

# Upfront U Kaiora

OFFERING INFORMATION, HOPE AND INSPIRATION TO THOSE AFFECTED BY BREAST CANCER

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## IODINE Does it have a role in Breast Cancer?

BY SUE CLARIDGE

To date the exact role of diet in the prevention or development of breast cancer has been elusive. In general, the research on the impact of diet on either reducing or raising the risk of the disease has been, at best, contradictory. While it would be nice to be able to say eat this sort or that sort of diet, science has so far not come up with a “magic diet” for preventing breast cancer.

Increasingly, research is showing that there is an overall benefit derived from eating more fruits and vegetables, but the jury is still out on the role of fats, dairy and meat. However, the research on a handful of specific nutrients and plant derived compounds is less equivocal.

For example, curcumin, found in turmeric, has been found to cause programmed cell death (apoptosis) in a variety of tumours, including breast cancer. Brassicas (broccoli, cabbage, cauliflower, mustard and kale) also contain a compound that inhibits tumour cell growth and causes cell death.

The role of Vitamin D in prevention is under scrutiny as evidence of a connection mounts, and the mineral selenium is also believed to influence the development of cancer with a higher incidence of cancer in people who are selenium deficient (see *Upfront* 75, pg 8). Another mineral which research suggests may have a role in breast health, and the development of breast cancer, is iodine.

### IODINE

Iodine is most abundant in seawater, and sea plants and animals, but large areas of the Earth's surface materials (rocks and soil) are devoid of the mineral. Iodine and its compounds are primarily used in medicine, photography, and dyes. Many readers will remember from childhood the bottle of

iodine in the medicine cabinet; the liquid was used as an antiseptic, and today iodine is the main ingredient in the over-the-counter Betadine® range of antiseptic products.

Iodine is an essential trace element and is critical in the manufacture of thyroid hormones T4 (thyroxine) and T3 (triiodothyronine). Through these hormones, iodine is responsible for regulating energy and metabolism and controlling cholesterol levels. Iodine also protects us to some degree from the harmful effects of radiation.

Too little iodine can cause hypothyroidism (thyroid deficiency); conversely, too much iodine can also cause low thyroid function. Iodine deficiency is also the leading cause of preventable mental retardation, particularly in children.

New Zealand soils have low iodine content, and in the late 19th and early 20th centuries iodine deficiencies were common. In 1924, iodine was added to salt to ensure sufficient dietary intake. However, decades of “low-salt” messages from the health sector has led to the re-emergence of iodine deficiency in this country, and goitre and hypothyroidism has become much more prevalent in the western world. Research published in the late 1990s found that in the US there had been a “sharp decline in iodine intake during the last 20 years, especially in women of reproductive age”<sup>1</sup> and that median urinary concentrations (the standard way of measuring iodine sufficiency or deficiency) of iodine decreased more than 50% between 1971-1974 and 1988-1994.

Other than iodised salt, which for most people is the main dietary source of iodine, seaweed, seafood, eggs and pumpkin are the best food sources of iodine.



### IODINE AND FIBROCYSTIC BREAST DISEASE

The breast concentrates iodine to a greater degree than the thyroid gland and breast milk contains four times as much iodine as thyroid tissue.<sup>2</sup> This is a vital mechanism that ensures that the newborn baby receives adequate iodine to meet his or her neurodevelopmental needs and for proper thyroid function.\*

Studies by Eskin and Ghent et al., have shown that iodine deficiency in rats leads to abnormal cell growth in mammary tissue (hyperplasia). In 1993, they and their colleagues published the results of a study using different forms of iodine\*\* to treat fibrocystic breast disease; they found that molecular iodine was effective and had significantly fewer side-effects compared with other forms.<sup>3</sup> Between 65 and 70 percent of the 276 participants given molecular iodine showed improvement in their symptoms.

In 2004, Dr Jack Kessler reported, in *The Breast Journal*, on a randomised, double-blind, placebo-controlled, clinical trial involving 111 women with a history of breast pain and fibrosis involving at least 25% of both breast surfaces.<sup>4</sup> Participants received either a placebo or molecular iodine at 1.5, 3.0 mg or 6.0 mg per day for six months. The women on

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3.0 and 6.0 mg per day recorded significant decreases in pain by the third month, and physicians assessed breast pain, tenderness, and nodularity each cycle, finding a reduction in symptoms in the same women at five months. More than 50 percent of the 6.0 mg per day treatment group recorded a clinically significant reduction in overall pain.

#### **BREAST CANCER**

I first became aware of a possible link between breast cancer and iodine when talking to women about their breast cancer experiences. I came across a surprising number of women who also had thyroid issues: cancer of the thyroid, enlarged thyroid gland or hypothyroidism.

Women in Japan have a lower incidence of breast cancer than in the US and Europe: according to the Cancer Incidence in Five Continents Vol. IX, IARC 2007 Japan's breast cancer incidence is 37 women per 100,000† of population while in the US it is 92, Canada 79, and the UK 82.<sup>5</sup> In Australia it is 84 and in New Zealand it is 86 per 100,000.

Japan also has lower rates of thyroid conditions<sup>2</sup> and daily iodine intake is as much as 25 times higher than in the US<sup>6</sup> (and probably New Zealand as we have similar diets and iodine deficient soils), and Dr Stephen Cann and colleagues in Canada have hypothesised that the higher iodine intake "may be associated with the low incidence of benign and malignant breast disease in Japanese women."<sup>6</sup>

US naturopathic doctor and contributing editor of the *journal Alternative Medicine Review*, Lyn Patrick, writes that "data on the link between breast cancer and thyroid disease is unclear, with some studies clearly showing an increased incidence of hypothyroidism and autoimmunity in breast cancer patients, while other studies show no significant association,"<sup>2</sup> although the link between the thyroid conditions and breast cancer was hypothesised as long ago as 1896.<sup>7</sup>

However, the link between iodine and the proliferation of malignant breast cells is stronger, indicating a possible role for iodine in the prevention or treatment of breast cancer.

