

Upfront U Kaiora

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

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OVER 70 - BREAST CANCER IN ELDERLY WOMEN BY SUE CLARIDGE

We are all too familiar with breast cancer among women from 45 to 69 years old. After all, those women get free mammograms because of the degree of their risk. Likewise, we are all too familiar with breast cancer in younger women who face issues specific to their age.

But what about our elderly women? After the age of 69, women no longer get publicly funded mammograms. From the age of seventy, these women become increasingly invisible. Staff at one rest home said that, not only did they have no experience of caring for a woman with breast cancer, they don't even look for it.

Yet elderly women are at as great a risk of developing breast cancer as women in their 40s, 50s and 60s. In 2005, the latest year for which the data is available, 598 women over the age of 70 were diagnosed with breast cancer; almost one quarter of all breast cancer diagnoses. Given the declining numbers in these age groups due to death, the actual rates per 100,000 women of the same age are high; the number of women diagnosed with breast cancer between 70 and 80 is almost as high as for women in their sixties and considerably higher than for women in their fifties (see the table above). While women in their eighties have a lower rate of breast cancer than those in the 60s and 70s it still exceeds the rates for those in their 50s.

In addition, many elderly women have comorbidities – other conditions, such as

INCIDENCE OF BREAST CANCER IN WOMEN IN NEW ZEALAND IN 2005		
Age	Number of diagnoses	rate per 100,000
0-14	0	0
15-19	1	0.7
20-24	1	0.7
25-29	13	10.0
30-34	42	28.0
35-39	91	57.8
40-44	203	123.5
45-49	340	228.4
50-54	331	257.1
55-59	306	260.2
60-64	291	318.9
65-69	262	348.5
70-74	192	306.3
75-79	173	310.4
80-84	119	271.1
85+	114	292.9
TOTAL	2479	

Source: Cancer: New Registrations and Deaths 2005, MoH

cardiovascular disease, diabetes, respiratory disease and cognitive impairment – that seriously impact upon their health, complicating treatment for breast cancer and adversely affecting their ability to cope with and recover from surgery, chemotherapy and radiotherapy.

How are we treating our elderly with

breast cancer? Are they receiving the quality of care that we afford our younger women and what are the issues and problems specific to elderly women with breast cancer?

Swedish researchers wrote in a 2006 paper, published in the *Public Library of Science Medicine* journal that:

“Age should not be a determinant for quality of care in breast cancer. In Sweden, as in many other countries, the population is ageing with a rapidly increasing number of elderly women diagnosed with breast cancer as a consequence. Today about 30% of all breast cancer patients in Sweden are 70 years or older at diagnosis. Despite this, there have not hitherto existed any well-established clinical guidelines for the management and treatment of breast cancer in older women.”

Undoubtedly the situation is similar in New Zealand. The Swedish researchers found that there were “significant differences in disease management ... as older women had larger tumours, had fewer nodes examined, and did not receive treatment by radiotherapy or by chemotherapy as often as the younger women.” They concluded that “less diagnostic activity, less aggressive treatment, and later diagnosis in older women are associated with poorer survival. The large differences in treatment of older women are difficult to explain by co-morbidity alone.”

The Swedish study lends strong support to previous reports that there is an age bias in management of older women. However, it is

BREAST CANCER NETWORK AGM BREAST CANCER NETWORK AGM BREAST CANCER NETWORK AGM

You are warmly invited to join us for the 2009 Annual General Meeting which will be held on Wednesday, 20th of May at 7.30pm, at Domain Lodge, Auckland Cancer Society, 1 Boyle Crescent, Grafton, Auckland.

The guest speaker will be Dr Robert Scragg, Associate Professor of Epidemiology & Biostatistics, School of Population Health, University of Auckland, on vitamin D and cancer.

Our AGMs provide women with an excellent opportunity to hear top-notch speakers - do join us on the 20th of May this year.

not just a simple issue of elderly women being poorly served in terms of their breast cancer treatment. There are a number of complicating factors and these factors must be weighed up in determining what the most suitable treatment for an elderly patient is.

One difficulty is that elderly women are often excluded from clinical trials, in particular because of the high rates of other health conditions in these women. Thus, the optimal primary treatment for elderly patients with breast cancer is unclear and currently ranges from tamoxifen as sole therapy to surgery alone, or surgery followed by adjuvant therapy.

There have been several studies that have compared primary endocrine (hormone) treatment (Tamoxifen alone) with surgical treatment. There has been a view that frail elderly women, or those with other diseases, should be spared the rigours of surgery and other aggressive treatments for breast cancer, and given tamoxifen as a primary treatment. However, research published in the *Annals of Oncology* in 2003, in the *British Journal of Surgery* in 2004, and a Cochrane Collaboration review (2007) all concluded that primary endocrine therapy instead of surgery was inadequate leading to increased progression of disease, subsequent therapeutic intervention and increased mortality. The Cochrane reviews concluded that primary endocrine therapy should only be offered to women who are unfit for or who refuse surgery.

In 2007, researchers from the University of Arizona in the US found that “most elderly women can tolerate breast cancer surgery without significant complications and should be offered a definitive surgical procedure.” They went on to say that “because most breast cancers in the elderly are hormone responsive, hormonal therapy remains the mainstay of systemic treatment in the adjuvant and metastatic settings. Chemotherapy can be used in elderly women, but treatment decisions must be individualised based upon risk-benefit analyses.”



French researchers address the need to assess elderly women with breast cancer in a 2008 paper published in the journal *Drugs and Aging*. Drs Gilles Allbrand and Catherine Terret developed an approach for “an individualised oncogeriatric care plan and follow-up based on several considerations: the average patient's life expectancy at a given age; the patient's co-morbidities, level of dependence, and the impact of these considerations on diagnostic and therapeutic options as well as life expectancy; and the potential benefit-risk balance of treatment.”

