VISION
COPING WITH CANCER

National shortage of essential cancer drug

A deadly national cancer drug shortage is approaching its third month and patients may have to go without until October - if they can make it.

Betanoid is not just used to treat brain tumours, the medicine is also prescribed to patients battling leukaemia, lymphoma and kidney diseases, warns Michael Herbst, health specialist at the Cancer Association of South Africa. Herbst says he is appalled at the shortage. For cancer patients, skipping a day of betanoid can be life-threatening.

Patients who stop taking betanoid have to be weaned off the drug slowly in order to allow their adrenal glands, where cortisol is produced, to slowly return to their normal function.

Herbst warns: "Patients cannot just stop taking betanoid. They could go into a state of shock - and nothing will be able to get them out of it."

Aspen Pharmacare is the sole manufacturer of betanoid for South Africa and says it cannot resume producing the drug until drug regulator, the Medicines Control Council (MCC), approves a new manufacturing facility, according to spokesperson Shauneen Beukes.

Aspen did not say when production will resume, but Cape Town's Groote Schuur Hospital's spokesperson Alaric Jacobs said they were told to expect stock by the end of October.

http://www.bizcommunity.com/Article/196/398/163912.html#more

Funding charities can be fun!

Laurie Stafford, President of the Randburg Bowling Club, handed over cheques to Wayne Wright of CanSurvive Cancer Support and Susan Elder of Healthy Active Lifestyle Organisation (HALO).

The money was raised at a Burlesque show held at the Club in June and organised by pancreatic cancer surviver, Susan Elder.

The Randburg Bowling Club will be holding their second annual Cancer Challenge on 3 November where each team must include at least one cancer fighter or survivor.

Make a note of the date and come along and enjoy a fun afternoon.

AMA-GROOTMAN promoting healthy relationships

We are proud of very proud of our members, Duke Khabazela (Mkhize), William Genge and AMA-SISTER, Kate Molefe, who represented CanSurvive at the first session of AMA-GROOTMAN on 10 June at Molobane Estate Lodge, Zuurbekom.

AMAGROOTMAN, is a men's forum aiming to promote healthy relationships and stop women abuse.

Details of these events can be obtained from Ms Atrayah Janeh 0215527524.

CancerCare Outeniqua celebrate International Cancer Survivors Day through art and creativity

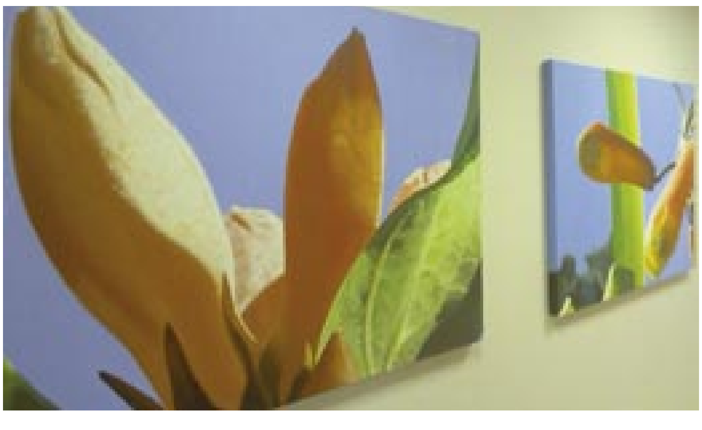
A "Cancer Survivor" is anyone living with a history of cancer from the moment of diagnosis through the remainder of life. Surviving cancer is an attitude about life and living each day to the fullest.

International Cancer Survivors Day (4 June 2017) at CancerCare George aimed to honour cancer survivors for their strength and courage, celebrating the lives of so many individuals within our community living with a history of cancer. It also intend to remember and honour the life's of so many no longer with us.

The "Creating Hope, Leaving Footprints through Art and Creativity" - art exhibition (running for the full month of June) and art and craft skill development workshops (5-9 June 2017) at CancerCare in George were a huge success with cancer survivors inspiring visitors, sharing their talent and their stories of strength, courage and hope.

The idea of combining art, a journey with cancer and a message of hope came from Radiation Oncologist Dr Peter Kraus. The result is a combination of team work from the staff at CancerCARE GEORGE, individuals and businesses within the Garden Route and most of all the willingness of our artists who are also Cancer Survivors, in sharing their art and stories with others.

Work exhibited includes paintings, photography, pottery, stained glass, copper work and writing. For more info of the artists or this project CancerCare George can be contacted at 044 884 0806 or you can email us at engela.vandermerwe@cancercare.co.za



Knitting Knitted Knockers

Knockers are hand-knitted prostheses for mastectomy patients and this group gathered at The Yarn Tree in Parktown for a Knitted Knockers function. The group included CanSurvive's Bernice lass.

Knitted Knockers are knitted with the softest, organic cotton as other fibres can irritate the sensitive skin and scars. The 100% merino wool filling breathes to ensure they are cool and comfortable.

Go to http://www.knittedknockers.co.za for more information.

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:

SOWETO, HapyD, 1432 Buthelezi St. Jabulani - 15 July 09:00

CHARLOTTE MAXEKE Radiation Department, Level P4 - 18 July

KRUGERSDORP Netcare Krugersdorp Hospital - 5 August

CHARLOTTE MAXEKE Radiation Department, Level P4 - 2 August

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

Enquiries:

Mobile 062 275 6193 or email cansurvive@icon.co.za

www.cansurvive.co.za :

www.facebook/cansurviveSA

The Groups are open to any survivor, patient or caregiver.
No charge is made.

Hearts Across The Nations

An invitation

I am writing to invite you to invite your breast cancer patients to participate in a new programme that I am developing to connect women around the world. We already, in two weeks, have connected women from Boston to women in Africa and Japan. At the moment, we have a waiting list of Boston area breast cancer patients, but surely would welcome women from elsewhere in the US. I suspect that a relationship between women in different parts of our own country could be equally wonderful.

Hearts Across The Nations is a programme to connect women living with breast cancer. We have more in common with each other than we have differences, and the opportunity to develop a rich friendship with a breast cancer sister is unique.

We welcome women from around the world to join us. Please contact:

Hester Hill Schnipper, LICSW
Manager, Oncology Social Work and Breast Cancer Survivor
BIDMC
Boston, MA
hhill@bidmc.harvard.edu

CANCER ASSOCIATION OF BOTSWANA

Cycling for a cause

Botswana's cancer conscious cyclists – Team Chainring embarked on a 1000 kilometres 'Ride for Pink' to create awareness and raise funds for the Cancer Association of Botswana (CAB).

The cyclists' 1000 kilometres voyage from the resort town of Kasane through several towns and villages to the capital Gaborone is one of the many initiatives CAB use to disseminate information.