In 1995 Eskin et al. wrote that iodine deficiency causes atypical tissue and physiologic

changes in mammary glands and found that lobular cell growth in rats mammary glands decreased with the administration of molecular iodine.<sup>8</sup> Kilbane et al., found that tissue iodine levels were relatively low in patients with breast cancer as compared with normal tissues or benign breast tumours (fibroadenomata).<sup>9</sup>

A number of studies have found that administration of iodine suppresses mammary tumours,<sup>10, 11</sup> inhibits tumour growth<sup>12</sup> or causes cell death in rat mammary tumours.<sup>13</sup> In 2005, Garcia-Solis and colleagues found that rats treated with molecular iodine which then had mammary cancers induced "exhibited a strong and persistent reduction in mammary cancer incidence (30%) compared to controls (72.7%)."<sup>14</sup>

In 2008 Dr Frederick Stoddard and colleagues from Drexel University College of Medicine in Philadelphia, wrote that while the "molecular mechanisms responsible have not been identified laboratory evidence suggests that iodine may inhibit cancer promotion through modulation of the oestrogen pathway."<sup>15</sup> They conclude that their work "suggests that iodine/iodide may be useful as an adjuvant therapy in the pharmacologic manipulation of the oestrogen pathway in women with breast cancer."

As with many other toxicities, environmental exposures or nutrient deficiencies, there is currently insufficient data to prove a causative relationship between iodine deficiency and breast cancer, or to confirm iodine therapy as a treatment for breast cancer. However, as Lyn Patrick writes, "animal studies using iodine as a therapeutic intervention in breast cancer have created an opportunity to investigate this therapy in human breast cancer trials."<sup>2</sup>

#### **CONCLUSIONS**

Iodine deficiency is clearly a problem in New Zealand, one that worries our health agencies sufficiently to consider mass medication through fortifying processed food with iodine (other than salt) as it has done with folate in bread. However, this concern does not extend to the impact of iodine deficiency on breast health.

Other than ensuring adequate dietary iodine intake through the consumption of

seafood, eggs and pumpkin, women should not self-medicate with iodine as toxicity is also harmful. Women concerned about their iodine status should seek advice from their health practitioner. Twenty-four hour urinary iodine challenge tests can quickly evaluate your iodine status. Your doctor is also likely to evaluate your thyroid function at the same time, as iodine status is critical to the correct functioning of your thyroid and production of thyroid hormones.

Although lack of iodine is unlikely to be the only cause of breast disease, for women with a history of fibrocystic breast disease or breast pain, and for women who are tested and found to be iodine deficient, there seems to be reasonable evidence that correcting the deficiency may help protect them from breast cancer.

\* if the maternal diet is deficient either during pregnancy or lactation, the baby can suffer mental retardation.

\*\* Iodine is found in nature in various forms: inorganic sodium and potassium salts (iodides and iodates), inorganic diatomic iodine (molecular iodine or I<sub>2</sub>), and organic monoatomic iodine.

† age-standardised

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### From the Editor....

It is always hard for charities to manage financially and it got a whole lot harder in 2008 with the international recession. Even many previously profitable businesses will struggle and some won't survive the downturn. So when an opportunity to fundraise arises, most charities will grab it quick before it fades. However, some fundraising opportunities present moral or ethical dilemmas.

You wouldn't expect a lung cancer charity to promote cigarettes or take money from a tobacco company. But it is not always so obvious that a fundraising opportunity will actually be sending the wrong messages. For example, if you take sponsorship from a pharmaceutical company will it look like you are endorsing their products?

Or worse, could the sponsoring company's products actually cause harm in some way?

There has been a lot of debate about the appropriateness of sports teams being sponsored by the alcohol industry. With what we now know about the causes of breast cancer it is important that breast cancer charities consider the same issues: does or could the product promoted by the sponsor have a role in the development of breast cancer. Would it be appropriate for a cosmetics company, whose products contain phthalates and parabens (oestrogenic compounds) to sponsor the Breast Cancer Network when we so strongly believe that endocrine disrupting chemicals contribute to the development of breast cancer? When it is known that body weight is linked to the risk of breast cancer, should a breast cancer charity accept money from a fast food chain?

Having been involved in a number of not-for-profit or charity groups over the last twenty-five years, I know how hard it is for such organisations to keep their heads above water, but with all that we know and all that we are discovering about breast cancer, the potential influence of a product on breast cancer must be considered when a breast cancer group is presented with fundraising opportunities.

Such moral and ethical dilemmas seem to entirely escape the attention of those who practice pinkwashing. The breast cancer "industry" is now so profitable that whole swags of companies are looking to jump on the gravy train. Pinkwashing was defined in the UK newspaper, *The Independent*, as the dark art favoured by certain companies (you know who you are) of using ostentatious support for breast cancer research to promote their products or services.

And it is hardly surprising that corporations have sided up to the breast cancer cause, given how much money can be made out of how women feel about their bodies and the threat that breast cancer poses to not only their life but the way they see themselves.

So where is the harm in that? As the next ten months until the next "breast cancer awareness months" stretches away in front of us ponder this:

Where does the money really go and how much of it actually goes to benefit women with breast cancer? Does the money you spend on their products really make a difference in the fight against breast cancer or is it just a gimmick designed to line shareholders pockets?

Then ask yourself if the product being sold might be contributing to breast cancer: cosmetics and personal care products containing endocrine disrupting chemicals, unhealthy food and drinks, vehicles that produce carcinogenic polycyclic aromatic hydrocarbons (PAHs). And among all the sales and promises to donate money "to find a cure" where are the prevention messages that might save some women the trauma of a diagnosis in the first place?

