VISION
COPING WITH CANCER
VISION, FEBRUARY 2017

World Cancer Day - South African style

Two new support groups for all cancers

CanSurvive are proud to announce that they will be starting two new support Groups in March. The groups are open to all patients and caregivers, no matter what cancer they have or what treatment they are undergoing.

On the first Wednesday each month a meeting will be held at Charlotte Maxeke Johannesbiurg Academic Hospital at the Radiation Unit on level P4. For details contact Duke Mkhize on 0828522432 Wilton Tshakaza: 0716243568 William Genge: 0716243574

On the third Saturday each month there will be a meeting in Soweto at HapyD, 1432 Buthelezi St. Jabulani. For further information contact Sister Bongiwe Nkosi: 0835760622 or Raynolda Makhutle: 0837534324

Pictured are some of the organisations celebrating World Cancer Day on 4 February

Top left: Lace Up for Cancer - some of the colourful participants in Greenpoint Stadium, Cape Town. The event raises awareness and funds for a number of cancer organisations.

Middle: A massive pink crowd watched South Africa play the Sri Lankan cricket team - and win, yet again!! Great support fo PinkDrive and breast cancer.

Below: CanSurvive Cancer Support chose the Radiation Department at the Charlotte Maxeke Johannesburg Academic Hospital as the venue for celebrating World Cancer Day. Supporting all cancer patients. More pics on page 6.

MEET THE GROUPS

Sunward Park

This Group is called The Champions – Sunward Park Cancer Support Group. They meet every month on the second Saturday at 2.30. The venue is at Trinity Community Church, Cresta Road, Sunward Park.

The group is open to all types of cancer patients, survivors, families, friends and carers.

They are a very active group, and take part in the Cansa Relays, and support their friends at the Reiger Park, Boksburg group and the Geluksdal, Brakpan group and also the Benoni group that started as part of the Wings of Hope.

They try to arrange speakers to give members more knowledge, coping skills and upliftment spiritually, emotionally and physically.

The photographs were taken at the amazing Christmas party which they held for members and their families, and close to 100 people at attended

The group has been going for about eight years now and is always very grateful when donations come their way.

Contact: Myrtle Bell, 0842067288, myrtle@bellfamily.co.za

Do you organise or know of a cancer support group which would like to be featured in our newsletter? Please send details of us at cansurvive@icon.co.za.

The Pelvic Radiation Disease Association

Dr Jervoise Andreyev, Consultant Gastroenterologist in pelvic radiation disease at the Royal Marsden Hospital recognised that his patients and their families were feeling isolated due to their difficult symptoms. He inaugurated an annual patient group meeting which evolved into regular support group meetings. This in turn gave rise to the Pelvic Radiation Disease Association (PRDA) in 2012. PRDA is a small but influential UK based charity with five trustees and an administrator. The principle aim of this charity is to publicise and increase awareness of PRD amongst both patients and professionals by:

- Improving awareness of the symptoms and impact of PRD.
- Providing direct support and advice to patients and carers.
- Providing telephone and email helplines which are supported by multi-disciplinary expert teams. Providing reassurance to both patients and professionals.
- It also aims to reach patients who have undergone their cancer treatment many years ago, as often their current symptoms are not recognised as related to radiotherapy undergone many years ago.
- Facilitating support meetings which are opportunities for experts to present on topics such as diet, exercise, self-help, sexual health and radiotherapy.
- Signposting of patients to professionals who may be able to manage and/or reduce symptoms.
- Promoting its own work at professional conferences across the UK, providing opportunities to network with professionals, patient and carers.
- Providing literature for patients and health professionals.
- Providing clear and simple advice to health care professionals about how to refer patients to specialist clinics.

The charity works with all relevant health care professions: therapeutic radiographers, cancer nurse specialists, dieticians, oncologists, gastroenterologists, gastrointestinal surgeons, gynaecologists and urologists. ***http://prda.co.uk/***

Researchers improve how surgeons discuss high-stakes treatments

For frail older adults, acute health problems often have significant life-altering effects. Despite that reality, research shows that aggressive treatments, including surgery, are common near the end of life, even though the majority of older adults say they prefer to avoid burdensome interventions that could leave them with a diminished quality of life.

In a study published online in the journal JAMA Surgery, researchers from the University of Wisconsin School of Medicine and Public Health (SMPH) describe a novel communication model that shifts the focus of decision-making conversations from a problem with a surgical solution to a discussion about treatment alternatives and outcomes. Researchers say this framework for conversations, called "Best Case/Worst Case" (BC/WC), may allow patients and families to make treatment decisions that are better aligned with their personal goals.

The BC/WC model, developed by SMPH researchers, combines narrative description and handwritten graphic aids to illustrate choices between treatments and is designed to engage patients and families in the decision-making process. Using the BC/WC framework, surgeons use stories to describe how patients might experience a range of possible outcomes, from the best case to the worst case, and the most likely scenarios they could encounter.

"Incorporating stories that describe how surgery can impact the patient's overall quality of life can help surgeons, patients and their families avoid surgery when even the best-case surgical outcome is unacceptable," said Dr. Margaret "Gretchen" Schwarze, associate professor of surgery and principal investigator on the study. "Our study suggests that presenting and exploring a set of treatment options and plausible outcomes with patients can help patients and families think more strategically and make decisions based on what's most important to them."

Perhaps oncologists should also think of adopting this "novel communication model".

Cancersupport @Centurion

Join us at our monthly meeting for refreshments, a chat with other patients and survivors and enjoy an interesting and informative talk.

Next meeting: 15 February at 18:00
at Unitas Hospital boardroom
Please phone Marianne Ambrose or Matjatji Machubeng at 012 677 8271 office hours, if you have any questions

The group is open to any survivor, patient or caregiver.
No charge is made.
The Group is hosted by Netcare.