"Though they were not able to raise enough funds last year, they are taking the journey again fundraising and raising cancer awareness," said CAB chairman, Pele Moleta.

The seven day trip includes five activation points to do free health screenings including glucose level, blood pressure and testing for cervical and prostate cancer.

"The team also shares a common concern regarding the negative effects cancer has had in Botswana, socially, physically, psychologically and economically," said Team Chain Ring spokesperson, Thabo Okie said.

CAB has reiterated the need for the community to be aware, informed and pre-emptive in the cancer care, management and control situation locally and internationally.

The Association believes that to alleviate the cancer burden in the community calls for healthy lifestyle choices and early detection of cancer through various programmes: an awareness programme, the care programme, support programme and the education and research programme. – Andrew Maramwidze, Botswana

Contact number: +26 7 393 2948

CANCER ALLIANCE ADVOCACY TOOLKIT

Priority area #3 : Patients' right to healthcare

Our Constitution guarantees all South Africans the right to access to healthcare services, but in spite of South Africa boasting the biggest health budget in Africa, too often poor service delivery for cancer patients is seen in much of the state sector.

The Facts

Too many patients, with cancer that could be curable, are slipping through the cracks and dying unnecessarily. This is as a result of a combination of lack of awareness, lack of resources, and lack of access to affordable, effective and quality cancer services.

What we need

We need to see cancer patients, their families, communities and civil society stand up and demand their rights in terms of the following:

- The Constitution: Section 27 of the Constitution says every person has the right to have access to healthcare services.
- The National Health Act: This requires the Health Minster to, within the limits of available resources, endeavour to protect, promote, improve and maintain the health of the population.
- The Children's Act 38 of 2005 (as amended by Act 41 of 2007) stipulates that parents and their children have the right to information and treatment, and that informed consent is paramount.
- The Cancer Regulation of 2011 stipulates that cancer should be registered.
- The patent law of South Africa: South Africa must better balance its patent law to prioritise people's rights to access medicine, rather than commercial patent rights.
- The National Patients' Rights Charter: Launched in 1999 by the National Department of Health, this Charter is not a law, but sets out guidelines which healthcare workers and patients are expected to follow.

Batho Pele (People First): This initiative aims to get people working in public services, including healthcare, to become more service-oriented, and to strive for excellence towards continuous service delivery improvement.

How can we meet the challenges

Challenge 1: Patient education:

Patient-centred care is a human right, and the right to human dignity should be the standard for all cancer patients. But instead of knowing their rights, and being empowered to speak up for those rights, their voices are seldom heard. This threatens the constitutional right of cancer patients to dignity of care for all.

Challenge 2: Accepting responsibility

Communities, civil society, NGOs and the government all need to accept responsibility for the challenge of delivering locally appropriate, effective solutions that provide sustainable quality cancer services.

Good health is your right!

Everyone has the right to good health and quality healthcare, including:

- Living in a healthy and safe environment.
- Access to affordable, quality healthcare.
- Choosing the healthcare services you prefer to use.
- Receiving appropriate treatment from a qualified healthcare professional.
- Knowing that your personal information is treated confidentially.
- Being fully informed about any illness, diagnostic procedures, proposed treatments and related costs.
- Choosing to accept or refuse treatment.
- Getting a second opinion, where appropriate.
- Receiving ongoing care from your chosen healthcare provider.

You also have the right to complain about healthcare services that either violate your rights to good health or breach ethical standards, to have your complaint investigated, and to receive a full response thereafter.

THE TRAINING CURRICULA FOR HEALTHCARE PROFESSIONALS FALLS SHORT WHEN IT COMES TO CANCER, AND CONTINUING PROFESSIONAL DEVELOPMENT IS OFTEN NON-EXISTENT.

THE FACTS

Provision for training, and **education about warning signs** and **symptoms of cancer FALLS SHORT** in the **curricula** for healthcare professionals. **CONTINUING PROFESSIONAL DEVELOPMENT** is designed to **update skills and knowledge** in cancer detection centres at all healthcare levels. **TRAINING INTERVENTION** is **ESSENTIAL** if we want to fully **EQUIP OUR CANCER WORKFORCE** with the **right skills**, **knowledge** and **competencies** to meet the **NEEDS** of individuals and communities. [1]

CANCER ALLIANCE ADVOCACY TOOLKIT

Priority area #4 : Appropriate cancer training and education for healthcare workers.

The training curricula for healthcare professionals falls short when it comes to cancer, and continuing professional development is often non-existent.

The Facts

Provision for training, and education about warning signs and symptoms of cancer falls short in the curricula for healthcare professionals. Training intervention is essential if we want to fully equip our cancer workforce with the right skills, knowledge and competencies to meet the needs of individuals and communities.

What we need

ASK - The development of Attitudes, Skills and Knowledge

- Attitude: The current negative attitudes to cancer and cancer patients and the absence of patient-centred care add to the burden of patients already grappling with a devastating diagnosis.

(continued on page 3)

CANCER ALLIANCE ADVOCACY TOOLKIT

(continued from page 2)

- Skills: Capacity-building is essential, and this relates to training, use of equipment, and the implementation of standards of procedure and care.
- Knowledge: There are some clinics in rural South Africa where nurses and other primary healthcare workers have little knowledge of cancer, contributing to late diagnosis and late referral for treatment that impact treatment outcomes negatively.

How can we meet the challenges

Challenge 1: Increased training

The current rates of training of new health professionals fall well below current and projected demand. This risks a lasting impact on accessibility and quality of care, with delays in diagnosis and treatment, care provided by inadequately trained professionals, fragmentation of services, and worsening of disparities in cancer outcomes.

Challenge 2: Attitudes

We need to create an environment for patients in which they feel safe, and get the correct and sufficient information from health workers about their cancer.

But the reality is that negative attitudes and the absence of patient-centred care add to the burden of patients already grappling with a devastating diagnosis.

Challenge 3: Boosting capacity

This can be done in a variety of ways, from community volunteers to public-private partnerships.

Already a variety of upskilling initiatives are under way across the country, courtesy of the private sector, but these need to be formalised in order to ensure the correct people get the correct training. It's time to get innovative, and to build a skilled and supported cancer workforce by building on existing materials, training networks and infrastructure.

YE!

YOU'VE EARNED IT

The over-60s guide to discounts, benefits and savings

If you are over 50 we would like to suggest that you visit the You've Earned It website at www.youve-earned-it.co.za.

