

# Breast Cancer Network Australia



**Strength to Strength Conference  
25 – 26 October 2012**

**Summary of Presentations**

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# Breast cancer – why me?

## Lifestyle Factors & Breast Cancer

Professor Dame Valerie Beral  
Professor of Epidemiology, University of Oxford

### Lifestyle factors & breast cancer incidence

- In general, breast cancer incidence is higher in developed countries and lower in developing countries.
- Most of the difference is due to childbearing patterns, because until recently in developing countries, women had many children and breastfed them for a long time, reducing breast cancer risk.
- In developed countries, where women have few children and don't breastfeed for as long, incidence rates are higher.
- Annual incidence world-wide:
  - ~1,000,000 new cases in 2000
  - ~1,400,000 new cases in 2008
  - ~2,000,000 new cases in 2030 -- almost all the increase will be in middle/low income countries
- Breast cancer incidence at ages 50+ has fallen slightly in many high-income countries after 2002. This fall is linked to decrease in women using hormone replacement therapy (HRT).
  - The Million Women Study showed a rapid reduction in breast cancer incidence after stopping HRT.
- Death rates from breast cancer have been falling rapidly in high-income countries since about 1990, mostly because of improvements in survival and early detection, including screening.

### Menopause & breast cancer incidence

- Women experience a rapid decrease in oestrogen levels in the few years before and after the menopause
- A greater proportion of breast cancers are oestrogen receptor positive (ER+) in postmenopausal women than premenopausal women

### Childbearing & breast cancer incidence

- Relative risk of breast cancer is affected by:
  - Number of births (decreases when number of births increases)
  - Age at first birth (increases with an increase in the age of the mother at first birth)
  - Time since the birth (decreases as time since last birth increases)
  - Breastfeeding (decreases with longer lifetime duration of breastfeeding)
- Breast cancer incidence in developed countries would be more than halved if women had similar childbearing patterns to women in developing countries

### Nutritional factors & breast cancer incidence

- Relative risk factors are:
  - Age at menarche/first period (increased incidence in women who were young at menarche)
  - Height (increased incidence in taller women)
  - Weight (increased incidence with a combination of increased weight and time since menopause)
  - Alcohol (increased incidence with higher alcohol consumption)

**The most important factors in relation to lifestyle & breast cancer incidence are:**

- Childbearing and breastfeeding
- Large body size

Almost all known effects of lifestyle factors have something to do with hormones (especially for ER+ tumours).

### **Tamoxifen and breast cancer survival**

- Tamoxifen significantly reduces the risk of recurrence in oestrogen receptor positive (ER+) breast cancer over 10 years
- It has little effect on risk of recurrence in oestrogen receptor negative (ER-) breast cancer
- Also reduces cancer incidence in the other breast
- Aromatase inhibitors produce a similar effect to tamoxifen over 5 years

### **Conclusions**

- Fall in deaths from breast cancer is due to continuous improvements in treatment and early diagnosis (including as a result of screening)
- Hormones associated with reproduction are key for the causation, prevention, and treatment of breast cancer
- To reduce your chance of developing breast cancer – avoid hormone replacement therapies, keep your weight down, and minimise alcohol intake
- **To improve your chance of surviving breast cancer - use some type of hormone blocking therapy for 5 years or longer (ER+ cancers); as well as what seems right for you (i.e. exercise, diet, weight)**

# Personalised treatment – are we there yet?

## The Pathologist's View

Professor W. Fraser Symmons  
Director of Research Operations, Department of Pathology,  
The University of Texas M.D. Anderson Cancer Centre, Houston, Texas, USA

The pathologist's contribution to personalised medicine includes:

### Current standard practices

- determining the pathology of the tumour
  - diagnostic type, e.g.
    - Ductal carcinoma (more than 80 per cent of all breast cancers)
    - Lobular carcinoma
    - Subtypes including tubular, mucinous (colloid), adenoid cystic, neuroendocrine, medullary, metaplastic, micropapillary, inflammatory
  - grade
  - stage
  - whether the surgical margins are clear
  - receptor status (ER, PR, HER2)

### New and emerging practices

- the cancer's response to neoadjuvant chemotherapy (i.e. chemotherapy given before surgery)
- genomic tests to help predict the cancer's response to chemotherapy, e.g. Oncotype DX and MammaPrint
- emerging tests, e.g. Ki67 and CTCs (Circulating Tumour Cells)

### Pathologists perform prognostic tests and predictive tests

- Prognostic tests provide information about the level of risk related to the biology or natural history of the tumour, e.g.
  - lymph node status – the fewer lymph nodes affected, the better the prognosis
  - grade – the lower the grade of the tumour, the better the prognosis
- Predictive tests provide information about the probability that a procedure or treatment outcome will occur, e.g.
  - ER or HER2 status – these tests predict the likely benefit of hormone therapy (ER status) or Herceptin treatment (HER2 status)

### Oncotype DX gene assay test

- This test can be helpful for women with node-negative, ER+ breast cancer to determine whether chemotherapy may be of benefit. (*Note: This test is conducted in the USA and the cost to Australian women is \$4,000. There is no Medicare rebate available.*)

### Neoadjuvant treatment

- Neoadjuvant treatment is treatment such as chemotherapy or hormone therapy that is undertaken before surgery. It can be used for a number of purposes, including to help shrink a very large tumour so it is easier for the surgeon to remove. It can also be used to help predict whether the particular treatment will be of benefit following surgery.

### Conclusions

- Current standard pathology tests and reports already guide personalised treatment for breast cancer
  - e.g. if your pathology shows the tumour is ER+, you will most likely be treated with a hormone therapy such as tamoxifen or an aromatase inhibitor
- Other tests can provide additional information to estimate the risk of the cancer progressing and the potential benefit or otherwise of chemotherapy treatment
  - e.g. Oncotype DX can help to predict the usefulness of chemotherapy in women with node-negative, ER-positive breast cancer
- Neoadjuvant chemotherapy can be used to measure the tumour's response to chemotherapy and is strongly prognostic of the benefit of chemotherapy following surgery (adjuvant chemotherapy)
- **Current research will result in the development of new tests to enable us to better predict outcomes and guide treatment options**

# The Medical Oncologist's View

Assoc Prof Fran Boyle

Medical Oncologist

Associate Professor of Medical Oncology, University of Sydney

Director, Patricia Ritchie Centre for Cancer Care and Research, The Mater Hospital, Sydney

## Personalised treatment

Personalising treatment for breast cancer depends on a number of different things:

- the 'type' of the cancer
  - e.g. is it a slow-growing ER+ cancer, or is it an aggressive fast-growing triple negative cancer?
- your age and the stage of your life
  - e.g. are you a young mum juggling a family, or a retired grey nomad?
- where you live
  - the distance to your treatment centre may determine
    - choice of surgery – mastectomy v lumpectomy
    - access to radiotherapy
    - choice of breast reconstruction
    - scheduling of chemotherapy
- how you are travelling otherwise
  - do you have other health problems
  - are you pregnant
  - do you want to maintain your fertility
  - is there a family history of cancer
  - are there any psychosocial or mental health concerns
  - your culture and language

## Clinical trials

Treatments are tested in clinical trials to ensure their effectiveness and safety. Current clinical trials are helping to further personalise breast cancer treatments. They include:

### Hormone therapy treatment

- how long should aromatase inhibitors be taken for best effect (SOLE trial)
- do aromatase inhibitors prevent breast cancer in women at high risk (IBIS 2 trial)
- is it safe to take oestrogen creams for vaginal symptoms

