recovery requires patience, persistence, determination and dedication. When you have a goal of returning to the activities that you value, with your loved ones, without hindrances the hard work will all be worth it.

Useful resources

Prostate Recovery Map: Men's Action Plan: navigating your way to continence. Author Craig Allingham. This is available as an e-book from craigallingham.com

Conquering Incontinence. Author Peter Dornan. Available as an e-book from iBooks.

Lorraine Jacobs can be contacted at thrive@netactive.co.za and her website is www.physiosintouch.co.za

Men's health awareness on Mandela Day

Sister Ms M. Khasanyana who works for Moroka Clinic organised a Men's Health prostate awareness day there recently..

Dr Dlamini was the main speaker and he spoke about circumcision and prostate problems.

CanSurvive was represented by group organisers, Wilton Tshakaza and Archie Radebe



CanSurvive Group organisers at Charlotte Maxeke Oncology clinics

CanSurvive was well represented at a recent head and neck cancer awareness day at the Charlotte Maxeke Johannesburg Academic Hospital.

Wilton Tshakaza and William Genge, who organise the CanSurvive Support groups at the hospital were there to help and advise patients and caregivers. Call 062 275 6193 for more details about these groups as well as the Parktown and Krugersdorp groups.



PAIN - and the doctor's appointment

by *Christa du Toit*

In our previous articles, we discussed the definition of pain.

To reiterate. Pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage. Pain is always subjective. "Pain is what the patient says hurts" The cancer is not always the cause of a pain symptom and causal factors could have a major influence. This could include the treatment, concurrent disorders, worsened by insomnia, exhaustion and many more.--

The lifestyle adaptation programme shared in our February issue, often used in support groups, implements "The Pain Wheel- Understanding your pain in totality". With the result that the communication between the specialist of your pain - you yourself, your doctor, your family and any caregivers will improve. We need to walk this path together, adapt together. Concordance in perceived needs of family members and caregivers leads to greater need satisfaction, and it is advocated that the patient and family (rather than just the patient) be focused on due to the relationship between social support and patient recovery.

An excellent way to empower you to explain your pain to the health care practitioner is to use an alphabetical abbreviation. Dr Robert Twycross addresses this as the PQRST characteristics of pain:

P: Provocative. "What makes your pain worse or palliative, what makes it better?"

Q: Quality. "The descriptive words you use to explain that pain." What exactly is it like? Is it burning, stabbing, pinching, knowing? The way you describe your pain, could assist the doctor to prescribe the correct medication, different types of pain needs different medication/treatment

R: Radiate. Where does the pain radiate to? "Does it spread anywhere?" Where does it start and where does it end?

S: Severity. "How severe is it?" "We need to try and score the pain, this is often rated by the VAS (visual analogue scale-number out of 10) or many other rating scales. The objective being, to monitor the treatment and adhere accordingly. The medication could be changed, or the dosage altered. Very important "How much does it affect your life?" Remember pain is what the patient says hurts.

T: Time. When is the pain the worse? "Is it there all the time or does it come and go?" This could clarify many obstacles in your treatment plan. Is it before the next dosage is due (the dosage needs to be altered, medication needs to be changed). Perhaps the pain is more severe in the evening (poor sleeping hygiene?), did you forget to take the correct dosage?

Keeping a diary, keeping track of your own "history" and sharing this during your consultation not only clarifies your pain complexities but simultaneously sharing this information with your healthcare practitioners could eliminate misunderstandings. Remember the diary is to help you to remember, are we on the same treatment pathway, and not to ruminate for hours and force "the pain" the control your life.

"Christa du Toit works for Janssen Pharmaceuticals as MedicalScientific Liaison: Pain.

SICKLE CELL DISEASE

The most common severe inherited disease in Africa

by Dr Lindsay Farrant

Sickle cell disease (SCD) is the most common severe inherited disease in Africa as a whole, but not in South Africa. The incidence in South Africa is 1%, while in West Africa the incidence is highest, at 30-40%. The inheritance of the disease is autosomal recessive, meaning that it occurs in persons with two copies of the sickle cell gene – one from each parent (homozygous for the sickle cell gene, Hb SS). Carriers have the sickle cell trait (Hb AS), meaning they only have one sickle cell gene and one 'normal' gene. In sickle cell disease the resultant haemoglobin (Hb SS) causes a distortion of the red blood cell shape – creating the 'sickle cell'. SCD is one of the haemolytic anaemias where there is 1) increased red blood cell destruction, causing anaemia and jaundice; and 2) a compensatory increase in bone marrow erythropoiesis (red blood cell formation) and resultant bone and joint damage in the long term. Erythropoiesis can also occur in the liver and spleen, causing these organs to enlarge. In addition to these features, painful sickle cell 'crises' (vaso-occlusive crises) occur when blood vessels are blocked by the 'sickle cells' when they interact in a specific manner with the lining of the blood vessels and the blood plasma. These blockages can occur in any blood vessels, with the symptoms reflecting the areas that are receiving insufficient blood supply. Some of the complications resulting from these vaso-occlusive crises are: pain syndromes, stroke, leg ulcers or kidney dysfunction. These crises may be precipitated by factors such as dehydration, infections or exposure to cold.