As with previous studies they say that primary endocrine therapy should only be offered to elderly women with oestrogen receptor positive tumours who can not or will not undergo surgery and that radiation should be recommended to older women with a life expectancy of greater than five years, particularly those with large tumours, positive lymph nodes or negative hormone receptors. Drs Allbrand and Terret say that the exclusion of elderly women from clinical trials has made it difficult to provide a validated recommendation for use of adjuvant chemotherapy in elderly patients.

It appears that elderly women have a lower incidence of lymph node involvement and a 2008 paper published in the journal *Cancer* found that “elderly patients with early breast cancer and no palpable axillary lymph nodes may be safely treated by conservative surgery without axillary dissection and without postoperative radiotherapy,

provided that surgical margins are in tumor-free tissue and that hormone therapy is administered.”

Many of the medical papers pointed out the need for clinical trials of various treatments for elderly women.

The US NORA study (National Oncological Research observatory on Adjuvant therapy in breast cancer) found that that age is significantly related to later diagnosis and different patterns of treatment, and it seems clear that there is an age-related bias in the management of elderly women with breast cancer. The lack of a specific protocol when dealing with elderly women, combined with a paucity of evidence-based treatment information, because elderly women are excluded from clinical trials, has led to elderly women being poorly served when compared with younger women. Given that in New Zealand alone, almost 25 percent of new breast cancer diagnoses are in women over the age of 70, it is clear that the specific needs and concerns of elderly women with breast cancer must be addressed and that an equivalent level of research and investigation is required to ensure that our elderly receive the first class treatment that we demand for younger women with breast cancer.

Sources:

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From the Editor....

My maternal grandmother lived to 93 and my paternal great-grandmother to 92 – she died when I was 12. Her daughter, my paternal grandmother lived well into her 80s. And why do I mention this? Well, had any of them had breast cancer I would have wanted them to be diagnosed and treated with the best of available care. Perhaps not with chemotherapy and radiotherapy which would have made their lives a misery at their age, and quite possibly would have led to a premature death. But perhaps surgery and adjuvant hormone therapy if it were indicated. Why should my elderly grandmothers have had anything less than the best of care?

I'm not suggesting that surgery, or any treatment is a must. It depends on whether or not my grandmothers could have lived well and happily with a tumour and died with it not from it. My mother is now 70 – I struggle to think of her as elderly and would be horrified if she was treated differently just because she was now over 70. Treating the elderly is a matter of balancing their health and expected remaining life time against the benefits and the risks of treatment. And while many might handle surgery perfectly well, it is not without its risks, and adjuvant therapy such as chemotherapy can be positively horrendous for some.

It seems that Delcie, whose story appears in this edition of *Upfront U Kaioara*, may have had an inferior experience in the health system, simply because she was elderly when she was diagnosed with breast cancer. While each woman's treatment needs to be determined based on a wide range of factors, on a very individual basis, each woman, no matter her age, should receive the absolute best of care, and her worthiness of that care should not be based on her age. Ever!

Perhaps, what we need are some guidelines, a protocol for treating elderly women with early breast cancer. There don't appear to be any but I would be very happy to be corrected. The important point is that while elderly women have complicating issues that mean it may not be appropriate or safe for them to receive the same treatment as younger women, they deserve to be treated with dignity, respect and care; as though their lives are every bit as important as those who are in their 40s, 50s and 60s. After all, a civilised society is judged in part by how they treat their most vulnerable citizens, including their elderly.



LETTERS

CHOOKS AND HORMONES

As usual I greatly appreciated the articles from Sue Claridge and also Gillian Woods (whom I have been lucky enough to meet once or twice during a meeting) in your last issue. All these articles are important and useful – iodine, cleaning products, etc.

One thing I would like *Upfront U Kaioara* to mention one day if you do agree, is about how often chicken is chosen in all take-away restaurants, magazines and the endless food programs on TV. Of course, it is because it is a cheap product, but people like me who cannot suffer the horrible way those poor animals are brought up, think of all the growing hormones they are given to be killed only after a few weeks. So I imagine this kind of food cannot be recommended for survivors, like myself, and generally speaking for people who do not want another chemical as a possible threat of cancer. Of course, I always refuse to buy chicken food and explain why!

Maybe *Upfront U Kaioara* has already tackled the problem but I missed the article.

Thank you

Nicole Sabatier

Editor's Reply: Chicken can be a good source of lean protein, and as Nicole points out is a relatively cheap meat. For those concerned about the quality of the meat, additives and the way the chickens are raised, free range organic chooks are a good alternative (personally my family only buys free-range organic eggs for these reasons) but they are expensive.

As far as I can ascertain, no hormones are used in the raising of poultry in New Zealand. Only one synthetic hormone is regulated for use and it is only used for some beef cattle. A ministry of Agriculture and Fisheries brochure (<http://www.nzfsa.govt.nz/animalproducts/subject/hgps/hgpleaflet.pdf>) states that: "HGP's [Hormonal Growth Promotants] may be used in cattle only. The use in other species is strictly prohibited." I understand from a telephone discussion with an NZSFA staff member about three years ago that cattle raised with hormones is destined for the US market and little if any is sold in this country.

The New Zealand poultry industry association (PIANZ) also states on its website that "growth hormones never have been and never will be used in New Zealand's poultry industry." For more information go to http://www.pianz.org.nz/Exotic/growth_hormones.php.

I believe that of greater concern is the antibiotics fed to chickens as a prophylactic to prevent disease. This is a particular issue in light of the increasing prevalence of antibiotic resistance of many pathogens in the community. Poultry are supposed to have a withdrawal period prior to slaughter; that is, the removal of medications from feed in order to comply with maximum residue limits (check out <http://www.nzfsa.govt.nz/acvm/subject/antibiotic-resistance/2004arreport-final.htm> and <http://www.nzfsa.govt.nz/publications/media-responses/whatsinyourfood.htm> for more information on this).

