January 2008

Call of the Amazons

Humboldt Community Breast Health Project

Volume 9, Issue 1

Personalized Cancer Medicine:

Challenges and Opportunities in Breast Cancer Therapy in 2007 and Beyond

by Uma Suryadevara, MD, Eureka Internal Medicine

Breast cancer is NOT one disease. All breast cancers are not created equal, therefore should not be treated the same. This was the take-home message from this last American Society of Clinical Oncology (ASCO) annual meeting and Breast Cancer Symposium conducted in San Francisco, September 2007.

While cancer research is generally moving away from empiricism, focusing toward individualization of therapy, it is especially true with breast cancer treatments. There is known variability (heterogeneity) between tumors but also within the tumor. Breast cancers are classified by the routine IHC staining and histologic grading by pathology into different biologic subtypes including HER-2neu over expresser, ER (estrogen) positive or negative, PR (progesterone) positive or negative, and high or low grade. It is also shown for a tumor to exhibit this variation internally within the patient. For example, there may be some areas of both high grade along with low grade in the same tumor. Traditionally patient and tumor pathologic information including the ER/PR status, Her-2neu status, histologic grade, tumor size, number of lymph nodes involved, age, and comorbidities are taken into account by medical oncologists to recommend additional chemo-therapy for tumors that are not considered either hormone sensitive or felt to have a recurrence risk high enough to justify the added toxicities from the combination of chemotherapy with an anti-estrogen agent. This is an over-simplification of the treatment decision process for early stage breast cancer. The reality is that the

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National Cervical Cancer Awareness Month

Free Pap tests from Jan. 14-18!

In recognition of January as National Cervical Cancer Awareness Month, the Open Door Community Health Centers will for the fourth year be offering free Pap tests at their six Humboldt and Del Norte county locations. Women will be enrolled for financial assistance through the Cancer Detection Program or Family Planning if eligible. Those who do not qualify will receive a Pap test at no cost. The results of the Pap test will be sent to the woman's primary care physician, and follow-up will be done by the clinic staff for women who do not have a primary care physician.

Pap tests free of charge may be scheduled for the week of January 14-18, 2007, by calling one of the following locations:

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

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

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

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

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

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

From the Director by Dawn Elsbree

Change and opportunity are again on the schedule for the coming year at the Breast Health Project. New funding from the Mel and Grace McLean Foundation will allow us to develop a comprehensive wigs and prosthetics program for our clients. We will also be exploring avenues for creating healing through the arts programs and for integrating digital storytelling into our client services program. Above all, we remain committed to ensuring that all women in our community receive equal access to excellent health care with regard to their breast or gynecologic cancer concerns. We continue to build a strong outreach program designed to reach the underserved women of Humboldt County and are able to provide translation and interpretation services for Latina clients who are not English speakers.

Recently a letter from a client came across my desk. Her heartfelt handwritten words made us all feel once again the value in what the Project provides. Her story highlights both the circle of support we provide, and the empowerment women feel when they can continue their healing through volunteering to help others. This is part of her letter:

"I received a call from the hospital telling me they found something on my mammogram. That something turned out to be cancer. I was really scared and was referred to HCBHP where I met Sharon Nelson. My daughter and Sharon were such a big help to me. Sharon helped me in answering all my questions and in letting me know what to expect. The day I went in for the biopsy, Sharon brought me a pair of socks. It was the nicest thing someone could do. I wore the socks there and I still wear them now. After my radiation treatments, I wanted to give back for all that was done for me so I volunteered to sew socks. I have been sewing socks now for two years." Betty Drake.

We have come a long way since our beginning at Julie's kitchen table ten years ago, and we have lofty goals and aspirations for our future. In 2008 we hope to hire a volunteer coordinator to fully utilize the skills and enthusiasm of our hundreds of volunteers. We envision owning our own building some day with room to provide more on-site programs and make our support groups more comfortable.

In the midst of all this change, looking back to see where we started and looking forward to see where we plan to go, I have to report that I will be leaving the Breast Health Project after five wonderful years. It is with great regret, sadness and hope that I resign from my position as Executive Director. The Breast Health Project has grown in positive and productive ways, but its needs are way beyond the kind of part-time work I had originally wanted in my life while raising three children.