There is no curative treatment for SCD. A sickle cell crisis requires prompt supportive treatment to correct dehydration and acidosis, treat infections, and to relieve the underlying pain. This may be done at home or in hospital, depending on the severity of the attack. The acute pain in a crisis is caused by ischaemic (lack of blood supply) tissue injury. Chronic pain is the result of repeated destruction of bones, joints and organs. The acute pain of unpredictable and recurrent crises interacts on a background of chronic pain over the lifetime of the person.

The framework for management of pain in this disease should include treating acute pain crises effectively and promptly, preventing crises in the long term, and treating the chronic pain and related complications that can result from repeated crises. Adequate treatment of pain requires a comprehensive assessment of the patient's pain. A brief assessment involves predominantly the physical aspects of the pain to enable prompt and adequate pain control in a crisis. This is followed up by a more comprehensive assessment involving the assessment of the multidimensional nature of the pain and is important for forward planning of the management of the patient's pain.

A comment on the mechanisms of pain is important. Nociceptive pain is a result of the damage to the tissue. Neuropathic pain is a result of damage to nerve fibres in the area of tissue damage, often, but not only, as a part of the chronic pain picture. Nociceptive and neuropathic pain are treated differently and as such it is important to identify the specific nature of the pain. Mixed pain refers to pain of mixed type (acute and chronic) and mixed mechanism (nocicep-

tive and neuropathic). Mixed pain is not uncommon in SCD and should always be considered. The totality of the pain experience for the patient makes the comprehensive pain assessment a vital part of the pain assessment and enables adequate patient support. Psychological, social, cultural and spiritual support is important in the long term management plan for SCD patients. Acute admissions for crises should always be seen in the context of a chronic disease, with possible chronic pain. The NICE guideline: Sickle cell disease: Managing acute painful episodes in hospital (CG143) is very helpful in the acute setting.

(<https://www.nice.org.uk/guidance/cg143/resources/sickle-cell-disease-managing-acute-painful-episodes-in-hospital-pdf-35109569155525>) The American Pain Society guideline recommends that patients have a detailed clinical assessment of their pain, at least once per year, but more often if their pain is frequent or chronic. Pharmacological management of acute and chronic pain in SCD follows standard pain management guidelines. This includes the use of non-opioids, opioids and neuropathic pain agents for acute and chronic pain. Not infrequently, according to a number of studies, have doctors incorrectly label patients with SCD as being addicted to opioids. Preboth writes "Opioid tolerance and physical dependence are expected with long term opioid treatment and should not be confused with psychologic dependence". It is important that all pain be adequately treated with appropriate dosing of all analgesia. Specialist opinion and involvement may be required at times for some patients or more regularly for patients with particularly complicated pain.

Patients with SCD as children, grow to become young adults. Transition of care between paediatric and adult services is an important part of care. The NICE guidelines point to the importance of adult and paediatric services working together for patient-centred care to ensure continuity of care. Life expectancy in persons with sickle cell disease is reduced. Death may be due to pulmonary complications, strokes, infection and its sequelae, acute splenic sequestration and chronic organ damage and failure. Acute death in a crisis, particularly a pain crisis, acute chest syndrome or a stroke occurs in around one third of patients, indicating the unpredictability of timing of death. This points to another key part of the holistic care of patients with SCD – the discussion of and preparation for the end of life. The WHO endorses palliative care for adults and children, as "an approach that improves the quality of life of patients and their families facing the problems associated with life threatening illness". This is done "through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual." According to this approach, many patients with SCD would derive benefit from a palliative care approach, while a smaller number of patients with SCD will require specialist palliative care for pain and symptom control and quality of life support. Quality of life is important throughout life, including at the end of life, and as such, for patients with a chronic, life-long disease, support and management aimed at the best possible quality of life is imperative for the entirety of that person's life. While there is a need for more research into the specific palliative care needs of patients with SCD, impeccable pain control in a crisis and at all other times should be an integral part of the aims of any care package offered to patients with SCD.

The article was first printed in the newsletter of PatchSA and is reproduced with their kind permission. They can be contacted at info@patchsa.org and through their website www.patchsa.org.

