Prevention of Cervical Cancer

by Julie Ohnemus, M.D.

In June of 2006 the first vaccine to prevent cervical cancer was approved, and is scheduled to be available in Humboldt County in January 2007 – Cervical Cancer Awareness Month. This is considered a major breakthrough for women’s health, because cervical cancer is the second most common cancer worldwide. Cervical cancer once claimed the lives of more American women than any other type of cancer. But over the last 40 years, the widespread usage of cervical cancer screening using the Pap smear has markedly reduced its occurrence and mortality. Too, it was discovered that the cause of cervical cancer is actually a virus, the Human Papilloma Virus (HPV), which is sexually transmitted.

HPV is the most common sexually transmitted infection in the U.S., with approximately 20 million Americans currently infected. Each year, an additional 6.2 million people are newly infected, and half of those infected are between the ages of 15-24 years old. Detecting infections is difficult because most people have no symptoms. Over half of sexually active women and men are infected with HPV at some point in their lives, but 90% of women with HPV infection kill or suppress the virus without treatment. The only way to detect or monitor it is with HPV DNA testing, which can be done with your Pap smear. This is why it is important that all women begin having Pap smears 3 years after beginning to have sex and no later than 21 years of age.

The 10% of women with persistent infections are at increased risk of cancer. There are 9,710 new cases of cervical cancer, and 3,700 deaths per year in the United States. Latina women have the highest risk of developing cervical cancer – about twice as high as other women.

There are over 30 sexually transmitted types of HPV, which are categorized as low or high risk, depending if they cause cancer or not. HPV types 16 and 18 cause about 70% of cervical cancer cases. These 2 viruses, and HPV types 6 and 11, which are associated with 90% of genital warts, are what the vaccine targets. The vaccine should be given to females aged 11-26, though it is safe to give as young as 9. The vaccine is a 3-shot series given over 6 months at $120 per dose, but is covered by state and federal vaccine programs. It should be given before a girl becomes sexually active.

The vaccine can be given to women who are breastfeeding or immuno-compromised, but not if they are acutely sick, or severely allergic to yeast. Even though rated safe during pregnancy, it is not recommended to start the vaccine when a woman is pregnant, and should someone become pregnant during the series, the remaining shots should be postponed until after the pregnancy. It can also be given to women who have abnormal Paps or genital warts, however, the vaccine may not benefit the existing infection. It has not shown any serious side effects and is known to be effective for at least 5 years.

In recognition of January as National Cervical Cancer Awareness month, the Open Door Community Health Centers will once again be offering free Pap smears at their four Humboldt county locations. Women will be screened for Cancer Detection Program and Family Planning eligibility for financial assistance, and will be enrolled if eligible. Those who do not qualify will receive a Pap smear at no cost. The results of the Pap smear will be sent to the woman’s primary care physician. Follow-up will be done by the clinic staff for women who do not have a primary care physician.

During the week of January 22-26, 2007, Pap smears will be done free of charge at the following locations:

- North Country Clinic
  785 18th Street, Arcata
  (707) 822-2481

- Arcata Open Door Community Health Center
  770 10th Street, Arcata
  (707) 826-8610

- McKinleyville Open Door Community Health Center
  1644 Central Avenue, McKinleyville
  (707) 839-3068

- Eureka Community Health Center
  2412 Buhne, Eureka
  (707) 441-1624

- Del Norte Community Health Center
  200 A Street, Crescent City
  (707) 465-6925

- Smith River Community Health Center
  110 First Street, Smith River
  (707) 487-0135

Free Pap smears during the week of January 22-26, 2007 at the locations above!
From the Director
by Dawn Elsbree

Once again the past few months have been a time of change, growth, sadness and hope here at the Project. We feel the hole left by the resignation of our first employee, Maria Carrillo. For the past ten years she has gently and with great grace and determination contributed to the development of the Project. She is part of everything we do and will remain in our hearts and minds.

I would like to offer a huge thanks to the community for its support during the Fall of 2006. Over 110 businesses participated in our various projects, and I cannot emphasize enough how much this means to us. Through our work together we bring healing to our families and friends. Our educational outreach efforts, the Sales for Survivors campaign, and the sold-out fall concert were more successful than ever before, because of the warmth and generosity of our rural county. Bringing together all of the local mammogram providers and enrolling over 300 women in this year’s giveaway was one of the highlights of the fall.