The Board and I see this as an opportunity to bring in a new person who can commit to full-time leadership and bring the Project through the next phase of development. I am working with the Board and the staff to ensure a smooth transition and will remain until we have that accomplished. The Breast Health Project is a magical place and some lucky person will become our new Director. Thank you to everyone who has been so supportive of both the mission and me personally over the last five years – your warmth and caring has been the best part of a rewarding job. ❖

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, grassroots 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.

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It's Raffle Time

Well, here we go again! It's almost raffle time, when several hundred volunteers join the effort to make our largest fundraiser a success.

Four fabulous vacation prizes are being offered. This year, for the first time, three of the trips include airfare, along with the accommodations, for two. Trips to France, Hawaii, and Mexico should entice ticket buyers. How often would you get a chance to live in a castle in Normandy, explore a bed and breakfast organic farm on Kauai, or have endless sun and surf in Sayulita on Mexico's Pacific Coast? If you miss the first three, there's a backup adventure: a tree-house cottage in the redwoods of Carlotta.

The raffle committee is seeking your ideas on how/where we can reach more people to increase ticket sales and insure the Project's future. Contact Dawn at dawne@hchbp.org if you have ideas or would like to participate. We really need your help to succeed. ❖

Margot Julian, RN

In January 2004, I learned I had breast cancer and I became a client at the Humboldt Community Breast Health Project. The staff and volunteers at the Project gave me support all through my cancer journey. When I was able, I joined the Project as a volunteer so that I could pass on to others some of what I learned here. Now as an employee, I can take that even further. My one-word description of myself is "teacher." Teaching has been a vital part of my many life roles: parent, nurse manager, welfare worker, retail storeowner, clerical worker, cancer survivor, different nursing and teaching positions and now Client Services Coordinator here at the Project. Information is one of the best tools we can use and information is one of the main services the Project provides.

Margot Julian, RN

I am happy to join the staff at HCBHP helping people cope with cancer. I am also a self-employed nurse consultant working with a number of local health-related organizations. My husband and I live in Eureka. I have four grandchildren, a grown daughter in Arcata and a grown son in Torrance. ❖

New Client Binders

Good ideas are always percolating at the Breast Health Project, and sometimes one comes to reality that makes us say: "Why'd it take so long?" The New Client Binder is one of those ideas whose time has finally come.

Knowing how important it can be, we encourage newly diagnosed clients to gather their medical information together. Pathology reports and imaging studies find their way into bags, files, purses, or the back seat of the family car. To the uninitiated, the act of acquiring the information, and understanding it, is very powerful. To the inexperienced however, it can also be overwhelming and so years ago we started encouraging women to organize their information into a three ring binder. Contained, portable and expandable, a binder channels the tide of medical information into a manageable unit at a time when the rest of life does not seem so simple.

One day, it dawned on us to stop encouraging and start giving out the binder

Great advice. And then one day this summer, it dawned on us to stop encouraging and start giving out the binder. Sharon Nelson, Director of Client Services, flipped the switch on this light bulb and with Bet Pinkerton doing some legwork a prototype binder was made. Complete with pre-labeled dividers, blank paper and a pen, the binders not only provide the container, but the organization born of experience. In addition to sections that confine medical information, there are also sections to orchestrate bills and physician communication.

The binders will continue to be a work in progress as we fine-tune the contents but the true value became apparent immediately. It turns out that the binder is not just a gift of organization; to many women it represents the ability to contain cancer, to make manageable what is unthinkable and to make do-able what seems insurmountable. The true gift is the gift of empowerment. And at the Breast Health Project, to give is to receive.

As are all the client services at the Project, there is no charge for the binders. ❖

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HSU Student Nurse Intern Program

Carolina Gastman completed her Community Health internship at HCBHP in November. Carolina came to the Project as the mother of two grown sons. Before entering the HSU nursing program she had a career as an airline stewardess.