New oncology unit launched at Netcare Pinehaven Hospital

The new unit was launched at the end of July at Netcare's Pinehaven Hospital in Krugersdorp. Several cancer-related organisations were there to answer questions from patients and staff.



VISION E-NEWSLETTER

VISION is produced for CanSurvive Cancer Support and is an e-newsletter for cancer patients and caregivers everywhere and with any type of cancer.

Please send details and pics of any support meetings and cancer related events anywhere in South Africa so that we can include these in the newsletters.

Your comments, articles, and letters submitted for publication in VISION are always welcomed and can be sent to the Editor at: cansurvive@icon.co.za.

Subscription to the newsletter is free - just email us.

Enquiries: 062 275 6193

Cancer, mass, tumour ...what's in a name?

Today, a patient said to me, "Doc, I understand I have cancer, but when you start talking about tumours I really get scared." Now, I certainly did not intend to frighten him, I was just trying to explain the situation. I started thinking about these loaded words and the confusing messages they can deliver. Is "cancer" the same as "neoplasm?" Can you have "tumour" without "malignancy?" Are there "benign masses?" So, in the interest of clarity, and so I stop needlessly unnerving my patients, I present the following definitions:

Growth – any abnormal tissue that can increase or is increasing in size. May be benign or malignant.

Neoplasm – a growth of cells. The growth may be out of control and never stop (in which case it is cancerous) or may grow only in one place and never spread (in which case it is benign). All cancers are neoplastic, but not all neoplasms are cancer.

Benign – a group of cells which grow in one place and can not spread to another part of the body. Most eventually stop growing. There are benign and cancerous tumours of most tissues in the body. This is why it is vital to do biopsies to determine how a growth is likely to behave.

Cancer – any growth of identical cells which is out of control and never stops. Cancers have the ability to invade into the tissues around them and to spread beyond their site of origin. Unlike normal cells, which have limited life span, cancerous cells are referred to as "immortal." Cancers can be solid, like lung cancer, breast cancer or prostate cancer, or can be "liquid" as in leukemia. There is no such thing as a benign cancer.

Malignant – same as cancer. All cancers are malignant and all malignancies are cancer.

PSA and male cancer support group

Monthly support groups are held at the Boardroom at MediClinic, Constantiaberg, Plumstead

15 August 17:45 – 19:00

The speaker will be Dr Greg Hart of GVI Oncology

For more information contact:

Helpline: 076 775 6099

Email: info@can-sir.org.za. Web: www.can-sir.org.za

Our grateful thanks to Medi-Clinic for providing a home for our activities and refreshments for our members.

It is much appreciated by us all.

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, including the Physicians Leadership Award in Palliative Care.

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



Tumour – any mass or solid growth of cells. May be malignant or benign. Not leukemia, which is liquid.

Mass – the same as tumour. A mass, like a tumour, may take any shape and is usually not round.

Cyst – any abnormal fluid filled, bubble-like structure. Can be benign or malignant. More likely to be malignant (cancer) if not a simple bubble but has multiple internal walls and is "complex." A cyst, which is infected, is called an "abscess."

Plaque – Cancerous growth as a coating or layer on the outside of an organ (like the lung or intestines). This can be as thin as a coat of paint, thick like crust on Italian bread or very thick like carpet. Such plaques are as hard as cement and can invade the organ they are touching.

Effusion – liquid that builds up in a space inside the body. A "pleural" effusion is fluid that collects in the chest cavity around the outside of the lung. "Ascites" is an effusion which builds up in the abdomen outside of the intestines. Effusions can be full of cancer cells, in which case they are malignant or can be caused by other problems (such as bleeding, infection or liver disease).

Metastasis – the spread from the original site of a cancer. For example, a lung cancer that spreads to bone. A metastatic cancer keeps the name of the site from which it started. A lung cancer in bone is still lung cancer, not bone cancer.

With the above definitions, the following sentences should make sense:

- The malignant breast tumour metastasised to the lining of the lung forming a plaque, which made the patient short of breath.
- The biopsies determined that the two neoplasms of the liver were not cancer but were benign masses and did not need treatment.
- We were worried that the growth in the ovarian cyst might mean ovarian cancer but it turned out to be benign.
- In the effusion we found malignant cells and realised it was metastatic colon cancer.
- Benign neoplasms never become cancerous tumours.

I hope this helps. This stuff is scary enough without the words themselves being the enemy.

"Soap and water and common sense are the best disinfectants."

- Sir William Osler

CANCER ALLIANCE ADVOCACY TOOLKIT

Priority area #5: Cancer stigma



Cancer doesn't discriminate, yet the disease remains taboo in too many communities in South Africa. Urgent interventions are essential to reduce stigma and dispel damaging myths and misconceptions which represent a serious public health risk.