### HER2 treatment

- How long should women with early breast cancer take Herceptin – one year v two years (HERA trial)
- Is it better to block HER2 with two drugs than with one – e.g. is a combination of Herceptin and Tykerb, or a combination of Herceptin and Perjeta (pertuzumab), better than Herceptin alone
- Can chemotherapy side effects be avoided – e.g. through the use of targeted chemotherapies such as T-DM1, which combines chemotherapy with Herceptin into one drug and delivers both the chemo and Herceptin directly into the cancer cells

### Triple negative breast cancer

- Is there a role for PARP inhibitors
- Platinum based chemotherapies
- Should maintenance oral chemotherapy be offered after initial IV chemotherapy

## Secondary breast cancer

- **There are many potential treatments for secondary breast cancer and what is offered will depend on the nature of your cancer**
  - e.g. is it fast growing or slow growing?
- BCNA's *Hope & Hurdles* pack has been personalised so that you can order separate booklets specific to your diagnosis, e.g.
  - Secondary breast cancer in the bone
  - Secondary breast cancer in the liver
  - Secondary breast cancer in the lungs
  - Secondary breast cancer in the brain
- Earlier detection of brain metastases has enabled more targeted treatment, including surgery and localised radiotherapy (e.g. stereotactic and gamma knife) instead of whole brain radiotherapy



# My Body – My Choices

## Healthy Bones

Dr Richard de Boer  
Medical Oncologist  
Royal Melbourne and Epworth-Freemasons Hospitals

### Background

- Ensuring bones are healthy is an important part of breast cancer care
- Bone loss is caused by aging, natural menopause, and various cancer treatments
- Bone is a common site of secondary breast cancer and leads to pain and skeletal related events
- Bisphosphonates and the newer rank-ligand targeted therapy are the most commonly used agents to manage bone loss and bone metastases

### Secondary Breast Cancer in the Bone

Bone is the first site of relapse in 40-50% of women with secondary breast cancer.

Treatment options for secondary breast cancer in the bone include:

- Analgesics (pain relief)
- Systemic anti-cancer treatment (e.g. chemotherapy, Herceptin, hormone therapies)
- Surgery
- Radiotherapy
- Osteoclast Inhibition
  - Bisphosphonates
  - Inhibitors of RANK/RANK Ligand

Normal bone remodelling is a coupled and balanced process. Cells called osteoclasts break down bone. Cells called osteoblasts then enter the scene and form new bone in the area. This process is interfered with in women with bone metastases. Bisphosphonates may help.

### Aims of Bisphosphonate Treatment

- To normalise the rate of bone resorption (i.e. the normal breakdown and reformation of bone)
- Prevent skeletal morbidity
- Relieve pain
- Minimise disruption to the quality of life.

### Bisphosphonate Trials

- Findings from recent bisphosphonate clinical trials:
  - Both denosumab and zoledronic acid reduce the period of time before women experience a 'skeletal-related event'
  - Denosumab was slightly better at lengthening the time before women experience moderate to severe pain.
  - Both have similar adverse events

### **Cancer Treatment–Induced Bone Loss**

The following breast cancer treatments accelerate bone loss:

- Menopause caused by chemotherapy
- Ovarian suppression
- Aromatase inhibitors (or tamoxifen in premenopausal women)

### **Ways to predict risk of bone fracture:**

- A bone mineral density (DXA) scan will give doctors a femoral neck T-score

- Serial monitoring should be done on the same equipment at the same site
- Age
- Medications
- History/presence of vertebral fracture
  - The best predictor of a subsequent fracture is an existing one
- Risk of falls
- Vitamin D levels

### **Conclusions**

Many individuals diagnosed with cancer will be long-term survivors.

- Optimising bone health and preventing osteoporotic fractures and skeletal related events is critical
- **Knowing your Vitamin D level and Tscore (DXA scan) is important**

# Physical Activity and Breast Cancer

Associate Professor Sandi Hayes  
Exercise Physiologist and Senior Research Fellow  
Institute of Health and Biomedical Innovation, Queensland University of Technology

## So why is exercise so good – irrespective of breast cancer?

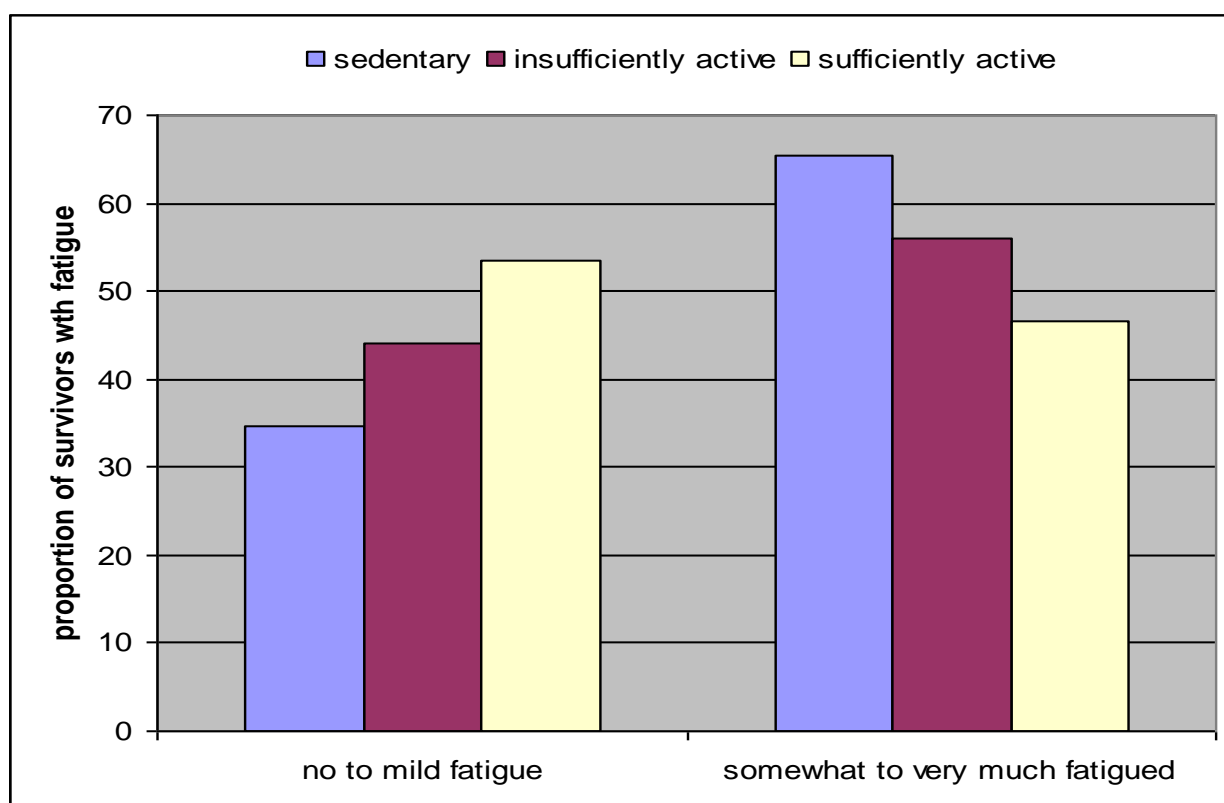
### Exercise improves your health

- It impacts your:
  - heart, lungs, circulation
  - Muscles and bones
  - Immune system
  - Weight and body composition
  - Mental health
  - Fitness, function, Quality of Life and survival

People who exercise experience:

- Higher satisfaction with weight, shape and appearance
- Increased self-esteem and confidence
- Reduced depression
- Reduced anxiety and worry
- Reduced stress
- More likely to engage in other healthy behaviour changes (e.g. stop smoking)

## Exercise following breast cancer: treatment-related symptoms



## Lymphoedema

- Exercise does not cause lymphoedema
- Exercise does not worsen lymphoedema
- Exercise may reduce how often lymphoedema is exacerbated.