I also want to share with you just one success story from our outreach around early detection. Our Client Services Director, Sharon Nelson and a volunteer, Carol Vander Meer, did a radio show on KHSU on Katie Whiteside’s Homepage. Carol is a gynecologic cancer survivor and the show was focused on symptoms of uterine cancer and the importance of early diagnosis. A local woman was driving down the road listening to the show. She pulled off, listened to the whole show, and recognized that many of the symptoms were occurring in her own body. She then called her doctor on her cell phone to make an appointment. Shortly thereafter she was diagnosed with early stage uterine cancer and has since become a client of the project. Her early detection is the key to her positive prognosis. Stories such as this one feed us all here, volunteers and staff alike.

We look forward to 2007, the 10th anniversary of the start of the Project. In addition to continuing to train and nurture more volunteers to provide critical support services for clients, we plan to continue to find new and innovative ways to respond to the needs of those in our community with breast and gynecologic cancer and with breast health concerns. Look for more information to come on our new Digital Storytelling program, which will be developed in 2007.

Humboldt Community Breast Health Project

is a community resource of support and education for those facing a breast health concern or a diagnosis of breast or gynecologic cancer.

We are a client-centered, grass roots organization with services provided by breast cancer survivors and their support persons.

We promote healthy survivorship through education, healing support and hope, enabling each person to become their own best medical advocate.

We support and challenge our community to address breast health concerns responsibly and holistically.

As survivors we heal through service and by bearing witness to others.

OFFICE HOURS: Monday-Friday 9 a.m.-2 p.m.
Evenings by appointment
987 8th Street, Arcata, CA 95521
(707) 825-8345 toll-free (877) 422-4776
FAX: (707) 825-8384
www.hcbhp.org E-mail: info@hcbhp.org

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Maria's Personal Story

by Maria Carrillo

On February 29, 2007, I will celebrate the ten-year anniversary of my metastatic breast cancer diagnosis. My journey with cancer began before the formation of the Breast Health Project. I was supported by a breast cancer survivor, Melinda Wilson, who later in that year joined us in becoming one of the several founders of the Project.

With a very small lump that was undetected by the mammograms, I wanted to believe it was only a fibrous cyst. “Why should I question these experts when my life was already busy and stressed out, like most women in my age group,” I thought. At that time, I worked as a Public Relations Assistant for a local hospital, and I had a wonderful practitioner whom I trusted when she said to have it filmed in six months.

Needless to say, one year later the film confirmed the diagnosis, and a surgical biopsy was ordered only because a close friend of mine, who is a mammogram technician, recommended it. Within the first year, I had a lumpectomy and radiation to that breast, and a metastatic involvement in one of my ribs.

After that, it’s all a blur of continuous testing, drugs and treatments: more radiation therapy; a succession of hormone therapies; Zometa; Zoladex, Xeloda; six rounds of EC; more radiation; and now six more rounds of chemo with Abraxane. In looking back at all these years, I see a life filled with a lot of fear and an unknown future, but it is also balanced with much self-reflection, heightened periods of serenity, joyfulness and acceptance of the reality that we cannot fight our imminent death.

Abraxane promises to be easier, but also has a lower chance of pushing back the disease that is now in my liver, lungs and scattered all over my skeleton. Despite the dismal scan reports and rising tumor markers, I continue to be (almost) unstoppable.

This journey has been an arduous one but I would not have had it any other way. Because of this disease, I have traversed the ups and downs that sometimes lead to pastures of tremendous insight and knowingness. I don’t know how much more time the continued doses of drugs and radiation will promise me, but I am blessed to have traveled this journey for as long as I have. It has led me to the remarkable work and women at the Breast Health Project, and to trailblaze an untrodden path in therapeutic music. It has also opened my eyes to a deeper understanding of why I’m here and will one day leave.