Carolina Gastman

Carolina has a long standing interest in breast cancer as the result of her family's experience with the disease. Two of Carolina's cousins died of breast cancer. Eventually an older sister was diagnosed and is now a five-year survivor. Carolina felt that doing an internship at HCBHP would give her the chance to become informed and to confront her fears about the disease.

While at the Project, Carolina contributed a great deal not only to our clients, volunteers and staff but also to the community as she involved herself in outreach to both Latina and Native American women. Carolina expects to graduate this May and is considering a career in oncology nursing. We wish her the very best! ❖

Volunteer Voices: Jean Wichelman

Jean Wichelman brings to her volunteer work an enthusiasm and professionalism that is not unusual at the Project. Not only has she been a dedicated member of our Board of Directors, but she also helps with fundraising, brainstorming, baking, tabling and so much more.

Jean Wichelman

Jean's favorite times, though, are when she warmlines at the front desk. "Sometimes, it's only that you've listened. It's the ability to know that you've helped people." She enjoys creating calm and coherence on part of a difficult journey. One day while Jean was warmlining, a woman came in who had recently had a mastectomy. Jean helped the woman find the correct prosthetic bra. She understood the difficulty of losing a breast because of her own experience of having a mastectomy eleven years ago. On her way out the door, wearing her new prosthetic breast, the woman had her head held high. From her own experience Jean knew how reassuring the effect would be.

Fortunately for the Breast Health Project, Jean's world of experience has led her to successfully oversee the Fall Concert, which regularly raises $10,000. She gives credit to the concert committee and appreciates how everyone comes together on the day of the concert to ensure a smooth performance and reception. Jean especially enjoys singing along with the finale, *You'll Never Walk Alone*.

When she's not at the Project, Jean likes to cross-stitch and watch the variety of birds that come by her house. She looks forward to traveling to England to see her family and she is also a fabulous chef. Her many talents have been given to the Project in so many ways. We are ever grateful! ❖

Amazon Writers: Selected Writings

Amazon Writers meets on the second and fourth Wednesdays of the month from 2:00 to 4:00 p.m. No experience is necessary! Please contact Carolyn Ortenburger for more information at (707) 825-8345, ext. 135, or carolyno@hcbhp.org.

Falling down into my grandmother's arms

by Sheba Goldstein

Some days
I'm falling like Alice
Deep down into the great tunnels of darkness
Deep into the very roots of the tree
So many ways to be
I try to grasp at things I've been told
While I fall
I'm learning how to fall
To let go and let life in
I'm learning how to fall
Silently and without fear
I'm learning to unwind as I fall
A gentle floating dance
A sweet gliding back and forth
Like a leaf, free
A gentle warrior
In comes wind, again
Sweeping me away
Reaching and grabbing for hope
Falling and grasping for more things I have been told
Falling and accepting I'm falling
Knowing I'm falling
That we are all falling
Deep down into the roots of life
Back down
Deep into the sweetness and comforts
Of our beginnings ❖

Her Left Foot

by Kay Thornton-Fitts

My father said
look how beautiful her feet are
no matter how sick she got
her feet were beautiful.

Slim ankles, bones prominent
high arch, long slim toes exactly formed
they made a perfect curve
her beautiful feet.
No stories about what it means
if the second toe is longer than the first.

I wonder if he thought of the ring
she wore on her toe
when they were young and wild
on the LaFouche River.
She walking barefoot
red dust floating up her ankles
powdering her skirt hem.

Later she would wear spectator shoes
smell of perfumed dusting powder
seldom go barefoot
and wear no rings.

The LaFouche River faded into their past
but carried their sons to fishing holes
and swimming times.
She wore practical shoes
with laces not unlike her sons' brogans.
Her beautiful feet carried her past their youth,

into the time of putting the feet up,
into times of remembering
the LaFouche River,
telling the story of the ring
on the great toe
of her beautiful left foot. ❖

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Notes on death

by Karin Salzmann

G flat is a black boot.
E has the legs of a bird.
—from *Piano Lessons* by Billy Collins

Synesthesia is a celebration of the senses: one sense overflows into another because there is so much of each, like two very wet watercolors running wild. Like lovers.