## Other- symptoms are also reduced with regular exercise

Preservation or improvements:	Reductions:
<ul style="list-style-type: none"><li>• Muscle mass, strength, power</li><li>• Cardiorespiratory fitness</li><li>• Physical function</li><li>• Physical activity levels</li><li>• Range of motion</li><li>• Immune function</li><li>• Cognitive function</li><li>• Chemotherapy completion rates</li><li>• Body image, self-esteem and mood</li></ul>	<ul style="list-style-type: none"><li>• Number of symptoms and side-effects reported, such as nausea, fatigue and pain</li><li>• Intensity of symptoms reported</li><li>• Duration of hospitalisation</li><li>• Psychological and emotional stress</li><li>• Depression and anxiety</li></ul>

Research indicates that there is around a 34% reduced risk of death from breast cancer among women who did 180 minutes per week of aerobic activity

### When should you be active following breast cancer?

#### NOW!!

- Pre treatment
- During treatment
- Post treatment
- Forever

### What should you be doing?

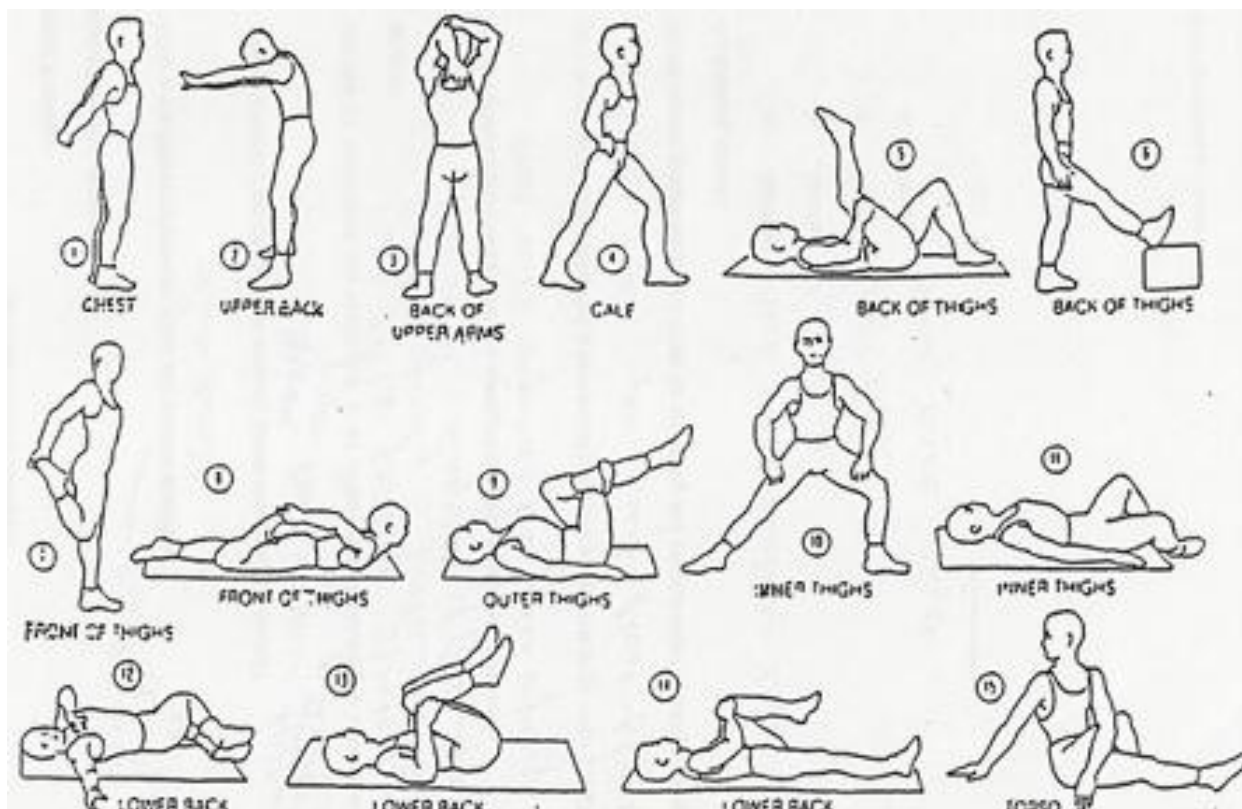
National recommendations: At least 5 days per week for at least 30 minutes per day  
Incorporate aerobic-based as well as resistance-based exercise of moderate intensity

### Where to start?

- Step 1: "think about what would make you completely exhausted. *E.g. walking briskly for 30 minutes or climbing 2 flights of stairs.*
- Step 2: Halve it. *E.g. walking at a light pace for 15-20 minutes or walking on a flat surface.*

\*This becomes the starting point

## Warm up and cool down



### When to mix it up?

- Progress gradually and re-assess anytime there is a change in situation (e.g. change in treatment, additional surgery, return to work)
- Goal: don't make symptoms worse!

### General Exercise advice

- It is important to have good communication with and support from your clinicians and GP.
- Be flexible when it comes to dealing with good days and bad days. Some days you will be able to do more than others.
- Define your progress.
- Keep a diary.

### What should you be doing?

- Anything is better than nothing
- Frequency and Duration
  - Some is better than none, more is generally better than less
- Intensity
  - Low to vigorous

### Don't forget about incidental exercise

- Think of movement as an opportunity, not an inconvenience.
- Be active every day in as many ways as you can.
- Any activity that you do as part of your normal daily routine can be used to increase your physical activity level and benefit your health

**This is all easier said than done!**

**Issues to deal with:**

- Mixed advice re: activity, diet, weight
- Medical concerns – fatigue, lymphoedema
- Concerns of those around you
- Personal reasons – not sure what to do, fears about what to do
- The usual issues – such as time, it's boring, too hot
- Breast cancer specific issues – wig makes head too hot, can't wear a bra, arm restricted from compression garment

**Exercise – advice that may help**

- Do not feel guilty about not exercising but it is important to know that being regularly active is vital for sustaining short- and long-term good health
- Need for setting 'SMART' goals
  - Specific
  - Measurable
  - Attainable
  - Relevant/Realistic
  - Time-bound (when do you want to achieve you goal by?)
- Do something you enjoy and/or do it with someone you like spending time with
- Identify and overcome exercise barriers
- Identify sources of motivation and support

**The dilemma**

*"If someone offered you a drug that could help prevent five major health concerns, including cardiovascular disease, cancer and diabetes, wouldn't you rush to take it? If you were told that this same drug could keep your weight down, reduce the need for antidepressants, boost your self-confidence and reduce your chance of getting osteoporosis, wouldn't you be emptying your coffers in order to stock up on supplies? Well, such a drug is available. It's called exercise."*

Beverley Hadgraft, Qantas The Australian Way Magazine, January 2008

# Breast Cancer & Body Image

Dr Kerry Sherman

Senior Lecturer, Centre for Emotional Health at Macquarie University  
Consultant researcher, Westmead Breast Cancer Institute

Many treatments for breast cancer have side effects that are:

- Physical (nausea, pain)
- Functional (limited arm and shoulder mobility)
- Visible (changes to appearance)

## Visible body changes include:

### Surgery

- partial or complete loss of breast(s)
- poorly aligned and asymmetrical breasts
- extensive scarring
- altered breast and nipple sensation
- need for a breast prosthesis
- Lymphoedema
- 

### Chemotherapy

- hair loss
- weight fluctuation
- skin and fingernail discolouration

## Impact of breast cancer on a woman's body image

In our society most women value their appearance – it is a source of self-worth.