I leave the Project with gratitude, a legacy as one of its mothers, and a wonderment at the soul’s capacity to keep moving forward even when it can sometimes barely take the next step. I leave with marvel at life’s beauty and the wonderful memories I’ve shared with my extended family, the Amazon Warriors Extraordinare. I extend my thanks to all of you who have shared my journey since the beginning. I especially extend my gratitude to Dr. Julie Ohnemus to have shared the gift of participating with her in the collaborative effort to begin the Project, and for her willingness to go the extra mile with me.

Maria Carrillo and SueAnn Armstrong

Forever a True Amazon Warrior

Maria Carrillo is one of the founding mothers who sat around my kitchen table to establish HCBHP’s vision and mission. I hired her as the very first office staff person who opened our doors to the public. Maria went on to design our newsletter, which offered healing touches with her thoughtful and heartfelt graphic design.

Beyond her presence, the greatest gift she gave to the Project was the creation of the Amazon Warrior symbol. Maria not only created but also embodies the spirit of HCBHP’s Amazon Warrior symbolism in the witness of her own breast cancer journey. She teaches us how to live and accept uncertainty, while embracing each moment. She has an innate understanding of the Amazon Warrior’s knowing when to fight and when to let go. We will deeply miss her, but her legacy will live on in the courage and support the Amazon Warrior offers to each one of our clients.

Forever grateful — Julie Ohnemus
In the Sixth Year of My Journey  
by Ione Ellis ~ November 18, 2006

When I first thought of writing about my experiences with inflammatory breast cancer (IBC), I thought to tell you about how sneaky and insidious it is. I thought to tell you more about the disease itself. I will leave all that to others. I will tell you only about the affect it had on me. While physically IBC manifests differently from other breast cancers, it has the same deadly psychological effects as any other life-threatening cancer. I will take you on a short walk along my path.

I am currently in a clinical trial in the hope that I am receiving a drug that will halt the progress of the cancer that is in my body. No one knows if I am receiving the study drug (except the drug company), and no one knows if it will help me if I am. I proceed from one day to the next thankful that I have another day.

Inflammatory breast cancer raged through my body for nearly eighteen months from the time I first realized that something was amiss until it was finally diagnosed. It didn’t reveal itself on a mammogram, and the doctors who examined me did not recognize it. I cannot go back and change what happened to me (or didn’t happen, depending on your point of view); however, I can, and do, caution every woman I know to be diligent when it comes to something that “just isn’t right” in her body.

I share the responsibility for my condition because I was too complacent. I heard what I wanted to hear. When the first specialist said I had “mastitis,” I was willing to accept that. When a year later he said it was “chronic mastitis,” I still accepted it, but with a niggling little doubt. I should have researched more carefully. I should have sought a second opinion earlier. I should have…. should have…. One doctor (of the six who actually saw my breast before a definitive diagnosis was made) opined, “Well, I’m pretty sure it isn’t cancer.” At that moment I breathed a small, thankful sigh, but still with a niggling little doubt in the back of my mind. It was those little doubts that brought me finally to Dr. Ellen Mahoney and the devastating realization that I did, indeed, have cancer.

When my particular cancer journey commenced, I already had widespread nodal involvement. My treatment began with chemotherapy, followed by a mastectomy, more chemotherapy and radiation. As those who’ve tread this same path know, it is a hard physical journey. I nearly reached five years from initial diagnosis to the discovery of metastases to the bones. I had radiation to the spine. Then cancer appeared in my liver. I did more chemotherapy, and the disease was at bay—but just momentarily. The recurrence in my liver is what brought me to this moment and to the clinical trial.

I wish I could say that I accept my plight gracefully. I don’t. I have moments of anger, frustration, and despair. I write poems to dispel my demons. Overall, I do not dwell on where I am going, but rather on what joys come with each step, each day: a doe with her fawns browsing on whatever foliage is at hand yet wary and watchful as they make their way across my yard, a multicolored sunset that turns the horizon into a blaze of glory, or the seemingly effortless swooping and gliding of turkey vultures moving against the backdrop of ever-changing Humboldt skies. Nature is solace for my soul. I am nourished by a visit from a friend, a call from a loved one, a hug, or most particularly, by the warmth of my husband’s hand in mine. I have survived to be present at the birth of my only grandchild. I have the constant support of my family. I learned the importance of the phrase “living in the moment.” I learned that it is OK to be angry occasionally. I learned that nothing is as important as the relationships we share with others. To use a perhaps overtired metaphor, my path is strewn with roses—not just rose petals, but the whole flowers with stems and thorns included!