*Sue Claridge*



On behalf of Breast Cancer Network (NZ) our congratulations have been extended to Professor David Skegg, Vice Chancellor, University of Otago, on receiving the New Year's honour, 'Distinguished Companion New Zealand Order of Merit'. This is particularly pleasing and relevant to women who have experienced breast cancer because of his work regarding hormonal contraception and breast cancer incidence, and his contribution in establishing free and readily available mammographic screening.

STOP CANCER WHERE IT STARTS

## REDUCE YOUR RISK; SAY NO BY SUE CLARIDGE

**T**is the season of good cheer and that good cheer often comes by way of wine, beer or spirits!

But you don't have to be an alcoholic for alcohol to cause you harm.

While many of the things that contribute to an increased risk of breast cancer may be harder to avoid, and may be things over which you can't exert total control, how much alcohol you drink is totally under your control and limiting your alcohol intake is one positive way of reducing your risk.

Breast surgeon, Mr Trevor Smith, a staunch advocate of breast cancer prevention, told the *New Zealand Herald* in October that "alcohol was among the lifestyle choices that contributed towards New Zealand having one of the highest breast cancer rates in the world."

In the 2007 World Cancer Research Fund (WCRF) report, *Food, Nutrition, Physical Activity, and the Prevention of Cancer: a Global Perspective*, it states that "the evidence is that alcoholic drinks are a cause of cancers of the mouth, pharynx, and larynx; the oesophagus; the colorectum in men, and the breast; and probably of liver cancer, and colorectal cancer in women."

Numerous studies have found a link between alcohol consumption and breast cancer. Reporting on data from the Women's Health Initiative, Dr Shumin Zhang and colleagues from the Harvard School of Public Health in the US, concluded that even moderate alcohol consumption increased the risk for oestrogen receptor and progesterone receptor positive tumours, and the association seemed strongest among those taking postmenopausal hormones.

The study found that daily consumption of one standard drink was significantly associated with a nine percent increase in risk of invasive breast cancer, and the risk increased with increasing categories of alcohol; consumption of three drinks per day of alcohol was significantly associated with a 43 percent increase in risk.

In the 2005 paper "The etiology of alcohol-induced breast cancer", the authors say that "alcohol consumption may cause breast

cancer through different mechanisms", including through genetic mutations caused by acetaldehyde which is the main metabolite of ethanol (alcohol), by interfering with oestrogen pathways in multiple ways, influencing hormone levels and affecting oestrogen receptors, and by negatively affecting folate levels, which in turn affects DNA methylation which is associated with carcinogenesis.

The WCRF report stated that "in many countries, alcohol is a public health problem. This is not so much because of the average level of intake, but because a minority of the population, which in high-income countries includes an increasing number of young people, drink alcohol excessively ('binge' drinking)." There is no doubt that this is the case in New Zealand. Once the preserve of young men, 'binge' drinking is now common among young women as well. A 2007 Ministry of Health report on alcohol use in New Zealand found that there was no difference in the numbers of men and women drinking more than the recommended maximum number of drinks on a typical drinking occasion; 23 percent of non-Maori, and 50 percent of Maori New Zealanders exceeded the recommended maximum on a typical drinking occasion.

A March 2008 paper published in the journal *Breast Cancer Research and Treatment* had particularly bad news for New Zealand's heavy drinking women. The Norwegian and American researchers evaluated whether early, lifetime or recent alcohol intake was associated with breast cancer risk in 1,728 newly diagnosed breast cancer patients and 435 control subjects aged 20 to 49 years. They found that consumption of two or more alcoholic drinks per day during the five years prior to diagnosis was associated with an 82% increase in breast cancer risk relative to those who never drink, and they concluded that recent alcohol consumption may be associated with increased breast cancer risk in young women.

The WCRF report made specific recommendations regarding consumption of alcohol:



Source: Corena, MorgueFile.com

"For those who do consume alcoholic drinks, no more than two drinks per day (men) and no more than one drink per day (women) are the recommended limits. These limits are expressed as amounts per day, because occasional heavy drinking (say, at weekends) while at other times alcoholic drinks are not consumed, is particularly likely to lead to adverse outcomes."

In a letter to the *New Zealand Medical Journal* on the subject, Trevor Smith said that "the use of this information on alcohol as a significant and modifiable risk factor for cancer should be used in harm minimisation approaches to discourage excessive alcohol consumption, and should be included in public awareness campaigns and individual consultations. This is particularly appropriate in New Zealand, in terms of achieving the objectives of the *New Zealand Cancer Control Strategy*."

While the Breast Cancer Network is not advocating total abstinence, limiting alcohol intake to special occasions and thinking seriously about that second drink could do you a world of good.



**LETTERS**

**CONGRATS FROM THE US**

Dear Ladies,

I just read the good news regarding the banning of endosulfan in NZ. What a nice holiday present! Congratulations and Merry Christmas.

Warm regards,

**Maricel Maffini**

Tufts University, Boston

*See Page 8 for the update on Endosulfan - Ed.*

**NZBCF ON PINKWASHING**

You have requested details of the NZBCF's position on "Pink Washing" which we are pleased to provide.

The term Pink Washing covers two areas: (1) alignment of breast cancer fundraising with products that may pose a health risk to women and (2) companies use of the Pink Ribbon trademark without providing a reasonable financial contribution to breast cancer fundraising.

Breast cancer foundations around the world base their existence on research into causes and treatments of breast cancer. The public health messages on breast cancer and breast health from The New Zealand Breast Cancer Foundation (NZBCF) rely on good scientific research all of which is reviewed by our Medical Advisory Committee of breast surgeons, oncologist and breast health physicians.

No one knows a definitive cause for breast cancer which means that we can't prevent it but certain risk factors have been identified. It has been scientifically proven that moderate alcohol consumption can increase a woman's risk of getting breast cancer. The Foundation does not have any partnerships with alcohol companies. However, the Foundation does not prohibit our supporters and sponsors serving alcohol at fundraising events as they always comply with good practice of host responsibility.