NETCARE
You're in safe hands

Pain

Pain relief journey

by Christa du Toit

For the next few months we are going to talk about the journey to pain relief. This entails not only the patient but the family/caregivers who are definitely incredibly important

The word pain is actually very interesting. It is defined by the International Association for the Study of Pain as an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage. Pain is always subjective

We all have a different pain threshold. In day–to –day life a slap in the face could provoke tears in one person, but could be laughed off by another. Variability is the rule.

In pain expression variability has traditionally been attributed to psychosocial and cultural factors, emotional intelligence, personal upbringing and many more. In some societies for example, people do not hesitate to express their pain, whilst others are taught to be more stoical. In most cultures there is a marked sex difference in the degree to which pain is sanctioned; girls are expected to cry whilst boys are taught not to be "crybabies"! Because of the obvious effect of early socialisation, the observation that pain expression tends to run in families and societies has traditionally been interpreted in terms of shared upbringing and environment. New evidence suggests that genetic factors also contribute importantly to pain response and individual variability

Pain can broadly be divided into two categories – acute pain and chronic pain, with chronic pain subdivided into chronic malignant pain and chronic non-malignant pain.The distinction between acute and chronic pain is made not only in terms of pain duration. While acute pain is caused by external injury or damage, chronic pain is typically uncoupled from the causative event. Chronic pain is often associated with the emergence of a complex set of physical and psychological changes that are an integral part of the chronic pain problem.Chronic pain poses particular therapeutic challenges.

Chronic pain often has serious consequences for both the body and mind and may never disappear completely. It causes suffering. You need to adapt your lifestyle together with the family and caregivers

Lifestyle adaptation not only entails a correct diet and exercise programme, the correct usage of medication, but a total new attitude to life. To adapt is the term used to make fit or suitable, to be able to take control of a certain situation, so that it suits you. The key is you need complete current and accurate information in order to adapt

Stephen Covey postulated that "…when people are truthful, open, honest and confront others with the reality and then attempt to understand the full reality of other people's concerns and lives…", then the process of synergy is unleashed.

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

The end of the data doctor

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

"Often when you think you're at the end of something, you're at the beginning of something else." - Fred Rogers

It is with pride that the medical profession is the smartest person in the room. Nourished, selected and manicured, almost from birth, the physician defines "the best and brightest." This powerful intellect is needed and justified because of their awesome responsibility for human life and limb. Their task is daunting. They must achieve mastery of a massive set of scientific research, technology, manual skill and then maintain that encyclopedic knowledge through a life of voluminous memorization. The doctor is a storehouse of data.

We pick the top-of-the-class, the cream of the crop. Top SAT and MCAT scores. Training that can last more than 14 years after high school. That is why, through their entire lives, physicians spend many hours, each week, in Talmudic-like study. This is the basis for career-long complex, painful, testing and testing and retesting. The doctor must know, with Dewey-decimal like accuracy, everything about the medicine they provide.

That was yesterday, but it will not be tomorrow.

In oncology there are over 40,000 articles published each year. At the blindingly fast reading rate of one article per minute, 10 hours a day, no breaks at all, I can "keep up," if I read day and night, for 70 days. This does not include conferences, tumour boards, or grand rounds, all of which I need to attend and assimilate. For a doctor to maintain mastery in any area of health care, means not actually having the time to provide healthcare.

The classic answer to this conundrum has been specialization. Therefore, in oncology we have lung cancer specialists, leukemia experts and brain tumour mavens. I am still waiting for my first "right" breast cancer sub-sub specialist, verses the "left" clinic, down the hall. When you cannot go broad, go deep. Neurologists narrow down their "sub-speciality" to epilepsy, stroke or Parkinson's. Cardiology divides the heart into EP, vascular or structure. A primary doc "does cholesterol," but not diabetes. Family medicine, does not really mean the whole body, let alone the whole family. In this model the doctor accepts ignorance of the remainder of medicine in order to have focal perfection.

This antiquated model is reflexive, colloquial and flawed. First, we simply do not have enough providers to treat broad populations, if we continue to divide the entire medical profession into micro-specialties. Even then, no single provider can actually "be current" or cutting-edge. What is discovered today in Peking, is not applied in Paris or New York for another year.

In addition, rare is the patient with a single medical problem. The fractured hip is connected to a body with atherosclerosis, emphysema and depression. Pregnancy raises questions of hypertension, coagulation and genetic counseling. Immune therapies to treat cancer result in lupus-like flares, followed by devastating electrolyte wasting renal or GI catastrophe. Anatomic and physiologic deconstruction into innumerable sub-pathologies results in chaotic care coordination, medical error and angry, poorly supported patients.

Finally, as medicine transitions into a protocol driven, metric monitored, value based system, linking quality with cost and safety, it is absolutely a fantasy to believe that the physician can integrate, monitor and actuate all these key performance and outcome factors.

Every patient needs a master clinician who is the repository of all learned medical knowledge. Alas, he is no more.

Therefore, the inefficient, financially irresponsible, and ancient fantasy of the know-it-all doc, must end. The medical profession must transition from its role as walking, breathing, gesticulating information repository. While the terminal application of healthcare must remain, where it should be, in the hands of the doctor, information and complex analysis must move to where it should be ... in a silicon data bank.

Just as all of society is shifting knowledge to the cloud, so must it be with medicine. The infinite capacity of server farms to organise, archive and collate our invaluable store of human biologic learning is the answer to the data deluge which swamps every doctor and thus threatens to drown every patient.