Physical changes from breast cancer surgery and treatment can negatively impact:

- A woman's sexuality
- How *she* perceives her physical appearance - her BODY IMAGE.

One in three breast cancer survivors experience distress directly related to a change in body image, even when they are medically well. Younger women are particularly affected.

## Body Image: Physical activity and distress

Breast cancer treatment can increase the discrepancy between how a woman would like to appear, and how she actually appears.

*Self-compassion* can help counter the effects of negative body image in women with breast cancer.

Definition of self-compassion: The ability to kindly accept oneself while suffering (Neff, 2003, 2009)

There are three components to self-compassion:

- 1 self-kindness (vs. self-judgement)
- 2 mindful awareness of one's emotions
- 3 understanding the universality of human suffering (vs. isolation of self)

Self-compassion has been linked to psychological wellbeing (in non-cancer populations)

## **Our research: Body Image and Self-compassion**

### **Astrid Przedziecki, PhD candidate**

Our research questions:

- Do women who have low body image and low self-compassion experience high psychological distress?
- Can self-compassion influence the negative effect of low body image?

Our Method

- 279 women who were members of the BCNA consumer network participated
- Participants had completed active cancer treatment
- Online questionnaire

What did we find?

Women with higher psychological distress also had:

- Lower body image
- Lower self-compassion

How can a woman counter the negative effects of low body image?

- You may like to try an Enhancing Self-compassion Writing exercise (Neff; Gilbert)
- Imagine an endlessly self-compassionate friend – what would you like that friend to say to you?
- **Now write a letter to yourself from an imaginary self-compassionate friend's perspective**



# Breast Cancer & Family History

## Myth Busting and Facts

Professor Judy Kirk

Director of the Familial Cancer Service, Westmead Hospital, Sydney

### **Myths about Risk:**

- Family history always means an increased risk
- Family history on dad's side doesn't count
- We add the history on mum's side to that on dad's side

Risk based on family history depends on:

- The number of relatives (on one side of the family) with breast cancer (and/or ovarian cancer)
- The closeness of that relationship
- The age at onset of the cancers
- Ashkenazi Jewish background
- Other factors
  - Bilateral disease
  - Male breast cancer
  - An individual with both breast and ovarian cancer
  - Pathology of breast cancer
  - Pathology of ovarian cancer

### **Definition of 'High Risk'**

- Less than 1% of the female population have a 'high risk'. As a group, their risk of breast cancer up to age 75 is between 1 in 4 and 1 in 2. Risk may be more than 3 times the population average. Individual risk may be higher or lower if genetic test results are known.
- Two 1° or 2° relatives on one side of the family diagnosed with breast or ovarian cancer plus one or more of the following on the same side of the family:
  - additional relative(s) with breast or ovarian cancer
  - breast cancer diagnosed before the age of 40
  - bilateral breast cancer
  - breast and ovarian cancer in the same woman
  - Jewish ancestry
  - breast cancer in a male relative.
- One 1° or 2° relative diagnosed with breast cancer at age 45 or younger plus another 1° or 2° relative on the same side of the family with sarcoma (bone/soft tissue) at age 45 or younger
- Member of a family in which the presence of a high-risk breast cancer gene mutation has been established.

### **Familial Risk Assessment Tool**

<http://canceraustralia.gov.au/clinical-best-practice/gynaecological-cancers/familial-risk-assessment-fra-boc>

### **Myths about Genetic Testing**

- Everyone should have a genetic test for breast cancer risk
- Genetics can tell you nothing
- Genetics can tell you everything
- Genetic testing is cheap and easy

### **Myths about Managing Risk**

- Why would you want to know? There's nothing you can do about it anyway!
- Everyone with a faulty gene should have a double mastectomy
- "Ovarian cancer" is cancer of the ovary

### **What can be done?**

- Screening detects early breast cancer
- Medical prevention
- Risk-reducing surgery\*
  - Risk-reducing mastectomy (Risk reduction 90%+)
  - Risk-reducing bilateral salpingo-oophorectomy
    - Ovarian/tubal risk reduction
    - Breast cancer risk reduction 50% (around age 40)
    - Lower all-cause mortality, breast cancer-specific mortality and ovarian cancer-specific mortality

**The risk cannot be zero.**

### **Lifestyle Factors**

Modifiable factors associated with a modest increased risk of breast cancer include:

- overweight and obesity for post-menopausal women (BMI >25 kg/m<sup>2</sup> vs. <21 kg/m<sup>2</sup>)
- alcohol consumption (relative risk increased by 7% for each additional standard drink per day)

Physical activity (>2 hours of brisk walking or equivalent per week) is a protective factor.

# Menopause & Breast Cancer

## I'm still hot, but it comes in flushes!

Dr Julie Thompson  
General Practitioner, Warragul Vic  
BCNA Clinical Advisor

### Menopause

- Definition is retrospective – i.e. when a woman has not menstruated for 12 consecutive months
- Large range of symptoms including:
  - breast tenderness
  - vaginal dryness
  - night sweats
  - hot flushes
  - dry eyes
  - depression
  - difficulty concentrating
  - insomnia
  - rapid heart beat
  - lack of energy
  - backache
  - shortness of breath
  - skin irritation
  - nervous tension
  - stiff joints
  - loss of libido
  - aching joints
  - swelling of hands and feet
  - anxiety
  - urinary symptoms

### Causes of menopause in women with breast cancer

- natural menopause
- withdrawal of hormone replacement therapy (HRT)
- menopause induced by breast cancer treatment
  - surgical menopause (removal of ovaries)
  - chemotherapy treatment
  - a side effect of hormone therapy

### Hormone receptor positive (ER+) breast cancer

- Oestrogen receptor positive (ER+) tumours are diagnosed in
  - 80% women > 50 years at diagnosis
  - 50-60% women < 50 years at diagnosis
- Oestrogen receptors are like antennae on the cell. They bind with oestrogen circulating in the body to activate chemical changes in the cell. Normal female tissue especially brain, breast, vagina, skin and bones need oestrogen to remain healthy.
- Having an ER+ cancer means that the cancer cells may respond to oestrogen circulating in your body and grow.

### Treatments for hormone receptor positive breast cancer

- Tamoxifen: binds to the oestrogen receptors, preventing oestrogen from entering and feeding the cancer cells
  - Used in women of all ages: premenopausal and postmenopausal

- Aromatase inhibitors (AIs): Block aromatase that converts androgens to oestrogen in postmenopausal women, so reduces the amount of oestrogen produced by the body.
  - AIs include anastrozole (Arimidex), letrozole (Femara), exemestane (Aromasin)
  - Only used in post-menopausal women
- Tamoxifen and AIs reduce the risk of breast cancer recurrence and of a new breast cancer in the opposite breast, and improve survival.