The NZBCF was founded in 1994 at the behest of the Estée Lauder Companies as part of a world wide movement to fight breast cancer. Estée Lauder is a strategic partner of The Foundation providing services instead of a cash contribution.

Questions have been levelled at Estée Lauder about the presence of phthalates in their products.

DBP, commonly used in nail polish for long lasting wear, was removed from Estée Lauder Companies nail polish formulas as of 2004. The phthalate DEHP is no longer used in any of their product formulas, and it is now policy not to use DEHP as a component added to packaging materials.

Another phthalate, DEP, commonly used as a solubilizer for fragrance ingredients, has a long history of safe use and is internationally accepted by global regulatory authorities for this purpose. For this reason, some Estée Lauder Companies brands continue to use DEP in fragrance products.

The assertion that cosmetics are harmful to our health is unsubstantiated. In essence, it is distracting women from the known risk factors of breast cancer. The NZBCF would not risk the credibility and ethics of its mission if we believed there was any scientific evidence linking ingredients in Pink Products and breast cancer.

It is difficult to address the second aspect of Pink Washing as the return to The Foundation from its commercial partnerships isn't measured just in dollars. In some cases an annual cash donation is accepted. In others, the relationship is about the provision of services or creation of fundraising events that allow The Foundation to extend our education and awareness campaigns through new initiatives.

All charitable organisations seek some form of funding from corporate entities. Compared to the United States where the Pink Ribbon is not trademarked to any one organisation and pink washing is rife, New Zealand is a very small market. In New Zealand, the Pink Ribbon is trademarked to the NZBCF and as a result, we have been able to better manage the relationship between the product and the return to The Foundation.

The Foundation does set minimum contribution criteria for the use of the Pink Ribbon and has established a comparable value measure for those strategic partners such as Estée Lauder, Deloitte and Bell Gully who provide services in kind.

Over the years the NZBCF has built very strong relationships with our sponsors and supporters. The Foundation believes they are receiving value in being affiliated with the Pink Ribbon, not just in terms of cause-related marketing but also for the vital work we do in the community in education, awareness, research, advocacy, medical support & development and funding of community outreach programmes.

Anyone seeking more information about the work of the NZBCF can keep an eye out for our Annual Summary of Key Activities (year ended 31 March 08) which will be published on our website shortly. [www.nzbcf.org.nz](http://www.nzbcf.org.nz)

Yours sincerely

**Suzanne McNicol,**

Marketing & Communications Manager,  
New Zealand Breast Cancer Foundation

The editor reserves the right to edit, abridge or decline any letters without explanation.

**WOMEN'S CHALLENGE**

April is usually the month for the Women's Challenge. Unfortunately ACC have stopped organiser, Dick Quax, from using the waterfront for the Women's Challenge. He is currently looking for another venue and hopes to hold the event at the end of winter.

## SAN ANTONIO BREAST CANCER SYMPOSIUM

The San Antonio Breast Cancer Symposium is held annually in San Antonio, Texas and offers “state-of-the-art” information on the biology, prevention, diagnosis and treatment of breast cancer. Some of last December’s papers are reviewed here. Please note that the findings in these papers are often new and need to be confirmed by further peer-reviewed research.

### SKIN CREAMS MAY EXPOSE WOMEN TO OESTROGEN

Breast cancer patients may unknowingly expose themselves to oestrogen by using certain skin moisturisers, breast cancer survivor and Doctor of Pharmacy, Adrienne Olson, told the symposium.

Laboratory analyses identified half a dozen different products containing measurable levels of oestriol and oestrone. None of the products listed the oestrogenic hormones among its ingredients.

Dr. Olson became interested in the oestrogen-moisturiser association during her own treatment for oestrogen receptor-positive breast cancer. Whether this transdermal exposure to oestrogenic hormones can influence the behaviour of ER-positive breast tumours is unclear.

“Until the late 1970s, the intact epidermis was thought to be impermeable to medications in creams and ointments,” said Dr. Olson. “We now know that the skin is much more porous than we previously believed.”

*SABCS 2008 Abstracts. 282s. Abstract 4087.*

### BREAST CANCER FEAR COMMON AMONG ADOLESCENT GIRLS

Adolescent girls fear breast cancer even though they generally know the disease is uncommon in their age group, according to a survey of 1,700 girls from eight to 18. Overall, 26% said they feared they would get the disease, and three quarters feared their mothers would develop breast cancer, even though only 3% of the girls’ mothers had done so, the investigators said. However, most of the respondents knew of a relative or close acquaintance of a friend who had breast cancer. And all are sensitive to media reports.

“These factors seem to contribute to their fear of the disease and their tendency to overestimate breast cancer risk,” Dr Marisa Weiss of Breastcancer.org said.

Many of the girls’ answers to survey ques-

tions suggested substantial misinformation and ignorance about breast cancer risk factors and breast health. Twenty percent of respondents believed breast cancer could result from infection, drug use, stress, and tanning, 10% to 20% believed that caffeine consumption, bumps or bruises to the breast, and antiperspirants could cause breast cancer, and 8.5% thought breast-feeding increased the risk of breast cancer

“The impact of a girl’s unrealistic fear of breast cancer is unknown,” Dr Weiss and colleagues concluded. “We are concerned that it may deter rather than motivate healthy behaviours. Breast health programs are necessary to replace fear and inaccurate information with facts and reassurance.”

*SABCS 2008; Abstracts. 332s. Abstract 5078.*

### RISK VARIES IN YOUNG WOMEN WITH BENIGN BREAST DISEASE

Benign breast disease in young women, especially atypical hyperplasia, significantly increases the risk of a malignancy, but by how much varies according to histology and other factors reported to Dr Karthik Ghosh of the Mayo Clinic.

The review identified 4,460 women younger than 50 who were followed for a median of 20 years after diagnosis of benign breast disease.