And so Maria, ravished by pink, ate the rose.

Death, like birth, runs along the edge of the universe. The world is unmeasured, blurred and — if we know how to look — exquisite. Free. ❖

Skipping Rocks

by Sharon Malm Read

I remember holding my father's hand and walking down to the river to skip rocks. My father was an expert rock skipper.

First, we had to look for flat, smooth rocks. Then he would show me how he did it. He could always make it skip through the water at least 3 times. As a child of 5 or 6 years, it took me quite a few years of practicing before I could do it.

We used to walk along the Mad River and look for rocks. When I was older we had a cabin in Willow Creek where we would spend summers. My Dad would come up on Wednesdays and Saturdays. We were never allowed to go down to the river without an adult. My Dad would take us down to the beach on Thursday and on the weekend. The first thing we would do — after we set up our umbrella and towels — would be to look for smooth rocks for skipping. They had to be the right elliptical shape and smooth to be "good skippers." My first dog was named "Skipper," and my Dad named him before I was born. I remember that there was a picture of a terrier dog — over my crib — that looked just like "Skipper."

It was sort of a rite of passage when I could skip rocks. I was the oldest of five children — so I was the first to learn.

One by one, we all learned to skip rocks. I think my Dad was the proudest when my brother John learned as he was the youngest and the only boy.

And, now — my partner, Michael, has a real passion for agates and rocks. Whenever he comes back from Agate Beach, he has a pocketful of beautiful rocks, as well as agates.

I like to look at them and feel their cool surfaces.

Many things they bring to mind — the smooth rocks. ❖

My Husband's Journey

by Margot Julian, on April 11, 2007

It is the first anniversary of the day I flunked my mammogram. I have been through a lot since that day. I am not expecting to have any more treatment beyond a daily pill for hormone blocking therapy. This will be a time of watchfulness and hope that cancer will not return. I may be healthy (at least for now), but there is a new concern. My husband has had an alarming experience. Later, when the doctor says, "I understand you have some blood in your urine," my husband answers, "Well, I think I had some urine in my blood."

Here we are two weeks later and he is having an ultrasound. I watch the screen and there it is — a large tumor. You do not have to be a radiologist to know that whatever it is, it does not belong there. My husband lies on the table while the technologist passes the wand back and forth over the area. No questions are asked; no impressions given. Later, my husband tells me that he knew then that he had bladder cancer. Ironically, it is the same technologist who did the ultrasound of my breast. The same radiologist will read my husband's ultrasound — and it is the same date.

And so my husband's journey begins. As he goes through two surgeries and two years of immunotherapy, I am by his side feeling helpless and frightened. The tumor turns out to be the size of an orange. The treatment is successful. That terrible time is fading from his memory. But not from mine. This is much harder than living with my own cancer. For the first time in 30 years, I face the possibility that he might die. For now I realize that someday he may be gone and I may be learning to live without his love and support.

At 80, he is 19 years older than I. We have always known what the statistics indicate, but it never seemed <u>real</u> before. We have joked about this. Early in our relationship, he asked if the age difference bothered me. "I can't help but worry some about widowhood," I replied. "Don't worry," he said, "I can always marry again." Now I think about losing him and the possibility feels unbearable. ❖

Mammogram Drawing Success!

In October 2007, the third annual Free Mammogram Drawing enrolled 476 women from Garberville to Hoopa to Crescent City. 36 mammograms were generously donated by Humboldt Radiology Group, Jerold Phelps Community Hospital, Mad River Community Hospital, Redwood Memorial Hospital, St. Joseph Hospital, and Sutter Coast Hospital. All of the winners received a gift basket which included the certificate for a free mammogram at the facility of their choice, as well as hand sewn fleece socks, soap donated by Bubbles, and a packet of literature focused on early detection.

We are grateful to all those who helped make the drawing a success. The poster was original artwork created by Carolyn Ortenburger's sister Teresa. The drawing received a great deal of publicity in the local newspapers (both the Times-Standard and the Eureka Reporter were very generous) as well as on radio and television. The American Cancer Society and HCBHP collaborated to organize the project.