I have an extended family at HCBHP, and I have been supported all along the way by both the staff and the members of the support groups I attended. I count among my dearest friends many women who are traveling the same road. I will be forever grateful to Dr. Julie Ohnemus for having the vision to provide the community with such a tremendous resource and to Dr. Ellen Mahoney who first spoke to me of the importance of healing. I am not cured, but I feel I am healed! And my journey is not over yet! ❖
New Service – Amazon Writers!

HCBHP is pleased to announce a new service for our clients and volunteers: a writing group. Amazon Writers gives each woman the chance to write about her own journey with cancer and to bear witness to the experiences of the other women in the group. Writing together and sharing our stories is a powerful way to understand and make meaning out of our experiences. No previous writing experience is required. Amazon Writers is for anyone who loves to write or has always wanted to try!

Call or e-mail Carolyn at the Project office (825-8345, ext. 135, or carolyno@hcbhp.org) for more information, including the dates and times of the third series of writing workshops, which begins in February. 

Journey of the Heart:
March 4-26, 2007

Join us for this exhibition of art by breast and gynecologic cancer survivors and their supporters. The Opening Reception will be Sunday March 4, 2007 from 1:00 to 6:00 p.m., with wine, cheese, hors d’oeuvres and desserts. The reception includes a silent auction and raffle.

Exhibit hours are 1:00 to 4:00 p.m., Thursday through Sunday until March 26. The exhibit is located at the Westhaven Center for the Arts, 501 South Westhaven Drive, Westhaven. For more information, call (707) 677-9170.

Volunteer Voices

By Sharon Nelson, RN

Our current staff of client service warmline volunteers is the strongest it has ever been. As the Project has continued to grow so has our dependence on volunteers. Given the increased number of women and their families that we are serving, we simply could not fulfill the need without these dedicated, hard-working, openhearted volunteers. The majority of these women (myself included) are previous clients who came to HCBHP with a diagnosis of breast or gynecologic cancer looking for information and support.

What they found inspired them to come back with the intention of giving to other women that which had been given to them.

As women in our community face a breast health concern, breast cancer or gynecologic cancer, these warmline volunteers greet them over the phone and in person to model healthy survivorship while sharing information, support and hope. The warmline volunteers include Rinda McClure, Sheryl Sandige, Chris Angell, Jane Crosbie, Linda Marlow, Mia Matsumoto, Margot Julian, Jean Wielelman, Bonnie Etz, Louanne Farrell, Harriet Watson, and Joy Hardin. A heartfelt thank you to each of you.

Kids' Day to Play

A very special thank you to volunteers Sheryl Sandige and Harriet Watson, who produced the 3rd Annual Kids' Day to Play which took place Saturday, September 16, 2006.

Together with their husbands and children, they created a day of fun and play for children who have experienced the impact of breast cancer or gynecologic cancer in their lives – another great Project event that would not have happened without their efforts. Thank you, Harriet and Sheryl.
HSU Student Nurse Intern Program

Willow Lyons completed her Community Health Internship at HCBHP in November. Willow came to the Project with an English degree, EMT certification and work experience as a ski instructor and a river rafting guide. She hopes to pursue a career in trauma nursing after her graduation in May 2007.

Willow’s personal experience of breast cancer in her family as well as her interest in women’s health issues motivated her to become involved with HCBHP. We thank Willow for her contributions including her hard work on our fall outreach campaign. We wish her all the best in her nursing career.

Fall Concert – Music from the Heart

Pictured here are some of the major community sponsors for the 2006 fall concert – Music from the Heart: American Composers. From left to right: Arla Ramsey, Diane Holliday and Claudia Brundin from the Blue Lake Rancheria; Dawn Elsbree of the Breast Health Project; Tom Ayotte from Mad River Community Hospital; and Alison Hong of Wells Fargo Bank.

Major sponsors not pictured are Humboldt Radiology and Bear River Rancheria.