Women with atypical hyperplasia had a seven-fold increased risk of breast cancer, irrespective of family history; women with proliferative disease without atypia had a two-fold increased risk of cancer; and non-proliferative breast disease in the absence of a positive family history was associated with an increase of 1.2 times. In contrast, lobular involution seemed to have a protective effect with a lower than normal risk of breast cancer compared with those without lobular involution\*.

\* Lobular involution, part of normal aging, is the regression of the milk-producing glands or lobules in the breast.

*SABCS 2008 Abstracts. 77s. Abstract 62.*

### COMBINATION ENDOCRINE THERAPY DELAYS METASTATIC BREAST CANCER PROGRESSION

For postmenopausal women, the combination of lapatinib (Tykerb) and letrozole (Femara) may control endocrine-sensitive metastatic breast cancer better than letrozole alone, researchers from the Royal Marsden Hospital in London found.

Among patients with hormone receptor- and HER2-positive metastatic tumours, combination therapy more than doubled the median progression-free survival to eight months compared with three months on letrozole alone.

This combination, though unapproved for this use, potentially offers an orally active first-line treatment for this group of patients deemed suitable for endocrine therapy based on performance status, sites of disease, and the absence of rapidly progressive visceral disease, Dr Stephen Johnson said.

*SABCS 2008; Abstract 46.*

### FIRST-UP LETROZOLE COULD BE BETTER THAN TAMOXIFEN

For women with endocrine-responsive early breast cancer, letrozole (Femara) as the initial adjuvant endocrine therapy may modestly improve overall survival compared with tamoxifen.

After initial reports on the Breast International Group (BIG) 1-98 trial in 2005 showed that five years of letrozole prolonged disease-free survival and reduced risk of distant metastases, Dr. Mouridsen and colleagues randomised 3,088 patients to two years of tamoxifen followed by three years of letrozole or vice versa. At a median 76 months of follow-up, the five years of letrozole was associated with improved overall survival, disease-free survival and time to distant recurrence compared with tamoxifen alone.

Patients who switched to letrozole from tamoxifen tended to have a higher risk of recurrence than those who started with letrozole (9.1% versus 7.3% at five years).

“I think a lot of people looking at those [data] will take the clinical message that it’s better to start with letrozole, particularly for patients at high risk,” researcher Dr Henning Mouridsen said.

Co-researcher Dr Alan Coates, of the University of Sydney, said that given these findings, five years of upfront letrozole rather than tamoxifen should be the standard of care.

The researchers acknowledged some bias in the study methodology, but Dr Susan Love, who was moderating the press conference at which the study results were presented, said that it was reassuring that “the difference isn’t that large - patients aren’t taking their life in their own hands” by deciding to switch to tamoxifen.

*SABCS 2008; Abstract 13.*

## PHTHALATES IN MOTHERS' MILK BY SUE CLARIDGE

A small study in Northern Carolina, US, has offered some relief to women concerned that their own phthalate exposure will be passed on to their babies in breast milk.

Phthalate is an oestrogenic compound commonly found in plastics. Along with compounds such as bisphenol A, parabens and other common chemicals, the exposure to oestrogenic phthalates in our everyday lives gives great cause for concern for our health. Environmental oestrogens are implicated from as early as conception in the development of breast cancer and are also believed to contribute to genital tract deformities in boys and early puberty in girls.

In a paper published in the January 2009 issue of *Environmental Health Perspectives*, researchers reported that despite the presence of phthalate metabolites in more than 85% of urine samples and more than 80% of blood samples, phthalate metabolites were detected in fewer than 10% of the breast milk samples.\*

The authors of the study write:

"Phthalates are ubiquitous in the environment, with annual global production at more than three million metric tons. Since their introduction in the 1930s, phthalates have been used as plasticisers and in cosmet-



ics, food containers, medicine coatings, lubricants, adhesives, ink, medical devices, and tubing. Certain phthalates have been shown to be endocrine disruptors in laboratory animals. The toxicity of phthalates in animals is related to the structure of the phthalate, the dose administered, and the animal's age at exposure."

Dr Erin Hines of the US Environmental Protection Agency, and her co-authors con-

cluded their results "suggest that phthalate metabolites are most frequently detected in urine of lactating women and are less often detected in serum, milk, or saliva. Urinary phthalate concentrations reflect maternal exposure and do not represent the concentrations of oxidative metabolites in other body fluids, especially milk."

Interestingly, the study found a strong correlation between urinary phthalate concentration and nail polish use among the participating women. Personal care products, including nail polish, have been reported to contain diethyl phthalate and the authors point out that women who use nail polish may also use perfume and other personal care products that may contain diethyl phthalate, which may also contribute to the level of phthalates detected in their urine.

While this study is good news for women concerned about passing endocrine disrupting chemicals onto their babies through breast milk, it does little to allay health fears regarding diethyl phthalate (DEP) exposure among the women themselves.

*Environmental Health Perspectives Volume 117, Number 1, January 2009.*

\* the metabolites detected were those of diethyl phthalate (DEP) and di(2-ethylhexyl) phthalate (DEHP)

## FRUIT AND VEGE MAY REDUCE RISK OF RECURRENCE

A large, multicenter clinical trial has shown that a diet loaded with fruits, vegetables and fiber and somewhat lower in fat compared to standard federal dietary recommendations cuts the risk of recurrence in a subgroup of early-stage breast cancer survivors – women who didn't have hot flushes – by approximately 31 percent. These patients typically have higher recurrence and lower survival rates than breast cancer patients who have hot flushes. The study team, led by researchers at the Moores Cancer Center at the University of California, San Diego, reported its results online in the *Journal of Clinical Oncology* on the 15th of December 2008.

"Women with early stage breast cancer who have hot flushes have better survival and lower recurrence rates than women who don't have hot flushes," said Dr Ellen Gold. "Our results suggest that a major change in diet may help overcome the difference in prognosis between women with and without hot flushes."