### **Menopause symptoms**

- Vasomotor symptoms
  - Hot flushes, sweating, palpitations, nausea, night sweats
  - Result from destabilization of hypothalamus which regulates body temperature
  - Hot flushes may also be associated with redness and sweating
  - reported in up to 80% of women with breast cancer (particularly younger women)
  - may be more severe and frequent compared to menopausal women without breast cancer
  - a decrease in the frequency of hot flushes at 6.3 years post diagnosis was reported in a longitudinal study of BC survivors
- Mood and cognitive problems
  - the relative contributions of menopause and the breast cancer diagnosis/ treatment to psychological distress are often difficult to determine
  - Mood and cognitive problems and a reduction in quality of life are observed in women treated with breast cancer chemotherapy who then experience menopause
  - Depression and/or anxiety was observed in almost 50% of BC women in the year following diagnosis
    - persisted in 25% of women at 4 years & 10% of women at 5 years
- Urogenital symptoms
  - Problematic in 50-75% of breast cancer survivors
  - especially those women taking aromatase inhibitors
- Younger women and early menopause
  - Report more physical symptoms, psychological distress and poorer sexual functioning compared with other breast cancer survivors
  - Persistent physical complaints including vasomotor symptoms are associated with an increased risk of moderate to severe psychological distress, including anxiety and depression.

### **Managing vasomotor symptoms**

- Lifestyle measures
  - Stop smoking
  - Undertake at least 30 minutes exercise daily
  - Maintain ideal weight
  - Dress in layers, wear natural fibres
  - Use cold packs
  - Avoid hot environmental temperatures
  - Avoid potential triggers – spicy foods, alcohol, caffeine, stress
  - Minimise stress and anxiety
- Complementary therapies – caution advised as safety unknown
  - Phytoestrogens – soybean – safety unknown
  - Herbal therapies – safety unknown
    - Include ginseng, passionflower, valerian, chaste tree, ginkgo
    - black cohosh – known to cause liver toxicity
    - St John's wort – not advised - interferes with tamoxifen
- Alternative therapies
  - Mind body interventions show promise
    - Yoga, hypnosis, relaxation therapy, paced respiration, acupuncture, cognitive behavior therapy

- Lack of evidence for homeopathy, reflexology, body manipulation
- Non hormonal therapies are effective
  - Gabapentin (Neurontin) – up to 65% hot flush reduction
  - serotonin/noradrenaline reuptake inhibitors e.g. Efexor – up to 65% reduction
  - Clonidine (Catapres)– 25-40% reduction

### **Managing joint symptoms**

- More common with aromatase inhibitors because they reduce circulating oestrogen levels
- Stiffness usually occurs in the morning and settles with mobilisation
- The time at which symptoms are first felt varies considerably, most often in first 6 months of treatment but can occur 1 or 2 years after starting treatment
- Up to 35% of women report arthralgia (joint pain) when taking aromatase inhibitors
- Increased risk factors include age, pre-existing rheumatoid or osteoarthritis, being overweight.

#### *Practical measures:*

- Do not stop treatment without discussing with your doctor – joint symptoms may be a sign your treatment is working
- Exclude other causes of the pain
- Maintain a healthy weight
- Gentle exercise, such as hydrotherapy, yoga or Tai Chi can help
- Acupuncture: twice weekly over 6 weeks has been shown to reduce severity of pain
- Paracetamol or a non-steroidal anti-inflammatory (e.g. Ibuprofen) can be useful
- Fish oil has anti-inflammatory properties, but is required to be taken in large doses to be effective
- Talk to your doctor – taking a different hormone treatment is a possibility, as is taking a break from treatment

### **Osteoporosis**

- You may be at increased risk if:
  - an aromatase inhibitor
  - Early menopause < 50 years
  - Family history osteoporosis
  - Very thin
  - Smoker
  - Asian descent
- Management
  - If at increased risk – bone mineral density (DXA) scan every 2 years
  - Weight bearing exercise 30 minutes most days
  - Vitamin D and calcium supplements
  - Medications: e.g. bisphosphonates

### **Useful websites**

- Jean Hailes Foundation: [www.jeanhailes.org.au](http://www.jeanhailes.org.au)
- Managing Menopause: [www.managingmenopause.org.au](http://www.managingmenopause.org.au)
- Bone Health for Life: [www.bonehealthforlife.org.au](http://www.bonehealthforlife.org.au)
- Early Menopause: [www.earlymenopause.org.au](http://www.earlymenopause.org.au)
- Australasian Menopause Society: [www.menopause.org.au/consumers](http://www.menopause.org.au/consumers)
- Cancer Australia: <http://canceraustralia.gov.au/>

# New Directions in Breast Cancer Treatment

## A Surgical Oncologist's Perspective

Prof Laura Esserman MD MBA  
Surgeon and breast cancer oncology specialist  
UCSF Carol Franc Buck Breast Care Center

Cancer is a collection of different diseases. Our understanding of breast cancer has evolved over time. As treatment is evolving, screening and prevention measures must also evolve.

*We know "Breast Cancer" is NOT one disease, but we approach screening, and even treatment as if it is . . .*

### What is new for High Risk Women?

*Problems/opportunities*

Standard therapy for breast cancer has made a difference, but this treatment may not benefit everyone equally or at all.

There are hundreds of drugs/treatments/biomarkers and diagnostics in the pipeline but we have a limited ability to test them

The current model of drug development

- One FDA-Approved Drug - Start to Finish
  - 10- 15 Years
  - 1,000 – 6,000 Volunteers
  - \$1.3 Billion
  - ROI for oncology drugs ~ 0.3%

### Women at Risk for Recurrence

- Will not be cured with surgery alone
- The order in which surgery and systemic therapy (e.g. Chemotherapy, herceptin) are given has no impact on survival outcomes
- The neoadjuvant approach (chemotherapy or herceptin before surgery) is an opportunity to:
  - Downstage tumours and refine local therapy options if able
  - Better understand response to therapy, and a prognosis
  - Accelerate targeted drug development to improve outcomes in highest risk women
  - Particularly relevant as a tool to sort out optimal treatments in the molecular era

### Breast Conserving Treatment vs Mastectomy

Things a surgeon should consider:

- What is the patient's preference?
- Will radiotherapy be recommended?
- Did the patient start with diffuse disease or a circumscribed mass?
- How certain can you be about response?

Breast reduction is an option to consider.

Additional Considerations for Mastectomy:

- Contraindications to radiation therapy
- Identification of factors that increase the odds of new cancers occurring
  - BRCA status

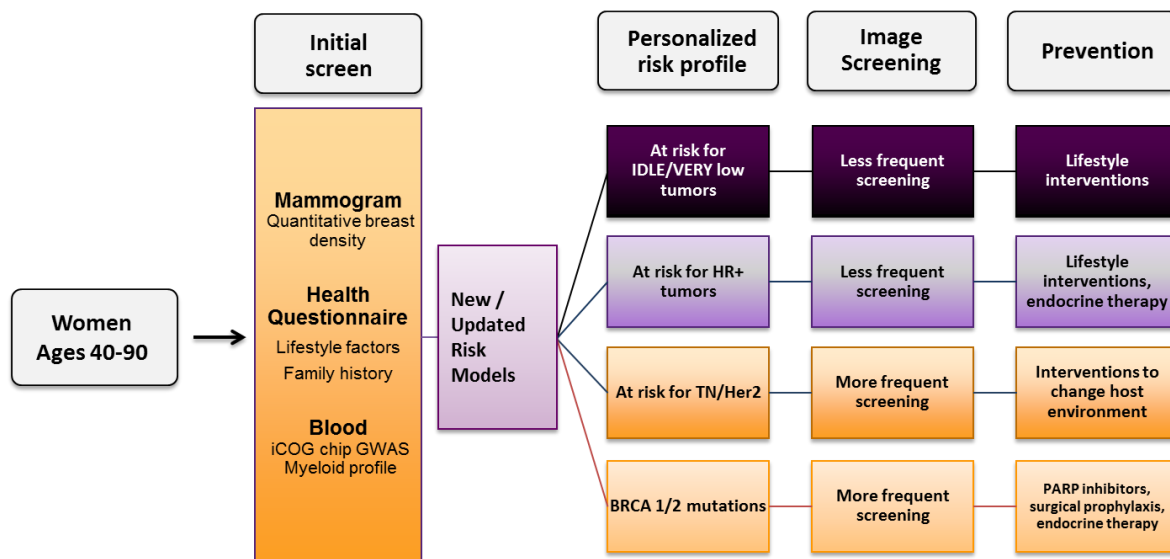
- Exposures
- Prognosis
  - Response to therapy