Thank you to all the participating facilities for their generosity. Because the mammogram remains the gold standard in detecting very early breast cancer we appreciate everyone's contributions toward making screening possible for women who might otherwise go without. We are all committed to the goal of decreasing the number of women in our community who are diagnosed with late stage breast cancer. ❖

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process is less accurate, and considerably more complex, and involves areas of grey.

At the 2007 ASCO and Breast Cancer Symposium investigators presented information on various molecular subtypes of breast cancer based on gene expression profiles which seem to better predict the risk of recurrence and likelihood of response to therapies. We are beginning to more accurately characterize these differences in breast cancer subtypes with improved knowledge of the biology of breast cancer. Molecular gene expression based analysis of tumor type (genomics) and protein expression profile (proteomics) help to advance a better understanding of these differences. Also presented was data on pharmacogenomics, which is the science studying individual patient genetic related factors that explain the differences in treatment responses to drug therapies among patients. For example, patients carrying a genetic variant of an enzyme involved in metabolism of the drug Tamoxifen were shown to be more likely to fail the drug therapy. The presence of a genetic variant, or use of certain drugs that interact with the ability of these individuals to metabolize the drug, resulted in those patients being less likely to convert the drug to the active metabolite needed for its efficacy. Correlating with the above, women who experienced more hot flashes as a side effect of Tamoxifen were likely active metabolizers of the drug and had a lower likelihood of recurrence while on Tamoxifen compared to women with fewer incidences of hot flashes. In women treated for early stage breast cancer, noncompliance with Tamoxifen therapy also increased the risk of their experiencing cancer recurrence.

Data is emerging from various clinical studies conducted in the treatment of early stage breast cancer which is beginning to define subgroups of patients that should be treated differently. ER values, for example, seem to predict response to anti estrogen agents, while lack of expression predicts higher likelihood of response to chemotherapy. Her-2neu positivity is known to predict response to Herceptin and also seems to suggest hormone insensitivity as well as added benefit from additional chemotherapy. Presence of Her-2neu positivity and or ER/PR negativity seems to predict higher likelihood of tumor response to the drug Taxol. Over-expression of the enzyme topoisomerase alpha2, detected by protein IHC stain or gene amplification analysis, seems to predict likelihood of response to Adriamycin based chemotherapy. There are however limitations with these types of data. For example, when choosing an optimal taxane agent to treat early stage breast cancer, we do not know how the various dosing schedules, including dose dense approach and weekly administration (both were shown to have differences in efficacy), are influenced by tumor subtype. Most of this information was based on retrospective analysis of subsets of patients in clinical studies. Additional information is needed from ongoing trials tailoring treatment to individual patients and their cancer subtypes. Until then this information is considered by most expert opinion to be suggestive data which is not definitive enough at this time to result in the adaptation of routine clinical practice.

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The gene expression profiles of tumors (molecular prognostic signatures) which predict the clinical outcome in breast cancer are felt to outperform the current clinical-pathologic parameters for treatment decision making. Problems with this approach include their availability and the presence of more than one gene expression profile such as the 76 gene, the 70 gene (Mammaprint), and the 21 gene recurrence score (Oncotype DX assay). Most are considered preliminary, while some such as Oncotype DX, and Mammaprint, which were developed early on, are being validated in clinical studies. These genomic risk models seem to categorize tumors with improved accuracy into low risk tumors that are hormone sensitive and treated with anti estrogen therapy alone, versus high risk tumors that require systemic chemotherapy as well as hormonal therapy resulting in risk reduction.