The facts

Stigma is one of the biggest challenges in identification, reporting and treatment of childhood, young adult, and adult cancers. In the stigma cycle, lack of information leads to poor knowledge of cancer which enables the entertainment of myths and dangerous misconceptions, which then cannot be dispelled without the provision of good cancer information and education. In other words, it breeds silence, which fuels the fear and ignorance, which in turns continues feeding stigma. These negative public perceptions make patients feel invisible, stifle informed public discussion, and perpetuate a cycle of fear, silence and misinformation – which negatively impacts awareness efforts, hinders healthy behaviour, and contributes to lack of early diagnosis.

There are three categories of stigma.

- Self-stigma – where the person with cancer personally feels shame or guilt around their diagnosis.
- Perceived stigma – where the patient perceives that others are judging them negatively, based on their cancer diagnosis.
- Active stigma – for example, a husband leaves his wife because of the stigma around cancer, or an employer fires an employee because they think a cancer survivor is in constant pain and cannot continue working, or neighbours who isolate patients because they are afraid of “catching” cancer, and don't want “that influence” in their community.

So what do we need?

- To break the vicious cycle of fear and misinformation.
- To break down ignorance that is impacting cancer stigma
- To understand and respond to cultural beliefs and practices.
- To work to counter discrimination in the workplace.
- Effective public health and health promotion programmes.
- Support from the media to combat stigma
- Systemic changes supported by policy and legislation to protect cancer patients and their carers from discrimination.
- To make sure that staff are well informed about cancer

But we cannot do without:

- Ensuring that fighting stigma and fear becomes a key component of a national cancer control policy and is supported by cancer related policies.
- Evidence-based, culturally-relevant, and targeted prevention and intervention campaigns.
- Increasing access to treatment.
- Securing buy-in from all the government departments involved, including Health, Labour, Basic Education and Social Services to ensure ongoing education efforts.
- Including the traditional healer sector.

- Partnerships with the media, civil society and community leaders.

How can we meet the challenge?

In the Photovoice research project Edwards and Greeff (2017) reported “Cancer stigma was reported by 31% of participants. Beliefs that provoked stigma included the idea that cancer was contagious, caused by evil spirits, a death sentence and tainted those it affected. Cancer stigma led to families being reluctant to speak about cancer and contributed to patient-experiences of isolation, shame, fear, discrimination and rejection.”

Challenge 1: Breaking the stigma cycle

A lack of information and education on cancer has led to some dangerous misconceptions and myths, and any interventions must take into account all three categories of stigma.

Addressing the issue requires a multi-pronged strategy that includes;

- Access to treatment
- Education from primary school level to tertiary level and
- Buy-in from all government departments involved, civil society and communities, in order to launch innovative campaigns to address negative public perceptions and stamp out cancer stigma

Challenge 2: Cultural beliefs and practices

In a culturally rich society, cancer is perceived differently by the various cultural groups. In many cultures, cancer is regarded as a bad omen or a curse, a message from unhappy forefathers who inflicted the disease as punishment, or a sign the patient has been bewitched.

Many regard their illness as a sign of weakness, and this is particularly true for many men.

More effort must be made to integrate traditional healers into South Africa's healthcare system, because they can have a substantial impact on cancer care. This aspect is however not well-understood and needs to be explored as a matter of urgency.

Challenge 3: Educational programmes at schools, workplaces and in communities

We know that cancer patients are subject to severe effects as a result of stigma, whether in the family, the community or in the workplace. Apart from psychosocial problems, this can and does have serious consequences for adherence to treatment, etc.

Cancer stigma can be reduced via culturally-relevant and targeted messaging in a two-pronged approach:

- Raising awareness of cancer stigma at national level.
- Reinforcing cancer education and anti-stigma messages at community level.

The Department of Basic Education must be lobbied to include basic cancer awareness teaching for children in primary school, to begin to address stigma from an early age. Children need to understand that they can make their own lifestyle choices, and that these choices may have good or bad consequences for their health.

Challenge 4: Policy and legislation

The fight against the ignorance and fear that drives stigma must become a key component of South Africa's national cancer control policy and other cancer related policies – or awareness-raising efforts about cancer prevention will continue to be hindered, also impacting on health seeking behaviour, and the seeking of early diagnosis for signs and symptoms.