### DCIS (Ductal carcinoma in situ)

- The detection of DCIS has increased 500 fold since mammographic screening was introduced.
- It is unlikely that the majority of DCIS detected is destined to become significant cancers
- Patients assume that cancer, left untreated, will kill you. Physicians too

### Risk Based Screening

In the future, screening for breast cancer may be tailored according to an individual's risk:



### On the Surgeon's Personalized Medicine Horizon

- Molecular profiles that determine type and success of systemic therapy (e.g. chemotherapy)
  - This may give surgeons an opportunity to determine when and whether to operate
- Molecular profiles of DCIS that determine the risk of invasive cancer and what type
  - This may reduce the amount of surgical intervention in women with DCIS
  - Many DCIS lesions may, in the future, be approached by prevention measures such as lifestyle modification
- Profiles of inherited risk, breast density, and exposure will provide opportunities for personalised recommendations for screening and prevention

# A Medical Oncologist's Perspective

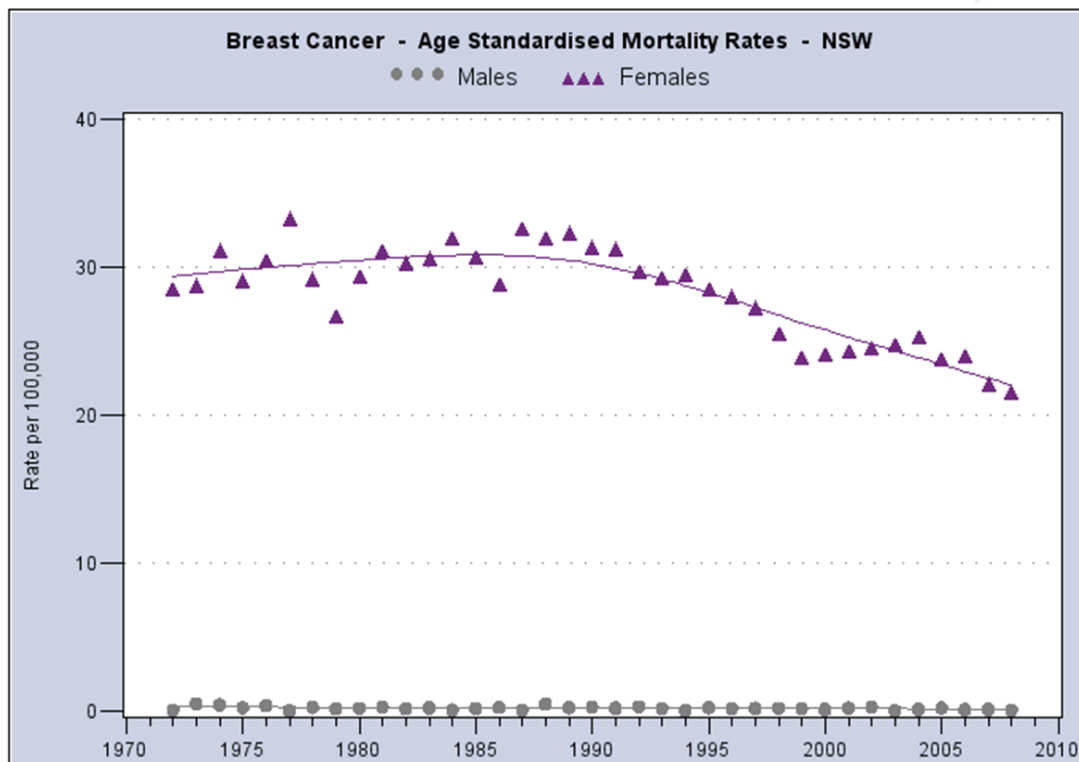
Assoc Prof Nicholas Wilcken

Medical Oncologist

Director of Medical Oncology, Westmead Cancer Care Centre, Sydney

Associate Professor of Medicine, University of Sydney

## Death rates continue to fall



## Promising new drug treatments

Endocrine (hormone-blocking) therapy: ways of stopping breast cancer cells becoming resistant to hormone therapy

- New treatment may involve adding *everolimus* tablets to hormone therapy.

Chemotherapy: ways of making triple negative breast cancer cells more sensitive to chemotherapy

- Many chemotherapy drugs work by damaging DNA. Can we find a way of increasing the damage to cancer cells but not normal cells?
- ANZ Breast Cancer Group is trialling olaparib tablets for women with triple negative breast cancer. This may stop some types of DNA repair in tumour cells and shrink some secondary tumours. It has previously not worked very well with IV chemotherapy. In 2013, the trial will be looking to see whether adding low dose chemotherapy tablets will help.

Anti-HER2 therapy: new drugs to improve upon herceptin

- Drugs currently being tested include pertuzumab and T-DMI.



# Recent Developments in Breast Care Nursing

Professor Patsy Yates

Professor of Nursing

Institute of Health and Biomedical Innovation, Queensland University of Technology

A recent development in breast care nursing is the introduction of tools to support a population based approach to breast care nursing care.

## Population Based Approaches to BCN Practice

- Who has access to BCN care and when?
- Who needs access to BCN care?
  - All patients?
  - Patients with complex care needs?
  - Vulnerable patients?
  - Patients at critical phases of the cancer experience?
- All patients require some level of specialist care
  - Some patients have more complex needs, requiring more BCN support
  - Screening tools and referral processes can match individuals with their required level of service at all stages of the cancer experience. Some examples of these are:
    - Victorian Supportive Care Screening Initiative
    - Understanding complexity of care (A/Prof Mei Krishnasamy, Peter MacCallum Cancer Centre)
    - Palliative Care Needs Assessment Tool

## Cancer Survivorship Self-management Training

The Cancer Survivor Self-management Care Plan Project was a project led by QUT to develop, implement and evaluate interventions that will help women to self-manage their care after active cancer treatment has finished.

The project led to the development of resources for both consumers and health professionals. They include a care plan completed by the nurse with women on completion of their treatment, survivorship resources, and other consumer-directed resources. It also involves training for health professionals, which includes three core modules:

- the evidence base for cancer survivorship care
- principles of chronic condition self-management
- Implementing self-management approaches to cancer survivorship

Health professionals are also given a number of resources to assist including:

- Facilitator guide
- Practitioner notes
- Modules
- Training DVD
- PowerPoints

# Shared Follow-Up Care for Early Breast Cancer

Dr Tony Hobbs  
General Practitioner, Cootamundra NSW  
Cancer Australia Shared Care Demonstration Project

## Shared Care Demonstration Project

The Shared Care Demonstration Project aimed to implement and evaluate shared follow-up care between GPs and specialists for women with breast cancer.