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

CORRECTION: In the story Living With Secondary Breast Cancer by Kristine Eaton-Hampton (*Upfront U Kaioara* 82 page 8) Sue Ryan's name was wrongly provided as Sue Ryder. Kristine and Upfront apologise for the error and any confusion that may have arisen

LIKE MOTHER, LIKE DAUGHTER BY SUE CLARIDGE

When Delcie Kirk was diagnosed with breast cancer at the age 78, it was quite a shock for her daughter Janet, the diagnosis coming only nine months after Janet discovered she had breast cancer at the age of 49.

JANET

Janet had had breast cysts from her teens, with three operations to remove them over the years. Concerned that her benign breast disease may be a precursor to something more serious, Janet had been paying to have regular mammograms since her thirties, all showing no problems. In early 2006, Janet discovered another lump, and with only nine months since her last mammogram, was unconcerned about it and felt sure it was just another cyst.

The initial mammogram and ultrasound were inconclusive; Janet was put on the waiting list at North Shore Hospital for further investigation, and it took two months before she got an appointment for a biopsy.

"My daughter is a nurse and she had the day off, and she said 'I'll come with you to the appointment.' I said to her 'Oh, don't be silly, love, I've had three cysts before; I'll be fine.'"

Janet had the biopsy done in the morning, went out to lunch with a friend relaxed in the knowledge that the biopsy was really just a formality, only to discover two glum-faced doctors and a nurse sitting in the doctors office when she returned for her results. It was cancer!

Not only was the lump malignant but, as Janet described it, the lump had grown from the size of a small birds egg to the size of a bantam's egg in just three months. It was an aggressive grade three, triple negative tumour. A mastectomy and sentinel node biopsy – with the removal of 11 nodes – was followed by six cycles of chemotherapy.

Despite the serious nature of the tumour, Janet came through surgery well, went back to work before the chemo

started and after the second cycle was well enough to return to work again. She put it all behind her and she and her family carried on with life... until December 2006, when a second diagnosis lay in wait.

DELICIE

Like her daughter, Delcie had had breast cysts since her teens, but in her late 70s, her heart health was of much greater concern. In fact, it was during an x-ray assessment of her heart, just before Christmas in 2006, that a lesion in her breast was discovered. Follow-up assessment confirmed that it was breast cancer. Delcie had continued with regular mammograms well after the 69 year cut-off for free mammography, but hadn't had one for about three years at the time her cancer was discovered.

As with Janet, Delcie's tumour was triple negative, but fortunately it was only a grade one tumour with no lymph node involvement. At this point in our conversation, it becomes apparent how hard this has been for the two women. Janet sheds a few tears of relief at the memory of her mother's diagnosis. Had it been a worse tumour, necessitating chemotherapy, Janet doubts that Delcie would have made it.

Delcie went into North Shore Hospital for a mastectomy in early January 2007. However, Janet is less than impressed with her treatment. Although the surgery went well, Delcie developed a huge haematoma on her chest; large clots came away from the surgery site and despite pleas from Janet, Delcie's surgeon insisted that nothing needed to be done, and the haematoma would be resorbed.

Finally, after ten days of pain and no improvement, Janet took Delcie to Middlemore where she was admitted and had further surgery to remove the haematoma, with a different surgeon, as her original surgeon still refused to acknowledge that there was a problem.

Janet firmly believes the problems were avoidable and is sure that had her

mother been a younger woman, the surgeon would have treated her differently.

"It is as though she didn't matter as much, because she was an old woman. There seemed to be an attitude of, 'well, you're going to die anyway.'"

Janet thinks that the aspirin Delcie was taking for her heart problems led to the formation of the haematoma. She had a full scan prior to her mastectomy to ensure her heart was strong enough to withstand the rigours of anaesthesia and surgery, but it seems that her heart medication was ignored by the surgeon.

"The surgeon should have known about the aspirin and should have taken it into account; he should have told her to stop taking it. Personally, from my experience, her treatment was butchery!" Janet says.

"For Mum to go through two lots of anaesthetic and two operations in ten days was really stressful."

After the second operation Delcie's recovery was good but slow; it took a good six months for her to return to normal. However, Janet says that Delcie had little support other than her family through her treatment. Elderly people have specific needs that differ from other women with breast cancer and it seems apparent that Delcie didn't get the consideration and support as an elderly woman that she needed. The difficulties with the aftermath of the mastectomy surgery and the lack of professional support made it a lonely journey for Delcie.

Interestingly, other than their breast cysts, Janet and Delcie have a lifestyle consistent with a reduction in breast cancer risk: both are non-smokers, Delcie is a teetotaller while Janet rarely drinks alcohol; Janet has been a vegetarian for years and both breast-fed their babies for an extended period of time. It is impossible to know but perhaps their cancers would have occurred earlier in their lives, and perhaps been more aggressive were it not for their anti-cancer choices.

TAURANGA WOMEN TO ATTEND REACH TO RECOVERY CONFERENCE 2009 BRISBANE, AUSTRALIA 12 - 15 MAY

Breast Cancer Support Service Tauranga Trust (BCSS) was formed in 1991 to offer support, education and information to women diagnosed with breast cancer in the Western Bay of Plenty. We are a member of the UICC (The International Union Against Cancer) and all our support visitors are trained to International Reach to Recovery standards. Each year a conference is held for members but this is usually in the Northern Hemisphere and until now we have been unable to attend.

However, this year the Conference is being held in Brisbane and being hosted by the Queensland Cancer Council.