CALENDAR

August 2017

- 15 Can-Sir Malecare Support Group, Mediclinic Constantiaberg, Plumstead, Cape Town, 17:45 – 19:00
- 16 CanSurvive Charlotte Maxeke Group, Radiation Floor P4.
- 16 Reach for Recovery Group meeting 13:45 Lifeline offices, 2 The Avenue, Cnr Henrietta Street, Norwood. Bryony Keigler will do a presentation on lymphoedema
- 16 CancerSupport@Centurion support Group at Netcare Unitas Hospital, Centurion at 16:00
- 19 CanSurvive Jabulani Group at HapyD, 1432 Buthelezi St.
- 24 Cape Gate Oncology Group, Oncology Centre 10:00. "Self-care - importance and practical tips".
- 26 Wings of Hope, Netcare Auditorium, Sandton. 10.00
- 28 Cancercare Support Group, Rondebosch Medical Centre, "Strategies for coping with cancer treatment"

September 2017

- 2 CanSurvive Cancer Support West Rand Group, Netcare Krugersdorp Hospital, 09:00
- 2 Bosom Buddies Support Group, Hazeldene Hall, Parktown at 09:30 for 10:00
- 6 CanSurvive Charlotte Maxeke Group, Radiation Floor P4.
- 6 Cancercare OuteniquaSupport Group, GVI Boardroom,3 Gloucester Ave. George 10:00 - 12:00
- 9 CanSurvive Cancer Support Parktown Group, Hazeldene Hall, Parktown 9:00
- 16 CanSurvive Jabulani Group at HapyD, 1432 Buthelezi St.
- 18 Cancercare Support Group, Rondebosch Medical Centre, "What about diet, supplements, alternative treatment etc."
- 19 Can-Sir Malecare Support Group, Mediclinic Constantiaberg, Plumstead, Cape Town, 17:45 – 19:00
- 20 CanSurvive Charlotte Maxeke Group, Radiation Floor P4.
- 20 CancerSupport@Centurion support Group at Netcare Unitas Hospital, Centurion at 16:00
- 21 Cape Gate Oncology Group, Oncology Centre 10:00. "Cancer and pain management".

October 2017

- 4 CanSurvive Charlotte Maxeke Group, Radiation Floor P4.
- 4 Cancercare OuteniquaSupport Group, GVI Boardroom,3 Gloucester Ave. George 10:00 - 12:00
- 7 CanSurvive Cancer Support West Rand Group, Netcare Krugersdorp Hospital, 09:00
- 7 Wings of Hope, Netcare Auditorium, Sandton. 10.00
- 7 Bosom Buddies Support Group, Hazeldene Hall, Parktown at 09:30 for 10:00
- 14 CanSurvive Cancer Support Parktown Group, Hazeldene Hall, Parktown 9:00
- 17 Can-Sir Malecare Support Group, Mediclinic Constantiaberg, Plumstead, Cape Town, 17:45 – 19:00
- 18 CanSurvive Charlotte Maxeke Group, Radiation Floor P4.
- 18 CancerSupport@Centurion support Group at Netcare Unitas Hospital, Centurion at 16:00

CONTACT DETAILS

CanSurvive Cancer Support
Parktown and West Rand Group ;
Contact: 062 275 6193 or cansurvive@icon.co.za

Charlotte Maxeke Group: Contact Duke Mkhize 0828522432
Jabulani Group: Contact Sister Bongiwwe Nkosi: 0835760622

CancerCareSupport Group, 4th Floor, Rondebosch Medical Centre. Contact: linda.greeff@cancercare.co.za or phone 0219443700 for more info

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

CancerCare Outeniqua, George Support Group. Contact:
Engela van der Merwe, 044 8840705,
engela.vandermerwe@cancercare.co.za

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

Cancersupport@centurion: Marianne Ambrose 012 677 8271 (office) or Henriette Brown 072 8065728

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

Prostate & Male Cancer Support Action Group,
MediClinicConstantiaberg. Contact Can-Sir: 079 315 8627 or
Linda Greeff: linda.greeff@cancercare.co.za, phone
0219443700

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

Clinton Support Group 10:00 Netcare 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 7633901. Meetings: Lifeline offices, 2 The Avenue,
Cnr Henrietta Street, Norwood

Reach for Recovery (R4R) : West Rand Group. Contact Sandra
on 083 897 0221.

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, Jenny Caldwell, 072 248 0008.t

Reach for Recovery: Harare, Zimbabwe contact 707659.

Breast Best Friend Zimbabwe, e-mail bbzfim@gmail.com

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

News in brief

EU report: more evidence on link between antibiotic use and antibiotic resistance

The European Food Safety Authority, the European Medicines Agency and the European Centre for Disease Prevention and Control are concerned about the impact of use of antibiotics on the increase in antibiotic-resistant bacteria. A new report from the three agencies presents new data on antibiotic consumption and antibiotic resistance and reflects improved surveillance across Europe.