Much is covered in this website – Health and Wellness, Travel, Financial Planning etc. One really nice feature on the Financial Planning page is that YEI members are able to ask finance-related questions via the website on anything from retirement planning, to queries on tax services, investments, wills and estate planning. If travel is your thing, the Travel page showcases some lovely trips. Like freebies? Competitions and ticket give-aways are featured regularly.

Make the most of this new offering by taking a look at www.youve-earned-it.co.za and while you are there, subscribe to their monthly e-Newsletter,and be the first to know what is on offer on this great website.

Collective South African Voices for Cancer

CANCER ALLIANCE

www.canceralliance.co.za

Price fixing and Fixing The Patent

The last few months have been very busy as we have been actively involved in doing direct advocacy re the pricing of Herceptin in the private sector and this life safer drug not being available in the public sector. The news of the Competitions Commission's investigation into price fixing by big pharma companies Roche, Pfizer and Aspen was a great relief for us as it brought so much attention to the core aspects of the price of cancer drugs that are so extremely inflated. We hope that with the review by the Competitions Commission we will get more clarity of how this problem will be addressed going forward. The main focus still remains to address the Patent Law issues that lay at the heart of this problems and with our partners, Section 27 and FixThePatentLaw organisation, we will keep the pressure up till we are sure that we have a new dispensation that will protect cancer patients from paying such high prices for their cancer treatment. We invite patients to contact us if they have problems with accessing cancer drugs needed for their treatment and we will see how we can assist you. Please email the Cancer Alliance - Executive Council at info@canceralliance.co.za if you need assistance in this regard.

KZN crisis

We have been actively involved in bringing the serious cancer crisis in KZN to the awareness of the NDOH and the Provincial Department of Health and have been reporting our concerns regarding the impact that this crisis has on the thousands of cancer patients in the Province. We are grateful to the Democratic Alliance (DA) that brought the plight of the patients to the attention of the Human Rights Commission who is now considering taking the KZN health department to the Constitutional Court after the Province failed to provide adequate cancer treatment to patients for over two years.

This comes after the Human Rights Commission recently found the provincial health department guilty of violating the rights of oncology patients in the "Province. The fact is this is a constitutional matter, as our constitution says everyone must receive proper healthcare. What is happening is actually sad: it is shameful that the rights of the poorest are being ignored and many patients have lost their life due to the total breakdown of cancer services in this Province and elsewhere in the country. The Human Rights Commission called on the provincial health department to repair all oncology treatment machines regardless of contractual disputes. We have also called for the State to engage in public-private partnership arrangements with private oncologists, assist and ensure that much needed services can be rendered in the meantime . We hope that this will happen soon. The issues still remain that only now after many years of advocacy are we seeing real action. Why does it take so long and why must patienst suffere so much.

Our Government need to seriously prioritise cancer in South Africa. The Cancer Alliance is committed to keep the pressure up to ensure we remain the voice of cancer patients in South Africa.

- Linda Greeff

THE CANNABIS CASE -

THE WCHC DAVIS RULING - WHAT IS THIS CASE ABOUT?

by J.S. O'Donoghue

As defined in the ruling by Judge Davis and the legal experts he engaged to examine the applications and current available evidence, this case asked the questions:

Are the laws which prohibit the possession, use, purchase and cultivation of Cannabis valid for personal, adult consumption in the privacy of the home?

Should the court or parliament decide on the validity of these laws?

According to Judge Davis, the applications "revealed a lack of legal precision, particularly in the framing of the relief sought". In other words the court had to determine itself precisely what outcome was being sought according to the information available in the applications. This was the major restriction in this case as the Court can only act within the scope of the challenge made by the applicants.

What the Court determined from the Prince application was that it related exclusively to the personal use of Cannabis in the home by adults.

This brought the following laws into question:

Sections 4 (b) and 5 (b) of the Drugs and Drug Trafficking Act 140 of 1992 read with part III of Schedule 2 to the Drugs Act "insofar as it relates to the simple possession, cultivation, transportation and distribution of Cannabis for personal consumption",

Section 21 of the Drugs Act

Sections 22 (9) (a) (i) and 22 A (10) of the Medicines and Related Substances Control Act 101 of 1965 read with Schedule 7 insofar as it relates to the consumption of Cannabis,

The highlighted provisions were ruled unconstitutional as they relate to the right to privacy when it comes to adult consumption and cultivation of Cannabis in the home. The ruling was suspended for two years to give Parliament time to bring the laws into alignment with the Constitution which protects the right to privacy. This was the ONLY right attended to in the applicants' case. The State has the option to appeal this ruling, if they fail and Parliament will decide on how to reword the law to protect this right.

It must be pointed out here that:

Although handled extensively in the ruling (see below) the legislative provision against the possession and use of Cannabis in Section 21 of the Drugs Act, which allows the Court to presume dealing in certain circumstances, was not specifically included in the final order. Most of these provisions have already been dealt with by Constitutional Court over the years.

Of more concern is that the Medicines & Related Substances Amendment Act, 2015 yet to be promulgated which places all natural substances used for the treatment or prevention of disease in humans and animals under the control of SAHPRA (the MCC), has not been challenged in this case. Nor did the applicants challenge the Medical Innovations Bill, clearly a bigPharma innovation, currently under Parliamentary review, in any way. Both of these Acts literally hand over control of all medicine, natural or not, and including Cannabis, to the pharmaceutical companies which lobby the Dept. of Health.

So, even a ruling that declares personal adult consumption of Cannabis in the home unconstitutional, is no victory at all if Cannabis is placed under the administrative and executive control of the Medicines Control Council, who have proposed extremely restrictive control systems for commercial Cannabis. If these regulations are endorsed by Parliament, all this mean is that only large corporations or wealthy individuals will be eligible to engage Cannabis and Cannabis related products commercially under license. Hundreds of thousands, if not millions, of people will be denied the opportunity to improve their lives significantly through Cannabis cottage industries.

The order has been suspended for two years which means that during that time, anyone can still be arrested and charged for possession and, if they plead not guilty and use this case as a defence, they will be granted a Stay of Prosecution until the matter is resolved. NOTHING is legal yet, and the ruling does not in any way declare Cannabis use of any form legal. It simply rules that the applicable laws are an infringement of the right to privacy – one of over fifteen platforms under the Bill of Rights from which to challenge Cannabis laws.

Although Acton did present information on other uses of Cannabis, the legal team determined that there was little actual evidence presented. Rather the information was a collection of articles, some written by Acton himself, and contained no expert evidence which the court requires in order to make an assessment. Consequently, Acton's evidence had no effect on the ruling.