Inflammatory Breast Cancer
by Julie Ohnemus, MD

In May a Seattle TV station did an educational story on inflammatory breast cancer (IBC). It occurs in 3-6% of all women with breast cancer, and rarely occurs in men. The story hit the internet airwaves and over 14 million people viewed it (www.komotv.com/ibc/). In October the video piece was sent to me in an e-mail, asking if our local medical providers knew about this. My response was that we would do an article on it in our next newsletter. Jone Ellis has graciously shared her journey with IBC and she is the expert having lived the disease (see page 4).

IBC is an unusual form of breast cancer, which doesn’t present as a distinct breast lump and doesn’t show up on mammograms or ultrasounds. It is caused by the cancer cells blocking the lymph flow in the breast skin, and often will present as a red, pink or bruised-like, warm area of thickness or a feeling of heaviness, burning, aching in one of your breasts. Your breast may increase in size, and the skin may have ridges or be pitted like an orange peel, which is caused by the buildup of fluid and swelling. Sometimes your nipple will go flat or face inward. The cancer develops as a sheet rather than a lump or tumor. Lymph nodes under the arm and/or above the collarbone can become swollen. It’s important to realize this can also be a sign of other conditions such as infection or injury.

Though uncommon it is an accelerated form—locally progressing over a matter of weeks to months. It is often misdiagnosed as a breast infection (mastitis). Commonly, providers will initially treat it with certain types of antibiotics to rule out infection and request that you return for a re-examination of your breast. If antibiotics don’t work in 10-14 days, then you should return to your medical provider for a skin punch biopsy. A mammogram and/or ultrasound, if tolerated, should also be performed, but the biopsy should not be delayed.

At the time of diagnosis it has often spread to your lymph nodes and other parts of your body. Chemotherapy is done prior to surgery and often started within days of diagnosis. Historically, survival statistics have been grim for IBC, but newer approaches are offering hope, and improving long-term survival. Too, as with all breast cancers, the earlier you are diagnosed, the better the prognosis. But because the symptoms are the first signs of the cancer, you as a patient need to listen to your body and be proactive in seeking attention and following through until the symptoms and signs have resolved or been diagnosed.

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Individualizing Breast Cancer Decisions
by Ellen Mahoney, MD

The appearance of a breast cell changes as a normal healthy cell becomes malignant. This was noted centuries ago, with the invention of the microscope. For a long time, all we had was the appearance of a cell to tell us what its nature and potential was. The degree of deviation in appearance from a normal breast cell determined the diagnosis of cancer, and treatment choices were limited.

About 100 years ago the sorting of genetic characteristics based on appearance of the pea or the fly was noted, and the field of genetics was born. It was also noted that the material in the nucleus of the cell was copied and divided between the 2 daughter cells as the cells divided. But no one understood exactly what a gene was, or what it did, or how.

A mere fifty years ago the DNA molecule was described. Finally we understood that genes are sections of the DNA molecule that serve as blueprints for making proteins in the cells. These proteins serve both the structure and the function of the cells. Every cell has all of the genes necessary to make all of the proteins in the body. It was around this time that the concept of mutation was born; something, be it a random mistake or a toxic foreign influence, changes the structure of the DNA while it is dividing. Most of these changes in the blueprint have no influence, and a few cause the cell to die. But some let the cell live, but cause changes in the DNA that ultimately can result in the gene making the wrong protein for that cell. One mutation doesn’t make cancer, but once the DNA is changed, and passed down to a daughter cell, the chances become greater that more mistakes will be made in successive generations of that cell, and over many years the result can be a cell that not only grows and divides without regard to whether you need more of that cell type, but that also is able to digest its way through normal tissue, leave the organ where it originated, live in the circulation of the body, attach itself to tissue elsewhere in the body, and recruit a new blood supply to feed itself, all while subverting the immune system which is always on the lookout for cells that are not normal. Then it is cancer. But many mutations of different types can result in cells that LOOK the same. And the appearance of the cell doesn’t really tell us what functional genes are in it. Now we know that cancer cells vary a great deal in their ability to move and grow, and we also have a large variety of treatments. How do we tell which cancers are more dangerous than others, and how do we match the most aggressive treatments to the most aggressive cancers? We do not want to risk undertreating or overtreating our patients, yet it is clear that the appearance of the cell is not enough to help us make these decisions.