Clinical risk assessment models utilizing conventional clinical pathologic risk factors like Adjuvant! Online (which is well validated in clinical studies for its predictive capabilities and often used by medical oncologists in risk assessments) often but **not** always, correlate with genomic risk assessment. In ER positive and node negative tumors about 40% of the time patients are reported with results of intermediate risk for recurrence on Oncotype DX assay and similarly about 30% discordance was found based on clinical risk assessment compared to genomic risk assessment using 70 gene expression profile (Mammaprint). There are two ongoing, well-awaited, phase 3 prospective clinical trials — TAILOR Rx and MINDACT studies — randomizing patients with intermediate risk recurrence score (TAILOR Rx) in ER positive, node negative patients to hormonal therapy alone versus chemotherapy added to hormonal therapy. The trial is evaluating the added benefit to reduction in risk of recurrence as well as death from breast cancer. Similarly, patients in the MINDACT trial are randomized to chemotherapy or no chemotherapy based on their discordant clinical or genomic risk assessments. Patients in both trials in the non randomized arm receive hormonal therapy alone for tumors classified as low risk by both models (Adjuvant! Online and genomic risk) and combination with chemotherapy for high risk tumors classified by clinical and gene expression profile.

The take-home message for patients is that risk assessments tend to vary between breast cancer specialists regarding the models used to predict risk. It is important to put risk into perspective and know your personal comfort zone. Risk predictions quote statistics which apply to groups of individuals. Where an individual falls on a statistical curve is often hard to predict with accuracy. What is feasible today with gene expression profile of tumors, including predicting risk of recurrence, and chemotherapy or hormonal (anti estrogen) sensitivity or resistance, still needs validation from ongoing clinical studies with prospective follow up for long term outcomes before becoming routine standard of care. It is expected that medical oncologists treating breast cancer in the future will integrate information from genomics, proteomics, modern imaging, tumor pathology, information about micro metastasis (by detecting circulating tumor cells) as well as patient factors including pharmacogenomics for making informed treatment decisions. This approach will move clinical practice in the direction of individualized medicine.

The take-home message for patients is that risk assessments tend to vary between breast cancer specialists regarding the models used to predict risk

Other highlights at these meetings included the updated results of Herceptin therapy combined with chemotherapy in patients with HER-2neu positive tumors in early stage breast cancer. Investigators reported on long term follow up data showing continued benefit with Herceptin (reduced the risk of recurrence by 52% and the risk of death by 35%) of similar magnitude to the early trial results. Also the cardiac risk associated with Herceptin usage of about 3.8%, as reported in preliminary results, was noted to level off after one year. Clinical risk factors identified as predictive of increased risk for cardiac toxicity included age, low baseline cardiac function as measured by an echocardiogram, or history of hypertension. Recommendations were for regular monitoring of cardiac function at least once every three months during therapy. In patients with asymptomatic decrease in cardiac function on therapy, most were able to recover their cardiac function on repeat testing off therapy. Patients with confirmed congestive heart failure are more likely to remain on cardiac medications.

Newer biologic agents targeting the Her-2neu protein such as oral dual Her-1 and Her-2 receptor inhibitor Lapatinib (also called Tykerb) was shown to have activity in treating patients with advanced breast cancer with brain metastasis, post radiation, who had progressed while on therapy with Herceptin. Lapatinib has unknown efficacy in tumors that are Her-2neu negative. Lapatinib is currently only FDA approved for tumors that are Her-2neu

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positive. Other agents targeting VEGF pathway as frontline treatment for advanced breast cancer, such as Avastin in combination with chemotherapy, were presented with increased response rates and duration. The benefits were more noticeable in tumors that were ER positive compared to ER negative. Currently both Avastin and Lapatinib are being tested in combination with chemotherapy in early stage breast cancer patients.

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In these last annual meetings data was presented on many gynecologic malignancies including ovarian, uterine, and cervical cancers. In ovarian cancer a study reported looking at the role of maintenance/consolidation chemotherapy with additional courses of chemotherapy following the standard six to eight cycles of chemotherapy for treatment of ovarian cancer following an optimal debulking surgery. This study failed to show a survival advantage (with a modest improvement in progression free survival) with the trade off of increased risk for toxicities. Various new targeted agents being evaluated for overcoming platinum resistance and chemo refractoriness in advanced stage ovarian cancer were presented, of which none appear ready for prime time use outside clinical trials. Some preliminary data presented during these meetings evaluating the role of systemic chemotherapy in high risk early stage endometrial cancer after surgical resection randomized patients to radiation therapy alone versus four cycles of chemotherapy followed by radiation. The results seem to suggest improvement in survival in patients able to receive both modalities.