The applicants were to a large extent asking for something that already exists. Anyone arrested for Cannabis may plead not guilty by reason of the unconstitutionality of laws relating to the prohibition of Cannabis on the basis of the many stays of prosecution granted to date. They will immediately be granted leave to go to High Court, and will basically be included in the Constitutional Court challenge of Myrtle and Stobbs, if they do not wish to present their own case. They can also present their own case alongside Myrtle/Stobbs. This case is presented to High Court who will rule whether it has to proceed to Constitutional Court or to Parliament for redress of the laws challenged.

The victory is that the Judge acknowledged the import of this case and has given us all a means to challenge these laws fully by participating in the process.

There is an argument and evidence available from SACCRA for the use of members. This argument goes way beyond the scope of the application ruled on here and includes original evidence as well as expert testimony in the form of signed affidavits from actual international experts. It also offers the Court alternate means to fulfil the purpose of prohibitive laws when it comes to commercial Cannabis, via the proposed Cannabis Community Association based regulatory structure.

The biggest mistake made by Prince in his previous challenges was agreeing that prohibitive laws were valid and served a valid purpose. The biggest mistake in this case is sticking to the domain of personal use in the home only, and not going all out to challenge the

(continued on page 5)

CANNABIS RULING (continued from page 4)

unconstitutionality of Cannabis prohibition altogether. It is a PLANT!

The SACCRA argument proves beyond the shadow of a doubt that:

a) Cannabis is a plant

b) Cannabis is beneficial nutritionally, medically, industrially, agriculturally, environmentally and in terms of socio-economic development for the sake and benefit of all South Africans, and offers a comprehensive plan for the implementation of a completely legal, responsibly regulated, community-based Cannabis industry.

c) Cannabis is safe and not addictive

d) Prohibition of Cannabis is unconstitutional and serves only corporate vested interests

e) It is possible to remove Cannabis from the law completely as any undesirable behaviour involving Cannabis can be prosecuted under umpteen other laws.

The bottom line is that there is NO RULING ON COMMERCIAL PURPOSES whether for INDUSTRIAL, AGRICULTURAL, ENVIRONMENTAL, MEDICAL OR ANY OTHER USE, and it certainly does not allow for the supply of any form of medicine outside of current MCC restrictions.

There is also nothing in the ruling relating to treating children with Cannabis, and giving children any form of Cannabis, even a topical balm or non-psychoactive tincture, remains completely illegal and will continue to do so unless Parliament decides otherwise. Also, being in possession of Cannabis in, on or within 100m of a school property means the act of dealing will be presumed and heavier penalties will apply.

As it stands already, unless you implicitly or explicitly allow an officer to search your person or dwelling without a properly constituted search warrant, he is acting outside of the right to privacy protected by the constitution, and the arrest is invalid. This was ruled on last year in Constitutional Court very clearly.

In future, officers will have to have clear probable cause and gather sufficient evidence to apply to a magistrate for a search warrant and serve it on you in order to be able to establish whether you have committed a crime. This search warrant has to be correct in every detail and can be challenged if any detail is not correct.

This has actually also always been the case as we have often said. Most often, the officers get away with it because the person complies with them and does not challenge their presence on their private property without a search warrant, or to arrest them without an arrest warrant. So, this ruling has given us some bite – if we are willing to stand in it.

In many cases these officers have come en masse and are extremely intimidating all of which we have proved in our experience can be politely challenged and which can lead to their own prosecution if they act outside of the law. It even goes as far as, if you own your property and are not a flight risk, they have alternate means to prosecute i.e. serve a summons to appear in court, rather than arrest you. Most Cannabis arrests violate the right to dignity, which is absolutely protected under the Constitution, since the actions of the officers do not fit the severity of the "offence".

The time has come for all of us to stand together and act intelligently to be the change we wish to see.

J S O'Donoghue
THE SOUTH AFRICAN CANNABIS COMMUNITY & REGULATORY ASSOCIATION
www.saccra.org.za

Potential drug interactions with marijuana

An article, published last month on the website Medscape (http://tinyurl.com/y86l2k8u), points out that " Patients using marijuana should be educated to avoid drugs that affect associated CYP450 enzymes. When these drugs cannot be avoided, and marijuana use is expected to continue, the patient should be monitored closely for potential drug interactions. Smoking more than two joints weekly is likely to increase the risk for drug-related interactions."

Other potential drug interactions with marijuana include:

Central nervous system (CNS) depressants.

Anticholinergic agents, cocaine, sympathomimetics.

Disulfiram and fluoxetine.

Warfarin..

Antiepileptic drugs (AEDs).

The article is a response to the question "What " and is written by Sarah T Melton, a Professor of Pharmacy Practice in the US.

Two support groups at Charlotte Maxeke Hospital for all cancers

On the first and third Wednesday each month CanSurvive holds a meeting at Charlotte Maxeke Johannesburg Academic Hospital at the Radiation Unit on level P4. For details contact Duke Mkhize on 0828522432 Wilton Tshakaza: 0716243568 William Genge: 0716243574

All cancer patients are welcome to attend.

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.

We would like to be able to provide information on suitable support meetings and cancer related events anywhere in South Africa so please, let us have your details of any groups you are aware of.

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.

CANSA Care Homes – "It feels like home"

The Cancer Association of South Africa (CANSA) offers a wide range of support and care services to cancer patients and their families. One such support service are the CANSA Care Homes, of which there are 11 across South Africa, in main metropolitan areas. They provide a home away from home environment, offering accommodation to patients undergoing cancer treatment on an out-patient basis, at treatment facilities far from their homes.

Patients find such comfort in staying at a place where there are other people in the same situation. The support that these patients offer one another is incredible. Staff at the Care Homes also offer individual counselling or support groups for the patients staying at the Homes, and understand their special physical and emotional needs during cancer treatment, and cater for that. One of the most important aspect of cancer treatment is a good support system – and that is exactly what these Homes offer.

Guests at the many CANSA Care Homes around the country stay for an average of six to eight weeks, while undergoing treatment. This makes treatment more accessible for those who do not live close to oncology clinics. While patients stay at the Care Homes, they also receive nutritious meals. Transport between the Care Home and treatment centres is also offered to the cancer patients, which makes treatment even more accessible. This makes recovery easier for patients, as they do not have the added stress of seeking transport, whilst being sick. "With the high occupancy and over-full hospitals, it highlights the value of our Care Homes and the fact that we can offer accommodation to out-patients from cancer treatment centres," says Strauss.

Another service offering at some of the Care Homes is our medical loan equipment. We have various medical equipment that can be hired out by patients, this includes wheelchairs, walking frames, wigs, hospital beds, bath chairs, commodes, egg-shell mattresses, sheep skins, etc." continues Strauss.