Vytenis Andriukaitis, European Commissioner for Health and Food Safety, said: "To contain antibiotic resistance we need to fight on three fronts at the same time: human, animal and the environment. This is exactly what we are trying to achieve in the EU and globally with our recently launched EU action plan on antimicrobial resistance .

"This new report confirms the link between antibiotic consumption and antibiotic resistance in both humans and food-producing animals."

The Joint Interagency Antimicrobial Consumption and Resistance Analysis (JIACRA) report highlights that there are still important differences across the EU in the use of antibiotics in animals and humans. Reducing their unnecessary use will have an impact on the occurrence of resistance.

Overall antibiotic use is higher in food-producing animals than in humans, but the situation varies across countries and according to the antibiotics.

In particular, a class of antibiotics called polymyxins – which includes colistin – is used widely in the veterinary sector. It is also increasingly used in hospitals to treat multidrug-resistant infections.

Other antibiotics are more often used in humans than in animals. These include third- and fourth-generation cephalosporins and quinolones, antibiotics that are also considered critically important for human health.

<http://tinyurl.com/y729b5r2>

FDA approves new treatment for sickle cell disease

The US Food and Drug Administration approved Endari (L-glutamine oral powder) for patients age five years and older with sickle cell disease to reduce severe complications associated with the blood disorder.

"Endari is the first treatment approved for patients with sickle cell disease in almost 20 years," said Richard Pazdur, M.D., acting director of the Office of Hematology and Oncology Products in the FDA's Centre for Drug Evaluation and Research and director of the FDA's Oncology Centre of Excellence. "Until now, only one other drug was approved for patients living with this serious, debilitating condition."

The safety and efficacy of Endari were studied in a randomised trial of patients ages five to 58 years old with sickle cell disease who had two or more painful crises within the 12 months prior to enrollment in the trial. Patients were assigned randomly to treatment with

Endari or placebo, and the effect of treatment was evaluated over 48 weeks. Patients who were treated with Endari experienced fewer hospital visits for pain treated with a parenterally administered narcotic or ketorolac (sickle cell crises), on average, compared to patients who received a placebo (median 3 vs. median 4), fewer hospitalizations for sickle cell pain (median 2 vs. median 3), and fewer days in the hospital (median 6.5 days vs. median 11 days). Patients who received Endari also had fewer occurrences of acute chest syndrome (a life-threatening complication of sickle cell disease) compared with patients who received a placebo (8.6 percent vs. 23.1 percent).

<http://tinyurl.com/ybx8hg92>

Right-sided colorectal tumours: An internal radiation advantage

For patients with colorectal cancer that has metastasised to the liver, having a primary tumour on the left side, as opposed to the right side of the colon, is known to be a significant advantage in terms of treatment response.

But now a new study, presented here at the ESMO 19th World Congress on Gastrointestinal Cancer, suggests this imbalance may be at least partially redressed.

Reversing the usual pattern, patients whose liver metastases had spread from right-sided primary tumours (RSP) had a 36% better survival rate after treatment with a combination of first-line chemotherapy and selective internal radiation therapy (SIRT) using Y-90 resin microspheres, compared to chemotherapy alone, according to the study.

This same treatment combination was no better than chemotherapy only in patients with left-sided primary tumours (LSP).

"These findings are good news for patients with right-sided primary tumours, who have a much worse prognosis and fewer treatment options than patients with left-sided tumours," said study investigator Guy van Hazel, MD, from the University of Western Australia in Perth, Australia.

<http://tinyurl.com/ycqto3gh>

Side effects not a major problem for new class of breast cancer drugs

A ground-breaking new class of oral drugs for treating breast cancer, known as cyclin-dependent kinase (CDK) inhibitors, are generally well-tolerated, with a manageable toxicity profile for most patients. This is the conclusion of a comprehensive review of toxicities and drug interactions related to this class of drugs, recently published in *The Oncologist*.

The excitement surrounding CDK inhibitors is due to their great potential for treating the most common type of breast cancer known as hormone receptor-positive (HR+) metastatic breast cancer, in which the cancer cells express hormone receptors. The first CDK inhibitors were recently approved by the US Food and Drug Administration (FDA), with palbociclib (Ibrance) approved in February 2015 and ribociclib (Kisqali) approved in March 2017, while a third, abemaciclib, is currently undergoing Phase 3 trials. All three CDK inhibitors have been designated "breakthrough therapies" by the FDA.

A major hallmark of cancer cells is their ability to multiply rapidly; CDK inhibitors interfere with this process by blocking the activity of

enzymes known as CDKs, particularly CDK 4 and CDK 6, that help to regulate cell division. For effectively treating breast cancer, CDK inhibitors are usually combined with endocrine therapy, which works by preventing hormones from binding with their respective receptors on the cancer cells.