This is not just a subtle switch to a new sort of library, a fancy set of index cards, a super new file drawer. This is a metamorphosis in what is means to be a doctor. This is a change in the healer's role in medical care and a restructuring of the healthcare system itself. This will change how and what medical schools teach, the service and support hospitals provide, and how the healthcare system itself, at the broadest and highest levels, is organised.

First, doctors will not know everything. She will need to have a highly sophisticated understanding of the science of medicine, anatomy, pathophysiology, genetics, pharmacology, research methods and a solid base in information technology. She will need to be a superb diagnostician. She will need to have comprehensive technical skill in the functions of her specialty, whether that is surgery, endoscopy or psychiatric analysis. Critically, she will be a superb listener, a patient teacher, an outstanding communicator and have an emotional intelligence second to none.

The doctor of tomorrow will interface software and wetware ... data bank and human, bridging an exploding scientific store of knowledge with that infinitely variable, staggeringly complex, idiosyncratic being, we call a patient. She will do more, with more, because she will focus on the human part of medicine, social, psychological, spiritual and physical, as she is augmented by the information machine.

More than ever, we will need the best and the brightest at the bedside. Healthcare will not get easier, less challenging and certainly not less complex. However, the doctor will be selected and trained differently. The ability to remember every last biochemical reaction will be less critical than understanding every nuance of the human mind and heart. The doctor will not be professor as in library and ultimate authority, but as in teacher, support and direct provider. One patient, one doctor fighting together for health, perfectly connected to the world community of healing.

"The more we tell our stories, the more we can heal ourselves" – Anonymous

We're celebrating 50 years of care.

Reach for Recovery owes its existence to a number of remarkably dedicated women.

Terese Lasser, after her own breast cancer surgery in 1952, realised there was very little support for patients who had been through a traumatic experience. She campaigned to convince the medical community that someone who has lived through a diagnosis and treatment for breast cancer is a valuable source of support and care for patients. The support network which Terese established in the United States grew and today gives hope and healing all over the world.

South Africa was one of the first countries to embrace Terese's vision. During her 1967 visit she inspired breast cancer patients to start their own group in Johannesburg. Pretoria was next, then Cape Town.

Fast forward 50 years and RFR now has 23 groups around the country, offering peer support to diagnosed breast cancer patients, breast health education, as well as a prosthesis support service to women without medical aid.

In 2013 the 17th Reach to Recovery International Breast Cancer Support Conference was held in Cape Town. With the theme "Together We Reach" and a strong focus on Africa, it was a resounding success.

With change taking place in South Africa on many levels, it became clear that RFR needed a new look and feel. Enter Stephné Jacobs, yet another gifted woman, passionate about her work as RFR Chairperson. She took up the challenge of transforming the organisation. October 2014 saw the launch of a new brand, with on-trend logo and website, while behind the scenes the structure was streamlined to reflect a professional business image.

During 2015/2016 RFR volunteers supported 5683 breast cancer patients and their families. Since 2011, the Ditto Prosthesis Support Project provided 4162 women with silicone breast prostheses to the value of R2.5 million. Without the commitment of trained RFR volunteers, who generously give their time and talents, this success would not have been possible. These very special women, many of whom have been volunteers for over 30 years, keep RFR alive.

"As we celebrate 50 years of care, I would like to express my admiration for the 'Wonder Women', our volunteers who truly believe in the value of our service, and have a deep desire to improve the lives of others through the power of shared personal experience. We are also very grateful to our partners, funders and friends who have played a vital role in our journey," says Stephné.

For more information on RFR services and projects, visit their national Facebook page at www.facebook.com/Reach4RecoverySA and their website at www.reachforrecovery.org.za.

Reach for Recovery meeting dates for 2017

DURBAN: 2nd Tuesday of each month. The venue is the Durban North Methodist Church Hall, 3 Swapo Road (Broadway), Durban North at 9:30 – 11:30am. Please contact Jenny Caldwell at 072 248 0008.

EAST LONDON: 2nd Tuesday of each month. The venue is the NG Kerk, Bonza Bay Road, Beacon Bay, East London at 14:00 – 16:00. Please contact Lorraine Schonknecht at 073 001 3993.

PAARL: Meetings will be held on 9/2, 11/5, 17/8, 5/10 and 9/11. Please phone Annalien Volgraaff at 082 817 1124 for more details.

JOHANNESBURG: Meetings will be held on 8/2, 5/4, 14/6, 16/8 15/11. Please contact Val Miles at 072 763 3901 for more details.

SOMERSET WEST & STELLENBOSCH: Meetings are held at 10:00 at the Mediclinic Strand, Altena Rd, Strand on 23/2, 20/3, 20/4, 25/5, 24/6,27/7, 31/8, 28/9, 26/10. Please check the District Mail (Somerset West), Eikestadnuus (Stellenbosch) and Bolander (Stellenbosch and Somerset West) for details of speakers and topics, or telephone us on 082 357 0497

PRETORIA: Meetings are held on 15/2, 6/4, 10/6,17/8, 5/10, 18/11 at CANSA offices, 32 Lys Street, Rietondale. Please phone Annemarie Joubert at 082 212 9933 for more details.

CAPE TOWN (PENINSULA): Meetings are held at the CANSA offices at 37A Main Road, MOWBRAY starting at 10:00 on the last Thursday of each month. Please check your local community newspaper for details of speakers and topics or phone 021 689 5347. The views and opinion expressed by speakers are their own and do not necessarily reflect those of Reach for Recovery.

CAPE TOWN (TYGERBERG): Monthly meetings are held at the Bellville Methodist Church (corner Linden & Kriger Rd). Please phone Cora Swano at 072 433 0127 for more information.

UITENHAGE: Monthly meetings are held at Willowdam Garden Centre, Uitenhage. Please contact Estelle Botha at 081 062 1123 for more information.