Gerrit Pretorius shares his gratitude at having housed his mother at one of CANSA's Care Homes; "We want to thank CANSA for looking after my mother during her treatment. All the staff were so professional, loving and respectful. Thank you to the kitchen staff for the lovely meals – my mother couldn't stop talking about their friendliness and helpful nature. My mom also appreciated the transport delivered by such competent staff – without them my mother wouldn't have been able to receive her treatment."

You can view our CANSA Care Home video here: https://youtu.be/W5IzdsMJXrE. Visit www.cansa.org.za for more information on all the CANSA Care Homes and services offered.

Are you in Gauteng?

Courses at Hospice Wits!

Hospice Wits
no end to caring

HospiceWits provides care to meet the physical, emotional, social and spiritual needs of patients and their families facing life-limiting illness. Through our training and education we offer workshops for professionals and the general public, such as the grief, loss and bereavement workshop, or a one-week Introduction to palliative care, a patient at home workshop, as well as various other workshops.

One-week introduction to palliative care: R2500.00

This 5 day intensive programme for Registered Nurses, Enrolled Nurses or Auxiliary Nurses and Care Workers, includes the following: Introduction to palliative care; Communication skills; Breaking bad news; Ethics; Genograms; Pain control; Syringe driver; Symptom control; Psychosocial and spiritual care; The dying process

Grief, loss and bereavement workshop: R1500.00

This 2.5 Day Workshop for Social Workers, Counsellors, Teachers, Community Leaders, Church Groups, Support Groups and other community members, enhances your knowledge and skills in the field of grief, loss and bereavement covering: Enhanced understanding of the Hospice philosophy of care; Enhanced awareness of self; Insight into the experiences of the dying and the bereaved; Conceptualisation of death and dying; Greater understanding of mourning and bereavement; Learn and practice interpersonal skills related to the field of grief, loss and bereavement.

We have only listed a few workshops, we also offer training on topics such as:

- ❒ Breaking bad news;
- ❒ 3 morning course for the carer at home
- ❒ 5 day physical assessment for nurses;
- ❒ HIV/Aids Workshops; as well as
- ❒ Custom designed workshops for companies.

Please contact René Kleynhans in the HospiceWits Centre for Palliative Learning for more information and workshop dates and to book and secure your seat now.
Tel: 011-483-9100. Email: training@hospicewits.co.za

The perfect way

There is only one correct, perfect, absolute approach to life and decisions near its end. This truth relieves the doctor of final decision. The right way lifts the burden of anxiety, confrontation or guilt. The perfect path makes giving care at a very hard time, much easier. That correct course, the only way to treat every patient and every family, is exactly what the patient and family say it is.

This idea is simplistic, even contrite. Each end-of-life journey, for every patient and family, is full of stop and go's, bumps and bruises, highs and lows. How can this be perfect? Because, we die as we live, with stops, bumps, highs and lows. The doctor, patient and family must understand that this is the human experience. We will come to the end of our journey by the road most natural for us and us alone. There is no right or wrong; there is the panorama of our lives.

The problem with this philosophy of care, which only requires informing each patient and family of choice and then supporting their decisions, is that it can produce what seems like unnecessary suffering. Often patients and families pick alternatives which almost deliberately result in pain, fear and loss. Doctors who have walked the path many times, see the horror around the bend. Therefore, supporting choices that are bound to increase suffering, feels futile, uncaring and desperate.

I recently saw three patients that illustrate such disparate experience. The diseases are similar, the final result will be the same, the paths chosen different.

They are less than 50 years old; a wife, a sister, a husband. They have advanced stomach cancer, metastatic colon cancer and spreading pancreatic CA. They have undergone extensive treatment; surgery, radiation and chemo. All have increasing, resistant disease, unlikely to respond to treatment. Wheelchair or bed bound, severely wasted with sunken, frightened eyes, they will die in the next few months. Each is in pain.

With their families, these patients have chosen their paths. The first has decided to build up, get stronger, so that she may begin new "aggressive" chemotherapy and fight the disease. Despite being told that the likelihood of benefit from chemo is slight, they plan to continue the battle. They demand IV hydration and nutrition, minimal pain control, physical therapy, transfusions, frequent lab tests and they intend to begin anti-cancer drugs, as soon as she is ready. She is full code; her doctors have been told to put her on machines, if her heart or lungs stop.

The second, is receiving off-label chemotherapy, which is unlikely to help and which is causing debilitating side effects, including precious days in hospitals or doctor offices. They do not plan to put her on a respirator if she stops breathing, but would use drugs to stimulate her heart or dialysis to support her kidneys.

The last patient and family, making decisions at a nearly identical life moment, has decided to focus on "aggressive" pain control. They will give intravenous hydration only if thirst becomes a significant symptom. They are moving into palliation and hospice. They do not want extraordinary measures of life support such as CPR, ventilator machines, artificial feeding or dialysis.

For the physician, knowing that two of these paths may result in preventable suffering, supporting these choices is not easy. Nonetheless, the patient and family must decide on the steps of the journey. Only they can put into these hard decisions in the context of their lives. Therefore, each of these plans are perfect and it is my job to design, administer and support. The real question is whether such suffering is necessary?

Life is complex and at no point do we make universally ideal decisions. Every moment is compromise. From the moment of birth, we make infinite choices between alternative paths. Only each person can understand the consequences; gain and loss, success and failure, joy and guilt. This mélange of dreams and loss comes to its final test in a brilliant naked moment as the universe screams "this is it."

It is within this personal zeitgeist that every patient and family, must make the hardest of decisions. This is not a context we can easily articulate or explain; it is the base and substance of who we are. We make decisions, many painful, built on the foundation of our lives. It is right for us, even if it would be deeply wrong for a friend, neighbor or doctor.

The physician will never completely understand the patient. That is not her calling. The job is to explain disease, treatment and the likely, possible, outcome. The doctor may recommend, based on the wisdom of a career; predict what is coming round the bend. However, the clinician's burden is to understand that for each patient and family there is one perfect path, and to support them on that journey.

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

Sexual health and intimacy in cancer

by Christa du Toit

We concluded in our previous month's article with the following words:

"You are the specialist of your pain; you have first-hand experience. You are the expert; you know when something is wrong. Some of the common fears and concerns entail fear of death, changes of social role/ lifestyle, interruption of your plans, concern for welfare of others, changes in body image and self-esteem and many more".

Dr Elna Rudolph a sexual health physician and clinical head of MySexualHealth.co.za wrote that sexuality is an integral part of every person.

Whether you are in touch with it or not, whether you enjoy it or not, whether you can still do it or not - you remain a sexual being. We all have the need to feel loved and give love in return. Apart from that, most people experience great joy from being close to another person - physically and emotionally.