<http://tinyurl.com/y6whjp9j>

SA Bone Marrow collaboration

The Medical Director and CEO of the South African Bone Marrow Registry explains how they are collaborating with bone marrow registries across the globe.

Ethnic diversity is one of the strongest defining characteristics of the South African nation. It makes our country unique but it also plays a powerful role in giving patients with life-threatening illnesses such as leukaemia or marrow failure the prospect of renewed health.

Often a blood stem cell transplant is the only chance of survival for those that suffer from blood cancers. Many different tissue types exist, which means that finding a suitable match is largely dependent on having a large registry of donors. This is why the SABMR, a not for profit organisation, collaborates with registries across the globe to give patients an increased chance of finding a donor match.

The SABMR truly epitomises the meaning of the word "Ubuntu": a uniquely African term that represents the belief in a universal bond of sharing that connects all humanity. When finding a donor, family members are looked to first; brothers and sisters are generally the most suitable matches. However, due to today's smaller family sizes, only about 30% of patients match with a donor in their own family.

If a suitable donor within one's family is not found, the SABMR will be approached by the Transplant Centre to find a potential donor within its "home" registry. The SABMR will also turn to the international database to see if there are any potential matches. Fortunately, it has access to an additional 30 million donors via the World Marrow Donor Association (WMDA) and the Bone Marrow Donors Worldwide (BMDW) service.

At present, the odds of finding a match is 1 in 100,000 but if there were more registered donors, more lives could be saved, locally and around the world. As such, the SABMR's goal together with The Sunflower Fund, is to grow the numbers of donors on the SABMR to ensure that the rich ethnic diversity of South Africa does not only benefit South African patients but those across the globe as well.

<http://ehealthnews.co.za/south-african-bone-marrow-registry/>

Gum disease may be linked to cancer risk in older women

A new study, reported in the journal *Cancer Epidemiology, Biomarkers & Prevention*, links gum disease with an increased risk of several types of cancer in postmenopausal women, even in women who never smoked.

So-called periodontal disease was tied to a 14 percent higher risk of developing any type of cancer, the investigators found. But the greatest risk was for esophageal cancer, which was more than three times more likely in older women who had gum disease than those who didn't.

In addition, gum disease was associated with a higher risk of lung cancer, gallbladder cancer, melanoma and breast cancer, the findings showed.

FREE DOWNLOADS

Nutritional problems due to cancer

The Anticancer Fund investigates the information on cancer therapies for evidence, so that evidence-based treatment choices can be made. We help patients to structure and absorb the complex nature of the information on registered, complementary or alternative therapies.

They have produced an interesting booklet "A guide for patients with nutritional problems due to cancer and the treatment", which may be downloaded from their website www.anticancerfund.org/sites/default/files/documents/dealing_with_nutritional_problems_due_to_cancer_0.pdf

Beating Bowel Cancer

A series of leaflets can be downloaded from <https://www.beatingbowelcancer.org/how-we-can-help/booklets-factsheets/>

Cracking the Cancer Code: Revealed

Free ebook "How to conquer cancer" A step-by-step guide on how to conquer - and prevent cancer.

<http://www.cancerchampions.co/>

Understanding cancer immunotherapy

Free 40-page booklet available from <http://www.patientresource.com/userfiles/file/Immunotherapy2016.pdf>

"These findings may provide a new target to test an intervention for cancer prevention - oral hygiene and periodontal disease treatment and prevention," said lead researcher Jean Wactawski-Wende. She is dean of the School of Public Health and Health Professions at the State University of New York at Buffalo.

Breast cancer, lung cancer and gallbladder cancer were linked with higher risk among women who smoked and had gum disease.

Although gum disease has been associated with heart disease, the exact reason it may be tied to an increased risk of cancer isn't known, Wactawski-Wende said.

People should be on the lookout for the telltale signs of gum disease, namely bleeding gums when you brush and loose teeth, he advised.

<http://tinyurl.com/yayqr8j4>

Chemicals in dogs: top threats detected

Whether the dog is cuddly and cute or tough, steadfast and stoic, most American canines have one thing in common: Chemicals in dogs are now detected at alarming levels, sometimes at levels 20+ times higher than what we're seeing in humans.

Medical journals are loaded with hundreds of studies looking at household chemicals and how they impact human health. But how do all of these endocrine disruptors, carcinogens, neurotoxic compounds and reproductive toxicants impact our pets?

Interestingly, a rise in human breast cancer is also paralleled by a rise in breast cancer in dogs, too, signaling that environmental factors are likely at play.