PORT ELIZABETH: Open meetings are held the last Wedensday of every 2nd month. Please contact Joanne Hurlow at 079 347 9591 for more information.

KIMBERLEY: Monthly meetings will be scheduled for every third/fourth Monday of each month. Please phone Tania Naudé at 083 250 6397 for more information.

EKURHULENI: Monthly meetings are held on 11/2, 18/3, 11/3, 8/4, 13/5, 10/6, 8/7, 12/8, 9/9, 11/11,9/12. Please contact Josey Nonkonyana at 082 335 3552 for more information.

West Rand CanSurvive Support Group

This CanSurvive group meets at the Netcare Krugersdorp Hospital on the first Saturday of each month at 09:00 and finishes at around11:30. If you have any questions or need any further information, you can contact CanSurvive at 062 275 6193

Finding and evaluating online resources

The number of websites offering health-related resources - including information about complementary health approaches (often called complementary and alternative medicine) - grows every day. Social media sites have also become an important source of online health information for some people. Many online health resources are useful, but others may present information that is inaccurate or misleading, so it's important to find sources you can trust and to know how to evaluate their content. This guide provides help for finding reliable websites and outlines things to consider in evaluating health information from websites and social media sources.

Checking out a health web site: five quick questions

If you're visiting a health website for the first time, these five quick questions can help you decide whether the site is a helpful resource.

Who? Who runs the website? Can you trust them?

What? What does the site say? Do its claims seem too good to be true?

When? When was the information posted or reviewed? Is it up-to-date?

Where? Where did the information come from? Is it based on scientific research?

Why? Why does the site exist? Is it selling something?

Not all online health information is accurate. Be cautious when you evaluate health information on the Internet, especially if the site

- ❒ Is selling something
- ❒ Includes outdated information
- ❒ Makes excessive claims for what a product can do
- ❒ Is sponsored by an organisation whose goals differ from yours.

Are you reading real online news or just advertising? Some time back the US Federal Trade Commission warned the public about fake online news sites promoting an acai berry weight-loss product. On a typical fake "news" site, a story described an investigation in which a reporter used the product for several weeks, with "dramatic" results. The site looked real, but it was actually an advertisement. Everything was fake: there was no reporter, no news organisation, and no investigation. The only real things were the links to a sales site that appeared in the story and elsewhere on the web page. Similar fake news sites have promoted other products, including work-at-home opportunities and debt reduction plans.

You should suspect that a news site may be fake if it:

- ❒ Endorses a product. Real news organisations generally don't do this.
- ❒ Only quotes people who say good things about the product.
- ❒ Presents research findings that seem too good to be true. (If something seems too good to be true, it usually is.)
- ❒ Contains links to a sales site.

Includes positive reader comments only, and you can't add a comment of your own.

Don't rely exclusively on online resources when making decisions about your health, discuss it with your health care provider first.

No more pregnant mothers in UK

In the UK, NHS doctors have been told not to call pregnant women 'expectant mothers' because it might offend transgender people. They must now call them 'pregnant people'.

This astonishing warning comes in official guidelines issued by the British Medical Association to its 160,000 members, which says mothers-to-be should be referred to as 'pregnant people' instead.

The British Medical Association issued the14-page leaflet titled, "A guide to effective communication: inclusive language in the workplace".

We love the comment one person made on Facebook "Dad was right about a lot of things and he nailed this one. He said that there would come a time when people became so open minded that their brains would fall out."

WORLD CANCER DAY CELEBRATION AT CHARLOTTE MAXEKE RADIATION CLINIC

PSA and male cancer support group

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

21 February 17:45 – 19:00

For more information contact:
Ismail-Ian Fife: 079 315 8627 Support Line
Linda: 082 551 3310 |
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.

Uncertain expertise

"An expert is a person who has made all the mistakes that can be made in a very narrow field." - Niels Bohr

Five experienced, well-published, and widely respected head and neck cancer surgeons are sharing the dais at the national medical meeting to explore the topic "Can We Be Better?" The panel represents a spectrum of experts from around North America and they have served as program leaders, department chairs, and deans. Those of us in the audience know that these people collectively have seen everything. They are smart, compassionate, and gifted. We would trust any one of them to care for a family member.

"So," intones the moderator as he displays a PET/CT scan with a massive cancer of the throat, "You did well on that last case. Let me make this even more difficult."

Each case is complex. The panelists work through discussions of patients who have undergone extensive surgical procedures and have received radiation therapy and chemotherapy, only to have the cancer return.

"Oh, boy. That's a recurrence after treatment? Wow. I wouldn't have much to offer that one," says one of the experts.

"How about some chemotherapy?" asks the moderator.

"I have had a few patients do surprisingly well when they were placed on long term anti-cancer antibodies," says one of the others.

"The data are not very supportive of that approach," says the moderator. "The research says it extends life by only a few weeks and the drugs cost about $10,000 per month."

"About one-quarter of lifetime medical expenses occur in the final year of life," notes another.

"I would have the patient and family work with the palliative care team. There was a Boston study demonstrating that people receiving no treatment actually lived longer than people receiving chemotherapy near the end of life," says another.

And so it goes. Back-and-forth with no textbook answers. The panelists gamely quote research and recall patients who have done well and have done poorly. They suggest palliative care, hospice referrals, and comfort measures. They discuss costs. They review the principles of shared decision making. They acknowledge that, at some point, further active treatment is always futile.

"And what if he was in his eighties instead of being in his fifties?"