We also all go through different stages in life when it comes to our sexuality. There is the hormonally driven and very awkward teenage stage, the young adult stage where most people start to form long term committed relationships, then comes babies and a few years after that, supposedly the best sex of your life is before you hit menopause as a woman or a significant decline in your sexual functioning as a man.

Once you receive your diagnosis, it has most likely interfered with one or more of these stages in your sexual journey. There will be challenges and changes associated, but it does not take away your sexuality or your need for love and intimacy. At some stage, you might feel that this it is easier to abandon your sexuality than to deal with these changes and challenges, but it is not necessary. If individuals and couples make an effort, your sex life can be one of the most rewarding areas of your life.

For all couples, good sex is about creating special experiences, not about being able to use hundreds of positions or reach certain goals. Excitement is important and so is having fun together and really connecting. It takes thought and planning but it can be done.

Take time to create a sensual environment. This could be a bubble bath with candles, but also give your partner a chance to spoil you, let him/her know what feels good. Make sure that you communicate your needs. He/she might feel they don't want to put the burden of sexual activity on you and therefore withdraw sexuality. If possible when your partner is so sick, get somebody else to do the nursing.

Lack of sexual interest can be due to many causes. Specifically, when you need to take some medications it can have a significant impact on your libido. Untreated depression and anxiety, lack of sleep and stress in general can cause it as well.

You and your partner should be able to feel free to discuss your problems with your doctor or nursing sister at your next visit. Various therapists can assist like physiotherapists, clinical psychologists or as stated a sexual health doctor.

Living with a chronic disease can be overwhelming and you can get really tired of all the medication, treatment modalities, doctors' visits and tests. Please ask for assistance, you do not have to do this alone.

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

'Simple sugar" glucose may be important in the fight against cancer

Glucose – commonly referred to as a 'simple' sugar – may be a crucial factor in the fight against cancer and inflammatory disease after scientists discovered a new role in which it stimulates cells that work on the front line in the fight against infection and tumours.

Glucose, which is generated from the food that we eat, is the most important fuel used in our bodies as our cells use it to generate energy and for growth and division. The cells of our immune system become very active during an immune response, such as when responding to infection, and as a result they tend to have high demands for glucose. Unsurprisingly, when immune cells are starved of glucose, as might occur within tumours for instance, they become dysfunctional.

However, new research led by scientists at Trinity College shows that the immune cells that monitor our bodies for signs of danger (dendritic cells) are different - when they are starved of glucose they actually become better at stimulating the vital players in the immune response (T lymphocytes).

The scientists believe this opens the door to new therapeutic possibilities to regulate immune responses to cancers and other immune-related diseases.

Ussher Assistant Professor in Cancer Biology, David Finlay, led the team whose work has just been published in leading international journal, Nature Communications.

Dr Finlay said: "It is becoming clear that glucose is an important signaller in our immune system, in that cells that have access to glucose behave very differently to those that do not. We have discovered that dendritic cells are actually better at stimulating immune responses when starved of glucose, which is not the case for any of the other immune cells that have been analysed."

"The discovery that T cells and dendritic cells compete with each other for glucose offers a new and exciting insight into how glucose can regulate dendritic cell function. We hope that by better understanding how nutrients such as glucose control the immune response, we can go on to develop new therapies to tackle a host of debilitating immune-related diseases."

Thank you to Netcare !

CanSurvive Cancer Support Groups 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 in Parktown and Krugersdorp.

NETCARE

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CALENDAR

July 2017

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

15 Wings of Hope, Netcare Auditorium, Sandton. 10.00 (Wings birthday).

18 Can-Sir Malecare Support Group, Mediclinic Constantiaberg, Plumstead, Cape Town, 17:45 – 19:00

19 CanSurvive Charlotte Maxeke Group, Radiation Floor P4.

19 CancerSupport@Centurion support Group at Netcare Unitas Hospital, Centurion at 16:00

27 Cape Gate Oncology Group, Oncology Centre 10:00. "Coping with my children's anxiety".

29 Bosom Buddies Support Group, Hazeldene Hall, Parktown at 09:30 for 10:00

31 Cancercare Support Group, Rondebosch Medical Centre, "What is palliative care"

August 2017

2 CanSurvive Charlotte Maxeke Group, Radiation Floor P4.

2 Cancercare OuteniquaSupport Group, GVI Boardroom,3 Gloucester Ave. George 10:00 - 12:00

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

5 CanSurvive Cancer Support West Rand Group, Netcare Krugersdorp Hospital, 09:00

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

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

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

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

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

CONTACT DETAILS

CanSurvive Cancer Support
Parktown and West Rand Group :
CanSurvive Head and Neck Support Group, Rivonia,
Contact: 062 275 6193 or cansurvive@icon.co.za
Charlotte Maxeke Group: Contact Duke Mkhize 0828522432
Jabulani Group: Contact Sister Bongiwe 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 bbfzim@gmailcom

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

News in brief

New treatment for enlarged prostate achieving positive outcomes

While many older men suffer from symptoms due to enlarged prostate, or benign prostatic hyperplasia (BPH) as it is known in medical terms, they often simply keep quiet and continue living with the uncomfortable symptoms associated with this condition.

“During Men’s Health Month in June we heard a great deal about male medical conditions such as prostate cancer, but few South Africans are aware of BPH although it is common among men,” points out urologist Dr Stephen Cornish, who is part of a team offering a new treatment for BPH called prostate artery embolisation (PAE) treatment at Netcare Sunninghill Hospital in Johannesburg.

“In addition, many of the men who suffer debilitating symptoms from BPH are not aware that highly effective new treatment options for this condition have become available in South Africa,” continued Dr Cornish.

“The focus on medical conditions such as prostate cancer is perhaps understandable given the fact that, unlike prostate cancer, BPH is rarely life threatening,” notes Dr Cornish. “Nevertheless, it is the most common non-cancerous prostate medical condition to develop in men by the time they reach their 60s, and it has been estimated that half of all men older than 60 years of age are likely to have at least some BPH symptoms.”

Dr Cornish says that symptoms of BPH may include trouble urinating, and/or a frequent and urgent need to urinate, particularly at night (nocturia); interrupted and weak urinary stream; urine leakage and sometimes sexual dysfunction. The prostate gland surrounds the urethra, the tube that conveys urine from the bladder so that it can be expelled from the body. As part of the natural ageing process, the prostate however often enlarges, sometimes to the extent that it presses on and partly blocks the urethra, causing problems with urinating.