Three high level questions informed the project evaluation:

- Is a shared care model for follow-up of women with early breast cancer **acceptable** to patients, specialists and the GP?
- Does a shared care model for follow-up care **support the delivery of best practice** according to national clinical practice guidelines (developed by NBOCC)?
- Is the **cost** of shared follow-up care delivery comparable to the existing model of follow-up care?

## Acceptability

The project evaluation indicates that shared care is a feasible model of follow-up care for early breast cancer.

- Shared follow-up care was successfully implemented for 1,214 patients across four demonstration sites
- Shared care was acceptable to the majority of patients with 78% of patients approached agreeing to participate
- Of those who declined to participate, more than 40% was due to their GP declining or the patient not having a GP
- 92% of specialists agreed they would continue to provide shared follow-up care
- 549 GPs were recruited during the course of the project:
  - 68% of GPs surveyed stated they were confident in delivering shared follow-up care
  - Although a majority of GPs agreed to provide shared follow-up care, gaining access to GPs to discuss shared care and receive their signed agreement was identified as a significant challenge.

## Benefits of shared follow-up care

- In Australia follow-up care for breast cancer is carried out mostly in hospitals by teams led by a specialist clinician. The specialist workforce in Australia is under increasing pressure associated with increasing demand, which is not being matched by an increase in the number of specialists. It is critical to increase the efficiency and effectiveness of the available health workforce and improve its distribution. New models of care, such as shared follow-up care, are therefore required.
- A key tool developed for the Shared Care Demonstration Project was the patient-held Shared Care Plan. This was designed to support the specialist and GP team by summarising information about the patient's diagnosis and treatment. It also supported the patient by providing access to information about their treatment and ownership for their shared care.
- Results from the evaluation of the project indicated that shared follow-up care is able to be provided in line with best practice recommendations. Over 90% of patients involved in shared follow-up care received a scheduled follow up in line with best practice recommendations. 78% of specialists and 64% of GPs surveyed agreed that the Shared Care Plan helped them to provide best practice follow-up care.
- Shared care improves access to follow-up care for women, including women in regional areas.

- Results from the evaluation show that patients found their local GP to be more accessible, and easier to make appointments with, particularly for regional patients.
- Patients who were interviewed reported cost savings experienced through the shared care model. These savings included not having to pay for hospital parking, transfers and overnight accommodation, and not having to organise childcare or take time off work to attend hospital visits.
- All patients who took part in the interviews felt involved in their follow-up care through their GP.

# Let's Talk About Sex & Relationships

## Sexual Wellbeing and Breast Cancer

Professor Kate White

Professor of Nursing, University of Sydney

Academic Chair in Cancer Nursing, Cancer Institute of New South Wales

- Sexual arousal and desire is driven by both physical and psychological factors.
- Sexual wellbeing is an important issue for 'older' people. 26% of 75–85 year olds are sexually active.
- Breast cancer has a significant impact on intimate relationships. 2011 research found that, for most women, breast cancer had an impact on their sexual relationships. For a quarter of women, this impact was dramatic.
- After diagnosis, women experienced a negative impact on their feelings of desire, intimacy, frequency of sex, sexual arousal and pleasure, and energy and interest in sex. Many of these changes were caused by low body image, fatigue, weight gain, and emotional issues such as lack of motivation, anxiety and distractibility
- Many couples experience intimacy challenges because there is a shift in roles. The woman shifts from a lover to a patient, and their partner shifts from a lover to a carer.

### Practical tips to help with intimacy and sex

- Practical tips to help partners:
  - This is a confusing time for partners. Often partners worry that if they initiate intimacy they will seem pushy, and if they don't they will seem like they're not attracted to the woman – "damned if you do, damned if you don't".
  - Make time for your partner and relationship regularly.
  - Talk about your relationship, including your fears.
  - Seek help if needed.
- Practical tips to help improve libido:
  - Try medications like ArginMax or arousal oil like Zestra.
  - Experiment alone first.
  - Fantasise.
  - Extend foreplay
  - Use massage
  - Take turns to focus on each other
  - Be intimate without having sexual intercourse
  - Increase sensitivity by using a vibrator and doing pelvic floor exercises
- Practical tips to help with vaginal dryness:
  - Moisturise and lubricate – they are two different things. Moisturisers (e.g. Replens) provide ongoing moisture, and lubricants are to use during sex.
  - Try different positions and communicating with your partner during intercourse
- To reduce pain during intercourse, make sure you are aroused, use a lubricant, and try different positions. Pelvic floor exercises help ongoing.
- Exercise is excellent at improving sexual wellbeing (as well as physical and emotional wellbeing)

# Managing Relationships with Family and Friends

Associate Professor Jane Turner

Psychiatrist

Associate Professor in the Discipline of Psychiatry, University of Queensland

- Many women are disappointed with the support they receive, which can be unexpected and hurtful.
- Sometimes family and friends don't offer support because they are scared or don't know what to say or do. Try talking to them without attacking them. Let them know how you feel.
- Many people expect you to 'return to normal' after active treatment. Many do this to distance themselves from the trauma of breast cancer, or because they don't know how to 'fix' the situation. Try acknowledging their feelings, telling them how it makes you feel, and telling them that they don't need to fix the situation.
- Many women are told to 'be positive' or to 'look on the bright side'. Try explaining that it's ok for you to be upset or down from time to time, and in fact 'letting it out' from time to time helps you to cope.
- Partners experience distress levels similar to women diagnosed but typically receive very little support
  - They are often fearful that their partner will die, and feel powerless. Many will try to reassure the woman, as a way of reassuring themselves.
  - Communicating with your partner is critical. Also try to provide them with information about breast cancer specifically tailored to partners.
- A breast cancer diagnosis is also a difficult time for children:
  - Young children feel anxious, and guilty at perhaps causing the cancer because of their bad behaviour. Many worry that their mum won't be able to look after them, or that the family may fall apart. This distress is expressed in their behaviour.
  - Middle children may see breast cancer as a disruption to their lives and their routine.
  - Adolescent children have many household tasks 'dumped' on them, and may feel anger at the situation, particularly the impact on their own life.
  - Strategies to help children cope:

Things that will probably help	Things that probably won't
Allowing others to offer support	Feeling that accepting help is weak or will lead to loss of independence
Letting children talk even about difficult things	Rushing to reassure
Encouraging children to work out some problems themselves	Trying to fix everything for them
Letting the school know	Keeping everything private
Maintaining rules and consequences	Letting discipline slip because of guilt
Letting children see that parents are upset sometimes	Always adopting a façade and pretending everything is OK

Things that will probably help	Things that probably won't
Talking	Keeping secrets
Maintaining routine	Letting go of structure and rules
Negotiating tasks	Giving orders
Telling children it is not their fault	Telling children to "be good for Mummy"
Encouraging children to participate in sport and normal activities	Expecting children to spend all of their time at home "because time together is precious"
Giving information in stages	Talking about possible outcomes far into the future

- Women with secondary breast cancer face unique challenges. Some people feel compelled to share with them every bad story about breast cancer they have heard. Others avoid the woman because they don't know what to say or do. Try taking the lead in the conversation to avoid these situations, or steer away from them.