Dr Bruce Campbell is a Head and Neck Cancer Surgeon. He has been a leader of the MCW Multidisciplinary Head and Neck Cancer Programme of the Froedtert Cancer Centre. He evaluates patients with tumours of the oral cavity, throat, sinuses, voice box, thyroid, and neck. Read his blog at http://www.froedtert.com/HealthResources/ReadingRoom/HealthBlogs/Reflections.htm

asks the moderator. "Would you change your mind based on his age?"

The panelists glance at each other and smile. "It depends," they say.

Those of us in the audience understand that the requisite skills to care for these difficult patients does not come easily, even to these world-class experts. Their abilities and judgement have accumulated slowly in layers over the course of long and thoughtful careers.

I look around the room and nod to one of my East Coast colleagues who does what I do. Other surgeons shake their heads and whisper to each other. I suspect they are all remembering patients and situations that were equally vexing.

Then one of the surgeons on the panel says this: "My worst nightmare is having all of my head and neck cancer patients come back from the grave to visit me."

It is a shock to hear him say this, but I know what he means. When things go well, our patients can live long and functional lives. When thing go badly, though, the final weeks and months can be horrible for both patient and family. As surgeons, we grieve as well, although we realise our suffering pales when compared to what the family experiences. The memories of those patients remain. Even when we have established solid relationships and have compassionately helped patients transition through the stages that approach the end of life, we still feel as though we have failed them.

I glance over my shoulder to check the reactions from the back of the auditorium. The rows are filled with young men and women - the medical students and residents - who are at the meeting to present their research and discuss their posters. They are just beginning their journeys as physicians, filled with anticipation while they decide on their potential careers paths.

I wonder: What must they be thinking, watching these senior surgeons appear to struggle with patient care decisions? If these chairs, deans, and surgeon-leaders nearing the ends of their clinical careers are still anxious and uncertain about caring for these patients, why would these young physicians ever want to select this field of practice?

It wasn't all that long ago when I was sitting in those seats and wondering the same thing. A few patient encounters, welcoming families, and serendipitous moments directed my footsteps. I still experience anxiety at times, although those anxious moments sometimes let me know I am still alive.

Building a career and a life around the difficult moments has rewards. Some of our students and residents will, in fact, be drawn to the flame. I try to share the rewards with them and encourage them to be reflective. My task is to help provide them the tools to find meaning and peace that will carry them deep into careers that will never, ever offer certainty.

CONTRIBUTIONS FOR PUBLICATION

VISION is an e-newsletter for cancer patients and caregivers and we would like to be able to provide information on suitable support meetings anywhere in South Africa so please, let us have your details for 2017.

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.

CALENDAR

February 2017

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

18 CanSurvive buddy training day, Netcare Auditorium, Sandton from 08:00 to 17:00. Email bernicelass@outlook.com for enrolment form.

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

23 Cape Gate Oncology Group, Oncology Centre 10:00. Nutrition during treatment.

27 Cancercare Support Group, Rondebosch Medical Centre, Giving back as part of healing.

March 2017

1 CanSurvive Charlotte Maxeke Group, Radiation Floor P4.

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

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

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

11 Wings of Hope, Netcare Auditorium, Sandton. 10.00

18 CanSurvive Jabulani Group at HapyD, 1432 Buthelezi St.

23 Cape Gate Oncology Group, Oncology Centre 10:00. Cancer and depression.

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

27 Cancercare Support Group, Rondebosch Medical Centre, Coping with family when going through cancer treatment.

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

April 2017

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

5 Reach for Recovery Group meeting 13:45 Lifeline offices,2 The Avenue, Cnr Henrietta Street, Norwood

5 CanSurvive Charlotte Maxeke Group, Radiation Floor P4.

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

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

15 CanSurvive Jabulani Group at HapyD, 1432 Buthelezi St.

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

20 Cape Gate Oncology Group, Oncology Centre 10:00. Living with pancreatic cancer.

22 Wings of Hope, Netcare Auditorium, Sandton. 10.00

24 Cancercare Support Group, Rondebosch Medical Centre, Nutritional focus after treatment maintaining your health.

May 2017

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

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 or Raynolda Makhutle: 0837534324

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

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

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

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

Cancerbuddies@centurion: Marianne Ambrose 012 677 8271(office) or Henriette Brown 0728065728

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

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

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

Reach for Recovery (R4R) : Johannesburg Group, 011 869 1499 or 072 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

US report highlights empty promises of pharmacy reform

In December the Chicago Tribune published an exposé, the third in a three-part series on dangerous drugs. The latest story found that 52 percent of Chicagoland pharmacies failed to warn patients that a pair of drugs, if taken together, could result in potential harm, even death. The results were "striking evidence of an industry-wide failure that places millions of consumers at risk," the story explained.

Reporters presented prescriptions for five pairs of drugs to 255 to pharmacists located in neighborhood pharmacies, Wal-Marts, supermarkets, and even in one of Chicago's premier hospitals. They discovered the pharmacists were dispensing the dangerous drug pairs, three of which posed life-threatening risks, at a "fast-food pace, with little attention paid to customers."

Pills are not burgers and fries, and in their haste, pharmacists in the paper's sample did not recognise drug combinations that could cause kidney failure, deprive the body of oxygen, trigger a stroke, or lead to unexpected pregnancy with a risk of birth defects.

That finding suggests that the public's belief that pharmacists are among the most trusted professionals may be misplaced. Furthermore, it was the independent pharmacies - which the paper noted pride themselves for offering personalised care - who fared worse in the study than retail chains. Independent pharmacies, as a group, failed to recognise the dangerous drug interactions 72 percent of the time compared to 49 percent for chain pharmacists. Grim stats indeed considering that, according to the paper, one in 10 people take five or more drugs–twice the percentage in 1994.