Dr Cornish says that while BPH is not commonly a life-threatening condition, if left untreated it can be an important risk factor for urinary tract infections as well as kidney and bladder stones. In some cases, a severely enlarged prostate can even completely block off urine flow, causing acute urinary retention. This would be considered a medical emergency and, if not treated, could potentially result in kidney damage. Such a case would usually require a urinary catheter to be inserted in order to allow the urine to be passed.

http://ehealthnews.co.za/new-treatment-enlarged-prostate/

Costliest cancer care may be least effective

Concerns about the value of cancer care have led the American Society of Clinical Oncology (ASCO) and the European Society of Medical Oncology (ESMO) to propose frameworks to assess the benefits of new treatments, Dr. Booth and his team note in their report, published online in The Lancet to coincide with a presentation at the American Society of Clinical Oncology conference.

In their study, they used the ASCO and ESMO frameworks to assess 109 randomised controlled trials of therapies for non-small-cell lung cancer, breast cancer, colorectal cancer and pancreatic cancer.

Using the ASCO framework, which does not have a pre-specified threshold for meaningful benefit, scores ranged from 2 to 77, with a median of 25. Thirty-eight percent of the studies met the ESMO framework’s threshold for a meaningful benefit. Drug cost data was available for 100 of the trials, which found a negative correlation between ASCO benefit score and incremental costs. The treatments with a meaningful benefit based on ESMO thresholds cost a median $2,981, vs. $8,621 for the treatments that did not show a benefit.

http://tinyurl.com/y7tqhnn2

WHO's new Essential Medicines List includes a 40-year first

The latest update to the World Health Organization's (WHO's) Essential Medicines List contains the biggest change to the antibiotics section in the list's 40-year history: creation of three categories; access, watch, and reserve - for guidance in deciding when certain antibiotics should be used.

"Access" indicates drugs that have lower potential for resistance and should be available at all times. This category includes drugs such as amoxicillin. The "watch" antibiotics are second-choice treatments that should be used only for a small number of infections. This category includes ciprofloxacin, used to treat uncomplicated cystitis and upper respiratory tract infections. The "reserve" group contains the last-resort drugs, such as colistin and some new-generation cephalosporins, that should be used for life-threatening infections involving multidrug-resistant bacteria.

The categories are aimed at improving outcomes, reducing emergence of drug-resistant bacteria, and making sure "last resort" antibiotics work when all others fail.

http://tinyurl.com/y7fz4umv

Combining vitamin C with antibiotics to destroy cancer stem cells

A combination of vitamin C and antibiotics could be key to killing cancer stem cells, a new study finds, paving the way for a strategy that could combat cancer recurrence and treatment resistance.

Researchers found that a therapy involving the antibiotic Doxycycline and ascorbic acid, or vitamin C, was up to 100 times more effective for killing cancer stem cells (CSCs) than 2-DG, a molecule currently being tested as an anti-cancer agent in clinical trials.

Study co-author Prof. Michael Lisanti, of the Biomedical Research Centre at the University of Salford in the United Kingdom, and colleagues recently reported their findings in the journal Oncotarget.

Stem cells are cells that have the ability to reproduce and transform into other cell types. Studies have suggested that some cancer cells act in a similar way to stem cells, reproducing in order to form and sustain tumours.

These CSCs are believed to be a main driver behind the growth, spread, and recurrence of tumours among patients with advanced cancer, and they also play a role in resistance to cancer therapy.

"Therefore, new therapeutic strategies are necessary to identify and eradicate CSCs," say Prof. Lisanti and colleagues.

http://tinyurl.com/y7blyu8h

Cannabinoids and leukemia

A number of cannabinoids have now been shown to successfully fight leukemia cells and earlier research found that some of these chemicals, when used in combination, become even more potent killers of cancerous cells.

A new study, published recently in the International Journal of Oncology, explored these combinations in more depth. They also looked at the potential use of cannabinoids in conjunction with the existing chemotherapy drugs cytarabine and vincristine.

The researchers were led by Dr. Wai Liu at St George's, University of London in the United Kingdom. Studying cancer cells in the laboratory, the team tested various combinations of cannabinoids and chemotherapy drugs to find the most effective groupings. They also tried to understand whether or not the order that the chemicals were given in would make a difference to success rates.

They also showed that an initial dose of chemotherapy followed by cannabinoids improved overall outcomes against the leukemia cells. Combining chemotherapy with cannabinoids provided better results than giving chemotherapy alone, or the combination of cannabidiol and THC. However, this increased potency was only seen if the cannabinoids were given after the chemotherapy, and not the other way around.

http://tinyurl.com/yc9owkux

Catholic bishops ask human rights commission to investigate cancer deaths in KZN

Catholic bishops are concerned about the crisis in oncology services in Kwazulu-Natal. They have asked the human rights commission to investigate possible deaths resulting from the crisis.

We are deeply concerned with the severe shortages of cancer specialists and the poor management of cancer-related equipment in the three hospitals in Kwazulu-Natal that offer cancer treatment in Kwazulu-Natal: Inkosi Albert Luthuli Central Hospital, Addington Hospital and Grey's Hospital.

We have taken note of the task team that the health minister, Aaron Motsoaledi, has set up to tackle the crisis. The crisis in the oncology services is a symptom of a deeper crisis of inefficient governance in the health department in Kwazulu-Natal.

We therefore ask the health minister to set up another task team as soon as possible to investigate the governance issues in the health department in Kwazulu-Natal that have contributed to the cancer treatment crisis. The health minister should consider instituting a Section 100 (1)(b) intervention in the health department in Kwazulu-Natal to assist the department to improve the delivery of health services, including the oncology services.

The crisis in oncology services in Kwazulu-Natal has been dragging on for too long. As a result, there is high possibility that many lives have been lost as a result of the ineptitude with which the crisis has been handled.

We have therefore asked the human rights commission to investigate and reveal the number of patients who have been diagnosed between January 2015 and June 2017 with stage one cancer in various hospitals in Kwazulu-Natal. The investigation should also reveal how many of them have died while waiting to access the MRI scan and to commence treatment.

If it is proven that, in the past two years, a significant number of cancer patients have indeed died as a result of ineptitude on the part of the health department in Kwazulu-Natal in remedying the crisis, those responsible should be identified and held to account.

http://www.bizcommunity.com/Article/196/342/163187.html

A dogged pursuit of aggressive brain cancer

Current therapies simply aren't very effective at treating very aggressive gliomas, such as grade IV glioblastoma, which spread very quickly throughout the brain.

And the survival rate is poor in both humans and dogs.

scientists know tumours from both species look almost identical on MRI scans and under the microscope. And based on this, the National Cancer Institute (NCI) created a comparative brain tumour consortium in 2015 to evaluate canine brain cancer as a model for human disease.

If the results show that canine brain tumours are indeed a good model for human brain tumours, then clinical trials in man's best friend could reveal which new immunotherapies have the best chance of success for humans.