"Our interest in looking at this subgroup came because hot

flushes are associated with lower circulating oestrogen levels, while the absence of hot flushes is associated with higher oestrogen levels. Reducing the effect of oestrogen is a major treatment strategy in breast cancer," said the Dr John Pierce, director of Cancer Prevention and Control at the UC San Diego School of Medicine and the Moores UCSD Cancer Center. "It appears that a dietary pattern high in fruits, vegetables and fiber, which has been shown to reduce circulating oestrogen levels, may only be important among women with circulating oestrogen levels above a certain threshold."



## ANOTHER HRT DILEMMA BY SUE CLARIDGE

Once upon a time, hormone replacement therapy (HRT) was promoted as a miracle cure. Not only was it going to take away the often debilitating side-effects of menopause that many women suffer, but it was going to protect women against coronary heart disease, stroke and dementia.

Then, in 2002 the results of two very large studies – the US Women’s Health Initiative study and the UK Million Women study showed that, in fact, HRT increases the risk for these conditions. Worst of all, HRT was found to increase the risk of breast cancer.

In 2004 the New Zealand Guidelines Group updated their guidelines on the use of HRT, in response to the US and UK studies. Their key messages included that the use of HRT is associated with an increased risk of pulmonary embolism, stroke and breast cancer, and in women over 65 an increased risk of developing dementia and that these risks increase with age and duration of use.

The guidelines recommend that HRT should be taken at the lowest dose for the shortest period of time necessary to control symptoms, and continued use should be reviewed at six-monthly intervals.

Substantial declines in the use of HRT were reported in subsequent years with a reduction of 68% for all hormone therapies and 36% for oestrogen-only therapies between 2001 and 2003.

In December 2006 researchers from the MD Anderson Cancer Center at the University of Texas, told the 29th Annual San Antonio Breast Cancer Symposium that there had been an overall seven percent relative decline in breast cancer incidence between 2002 and 2003 in the US - 14,000 fewer women were diagnosed with breast cancer in 2003 than in the previous year.

They believe that the decline in HRT use could well be behind the sudden drop in breast cancer cases. Professor Donald Berry, the study’s senior investigator, said in a press release issued by the MD Anderson Cancer Center, that he was, at first, very surprised by both the magnitude and the rapidity of the decline in incidence, but added that “it makes perfect sense” if you consider that use of HRT may be an important contributing

factor to breast cancer development.

Berry’s colleague, Dr Ravdin, said “Research has shown that ER-positive [oestrogen receptor positive] tumors will stop growing if they are deprived of the hormones, so it is possible that a significant decrease in breast cancer can be seen if so many women stopped using HRT.”

But what is the story for women who have a BRCA gene mutation? How does HRT impact upon their risk?

Recent research shows that far from raising the risk of breast cancer, HRT may offer some protective effect for women who have the BRCA1 gene mutation.

In a case-controlled observational study published in September 2008 in the Journal of the National Cancer Institute, Dr Steven Narod of the University of Toronto, and his American and European colleagues compared the use of hormone therapy in 236 breast cancer patients and 236 matched control subjects. All of the study participants carried a BRCA1 mutation.

Narod and colleagues report that 29% of the control subjects had used hormone therapy at some time, as had 20% of the women in the breast cancer group. The use of hormone therapy was associated with a 42% relative reduction (9% absolute reduction) in the risk of developing breast cancer.

“In this study, neither use of oestrogen alone nor use of oestrogen combined with progesterone was associated with an increase in breast cancer risk among BRCA1 mutation carriers. This observation is in contrast to the situation in the general (i.e. noncarrier) population, in which formulations containing both oestrogen and progesterone have been associated with a substantial increase in breast cancer risk,” the authors said in the paper.

The researchers could not account for the effect with any certainty nor explain why, when surgical menopause (removal of the ovaries) or tamoxifen, reduces the risk of breast cancer in BRCA1 women, exogenous oestrogen in the form of HRT should also be protective, other than to suggest that timing may be the critical factor:

“It may be that oestrogens and anti-oestrogens modify breast cancer risk at dif-

ferent stages of progression. For example, oestrogen might act early in carcinogenesis, on stem cells or preneoplastic lesions, and tamoxifen and oophorectomy might act at a later stage, e.g. in small established cancers.”

Research has shown that BRCA carriers typically, although not exclusively, develop triple negative breast cancers. Narod and colleagues “were able to obtain ER status for only about one-half of the breast cancer patients” and they stated that “the numbers are too small to draw a definite conclusion” regarding any relationship between HRT and oestrogen receptor positive status. However, it is possible that HRT has a beneficial effect on BRCA1 carriers precisely because they develop tumours that are not stimulated by oestrogen.

In an editorial that accompanied the September paper, Dr Rowan Chlebowski of the Los Angeles Biomedical Research Institute and Dr Ross Prentice of the Fred Hutchinson Cancer Research Center in Seattle, caution that observational studies have previously been misleading.

“Whereas earlier observational trials suggested that hormone therapy was not associated with an increased risk of breast cancer recurrence, randomized trials found a statistically significant increase in risk with menopausal hormone therapy use in breast cancer survivors,” they wrote in a media release coinciding with publication of the Journal.

“The results presented by [Narod and colleagues] regarding hormone therapy use in postmenopausal BRCA1 mutation carriers provide some evidence for safety but are insufficient to reliably inform routine clinical practice,” the editorialists wrote. “As a result, continued caution in prescribing hormone therapy to women with BRCA1 mutations who are at high risk for breast cancers remains prudent.”

### ENDOSULFAN BAN A SIGNIFICANT STEP FORWARD

The banning of endosulfan in New Zealand is a significant achievement for environmentalists and those concerned about the effects of chemicals on human health.