How many patients will know enough to ask? The Tribune story should be only a beginning for the media. This is a local story everywhere.

http://tinyurl.com/j9ll3fv

New technology to speed up testing of cancer drugs

A new technology that could speed up the testing of drugs and reduce the use of animals in the lab has been developed by scientists at The University of Nottingham.

Researchers in the University's Division of Cancer and Stem Cells have designed a device that allows dozens of tiny balls of cells, called spheroids, to be sliced simultaneously to examine their structure and function. This method will enable scientists to more rapidly assess whether new therapies and tissue engineering are likely to work in the real world, and could be up to 11 times more efficient than current methods.

Dr Delyan Ivanov said: "When I started exploring spheroids by slicing them, I was frustrated by the slow and gruelling nature of the process. I had to cut spheroids cultured in many different drugs and it was taking me months, there were many manual steps. Inspired by the principle of 3D printing, I decided to design my own tool for arranging all spheroids from an experiment in the same plane in a microchip-like pattern in a gel."

The team will now be sharing the design files and methodology openly with the scientific community to ensure that everyone can immediately benefit from the technology.

Many experiments currently done in animals could be done in these spheroid and organoid cultures reducing and ultimately replacing some animal testing in cancer research and tissue engineering

http://tinyurl.com/h57wska

Maya healers' similar conception of cancer

Understanding and integrating patients' cultural beliefs into cancer treatment plans may help improve their acceptance of and adherence to treatment in multicultural settings. Researchers examined traditional Maya healers' understanding of cancer and published their findings in the Journal of Global Oncology.

The analysis found that, while key differences emerge between Maya and Western medicine perspectives, they also share many fundamental concepts. Maya healers understand the origins of cancer in ways that align closely with Western medical concepts. When asked to identify the physical causes of cancer, 10 of 17 causes provided correlated directly with cancer risk factors as understood in Western medicine. Healers cited causes such as the consumption of harmful foods (46.3%), hereditary conditions (29.6%), and lifestyle factors such as smoking or working with toxic substances (29.6%).

One notable difference identified between the two perspectives is that Maya healers' view of cancer is not limited to the physical body, but rather includes a complex imbalance of the emotions, mind and spirit. The Maya treatment of cancer is consequently holistic and seeks to restore that balance. This is achieved through a combination of methods—such as regulating diet, plant therapy, detoxifying baths—as well as social, psychological and spiritual methods, the latter of which the authors note is harder to grasp in Western medicine.

Many indigenous people in Guatemala do not have access to Western medicine services, cannot afford them, or prefer Maya

CanSurvive
CANCER SUPPORT

Head and Neck Support Group

The CanSurvive Head and Neck Support Group is for anyone who has had trauma to the head or neck – not only cancer related – although that applies to the vast majority. The Group is for patients who are just starting this journey, as well as those who are many years down the treatment and recovery road.

The objective is to provide information, share experiences, and help with coping mechanisms. It is run FOR the patients BY the patients. There is always a medical member of the Morningside Head and Neck Oncology Team present. Partners are encouraged to attend the meetings as well.

The informal and supportive meetings are usually held on the first Thursday of each month at Rehab Matters, 1 De la Rey Rd. Rivonia from 18h00 to 20h00. The next meeting will be on Thursday 2 March. There is also a Facebook group: South African Head and Neck Support Group

For more information, contact Kim Lucas, on 082 880 1218 or e-mail: lct@global.co.za.

medicine even when Western medical treatment is available. Yet Western medicine practitioners have little to no training in multi-cultural management or traditional indigenous medicine.

http://tinyurl.com/zfg2ef7

Study casts more doubt on value of mammograms

Mammograms frequently detect small breast tumours that might never become life-threatening, causing women to receive treatment they likely don't need, a new Danish study finds.

About one in every three women between the ages of 50 and 69 who was diagnosed with breast cancer wound up having a tumour that posed no immediate threat to her health, the researchers reported.

At the same time, mammography did not reduce the number of advanced breast cancers found in women in the study.

"This means that breast screening is unlikely to improve breast cancer survival or reduce the use of invasive surgery," said study author Dr. Karsten Juhl Jorgensen, deputy director of research for the Nordic Cochrane Centre at the Rigshospitalet in Copenhagen. "It also means that breast screening leads to unnecessary detection and treatment of many breast cancers."

Dr. Otis Brawley, chief medical officer for the American Cancer Society, said the study shows that breast cancer overdiagnosis is real. But, screening for the disease saves lives as well. Doctors refer to the detection of non-life-threatening cancers as "overdiagnosis." Women overdiagnosed with breast cancer are frightened needlessly and undergo potentially harmful, but ultimately useless, medical treatments like surgery, chemotherapy and radiation therapy, Jorgensen said.

These results call into question the value of regular mammograms, Jorgensen said. Current U.S. guidelines recommend mammograms every other year for women aged 50 or older, although some medical societies recommend annual screening.

"Breast screening has not lived up to its promises," Jorgensen said. "All women must seriously consider whether participation in breast screening is right for them, after having sought balanced information about what it can and cannot do."

http://tinyurl.com/ztzymjc

A surprise advance in the treatment of adult cancers

A team of researchers at the Research Institute of the McGill University Health Centre (RI-MUHC) has found an epigenetic modification that might be the cause of 15% of adult cancers of the throat linked to alcohol and tobacco use.

This is a first in the field of epigenetics and the researchers are hopeful that the discovery can blaze a path in the development of new, targeted, more effective treatments that could arise over the next few years.

"This discovery was absolutely unexpected since it seemed highly improbable that the kind of alterations of the epigenome that we had previously found in other types of tumours in children and young adults could also target an epithelial tumour like throat cancer that occurs only in adults," explains Dr Nada Jabado, a researcher at the RI-MUHC and one of the principal authors of the study published in Nature Genetics.