The first major individualization based on the actual state of the DNA in a cancer cell was the determination of the estrogen receptor protein. This happened in the 1970s. Cells that had DNA that made this protein had a better prognosis, and also could be damaged by drugs that interact with this protein. This was the first time that we were able to match treatment with the actual state of the DNA, and it is still the most powerful. There have been some others, notably Her2/neu protein. This is an abnormal protein, so its manufacture is directed by an abnormal gene in the DNA. Tumors that have a lot of this type of damaged DNA can be effectively treated by an antibody to the protein, called Herceptin. These tests can help us select specific treatments based on specific genes, as determined by their products.

Progress in this area, though very exciting, has been very frustrating because it has been so slow. Meanwhile, every day, women and their doctors are trying to find ways to select treatment, and even someday to give better prognostic information. We have identified a lot of genes in breast cancer, but we don’t really know what all of them do yet. Cell cultures to determine the sensitivity of an individual’s cancer cells to individual drugs, analogous to culturing bacteria and testing antibiotics against them, have NOT been successful in breast cancer. How can we avoid over-treating or under-treating breast cancer?

Scientists decided to take another route to getting this clinical information by looking back at a cumulative collection of breast tumors from the 1980s, from women who did not have nodes involved (by our older and more inaccurate ways of determining that fact). Most, but unfortunately not all of them, had estrogen receptor proteins on the tumor cells and were treated with tamoxifen in NSABP B-14. This was a good choice, as the patients who have small ER+ tumors without nodes involved present the greatest dilemma in choice of therapy. Many of these patients will do just as well with or without chemotherapy if they are given hormone-blocking drugs. Is there a way to tell in advance which of these patients should get chemotherapy?

The tumors were analyzed for genes that they had in common, and out of hundreds of possible genes, 16 genes
Individualized Decisions...continued from page 7

were chosen, along with 5 reference genes. This panel was then compared, again retrospectively, to the tumors of women in several small studies (where many of the authors are employees or consultants for Genomic Health, the company that makes the test). The score is reported in 3 categories denoting the chance of recurrence: low, medium or high, and the results were intriguing. Intriguing enough to justify further study, using the score to select therapy, and then seeing if there is a difference in survival, but not intriguing enough to justify the widespread use of a very expensive ($3700) test, not always covered by insurance, to make clinical decisions today. Furthermore, one of the independent attempts to validate this panel of genes and the recurrence score, done at MD Anderson Cancer Center, did not show a relationship between the genes selected and the recurrence score.

The test was validated by “predicting the past”, looking at a set of genes that happened to occur frequently in a population and seeing how patients who had these genes did. We don’t even really know if the 16 genes that were selected are the most important ones, since there was nothing but observation used to choose them. There is absolutely no proven value in using Oncotype DX to select particular drugs and, at best, the test has limited utility in giving us one more possible “tie-breaker” to add to other information we have about a tumor that has mixed messages in its prognostic features. Prospective trials, where treatments are chosen on the basis of a particular set of genes and a survival benefit demonstrated, are now underway, and if they show a benefit, they will be the gold standard. There is also a competing 70-gene product called Mammaprint which is also undergoing prospective trials, so Genomic Health is working very aggressively to try to make clinicians think that OncotypeDX is the final word!