On the 15th of December the Environmental Risk Management Authority announced their decision to revoke the approvals for the insecticide endosulfan and prohibited its importation, manufacture and use in New Zealand. The Authority's decision came into effect on the 16th of January 2009. The Authority has also specified requirements for safe disposal of the chemical within 12 months.

In August, BCN and numerous other environmental and health groups, were dismayed by ERMA's preliminary recommendation that, rather than banning the endocrine disrupting and toxic pesticide, endosulfan should be prohibited from aerial use, domestic use, and for airblast application to citrus, and also that increased restrictions and controls be placed on all other uses.

The chair of the decision-making committee, Helen Atkins, said the Authority considered that the level of adverse effects to the environment, human health, the relationship of Maori to the environment, and to New Zealand's international relationships outweighed any positive effects associated with the availability of endosulfan in New Zealand.

In a press release issued on the 16th of December, the Breast Cancer Network expressed their delight at the decision.

"[Endosulfan] is acutely toxic and has hormone-mimicking qualities that are of great concern to Breast Cancer Network," said the press release. "Early exposure of our children and young people to endocrine-disrupting compounds may play an important role in New Zealand's high incidence of breast cancer."

Dr Meriel Watts, of the Pesticide Action Network, and supporter of BCN's efforts to reduce the risk of breast cancer through limiting exposure to such chemicals, described the decision as "an historic move for New Zealand."

In a joint press release from the Pesticide Action Network, the Soil & Health Association, and Safe Food Campaign Inc, Soil & Health spokesperson Steffan Browning said that "ERMA have made a real Christmas present for food safety and the environment by banning the use of endosulfan in New Zealand from January 16, 2009,"

The coalition of organisations pointed out that endosulfan is already banned in 55 countries including all the European Union countries, but said continuing use in this

country has resulted in enormous costs for exporters.

"It would have been deeply embarrassing for New Zealand to continue its use when the pesticide has entered the process for a global ban under the Stockholm Convention on Persistent Organic Pollutants," said Dr Watts.

"ERMA has made the right decision to get rid of a pesticide that is contaminating the global food supply," declared Ms Alison White of the Safe Food Campaign. "Endosulfan has been found in body fat, breast milk, placental tissue and umbilical cord blood, largely as a result of residues in food. We would also welcome an urgent reassessment of other hazardous pesticides still used in New Zealand, notably the herbicide 2,4-D and the organophosphate insecticide chlorpyrifos," she added. "Like endosulfan, these pesticides can have an effect on hormone function even at minute doses. Chlorpyrifos and 2,4-D have both been linked to brain damage in young animals, embryos and foetuses."

Although the banning of endosulfan represents significant progress, it is clear that we still have some way to go before all our food is safe and free of toxic chemicals and their potentially carcinogenic effects.

## WOOD ROASTED SALMON TABBOULEH

CONTRIBUTED BY SUE CLARIDGE

### INGREDIENTS

- 1½ cups of burghul wheat
- ½ cup of lemon juice
- salt and freshly ground black pepper
- 4 spring onions
- ¾ cup of fresh flat-leaf parsley, chopped
- ½ cup of fresh mint, chopped
- 1 telegraph cucumber, peeled, de-seeded and chopped
- 2 large tomatoes, chopped
- 200 gm wood-roasted salmon, broken into pieces (baked in the oven until just cooked through would be just fine)
- ¼ cup extra virgin olive oil

### METHOD

1. Place the burghul wheat in a bowl and cover with cold water. Allow to soak for an hour, then drain. Transfer the burghul wheat to a clean tea-towel and thoroughly squeeze out all the water.
  2. Combine all the ingredients except the olive oil and lightly mix. Drizzle the olive oil over the tabbouleh and serve.
- 4 SERVES.

## CLEAN GREEN AND HEALTHY

THE *UPFRONT U KAIORA* REVIEW OF WHAT YOU SHOULD AND SHOULDN'T BE PUTTING INTO AND ONTO YOUR BODY AND AROUND YOUR HOME.

### GREENER CLEANERS REVIEWED BY GILLIAN WOODS

Most people don't much like cleaning the house but it has to be done and brings its own particular satisfaction. It's important to get it done as easily as possible, know that the home is clean and be sure that the person doing it (who is, dare I say it, usually a woman) is not exposed to hazardous chemicals in the process. It's important to know the other occupants of the home will also be safe – especially the children.

For starters, it's a great idea in these tough economic times to restructure the cleaning cupboard and adopt a sinking lid, redundancy and rehabilitation policy for your household cleaners. Many people have 20 or 30 different cleaners, most of them toxic in various degrees. We simply don't need this number of cleaning agents to have a clean, hygienic home.

Check list: Read up online or check out your local library for information about the chemicals that are usually in household cleaners and make a top ten list of those to avoid. You could start by checking out the adverse effects of phenols, triethanolamine, alkylphenol compounds, bacteriocides such as triclosan, chlorine bleach, organic solvents, trisodium phosphate, ammonia, synthetic perfumes and other petroleum based products.

Try a new bottom line: When buying a commercially made product, ALWAYS choose an environmentally friendly one such as Ecostore, Ecover, and Seventh Generation or others that pass your check list. Only buy those with full disclosure of contents. Your store doesn't carry them? If they won't stock a suitable range, try ordering via the internet.

You might be able to reduce the number of household eco-type products you use to just a few: dish wash powder and liquid for hand dishwashing, laundry powder or liquid, toilet cleaner, general-pur-

pose cleaner and maybe a glass cleaner (glass cleaner can be used to polish stainless steel). Personally, I always have a chlorine solution for use when anyone is ill, but there may be an alternative which I have not discovered yet. Supplement these products with simple substances as below. Did you know that Consumer magazine chose Ecostore laundry powder as a top value product? The packet is smaller and you use much less than normal powders.