Because it is so close to home BCSS decided that it was a great opportunity to update our training and knowledge by attending the Conference. Members were surveyed and several registered an interest in attending.

We then set about raising money to make this possible and with support from our major sponsor, Medex Radiology, together with contributions from Roche and Naturalwear there is a delegation of eight going to the Conference. Those attending include Julie and Jenny from the office, together with four support visitors, one trainee visitor and a trustee, Barbara. Barbara is also a Specialist Breast Care

Nurse and will be attending a Nurses Symposium on the Tuesday as well.

There are several workshops that may be of interest to your members and rather than go into detail we suggest that members look on the website by googling "Reach to Recovery Conference 2009". If anyone is interested in feedback from any of the workshops please do not hesitate to contact us at bcstga@clear.net.nz and advise us of your particular interest. We will be endeavouring to spread ourselves around as many of the workshops as possible. We look forward to reporting back to you all about the Conference after our return.

PREGNANT WOMEN WITH BREAST CANCER DO NO WORSE THAN OTHERS

Women under 35 with pregnancy-associated breast cancer do just as well in the long term as others with breast cancer, researchers from the University of Texas M.D. Anderson Cancer Center have found. In a retrospective study, both groups of women had statistically identical 10-years rates of locoregional recurrence, distant metastases, and overall survival, according to Dr George Perkins. On the other hand, those with pregnancy-associated breast cancer have more advanced disease at diagnosis, suggesting that diagnosis, evaluation, and treatment may be delayed.

Pregnancy-associated breast cancer – defined as cancer diagnosed during or within a year after pregnancy – is a "relatively rare entity that presents unique challenges for both diagnosis and management," Dr Perkins and colleagues said. But as maternal age at the time of pregnancy rises its incidence is likely to increase as well.

To examine the long-term effects of such cancers, the researchers looked at medical records of 652 women (with 668 cancers) treated between 1973 and 2006 at the M.D. Anderson Cancer Center. Of the 652, 104 had pregnancy-associated breast cancer, with 51 developing during pregnancy and 53 within a year of delivery.

The outcomes of interest were locoregional recurrence, distant metastases, and overall survival, but Dr Perkins and colleagues also compared other clinical characteristics.

Analysis found no significant differences in the primary outcomes. Specifically:

- At ten years the rate of locoregional recurrence was 23.4% for those with pregnancy-associated breast cancer and 19.2% for others.
- The 10-year rates of distant metastases were 45.1% and 38.9%.
- And the overall survival rates at 10 years were 64.6% versus 64.8%.

There were also no significant differences in any of the outcomes when the researchers compared those whose cancer developed during pregnancy with those in whom it appeared later.

"Pregnancy itself does not impart a worse prognosis," they said. "However, pregnancy does mask symptoms and hinder diagnosis."

In addition, for those patients who developed breast cancer during pregnancy, any treatment intervention during pregnancy provided a trend toward improved overall survival compared with delaying evaluation and treatment until after delivery.

Cancer, 2009 March 15; 115 (6): 1174-84.

STOP CANCER WHERE IT STARTS

TAKING ON THE COSMETICS INDUSTRY – PART I TALKING TO DAWN MELLOWSHIP

Dawn Mellowship is an author, freelance journalist, ethical fashion columnist, web designer, and a Reiki teacher and practitioner. On top of that she has taken on the cosmetics industry with the publication of her new book, *Toxic Beauty*.

Upfront U Kaiora “interviewed” Dawn by email from her home in the UK, and got her take on cosmetics and chemicals.

Dawn began researching the chemicals in cosmetics as a result of personal health issues:

“I changed my lifestyle after developing chronic fatigue syndrome, fibromyalgia and multiple chemical sensitivities, cutting out all alcohol, coffee, tea, fizzy drinks and refined foods and switching to organic and vegan foods and products. When I became vegan I started looking at the ingredients lists on my beauty products to see if any of the ingredients were animal based and was surprised by the baffling list of chemical names,” she told *Upfront*.

She began researching the topic on the internet and in books, and discovered that many of these ingredients were toxic or potentially toxic, and that many chemicals in cosmetics were industrial chemicals also used in pesticides, insecticides, rocket fuel, paints, household cleaning products and other consumer and industrial items.

Women are bombarded with media messages about how they should look and the need to use cosmetics to be beautiful. Dawn says that the cosmetics industry spends a lot of money on advertising to maintain the carefully crafted illusion that we need beauty products and that they are somehow beneficial to our wellbeing.

“It’s part of their marketing strategy. Insecure and neurotic consumers buy more products to artificially bolster their confidence and make them appear more attractive to the opposite sex. Made up beauty is a myth. We still look the same when we wash beauty products off our skin, they don’t reverse the signs of ageing and they are in no



Taking on the cosmetics industry: Dawn Mellowship

way a substitute for healthy living and good nutrition.

“The industry thrives on our fears about ageing and how others perceive us, because if we all felt confident without make-up, we wouldn’t purchase their products and the industry’s profits would take a nosedive,” she says.

The industry spends a lot of money on PR to assure consumers that their products are completely safe and many people are assuaged enough by these reassurances enough to carry on purchasing conventional beauty products. However, some women have told Dawn that they are aware of the potential dangers but their desire to conform to a social stereotype of physical beauty outweighs any safety concerns.

The problem is that the cosmetics industry is huge and earns billions of dollars in profit every year. Anytime research reveals the dangers of many of ingredients in cosmetics, industry associations around the world gear up to refute the research. Asked about these constant denials Dawn points out that cosmetics industry tactics are the same as those of the tobacco industry in the 60s and 70s.

“They discredited the evidence linking cigarette smoking and lung cancer but eventually the scientific evidence became irrefutable and I am sure the same thing will one day happen with the cosmetics industry. Until that happens they are not going to jeopardise their profits or the reputation of the cosmetics and chemicals industries by admitting they are selling unsafe products.”