What should you do now? The main question is whether your case already has enough traditional indicators making the treatment decision very clear without the test. One of the features of the test is that we know from other studies that tumor size itself, and other features, are also important independent predictors of recurrence. Many will, and getting the Oncotype Dx test, if it is ultimately proven to be inaccurate, may actually lead to wrong decisions about your care. The next question is whether you fit the criteria for the test. Clinicians, faced with tough decisions, are already extending the use of the test beyond the categories of patients that Genomic Health has validated it for, even retrospectively. While this is tempting, and even I have fallen into this temptation, the results have to be viewed extremely skeptically, as there is not even retrospective validation for these patients. For instance, many patients who are considered “node positive” now are classified on the basis of the scrutiny of the sentinel node, which was not available in the 1980s. It can be surmised that some proportion of those women would have been node positive if sentinel node technology had been available. If the genes selected are in fact the correct list of genes, then the Oncotype Dx test may have value in looking at tumors with a small metastasis in a sentinel node, especially if there are other confusing factors, such as low tumor grade and favorable markers. If the criteria for the test are to be used rigidly, then we would have to use it only for patients whom we plan to treat with tamoxifen, and yet it is used for women where aromatase inhibitors are planned. Third, if you and your doctor want to do the test, and have thought through what you will do differently depending on the results, be sure that you get insurance approval with a promise to pay before the test is ordered. If the cost to you is minimal, it may be worth getting the information, but it is not yet proven to be so great that it justifies a large out-of-pocket expense. It is worth noting that the price is not based on the cost of doing the test, but on the value that the developers put on the test should it be proven to be accurate. It is true that it is worth at least $3700 if it saves anyone from getting chemotherapy unnecessarily, but it is not well-developed enough yet to make this claim, since we are not yet sure that it is that good. Also, our only response at this time to a high “recurrence score” is chemotherapy, but until the prospective trials are done, we won’t really know if chemotherapy does indeed reduce recurrence in patients with this particular gene pattern in the tumor. We are doing the only thing we can think of to do, and it sounds logical, yet we have no proof at all that it is the right thing to do.

Anyone who studied the “Scientific Method” in high school, or who entered a science fair, knows that the first step is observation, the second is formation of a hypothesis, and the third is testing the hypothesis. The developers of the Oncotype Dx test, and the other multi-gene tests, have made a hypothesis that they have found the right genes that do indeed predict who will benefit from chemotherapy, and who will not. The trouble is that that hypothesis has not yet been tested. The only way to do this is to use the test to make decisions about treatment in a randomized prospective study to see if it works. Those trials are under way, but not ready yet. The product being sold now depends on assuming that the hypothesis is correct, so predicting the outcome of the prospective trial before it has been completed. Until those trials are completed, I will remain skeptical, since the requirements of the scientific method have not yet been fulfilled, and scientific endeavors show many hypotheses that sounded great, so great that they

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 McKinleyville Office Supply
Meadow’s Café
Metro
Moonstone Grill
Northern Mountain Supply
Northtown Books
Old Town Chocolates
Pacific Paper
Pierson Building Center
Plaza Design
Plaza Grill
Plaza Shoes
Power 96.3
Ramones
Renata’s Creperie
Rita’s Taqueria
Rivendell Emporium
Sacred Grounds
Scrapers Edge
Six Rivers Brewery
Spa at Personal Choice
Stars Hamburgers
Sudden Link
Times Standard
Tomo
Woodrose Café

A grateful thank you to Carol and Richard Greaney, MD, for their generous underwriting of our support group program in 2007.

Thank you to our grantors:
California Breast Cancer Research Program
California Endowment
California Wellness Foundation
Humboldt Area Foundation

Richard and Emily Levin Foundation
Mel and Grace McClean Foundation
Safeway Foundation
St. Joseph’s Hospital Foundation
Union Labor Health Foundation
We're Forever Grateful to our Contributors

With deep gratitude and appreciation, we thank the following individuals who have made contributions to the Humboldt Community Breast Health Project from July 15, 2006 through November 20, 2006.

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With deep gratitude and appreciation, we thank the following businesses who have made contributions to the Humboldt Community Breast Health Project from July 15, 2006 through November 20, 2006.

Aalfs, Evans & Company
Arcata Bay Llamas
Barnes Arcata Family Drug
Baroni Designs
Blue Lake Casino
Caravan of Dreams
Finnish Country Sauna and Tubs
GAP Foundation
Humboldt Fasteners
Humboldt Water Resources
Mad River Gardens
Murphy's Market, Sunny Brac
North Coast Co-op
Pacific Memorial Anesthesia Care Inc.
Pacific Rim Noodle House
Wildwood Music

In Honor
Included in the lists of individual and business owners are donations made in the beloved memory of Phyllis Ericson and Michele Dern and to honor the 50th birthday of Charlynn Johnson.
Calendar of Programs & Events

All HCBHP programs are free of charge.

Arcata Breast Cancer Support Group
1st & 3rd Thursdays of the month, 6:00-7:30 p.m.

Fortuna Breast Cancer Support Group
1st Saturday of the month, 10:00-11:30 a.m.