Cervical cancer was reported as still one of the deadliest cancers worldwide despite the availability of screening tests that are proven effective in decreasing cancer related deaths. HPV, human papilloma virus, has been shown to cause 99.7% of cervical cancers. The most common are HPV 16, 18. HPV is also associated with other cancer types including oropharyngeal cancers, anal, vulvar and vaginal cancers. Annually 600,000 cases of HPV associated cancers are reported worldwide. About 274,000 deaths occur from cervical cancer mostly in developing countries. Prevention is crucial for elimination of this deadly disease. Investigators at the 2007 ASCO meeting updated the current status of vaccines for the prevention of HPV infection. Vaccine data in early human studies was presented targeting HPV in the treatment of established precancerous and invasive cervical cancer. In June of 2006 the FDA approved a quadrivalent vaccine, Gardisil for prevention of HPV infection against HPV 6, 11, 16, 18 which is responsible for causing 90% of genital warts and 70% of invasive cervical cancer. It is approved for females aged 9-26 and was shown to be effective in preventing 100% of anogenital warts, cervical, vaginal and vulvar precancerous lesions, and invasive cancer. The vaccine is made up of virus like particles which are pure proteins with no HPV DNA present and is considered highly immunogenic and completely noninfectious, and with no preservative eliminating the risk of idiosyncratic reactions associated with vaccination. Updated reports suggest cross protection offered by the vaccine against other HPV types. Another bivalent HPV vaccine approved in May 2007 called Cervarix is not yet available in the US. It is currently approved in Australia for prevention of precancerous and invasive cervical cancer.

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People Living With Cancer (www.plwc.org) is a website designed by ASCO for patients, caregivers and cancer survivors to provide up to date information on more than 120 cancers, including breast cancer. Additional information from all ASCO sponsored meetings can be obtained at this site including cutting edge cancer research news and patient friendly guides based on ASCO's clinical practice guidelines for physicians. Topics include follow up care after completion of breast cancer therapy, the role of imaging such as PET, and the role of tumor markers in cancer surveillance. It also has excellent resources for information concerning coping with the fear of side effects before treatment, coping with a cancer diagnosis, risk of recurrence, survivorship, and the management of side effects from therapy, as well as drug information and information about clinical trials. The site recently added a monthly ASCO expert corner, featuring nationally recognized experts on various topics reviewing frequently asked questions. Information is also available in Spanish translation. A monthly e-newsletter updates the latest headlines in cancer news. ❖

People Living With Cancer (www.plwc.org) is a website that provides up-to-date information on more than 120 cancers

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 28, 2007 through November 29, 2007.

Please notify us of any errors.

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In Memory

The following individuals and organizations donated in loving memory of Maria Carrillo:

Debbie & Jim Barnes
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With deep gratitude and appreciation, we thank the following businesses and service organizations who made contributions to HCBHP from July 28, 2007 through November 29, 2007.

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Calendar of Programs & Events

All HCBHP programs are free of charge.

Support Groups

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.

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

Advanced Disease Support Group
For those living with Stage 4 disease
Mondays, 11:00 a.m.-1:00 p.m.

Guys' Night Support Group
For men whose partners have cancer
1st and 3rd Mondays of the month, 6:00-7:30 p.m.

Amazon Writers
For those interested in writing about their cancer journey
2nd & 4th Wednesdays of the month, 2:00-4:00 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.

Special Events

Face to Face
(formerly called MD Open House)
January 3, 2008, 5:00-6:00 p.m. at HCBHP
Hosted by Julie Ohnemus, MD,
HCBHP Founder & Medical Consultant

2008 Benefit Raffle
Ticket sales will begin in February 2008

WeCAN (Women's Cancer Advocacy Network)
8th annual seminar for volunteers & community
(CE credits available)
Saturday, April 5, 2008

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January is National Cervical Cancer Awareness Month

Humboldt Community
Breast Health Project

987 8th Street
Arcata, CA 95521
(707) 825-8345 phone
(877) 422-4776 toll-free
(707) 825-8384 fax
www.hcbhp.org

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

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

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