In New Zealand we tend to take the lead of other countries and do little or no testing of any product, including pharmaceuticals, instead relying on the testing (and licensing) of products overseas. However, Dawn says that testing in the US – whose products generally turn up on our own shelves – is minimal and regulation abysmal.

“The industry is self-regulating. Cosmetics were not included in any regulation at all until the 1938 Federal Food Cosmetics and Drugs Act, because prior to then the beauty industry was believed to be insignificant and only affecting women who weren’t able to vote anyway (until 1918). It was only introduced because so many women were being poisoned by toxic cosmetics, and the industry as they always do, lobbied aggressively to get the bill shelved. The Food and Drug Administration (FDA) responsible for enforcing cosmetic and pharmaceutical regulations in the US do not require that ingredients are approved, tested for safety or reviewed before being marketed to consumers (apart from colour additives). Testing is left in the hands of the manufacturers.”

Kind of like leaving the fox in charge of the chook house!

Dawn says that the EU has the best cosmetics regulations in the world courtesy of the EU Cosmetics Directive and legislation called REACH which was introduced in 2007. Under the Seventh Amendment to the Directive, certain substances classified as carcinogenic, mutagenic or toxic for reproduction are banned. REACH aims to take a more precautionary approach, rather than banning

ingredients after they have been found to cause harm to humans or the environment, but the chemicals industry in the US and Europe lobbied heavily to get it watered down, so it's not as stringent as it could be.

Even when safety testing is carried out, Dawn says that it is the individual ingredients that are tested rather than combinations of chemicals, even though it is known that chemical mixtures can produce more potent effects.

Meanwhile, it seems clear that the cosmetics industry spends an incredible amount of money advertising their products – in some

cases more on advertising and promotion than on research and development, according to Cosmeticsdesign.com – and not a lot on making sure their products are safe. Dawn doesn't know how much the industry spends on undertaking safety-assessments but in the US 89 percent of the more than 12,000 cosmetic ingredients available for use have not been evaluated for safety.

Dawn believes that consumers should be demanding better from the manufacturers. We should expect individual ingredients and final formulations to be adequately safety-tested prior to being placed on the market.

“The public is becoming increasingly savvy about what's going into their products and the self-serving nature of many global industries, so hopefully there will come a time when they won't be able to get away with duping consumers anymore. Consumers need to take a stand and demand safer and more environmentally-friendly products.”

The next issue of *Upfront U Kaiora* will include Part II of our interview, with Dawn offering advice on the things women should be avoiding in their cosmetics and what organic brands to look for.

From the Project Desk...

BCN is pleased to bring you an update from the recommendations made by delegates at the First National Conference – 2007.

SECONDARY BREAST CANCER – LIVING WITH HOPE IN YOUR HEART

- “That participants in the workshop form a support network (via email/phone)”
- “That BCN develop a ‘chat room’ or an online message board facility on their website”

Good news about the online forum: Sweet Louise has their forum up and running and it's now available for all those in New Zealand with secondary breast cancer. Those outside of the areas where Sweet Louise operates can participate in the online forum by emailing Sweet Louise directly via www.sweetlouise.org.nz (There is no longer any need to email BCN first as we wrote in *Upfront U Kaiora* 82). I recommend that everyone with secondary breast cancer who uses the internet register with Sweet Louise, even if you do not wish to participate straight away. To register you will need initial confirmation of your secondary breast cancer from a health professional. Then you will be ready for the day when you may have the desire for online company, support or questions and all you will have to do is log in.

- “That more information be available to women with metastatic disease, particularly on the BCN website”

We will soon have a section for women with secondary breast cancer on the BCN website. There will be personal stories, articles, recommended books, and relevant links. Please contact us if you have some ideas for the web page. We would particularly appreciate your personal story – under a pseudonym if you wish. We have those with editing skills who can polish the final article for you, or you could talk to someone from BCN by phone and we can write the story for you.

BCN would like to remind members with secondary breast cancer that by contacting us, you can receive “The Inside Story” with your *Upfront U Kaiora*. This is the newsletter published by Breast Cancer Network Australia especially for those with secondary breast cancer. Alternatively you can read it on line at <http://www.bcna.org.au/content/view/565/582/>)

Barbara Mason



BREAST CANCER NETWORK POLO SHIRTS AND CONFERENCE PROCEEDINGS

Conference Proceedings booklet \$5.00
incl postage.

BCN polo style hot pink T-shirts - \$20
incl postage. Sizes 10, 12, 14 & 16.
(Sizes are very generous, quality is
excellent).

Also available free copies of
Conference Recommendations - send
your name and address.

LOBULAR INVOLUTION AND BREAST CANCER BY SUE CLARIDGE

Lobular involution – sounds like a nasty rash, or at least some weird disease you wouldn't want to have. What it is, is the natural degeneration of milk producing breast tissue. It happens to all of us... these lobules undergo involution; that is, they atrophy and regress. And the really important thing about this, is that as the lobules undergo involution, many chemical and physical changes occur in the cell linings.

This is important because it is the cell lining the lobules that are believed to give rise to most breast cancers, and Dr Lynn Hartmann, a professor of oncology at the Mayo Clinic in the US, believes that these chemical and physical changes may make the cells less likely to develop into cancer cells.

Lobular involution also seems to be associated with mammographic breast density, which is highly predictive of breast cancer risk. Women with higher breast density have a higher risk of cancer than women with a lower breast density, as measured by mammography. Dr Hartmann explained in a recent journal article that the exact relationship between breast density and involution is not known but that, in general, breast tissue that is less dense has more complete involution. Dr Leslie Bernstein, professor and director of cancer etiology at the City of Hope Comprehensive Cancer Center in Duarte, California, said that scientists believe that cellular changes that make the tissue less dense may also make cells less susceptible to becoming cancerous.