Advanced Disease Support Group
Fridays, 11:00-12:30 p.m.

Gynecologic Cancer Support Group
2nd & 4th Tuesdays, 3:00-4:30 p.m.

The meeting times of these groups may change. Please call (707) 825-8345 to confirm or to add your name to our support group reminder call list. All groups are held at the Project office except the Fortuna Support Group.

Save the Dates!

MD Open House
January 4, 2007, 5:00-6:00 p.m.
Hosted by Luther Cobb, MD, Surgeon, MRCH
March 1, 2007, 5:00-6:00 p.m.
Hosted by Phil Vogelsang, MD, Pathologist, MRCH

Amazon Writers
3rd session begins February 2007

2007 Benefit Raffle
Ticket sales will begin in late February 2007

Art Show Opening Reception
March 4, 2007, 1:00-6:00 p.m.
Westhaven Center for the Arts

WeCAN
7th Annual Women’s Cancer Advocacy Network Training
Saturday, March 24, 2007

January is National Cervical Cancer Awareness Month

HCBHP Tidbits

Consultation Planning (CP)
After your appointment with your doctor, have you felt: you forgot to ask all your questions; you lost your train of thought during the medical visit; or your fears or feelings interfered with your ability to ask questions or voice concerns? If so, a CP session can help you organize your questions and concerns to discuss with your doctor. Please call the office for more information.

Lending Library
Our library offers the latest books, tapes, and videos on western and complementary medicine to help breast cancer survivors and their families and friends.

Another Way to Donate
The Project has established an endowment fund at the Humboldt Area Foundation. This is a great way to contribute toward our long-term sustainability. For more information, call Dawn at (707) 825-8345.

Inflammatory Breast Cancer...continued from page 6

In November a new IBC clinic & research program opened at MD Anderson at the University of Texas in Houston. It is their hope to find better treatments and a blood test that diagnoses IBC. The clinic’s first priority, beyond treating IBC, is creating a collection of blood and tissue samples from IBC patients worldwide, and so they are looking for patients with IBC (see http://www.mdanderson.org/diseases/breastcancer/ and click on “inflammatory breast cancer” for contact info).

Individualized Decisions...continued from page 8

were put into practice based on the hypothesis, but were found to be untrue when rigorously tested (like bone marrow transplants). The tests will still be ordered, and the results used in the meantime, but I think it is important to have clarity in where we are in the process of validating this test. It has not yet been proven to do what it is hypothesized to do. We hope that someday it will.

So stand by! Even though this test isn’t all that we need now, it possibly will prove to be a next step in letting us know more about the biochemical capability and susceptibility of individual cancer cells based on their DNA, and that is the way the field is moving. The tests we really need to help us choose proper treatments and to help us know which tumors are particularly dangerous to your long term health are coming. They just aren’t proven to be here yet.
We Need to Hear from You!

The HCBHP needs to hear from you! In an effort to reduce waste, we are streamlining the distribution of our newsletter by removing people we have not had recent contact with and by adding the option of an electronic version of the newsletter.

If you are in our active volunteer, client or donor databases, you will continue to receive the printed newsletter unless you tell us otherwise.

If you are not an active volunteer, client or donor, please respond by February 28, 2007 in order to remain on the mailing list.

Please respond via one of the following methods:

1) Calling our office at (707) 825-8345.
2) Sending an e-mail to newsletter@hcbhp.org.
3) Mailing this completed form to:
   Humboldt Community Breast Health Project
   987 8th Street
   Arcata, CA 95521

Name: __________________________
Address: ________________________
Phone: __________________________
E-mail: _________________________

Check one:  ☐ Electronic Newsletter
           ☐ Print Newsletter

We are happy to continue provide newsletters free of charge to any interested community member, and a reply by February 28, 2007 will keep you on the list.

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Humboldt Community
Breast Health Project
987 8th Street
Arcata, CA 95521
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Toll-free: (877) 422-4776
FAX: (707) 825-8384
www.hcbhp.org

HCBHP Hours:
Monday-Friday
9 a.m. - 2 p.m.
Evenings by appointment

If you do not want to receive future newsletter issues, please call or e-mail office@hcbhp.org.