Mice do not grow brain tumours on their own. Their tumours are small, sometimes microscopic. They live in a sterile environment. And their immune response is biased, making it difficult to accurately assess immunotherapies.

Dogs, on the other hand, spontaneously develop large brain tumours. They have a natural immune response to cancer. And they live in the homes of their human families.

All new cancer drugs are tested for safety and effectiveness in the lab – often in engineered mouse models – before they are approved for clinical trials in humans or dogs.

http://tinyurl.com/yajg6fhc

Improved outcomes needed for those affected by neglected cancers

There are nearly 186 neglected cancer types, which currently account for a quarter of cancer diagnoses and nearly 40% of cancer deaths.

Andrew Giles, CEO, Garvan Research Foundation said, "While mortality rates for common cancers have dropped over recent decades, incidence and mortality rates for neglected cancers are actually rising. In fact, a patient with a neglected cancer is almost twice as likely to die as a patient with a common cancer." Garvan established Neglected Cancers Awareness Weekin the US to place a greater focus on the need for funding for research and clinical trials for patients with these cancers.

Neglected, or rare, cancers are defined as cancers affecting up to 12 in 100,000 people and include brain cancers and cancers of the central nervous system; cancers of connective tissue (eg bone and soft tissue); thyroid cancer, adrenal cancer, neuroendocrine cancers (eg pituitary); ovarian, mesothelioma; urinary cancers – kidney, renal pelvis, ureter, bladder, other urinary organs; oesophageal, liver, stomach, gallbladder, small intestine, pancreatic, anal cancers; blood cancers – Hodgkin's lymphoma, non-Hodgkin's lymphoma, multiple myeloma and plasma cell cancers, acute and chronic leukaemias; male and female reproductive cancers; Kaposi's sarcoma; cancers of unknown primary, and metastatic cancers.

http://tinyurl.com/y9xkg8mk

Treatment advances for colorectal cancers

The most recent South African National Cancer Registry data from 2012 shows that over 2,900 new metastatic colorectal cancer (mCRC) patients are diagnosed each year, with men slightly more predominant than women.

"The treatment of mCRC over the last 15 to 20 years has improved, making it a highly treatable and sometimes even a curable disease," says Professor Paul Ruff, chief specialist, professor and head of the division of medical oncology at the University of the Witwatersrand Faculty of Health Sciences

"In the treatment of mCRC, median survivals have increased from around one year to over three years, with the advent of medicines that inhibit blood vessel growth (angiogenesis) or signal transduction to the colorectal cell nucleus via the epidermal growth factor receptor (EGFR) pathway." Tumour cells require new blood vessels to proliferate, invade and metastasise, while EGFR signalling enhances tumour cell growth.

Medicines achieving exciting results in mCRC treatment include antiangiogenic agents such as bevacizumab, ramucirumab and aflibercept, anti-EGFR monoclonal antibodies cetuximab and panitumumab in RAS wild type patients, and more recently checkpoint inhibitors such as pembrolizumab in MSI-H tumours.

In addition, in the treatment of advanced mCRC, Ruff says: "We hope to achieve better biomarker driven patient selection especially for antiangiogenic therapy where there are no biomarkers."

http://www.bizcommunity.com/Article/196/335/163392.html#more

NHI white paper issues raised

The two fundamental issues with the new white paper on National Health Insurance (NHI) are a single payer fund and the nationalisation of private healthcare without compensation.

In terms of the single payer fund, the white paper believes that the NHI can use bulk purchasing power to drive down the price of healthcare services. However, it then simultaneously declares that it will accredit medical service providers - public and private - and then set the prices at which they can sell their services to the NHI. It specifically states that it will deploy a "uniform reimbursement strategy" and that accredited service providers will not be allowed to deviate from that.

This raises a fundamental question. If the NHI is going to regulate the price at which the services are being procured, why does it need to use the bulk purchasing power of a single fund to reduce prices?

The white paper also declares that medical schemes will not function in parallel to the NHI, but will only be permitted to offer "complementary services" that are not available under the NHI. This will destroy the current medical scheme market and effectively nationalise most private service providers, since they will have no choice but to contract with the NHI for the defined services at regulated prices.

In a further contradiction, the white paper states that citizens will not be forced to use NHI services but if medical schemes cannot co-exist with the NHI, how will this choice be achieved?

The two fundamentals of removing competition between funds and service providers will have disastrous consequences. Quality will suffer and the ultimate long-term impact will be higher prices – it's the undisputed consequence of removing competition from a market.

As the Department of Health currently operates, it's effectively a single payer fund. Citizens who cannot afford medical aid cover, have no choice but to receive their healthcare from state-funded public health facilities. The obvious quality problems that currently beset the public system are exactly what will transpire under a single payer NHI.

http://www.bizcommunity.com/Article/196/320/164151.html#mor

New three-in-one blood test opens door to precision medicine for prostate cancer

Scientists have developed a three-in-one blood test that could transform treatment of advanced prostate cancer through use of precision drugs designed to target mutations in the BRCA genes.

By testing cancer DNA in the bloodstream, researchers found they could pick out which men with advanced prostate cancer were likely to benefit from treatment with exciting new drugs called PARP inhibitors.

They also used the test to analyse DNA in the blood after treatment had started, so people who were not responding could be identified and switched to alternative therapy in as little as four to eight weeks.

And finally, they used the test to monitor a patient's blood throughout treatment, quickly picking up signs that the cancer was evolving genetically and might be becoming resistant to the drugs.

Professor David Cunningham, Director of Clinical Research at The Royal Marsden NHS Foundation Trust, said "This is another important example where liquid biopsies – a simple blood test as opposed to an invasive tissue biopsy – can be used to direct and improve the treatment of patients with cancer."

http://tinyurl.com/y8cutnz7

Less chemotherapy may be best choice for some patients with colon cancer

A shorter course of chemotherapy following surgery may be the preferred treatment for some patients with colon cancer, results of an international collaborative study suggest.

The findings come from an analysis of six concurrently run phase 3 clinical trials conducted in the United States, Europe, and Asia.

Results of the analysis Exit Disclaimer were presented June 4 at the American Society of Clinical Oncology annual meeting.

The nearly 13,000 patients in the trials had stage III colon cancer, meaning their tumours had progressed to the point that surgery alone is not considered sufficient to prevent the disease from recurring. For more than a decade, the standard of care for such patients has been six months of post-surgical, or adjuvant, chemotherapy.

But the analysis suggested that, for a large percentage of these patients - those whose cancer was considered to be at low risk of recurrence - 3 months of adjuvant chemotherapy may be enough.

http://tinyurl.com/yaqyxmem