To help figure out what is contaminating man's best friend, Environmental Working Group published a Polluted Pets report to

offer a comprehensive look at the chemicals winding up inside of our dogs. After testing urine and blood samples of 20 different mutts, mixes and pure breeds, researchers found 35 different chemicals detected among the pups. A whopping 20 percent of the chemicals turned up with average levels five or more times higher than levels seen in people.

<http://tinyurl.com/y9powy7t>

FDA clears wider use of cooling cap to reduce hair loss during chemotherapy

The Food and Drug Administration (FDA) has cleared a cooling cap - a device designed to reduce hair loss during chemotherapy - for use by patients with any kind of solid tumour. FDA initially cleared the device, the DigniCap® Scalp Cooling System, for patients with breast cancer in 2015.

The expanded clearance of DigniCap is for "reducing the frequency and severity of hair loss" in adult patients with solid tumours who are receiving chemotherapy types and doses that are associated with this common side effect, the agency explained in a statement.

Some types of chemotherapy can cause hair on the scalp - as well as on other parts of the body - to fall out. Although hair loss caused by chemotherapy is usually temporary, many patients with cancer consider it one of the most distressing side effects of treatment. "Hair loss can be so distressing that some people avoid getting the recommended treatment," said Dawn Hershman, MD, of the Columbia University Herbert Irving Comprehensive Cancer Centre, who wrote a recent editorial about two clinical trials testing scalp cooling devices.

Scalp cooling, which has been used in Europe for several decades, is thought to prevent hair loss by reducing blood flow to hair follicles, Dr. Hershman noted. Cooling the scalp causes blood vessels to constrict, which may limit the amount of chemotherapy drug that reaches hair follicles.

The idea of cooling the scalp to prevent hair loss has been around since the 1970s. Early efforts involved putting ice packs on the scalps of patients undergoing chemotherapy. More recent approaches have used cooling caps that are chilled and need replacing periodically during a session to maintain cold.

A second device, the Paxman Scalp Cooling System, has been evaluated in a randomised clinical trial and is under consideration by FDA.

<http://tinyurl.com/yc3zusbp>

Targeted radiotherapy limits side effects of breast cancer treatment

Breast cancer patients who have radiotherapy targeted at the original tumour site experience fewer side effects five years after treatment than those who have whole breast radiotherapy, and their cancer is just as unlikely to return, according to trial results published* in The Lancet recently.

The Cancer Research UK-funded IMPORT LOW trial revealed that five years after treatment, almost all patients were disease free.

The researchers at 30 radiotherapy centres across the UK, led by The Institute of Cancer Research, London (link is external), and the Cancer Research UK Cambridge Centre (link is external), studied more than 2,000 women aged 50 or over who had early stage breast cancer that was at a low risk of coming back.

Following breast conserving surgery, some patients were treated

Cure Day Clinics: entered for accreditation programme

To ensure that it provides safe, quality care to all its patients, the Cure Day Clinics Group is entering all its hospitals in the quality improvement and accreditation programme of the Council for Health Service Accreditation of Southern Africa (COHSASA).

Two Cure Day hospitals have recently been accredited by COHSASA and Cure Day is now placing the remaining six facilities into the programme.

Beginning operations at Medkin in March 2008, Cure Day Clinics – wholly owned by doctors and incorporating an authentic BBEE partnership – has grown to eight facilities. Four of these are in Gauteng (Medkin, Midstream, Erasmuskloof and Fourways), one in Bloemfontein and three in the Western Cape in Paarl, Somerset West and Bellville.

It is the Somerset West and Bellville hospitals that have recently been accredited by COHSASA. Both facilities achieved impressive scores with Cure Day Clinics Somerset West achieving a score of 96 out of a possible 100 and Cure Day Clinics Bellville scoring 95.

with whole breast radiotherapy – the clinical standard – while others received partial breast radiotherapy.

Women who received partial radiotherapy reported fewer long term changes to the appearance and feel of their breast, than those who had radiotherapy to the whole breast.

Following presentation of the initial results, the UK Royal College of Radiologists 2016 breast radiotherapy consensus stated that partial breast radiotherapy could be considered for selected patients using the IMPORT LOW technique. In addition, the Danish Breast Cancer Oncology Group also adopted this partial breast radiotherapy technique for selected patients.

Dr Charlotte Coles, Reader in Breast Radiation Oncology at Cambridge University, chief investigator for the trial and first author of the publication, said: "We started this trial because there was evidence that if someone's cancer returns, it tends to do so close to the site of the original tumour, suggesting that some women receive unnecessary radiation to the whole breast.

"Now we have evidence to support the use of less, but equally effective, radiotherapy for selected patients."

Professor Arnie Purushotham, Cancer Research UK's senior clinical adviser, said: "This approach could spare many women significant physical discomfort and emotional distress."

<http://tinyurl.com/y6wtw8kx>

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