# Life after Treatment

## Follow-Up Shared Care: How does it work?

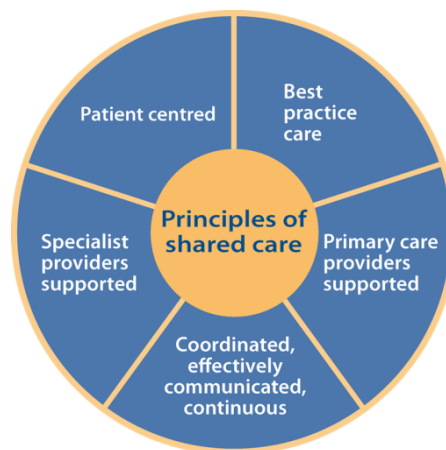
Dr Helen Zorbas  
Chief Executive Officer, Cancer Australia

Professor Bruce Mann  
Breast Surgeon  
Director of the Breast Service, Royal Women's and Royal Melbourne Hospital

There are increasing numbers of women diagnosed with breast cancer and more women are surviving after treatment.

Follow-up care after treatment for early breast cancer is recommended in Australia, and is generally provided by specialist clinicians. Due to increasing survival, more women are attending ongoing follow-up appointments with their specialist. As a result, there is increasing health service demand on specialist services. New models of follow-up care are needed to address these issues.

- The Shared Care Demonstration Project investigated shared care between specialists and general practitioners for follow-up after early breast cancer.
- Shared care provides a team-based approach to care, which has the potential to promote and support coordinated care and whole person care, beyond breast cancer.
- Access to care may also be improved by reducing the need for rural women to travel for follow-up appointments and decreasing the burden on specialist outpatient clinics.
- Studies show that follow-up care by general practitioners is safe and does not affect patient survival, cancer recurrence, serious clinical events or psychological morbidity, wellbeing and patient satisfaction.



The project demonstrated a model of shared follow-up care for early breast cancer that is:

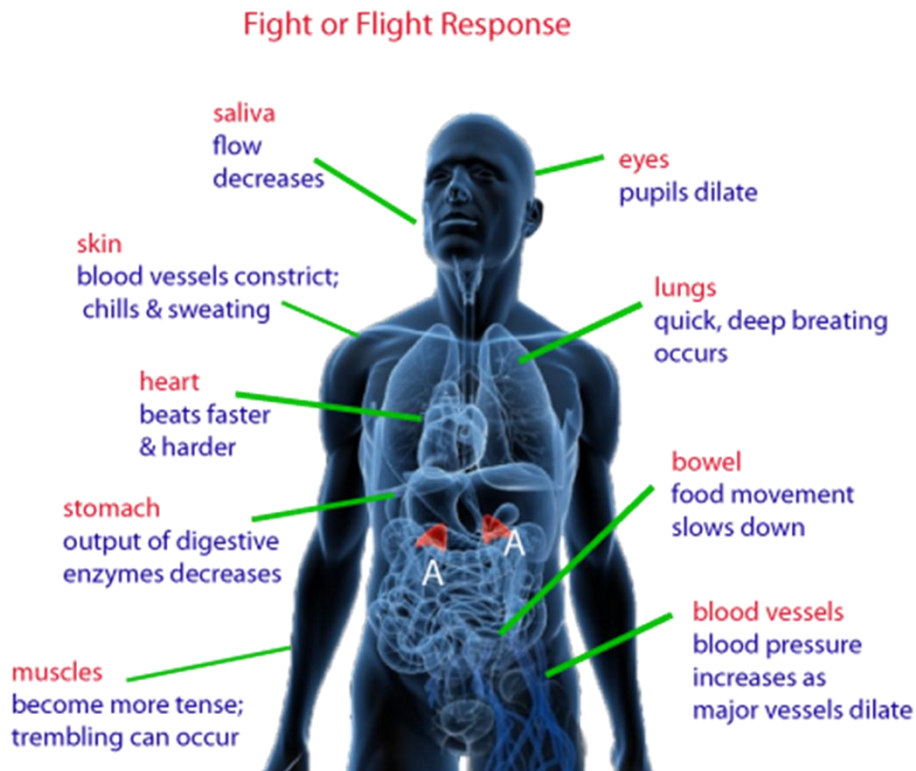
- Acceptable to patients, specialists and GPs
- A model that improves access to follow-up care for women, including women in regional areas
- A model that is sustainable, as more women are diagnosed with breast cancer and survival rates improve
- A model that makes optimal use of Australia's highly specialised workforce through an integrated, team-based approach to follow-up care AND
- A model that supports the provision of best practice care, by aligning with evidence-based guidelines for follow-up of women with early breast cancer.

# Managing the Fear of Recurrence

Dr Jane Fletcher  
Psychologist, Melbourne Psycho-Oncology Service

## What is Fear?

- An emotion induced by a perceived threat
- Part of basic survival mechanism
- Activates 'fight or flight' response



## Fear of recurrence

- One of the most prevalent long term psychological consequences of a breast cancer diagnosis
- Unlike other fears may not reduce over time - 5 years after diagnosis 70% breast cancer survivors still fear recurrence
- Prevalence - 29%-97% of women fear recurrence
- Risk factors - Age at diagnosis, younger women at more risk
- Can lead to
  - Dysfunctional behaviours
    - Anxious preoccupation
    - Excessive checking
  - Disorder
    - Anxiety
    - Depression
- Symptoms
  - Recurrent negative thoughts
  - Anxiety symptoms
- What is actually feared
  - Death – Death Anxiety



## **Practical Strategies**

### Challenging Negative Thoughts

- What is the evidence that supports the automatic negative thought?
- Are there errors in your thinking?
- Is there an alternative point of view?
- What is the worst/best that can happen?
- What is the consequence of my thinking? Is this particular thought helpful to me in this situation?
- What can I do?

### De-catastrophising

- Stop focusing on one potential outcome
- Look at other potentialities
- Bring awareness to here and now
- Focus on living as well as you can for as long as you can

### Meaning making

- The power of the narrative
- Processing the experience
  - What was the hardest thing about your experience?
  - What was the biggest surprise?
  - Where would you like to put this experience?
- Revising beliefs
- Revising goals
- Finding benefit – Post traumatic growth

Ask yourself what brings you meaning, joy...?

- What are your favourite things?
- Who and what is important to you?

## **Strategies to problem solve**

- No secrets – this enhances sharing, caring and coping
- Choose your supports carefully – serious illness challenges all relationships - put your energy into supportive relationships
- Make it clear what people can do to help – practical help is very important but people often need direction
- Helpful psychological strategies Expressive therapies
  - Journaling
  - Music
  - Art
- Support groups
- Peer support
- Active problem solving
- Obtain adequate information to reduce anxiety and increase control
- Hobbies
- Put the good things back into your life
- Be self-full and kind to yourself
- Utilising available resources and support systems
- Accept yourself and limitations
- Nurture the good things that happen to you

- Learn to say “no” and set limits
- Controlling what you can control not what you cannot
- Seek psychological support if required
- You have choices - Choose how you live!
- Stress reduction techniques
  - Mindfulness based stress reduction - meditation
  - Relaxation techniques
  - Guided imagery
  - Biofeedback

### Living well - lifestyle factors

- Exercise / sport
  - Evidence to indicate exercise impacts on mood and fatigue
- Sleep
  - Getting enough sleep
  - Good sleep hygiene

## Sleep The Final Frontier



### When do you need help?

If thoughts of recurrence are interfering with the way you live your life, then you may need professional assistance. Speak to your GP or other health professional.