Head and neck cancers, also called oropharyngeal cancers or throat cancer often have devastating consequences. Standard treatments involve surgery, radiotherapy or chemotherapy. Unfortunately, the side effects of these treatments are significant and relapses are common. That's why oncologists are searching to develop more effective treatments that will be less harmful and have fewer deleterious effects.

The discovery of this epigenetic modification opens new treatment possibilities. In fact, some promising drug molecules are already on the market for other illnesses and could possibly be tested for head and neck cancers as well as other cancers like multiple myeloma and lung cancer.

http://tinyurl.com/jttducj

Research reveals surprising health benefits of chewing your food

Scientists have shown that chewing your food properly can boost your mouth's immune system to protect you against illness.

The study led by teams at The University of Manchester and National Institutes of Health in the US, revealed that a specific type of immune cell, the Th17 cell, can be stimulated when you chew. This immune cell is important in protecting against bacterial and fungal infections that are commonly found in the mouth .

In other parts of the body, such as the gut and skin, Th17 cells are stimulated by the presence of friendly bacteria; it was previously assumed this was the case in the mouth. However, the team found that damage caused by the abrasion of chewing induced factors from the gums that could activate the same pathways as friendly bacteria and act upon Th17 cells.

However, stimulation of Th17 cells for immune protection can be a double-edged sword: too many Th17 cells can contribute to periodontitis – a common gum disease that is linked to complications in lots of diseases including diabetes, rheumatoid arthritis, heart problems and pre-term birth.

Lead researcher and biologist Dr Joanne Konkel, from The University of Manchester, said: "The immune system performs a remarkable balancing act at barrier sites such as the skin, mouth and gut by fighting off harmful pathogens while tolerating the presence of normal friendly bacteria.

"Our research shows that, unlike at other barriers, the mouth has a different way of stimulating Th17 cells: not by bacteria but by mastication. Therefore mastication can induce a protective immune response in our gums".

The University of Manchester

Lung cancer: Delayed chemotherapy after surgery may still be beneficial

A new study published in JAMA Oncology suggests that doctors should still consider chemotherapy in appropriately selected patients with NSCLC who are healthy enough to tolerate it, up to four months after surgery.

While the prognosis, or outlook, for patients diagnosed with lung cancer is usually poor, if the disease is diagnosed in the early stages, there is a higher chance of a cure.

The study - from Yale University in New Haven, CT - concerns NSCLC. In their paper, the researchers note the standard recommendation is that chemotherapy should be administered patients

whose cancer has spread to the lymph nodes, whose tumours are four centimetres or larger, or where there is extensive invasion into surrounding tissue.

Many doctors say that the optimum window for giving adjuvant chemotherapy to NSCLC patients is 6-9 weeks following surgery. However, there are cases where patients need to recover from complications following surgery, and they may not be able to tolerate chemotherapy so soon.

The analysis included 12,473 NSCLC patients and results showed that five-year survival for patients whose chemotherapy started 7-18 weeks following surgery differed little from patients whose chemotherapy started closer to the 6-9-week window that is generally followed.

The analysis also found that surgery followed by delayed chemotherapy was associated with a lower risk of death compared with surgery only.

http://www.medicalnewstoday.com/articles/315103.php

Study of esophageal cancer, offers insight into increasingly common disease

A comprehensive analysis of 559 esophageal and gastric cancer

New guidelines set benchmark for chemotherapy

A new set of comprehensive guidelines to manage the chemotherapy treatment process and improves patient and healthcare worker safety has been developed by a group of South African cancer specialists.

The Chemotherapy Administration Guidelines was compiled by members of the Independent Clinical Oncology Network (ICON) in consultation with oncologists and cancer experts from around the world. to address a significant gap in local cancer care protocol. The resource, which is a first for South Africa, will be released this month.

To date, there has been no single resource document in South Africa, and perhaps the world, that addresses best practice at all three levels of chemotherapy administration: the oncologists who prescribe the medication, the pharmacists who dispense it, and the nurses who administer it, says Dr David Eedes, clinical oncology advisor for ICON.

Administration errors

Because of the ever-increasing complexity of cancer treatments, and the fact that chemotherapy is potentially toxic if rigorous safety standards for both healthcare workers and patients are not followed, this initiative by ICON is long overdue, says Eedes. "Chemotherapy is a particularly specialised form of medical treatment," he explains.

Chemotherapy administration errors are a worldwide issue. Medical errors in general rank Error! Hyperlink reference not valid., and a 2013 study on chemotherapy found a error rate of over 30% in a sample of handwritten orders, while a study conducted in Turkey found that 83% of nurses reported one or more errors during chemotherapy preparation and administration. Other research by the National Centre for Biotechnology Information reported a lower rate, but a wider range of errors; from under-and over-dosing to giving chemotherapy to the wrong patients.

"Whatever the true statistics for errors are, we believe that by following well documented protocols by each discipline involved in this complex process, and ensuring good communication between the different groups of professionals managing cancer patients, this will reduce the risk for errors and also enhance the experience for professional and patient alike," says Eedes.

Improving standards and reducing costs

The ICON network is dedicated to providing cost-effective cancer treatment based on the latest evidence for the mutual benefit of patients, healthcare providers and funders. But, says Eedes, "ICON is not just about trying to cut costs, but also about improving standards of care for our patients and the quality of the working environment for staff. It's not only clinical protocols and formularies – we look carefully at the quality of care given to patients. Good clinical management is central to what we do."

He explains that the decision to draw up the chemotherapy administration guidelines came from the discovery of an unmet need while doing a routine audit of ICON's chemotherapy and radiation practices.