Interestingly, with involution there is an increase in oestrogen receptor positive cells, a decrease in proliferation but, in comparison to premenopausal breasts, a greater number of oestrogen receptor proliferating cells. The breast cancers that occur in women over 75 years of age are more likely to be oestrogen receptor positive, with a low growth rate and limited expression of HER-2.

WHY IS INVOLUTION IMPORTANT?

Researchers are always trying to improve risk models which determine a woman's risk of developing breast cancer. The "current 'gold standard' for determining breast cancer risk is the Gail model, a widely used and proven way to predict the number of diagnoses of invasive cancer that will occur in a population of women. But studies have shown that, for an individual woman, the model is fairly weak at predicting risk."

The Gail model, developed in the 1980s by a team headed by Dr Mitchell Gail at the US National Cancer Institute, is based on statistical data from nearly 6,000 women and "takes into account age, age at first menstrual period, age at first live birth, number of previous biopsies, number of first-degree relatives (mother, sisters, or daughters) with breast cancer, and ethnicity. From these data, the model estimates a woman's risk of developing invasive breast cancer in the next five years and by the time she is 90 years old."

Researchers have now turned their attention to lobular involution in an attempt to

improve the model and permit individual risk predictions; that is, predictions of risk for individual women not just across a population.

In her research Dr Hartmann has found that "women whose breast tissue had undergone complete involution had a statistically significantly lower chance of later developing breast cancer than did women whose breast tissue had only partially undergone involution or had not undergone any involution." She and her colleagues also found that "identified subgroups of women at increased risk for cancer; for example, a woman older than 55 years whose lobules had not yet begun involution had more than three times the risk of a woman of that age in the general population. In tissue in which involution seems to have stalled," they concluded, "the risk of cancer increases."

As the aging process goes, most women are more aware of the lines on their face and the grey in their hair – none too welcome changes for the majority – and far less aware of the changes going on in their breasts. But if ever aging was to bring a benefit, then lobular involution is it. Not only will it reduce your risk of breast cancer, but it may eventually give medical researchers a way of quantifying your risk over the rest of your life.

Beyond the Gail Model: Lobular Involution May Help Refine Breast Cancer Risk Assessment, 2009. *Journal of the National Cancer Institute*, 101(3):134-135

TWO FOOD ADDITIVES WITH PREVIOUSLY UNRECOGNISED OESTROGEN-LIKE EFFECTS

Scientists in Italy have reported on the development and successful use of a fast new method to identify food additives that act as xenoestrogens – substances with oestrogen-like effects that are stirring international health concerns. They used the method in a large-scale screening of additives and discovered two additives with previously unrecognised xenoestrogen effects. Their report appears in *Chemical Research in Toxicology*, a monthly journal.

In the study, Pietro Cozzini and colleagues cite increasing concern about identifying these substances and about the possible health effects. Synthetic chemicals that mimic natural oestrogens have been linked to a range of human health effects ranging from

reduced sperm counts in men to an increased risk of breast cancer in women.

The scientists used the new method to search a food additive database of 1,500 substances, and verified that the method could identify xenoestrogens. In the course of that work, they identified two previous unrecognised xenoestrogens. One was propyl gallate, a preservative used to prevent fats and oils from spoiling. The other was 4-hexylresorcinol, used to prevent discoloration in shrimp and other shellfish. "Some caution should be issued for the use of propyl gallate and 4-hexylresorcinol as food additives," they recommend in the study.

Chemical Research in Toxicology 2009, 22 (1), pp 52–63.

A FINE FEBRUARY LAUNCH FOR SINK OR SWIM

BY JANE BISSELL

A book launch is a wonderful celebration of achievement, made even more special, inspirational and poignant when the author has written about her personal story of overcoming a life challenge.

More than 80 invited guests gathered on the pool deck of Auckland's Rendezvous Hotel on a clear February evening to celebrate the launch of a new book by Hawkes Bay resident Shelley Hanna. *Sink or Swim* tells the story of Shelley's diagnosis, treatment and recovery from breast cancer. Guests enjoyed bottles of bubbles, delightful cheeses and breads, chutneys from Shelley's own Hanna Berry Farm brand and plenty of good conversation in the relaxed surroundings of the pool deck.

Organised by the Auckland YWCA and publisher HarperCollins, the launch brought together people united by breast cancer in many different ways – women who had experienced the disease, representatives of the many organisations who work to raise funds for and heighten awareness of breast cancer issues, and the family and friends who have supported loved ones through their diagnosis and recovery.

Many of those attending acknowledged how the sharing of a personal experience with breast cancer through the written word can bring comfort, support and direction to others facing a similar journey. Reading about the strategies another woman used to cope and the activities that helped her can offer reassurance and motivation. Captured between the pages of *Sink or Swim* is a truthful, honest story, and Shelley describes how exercise – in particular swimming – and accessing psychosocial support helped her to recover from breast cancer.

Shelley has a particular interest in the psychosocial aspects of recovery from breast



Sink or Swim author, Shelley Hanna

cancer. She leapt at the opportunity to train as one of the first YWCA Encore Exercise programme co-ordinators in New Zealand and has been running courses in Hawkes Bay since 2005. Shelley hopes that the enthusiasm she conveys in her book for Encore will encourage other women to experience the benefits of a programme that has helped so many women regain health, fitness and personal confidence after a diagnosis of breast cancer.

Guest speaker John Harman (surgeon at St Mark's Breast Centre) is a long time supporter of Encore and paid tribute to Shelley and her inspiring story. Carol Beu from The Women's Bookshop donated 10% of the evening's book sales to Encore.