**New goal – to use these simple non-commercial cleaners and items whenever possible.**

1. White vinegar – add a little to water to clean glass, chrome and mirrors. Use undiluted to disinfect bathroom surfaces and clean the toilet. (DON'T ever use vinegar on marble as it will damage it.) My bottle of white vinegar cost 79c! Use undiluted to wipe kitchen benches and disinfect chopping boards.
2. Baking soda – use the powder with a little water as a mild abrasive cleaner, or dissolve in water to clean and deodorise the refrigerator, use as a paste with lemon juice to clean tiles or drains in the bathroom.
3. Plastic squeeze bottles to apply the non-toxic cleaners
4. Table salt – removes rust; with lemon juice cleans copper (dry it well) and it's a good scouring powder with a little added water
5. Olive oil to polish wooden furniture
6. Microfibre cloths – excellent for all sorts of dusting and cleaning jobs – wash and re-use. Sponges, if used, should be free of bactericide, laundered regularly and replaced frequently.
7. Spices, herbs, bay leaves, essential oils. A few drops of essential oil in water makes a good air freshener- shake well and spray as needed. Some oils are antibacterial, for example, oregano, basil, clove and thyme oils.
8. Insect deterrents include dried cloves, cinnamon sticks, bay leaves, lavender and rosemary.

#### Other things to avoid:

- Aerosol sprays - the perfect way to transport chemicals into your lungs – they always have a propellant which is not likely to be good for us.
- Antimicrobiological agents (triclosan is a particular cause for concern) can break down forming dioxins and other toxins in the environment.
- Moth balls or crystals.

#### Recommended reading:

*Green This* by Deirdre Imus; Simon and Schuster, USA.  
*Clean House Clean Planet* by Karen Logan; Pocket Books



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### Websites

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<a href="http://www.environmentalhealthnews.org">www.environmentalhealthnews.org</a>	Issue 78 Page 5
<a href="http://www.bestcancersites.com/breast">www.bestcancersites.com/breast</a>	Issue 81 Page 6

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## BREAST EVENTS TO COME

[20 May 2009] – BCN's Annual General Meeting will be held at 7.30 pm, at [Domain Lodge, Auckland Cancer Society, 1 Boyle Crescent, Grafton, Auckland]. Guest Speaker *Dr Robert Scragg*, Associate Professor of Epidemiology & Biostatistics, School of Population Health, University of Auckland, on vitamin D and cancer.

### The New Zealand Breast Cancer Foundation Free Breast Health Seminars

- **17th February 2009**, Tuesday, 6:30pm start: Orana Motor Inn, 238 Commerce Street, Kaitaia,
- **18th February 2009**, Wednesday, 6:30pm start: Woodlands Motel and Conference Centre, 126 Kerikeri Road, Kerikeri.
- **19th February 2009**, Thursday, 6:30pm start: Forum North, 1 Rust Avenue, Whangarei
- **24th February 2009**, Tuesday, 7pm start: Queenstown Memorial Hall, Supper Room, 11 Memorial Drive, Queenstown.
- **25th February 2009**, Wednesday, 12:30pm start: Queenstown Events Centre, Mezzanine Meeting Room, Joe O'Connell Drive, Frankton, Queenstown.
- **26th February 2009**, Thursday, 7pm start: Central Stories Museum & Art Gallery Conference Room, 21 Centennial Ave, Alexandra.

These free seminars are presented by the Foundation's National Breast Health Educators Ginny Harwood and Valerie Pennick. Registrations can be made by phoning 0800 902 732, leaving your name, contact phone number and number of people attending. Alternatively, you can just come along on the night. You can also register via email enquiries@nzbcf.org.nz.



### MOST AND LEAST BY JULIE LAMB

Featured in *Upfront U Kaiora* 82, Most and Least is on sale now at [www.mostandleast.co.nz](http://www.mostandleast.co.nz), and BCN benefits from sales of the album and single *Cry As You Must*. I have bought the album and it is great – a cross-genre mix of music with two ballads, some reggae, rock, country and funk, grounded in R&B.

**VISIT THESE SITES FOR MORE BREAST INFO! [www.bcn.org.nz](http://www.bcn.org.nz) [www.breast.co.nz](http://www.breast.co.nz)**

*The opinions expressed in the various UPFRONT U KAIORA articles are not necessarily those of the Breast Cancer Network (NZ) Inc.*

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#### BCN VITAL STATS:

Breast Cancer Network (NZ) Inc. – established in 1993 is an organisation for women with breast cancer and their supporters. It aims to promote increased efforts to prevent and cure breast cancer- by advocacy, education, information and networking.

ADMINISTRATOR: Jennifer Woodrooffe; MAGAZINE EDITOR: Sue Claridge.

PATRON: Lois Muir.

HONORARY LIFE MEMBERS: Wendy Steenstra-Bloomfield, Barbara Holt,

Dell Gee, Jennifer (Jenny) Clark

COMMITTEE MEMBERS: Barbara Mason, Anne Iosefa, Gillian Woods, Linley Rivers, Sue McLeod and Carmel Clark

*BCN gratefully accepts any bequests. For more information please contact the office.*

#### TO JOIN BCN

**To become a member & receive a regular copy of UPFRONT U KAIORA send your name and address to:**

**BCN (NZ), PO Box 46018, Herne Bay, Auckland 1147 - \$25 survivors/supporters, \$20 unwaged, \$30 professionals, groups & libraries.**

For further information, phone our office on (09) 360 0090 fax us on (09) 09 360 2180 or email us at [admin@bcn.org.nz](mailto:admin@bcn.org.nz) .

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Please tick here if you have experienced breast cancer.

I am interested in helping with BCN activities

I agree to BCN (NZ) contacting me by email with news, information and updates

Breast Cancer Network (NZ) Inc., 300 Richmond Road, Grey Lynn, Auckland. Phone: (09) 3600090 Fax: (09) 3602180 Email: [admin@bcn.org.nz](mailto:admin@bcn.org.nz) Web: [www.bcn.org.nz](http://www.bcn.org.nz)