"During these inspection visits, the chemotherapy personnel requested assistance in their day-to -day work in the form of standardised chemotherapy processes for all chemotherapy practices," says Sister Belinda Bailey, a specialist nurse with extensive experience in chemotherapy administration, who was instrumental in developing the guidelines.

Role of the chemotherapy nurse

The central involvement of the chemotherapy nurses in developing these practical guidelines is critical, says Eedes. In South Africa, as in most parts of the world, it is the chemotherapy nurses who play the central role in this process. It is the nurses, believes Bailey, who are key in reducing administration and other errors, so improving outcomes and safety standards. The new guidelines, she says, will help them do their jobs better by providing them easy access to important, updated information.

Staff competencies and staff safety are some of the important chapters in these guidelines. "The more competent and focused a chemotherapy nurse is, the more unlikely it is that errors will be made," says Eedes. This is particularly crucial in some of the smaller medical practices where there is a small staff complement requiring the chemotherapy nurse to fill multiple roles - mixing and dispensing the medication and informing the patient. "If they are not adequately trained or supported this is a recipe for serious errors."

The finalised guidelines, will initially be released among the ICON clinical network, but later be made more broadly available to chemotherapy practices in general.

"It's an exciting project," says Eedes. "Our aim is to improve the overall standards of chemotherapy administration in South Africa and so serve our cancer patients better."

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samples, collected from patients around the world, suggests the two main types of esophageal cancer differ markedly in their molecular characteristics and should be considered separate diseases.

The study includes two key takeaways. First, upper esophageal cancers more closely resemble cancers of the head and neck, while tumours further down in the esophagus are virtually indistinguishable from a subtype of stomach cancer. Second, cancer clinical trials should group patients according to molecular subtype - in general, grouping lower esophageal tumours with stomach cancers, while evaluating upper esophageal cancers separately.

"These findings add several layers of depth and sophistication to our current understanding of esophageal cancer genomics," said Adam Bass, M.D., co-leader of TCGA's esophageal cancer study and physician-scientist at Dana-Farber Cancer Institute. "Our hope is this work settles several long-standing uncertainties in the esophageal cancer field and will serve as the definitive reference manual for researchers and drug developers seeking more effective clinical trials and new treatment approaches."

Physicians have known for decades that esophageal cancers, when looked at under the microscope, fall into one of two categories - adenocarcinomas, which resemble stomach or colorectal cancers, and squamous cell carcinomas, which are similar to some lung, skin, and head and neck cancers. What remained unknown was the extent to which adenocarcinomas and squamous esophageal cancers differ molecularly and the relationship between esophageal adenocarcinoma and stomach adenocarcinoma.

"We have shown that these clinical subtypes differ profoundly at the molecular level," said Peter W. Laird, Ph.D., a principal investigator in the international TCGA Research Network and a professor at Van Andel Research Institute. "These findings suggest that whether the tumour originates in the esophagus or the stomach is less relevant than the molecular characteristics of the individual tumours."

This study revealed that esophageal adenocarcinomas have striking molecular similarity to a class of stomach cancers called chromosomally unstable tumours, the hallmark of which are significant structural chromosomal aberrations. Oncologists say this nuanced view of the disease, including the detailed molecular taxonomy of esophageal adenocarcinomas, will likely change their approach to studies and treatment.

http://www.medicalnewstoday.com/releases/315056.php

Diet drinks a 'potential risk factor for chronic diseases'

A new commentary on existing artificially sweetened beverages (ASB) research and policy - published in the journal PLOS Medicine - argues that ASBs are just as ineffective in preventing weight loss as their full-sugar counterparts. The commentary is a collaborative effort between Imperial College London, University of Sao Paulo and the Federal University of Pelotas - both in Brazil - and Washington University in St. Louis, MO.

The researchers - led by Prof. Christopher Millett - argue that although SSBs are very high in calories, they contain almost no essential nutrients. Additionally, "convincing epidemiological evidence" has suggested that consuming SSBs increases the risk of being overweight or obese, as well as developing diabetes.

ASBs are becoming more and more popular as an alternative to harmful sugary drinks.

Because they taste similar to their full-sugar counterparts and have none of their energy content, ASBs are perceived as healthful, as it is believed they do not trigger any energy compensation mechanisms.

Additionally, "taxes and regulation on SBS and not ASBs will ultimately promote the consumption of diet drinks rather than plain water - the desirable source of hydration for everyone," mentions Prof. Carlos Monteiro, one of the authors of the review.

However, researchers explain why the common perception of diet drinks might be wrong.

ASBs can still cause a compensatory mechanism by stimulating sweet taste receptors. This can, in turn, increase appetite and stimulate the secretion of gut hormones. Knowing that ASBs are low in calories might amplify these effects and lead to excessive consumption of other foods. This chain reaction could lead to weight gain, obesity, and obesity-related complications.

In fact, Millett and team point out that several observational studies and meta-analyses have correlated ASBs with increased body mass index (BMI) and a higher risk of cardiometabolic diseases, such as type 2 diabetes and stroke.

However, observational studies are vulnerable to so-called reverse causality - for example, people with obesity might tend to consume more ASBs because they are trying to control their weight, rather than the ASBs causing the weight gain themselves.

Even so, randomised controlled trials of ASBs have shown either no effect at all on weight loss, or only minor reductions in weight.

The authors conclude: "The absence of evidence to support the role of ASBs in preventing weight gain and the lack of studies on other long-term effects on health strengthen the position that ASBs should not be promoted as part of a healthy diet. Far from helping to solve the global obesity crisis, characteristics related to ASB composition [...], consumption patterns [...], and environmental impact make them a potential risk factor for highly prevalent chronic diseases."

http://www.medicalnewstoday.com/articles/315101.php

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.

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