Shelley's friend and mentor, Mark Inglis, whose own remarkable story had inspired her, auctioned a case of wine donated by Hawkes Bay winery Elephant

Hill, raising a further \$450 for Encore. The YWCA's Marketing and Media Coordinator Tilda Bostwick spoke of Shelley's long involvement with Encore and recognised the generous support the programme receives from the New Zealand Breast Cancer Foundation. The guests enjoyed a small taste of the Encore programme when National Encore Training Manager Julie Cummins led the crowd in some upper body exercises.

In her launch speech, Shelley highlighted the importance of psychosocial support in a recovery from cancer. She feels patients can improve outcomes by supplementing conventional medical treatments with psychosocial support, not being afraid to ask for help when it is needed and by pursuing those activities and things that bring joy, hope and laughter. Shelley gave heartfelt thanks to those who had encouraged and supported her – husband Bruce, family and friends, John Harman,

Mark Inglis and the YWCA.

Shelley told the audience it was important to spend time doing those things that inspire happiness and fulfilment. Swimming was one such activity for her and she described the absolute joy she experienced when her relay team broke the NZ record in their age group at the World Masters Championships in Christchurch. She also spoke of lessons that we can all learn from her story, the simplicities of life we often think of but seldom make time to do. 'Spend more time doing those things you enjoy. Doing something you love changes your body chemistry and strengthens your immune system. Sometimes you have to step outside your comfort zone, stick your neck out to make a difference in life; otherwise you'll look back at life full of regret that you didn't do more, achieve more and take on more.'

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.

WELEDA IRIS DAY CREAM

Reviewed by Gillian Woods



For some years I have used moisturisers made from mainly natural products. In New Zealand we have some very good locally made natural cosmetics to choose from. However, in this issue I am writing about my favourite moisturiser which is Weleda Iris Day Cream, made in Germany. For my dry skin type, it provides just the right degree of moisturiser for daytime use and under makeup. I use very few skin care products but would never dispense with my moisturiser. This cream is absorbed quickly and has a delicate and delicious fragrance. It comes in a convenient tube and I can buy it readily at my local health store. Although not cheap, it is not as pricey as many other options. My eyes react with redness to quite a few cosmetics so I am careful to keep moisturiser and makeup away from my eyes. However Iris Day Cream is good from this perspective too.

According to Weleda's pamphlets their products are free of synthetic fragrances, colours, preservatives, emulsifying agents, mineral oil and parabens, and they are not tested on animals. Their body care products are designed with underlying anthroposophic principles to promote natural harmony and are quality controlled. What Iris Day Cream contains is a mix of natural oils, beeswax, witch hazel, fragrances from natural oils, alcohol, xanthan gum and a silicate compound related to Fuller's earth.

It is interesting that at the following web site, it is rated amongst the best group for lotions – see <http://lesstoxicguide.ca>

Another favourite product is Weleda Skin Food in a green tube which my daughter-in-law has sometimes thoughtfully given me for Christmas. It is a very thick cream suited to those who are not allergic to lanolin, it can be used on the face as a night cream and is great for hands and rough areas like heels.

CHICKEN RISONI

INGREDIENTS

1.5kg free range chicken
2 cloves garlic
2T extra virgin olive oil
1 onion, chopped
4 stalks celery, chopped
2 cups hot chicken stock
2 tins chopped tomatoes in juice,
plain or with herbs
1 cup risoni pasta
2 bay leaves
2t finely grated lemon rind
1T chopped parsley
1T chopped oregano leaves
Some pitted olives

METHOD

Wash chicken and pat dry. Crush garlic in half the oil, and brush all over chicken. Roast at 180°C for 1 hour on a rack. Baste once during cooking time.

Meanwhile heat remaining oil in a large pan and cook the onion until softened. Add celery, and stir for a few minutes until softened. Add stock, tomatoes, risoni, bay leaves and lemon rind. Simmer about 10 minutes, stirring occasionally, when risoni will have thickened.

After roasting the chicken for an hour, discard the fat drippings or transfer chicken to a large oven dish. Pour risoni mix over and around the chicken, and bake for 30 minutes or more until the chicken is fully cooked.

Remove chicken carefully, mix herbs and olives into the risoni. Serve chicken either whole or in portions, arranged on the risoni. Complement with a green vegetable and a spinach salad.

(Originally from the Australian Women's Weekly Cookbook series, the recipe used 500g grated celeriac. This is not always easy to find and we enjoy it made with celery.)

4-6 serves.



SINK OR SWIM BY SHELLEY HANNA
HARPER COLLINS PUBLISHERS, 2009
REVIEWED BY JEANETTE MALLINSON

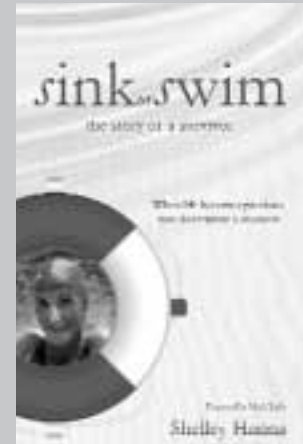
“When life becomes precious, you don’t waste a moment” says Shelley Hanna author of *Sink or Swim*, a book that reveals Shelley’s journey from despair at diagnosis of breast cancer, to satisfaction of success in recovery from treatment and return to joyful living.

As a young, busy working mother Shelley overcame the adversity of a double mastectomy and chemotherapy. She dispelled her anxieties with a refocus and positive approach to regain her health through a swimming programme devised by her coach, that she began four weeks after her last treatment. As there was little information available about the benefits of exercise in recovery from chemotherapy Shelley took the advice of her oncologist to “listen to her body and act accordingly”. Exhilarated by her early swimming attempts and through trial and error she used her judgment to develop techniques

and adopt a training schedule to improve her endurance and swimming skills; a programme that helped the return of strength and a level of fitness, relieved pain and gave her hope of a full active life.

The book charts her progress through a process of transformation from cancer patient to successful competitor in the Master’s Swimming Games to mark the first anniversary of her diagnosis. At each anniversary of diagnosis she set herself a new challenge to attain and accomplish with high-level personal goals that included swimming, distance running, cycling, winning gold medals at the Masters Games, triathlons and the most recent challenge a 500 kilometre charity cycle from Vietnam to Cambodia, demonstrating that her personal goals and effort have translated into global endeavour.

With personal knowledge of the benefits of water therapy in recovery Shelley extended



her interest and support of the launch of the YWCA Encore programme for breast cancer patients by becoming an instructor where she passes on her positive ‘can do’ attitude to life, to inspire other women and give them hope to regain health and rebuild physical and emotional strength.

This is an uplifting account of resilience, hope and survival in recovery from cancer treatment and documents the success of a shift in focus from treatment to achievement.

RESEARCH AND NEWS UPDATE

REACH FOR THE BROCCOLI

Women should up their intake of broccoli and cauliflower to reduce their risk of breast cancer.

While it has been known for some time that eating cruciferous vegetables, such as broccoli, cauliflower, and cabbage, can help prevent breast cancer, the mechanism by which the active substances in these vegetables inhibit cell proliferation was unknown – until now.

Scientists in the University of California Santa Barbara laboratories of Leslie Wilson, professor of biochemistry and pharmacology, and Mary Ann Jordan, adjunct professor in the Department of Molecular, Cellular, and Developmental Biology, have shown how the healing power of these vegetables works at the cellular level. Their research is published in the December 2008 edition of the journal *Carcinogenesis*.

“Breast cancer, the second leading cause of cancer deaths in women, can be protected against by eating cruciferous vegetables such as cabbage and near relatives of cabbage such as broccoli and cauliflower,” said first author Olga Azarenko, who is a graduate student at UCSB. “These vegetables contain compounds called isothiocyanates which we believe to be responsible for the cancer-preventive and anti-carcinogenic activities in these vegetables. Broccoli and broccoli sprouts have the highest amount of the isothiocyanates.

“Our paper focuses on the anti-cancer activity of one of



these compounds, called sulforaphane, or SFN,” Azarenko added. “It has already been shown to reduce the incidence and rate of chemically induced mammary tumors in animals. It inhibits the growth of cultured human breast cancer cells, leading to cell death.”

Azarenko made the surprising discovery that SFN inhibits the proliferation of human tumor cells by a mechanism similar to the way that the anticancer drugs taxol and vincristine inhibit cell division during mitosis. Mitosis is the process in which the duplicated DNA in the form of chromosomes is accurately distributed to the two daughter cells when a cell divides.

Hundreds of tiny tube-like structures, called microtubules, make up the machinery that cells use to separate the chromosomes. SFN, like the more powerful anticancer agents, interferes with microtubule functioning during mitosis in a similar manner to the more powerful anticancer drugs. However SFN is much weaker than these other plant-based drugs, and thus much less toxic.

“SFN may be an effective cancer preventive agent because it inhibits the proliferation and kills precancerous cells,” said Wilson. It is also possible that it could be used as an addition to taxol and other similar drugs to increase effective killing of tumor cells without increased toxicity.

Carcinogenesis. 2008 December; 29 (12): 2360-8.

RESEARCH AND NEWS UPDATE CONTINUED

RISK OF RADIATION-INDUCED BREAST CANCER FROM MAMMOGRAPHIC SCREENING FOR YOUNG BRCA MUTATION CARRIERS

BRCA mutation carriers are recommended to start mammographic screening for breast cancer as early as age 25–30 years. US researchers have used an excess relative risk model (based on 7600 subjects who received radiation exposure) to estimate the lifetime risk of radiation-induced breast cancer from five annual mammographic screenings in young women (under 40 years) with BRCA gene mutation. They then estimated the reduction in breast cancer mortality required to outweigh the radiation risk.

Breast cancer rates for BRCA mutation carriers were based on an analysis of 22 studies with 8139 subjects. For BRCA1 mutation carriers, the estimated lifetime risk of radiation-induced

breast cancer mortality per 10,000 women, resulting from annual mammography was 26 for screening at age 25–29 years, 20 for screening at age 30–34 years, and 13 for screening at age 35–39 years.

To outweigh these risks, screening would have to reduce breast cancer mortality by 51% at age 25–29 years, by 12% at age 30–34 years, and by 4% at age 35–39 years; estimates were similar for BRCA2 mutation carriers. If we assume that the mortality reduction from mammography is 15%–25% or less for young women, these results suggest that there would be no net benefit from annual mammographic screening of BRCA mutation carriers at age 25–29 years; the net benefit would be zero or small at age 30–34 years, but there should be some net benefit at age 35 or older.

Journal of the National Cancer Institute, 2009, 101 (3): 205-209.

BREAST EVENTS TO COME

- **27 April – Pilot of YWCA Encore Programme** in Wellington. On Mondays from 9-11am till 22/6, call 0800 ENCORE to enrol.
- **8 May 2009 - The 2009 Breast Cancer Cure – Mercedes-Benz Charity Golf Day** In partnership with The Rotary Club of Parnell. Friday 8 May at Titirangi Golf Club. A BCRT fundraiser for Breast Cancer Research. For more information contact rebecca@breastcancer.org.nz.
- **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.

VISIT THESE SITES FOR MORE BREAST INFO! www.bcn.org.nz www.breast.co.nz

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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 Woodroofe; 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 support the work of BCN & receive a regular copy of UPFRONT U KAIORA send your name and address to: **BCN (NZ), PO Box 46018, Herne Bay, Auckland 1147 (Office 300 Richmond Road, Grey Lynn.)** Membership – \$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 .

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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

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