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Latest News in Breast Cancer Research

*Highlights from the 2008 San Antonio
Breast Cancer Symposium*

Editor

Edith A. Perez, MD

Mayo Clinic

Jacksonville, Florida

Learn about:

- Treatment advances in breast cancer
- Medications on the horizon
- Coping tips
- Breast cancer resources



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Researchers continue to make important progress in treating breast cancer.

This special edition of the CancerCare Connect® booklet series presents highlights from the 2008 San Antonio Breast Cancer Symposium, which took place December 10–14 in San Antonio, Texas.

This guide includes information on advances in the treatment of breast cancer, as well as other promising treatments that researchers continue to study in clinical trials. It also provides tips for coping with breast cancer and additional resources for support.

Please note that some of these treatments are still in the earliest phases of research and may not be available to the general public outside of a clinical trial.

The information in this booklet is intended for discussion with your doctor. He or she can let you know if these research findings affect your treatment plan and whether a clinical trial may be right for you.

Early-Stage Breast Cancer

Breast cancers are diagnosed by stages according to their size and extent of their spread. “Early-stage” breast cancer refers to smaller tumors that have not spread to other parts of the body.

Doctors describe breast tumors by whether or not their growth is fueled by the female hormones estrogen and progesterone. Some breast cancer cells have more receptors on their surface that act like doorways to allow the hormones to enter the cells. These cancer cells are said to be estrogen- or progesterone-

receptor positive. They are treated with medications designed to block the body's production of the hormones or their effects.

Breast tumors are also characterized by whether their growth is fueled by a gene called HER2. This gene makes a protein, also called HER2, that controls cell division. If a breast cancer cell has too much HER2—that is, if it's HER2 positive—it tends to grow more quickly. HER2-positive breast cancer is treated with medications that block the activity of the HER2 protein.

TAMOXIFEN VERSUS AROMATASE INHIBITORS

For women with hormone receptor-positive breast tumors, letrozole (Femara), anastrozole (Arimidex), and exemestane (Aromasin) may offer some advantages over the standard, still-effective drug tamoxifen (Nolvadex and others).

Traditionally, women with hormone receptor-positive breast tumors have been treated with hormone therapy, including such medications as tamoxifen. Newer drugs called aromatase inhibitors (which include letrozole, anastrozole, and exemestane) are also used, although only in postmenopausal women. Aromatase inhibitors block the production of the female hormone estrogen, which fuels the growth of these breast cancers.



Several recent studies have compared tamoxifen with aromatase inhibitors to see which type of treatment is more effective in women with early-stage hormone receptor-positive breast cancer.

One study, called the BIG 1-98 clinical trial, compared tamoxifen with the aromatase inhibitor letrozole. More than

8,000 women from around the world took part in the study. Researchers found that women who received five years of letrozole went longer without their cancer returning than those who received five years of tamoxifen.

When updating results for nearly 5,000 of these women, the researchers also found that:

- Women who were treated with letrozole tended to live longer than those treated with tamoxifen.
- Using these two medications in sequence—for instance, two years of letrozole followed by three years of tamoxifen, or vice versa—did not appear to be more effective than five years of letrozole alone.

Researchers concluded that letrozole seems to offer a slight benefit over tamoxifen in the treatment of early-stage breast cancer, but that tamoxifen

remains a worthwhile treatment option as well.

Another study, called the TEAM clinical trial, compared tamoxifen with the aromatase inhibitor exemestane in postmenopausal women with early-stage breast cancer. Researchers found that nearly three years after treatment, women who received exemestane went longer without their cancer returning

than those who received tamoxifen. It also took longer for their cancer to spread to another part of the body. These findings, say the researchers, may lead to longer survival for these women.

A third study that compared tamoxifen with aromatase



inhibitors was a two-part analysis of a group of clinical trials. The study combined information on more than 18,000 women studied at several international research centers. The first part of the analysis studied data from nearly 10,000 women, divided into two groups. One group received tamoxifen; the other group received an aromatase inhibitor (either anastrozole, exemestane, or letrozole). The second part of the analysis studied data on 9,000 women who were given an aromatase inhibitor after taking tamoxifen for two to three years.

In both parts of the analysis, the aromatase inhibitor significantly decreased the risk of the cancer coming back. For women who received the aromatase inhibitor for the entire time, the risk of their cancer returning was reduced by nearly three percent five years after treatment, and by nearly four percent eight years after treatment. Similar results were seen in the second part of the analysis, in which women took aromatase inhibitors after tamoxifen treatment. More research is needed to learn whether taking aromatase inhibitors for longer periods would benefit patients.

Taken together, the encouraging results of all of these studies show that aromatase inhibitors offer women with early-stage breast cancer an effective treatment option.

BONE HEALTH IN WOMEN BEING TREATED WITH AROMATASE INHIBITORS

A drug called denosumab may strengthen and protect bones throughout the body for women with hormone receptor-positive breast tumors.

Aromatase inhibitors have been associated with a loss of bone and a slight increase in the risk of bone breaks. A recent clinical trial has shown that a bone-strengthening drug called denosumab may be an effective medication for women with breast cancer who are being treated with the aromatase

inhibitors letrozole, anastrozole, or exemestane.

Half of the 250 women who took part in the clinical trial received a shot of denosumab every six months. The other half received a placebo—in this case, a shot containing no active ingredient. Researchers used a measurement of bone



strength and health called bone mineral density (BMD) to compare the two groups. This test works by measuring the density of calcium and other minerals in specific bones, usually the spine, hips, and wrists.

Six months after the final shot of denosumab, researchers observed increases in BMD in the lower spine, at the top of the thigh bone, and in the lower part of the arm (near the wrist) in women who received this medication compared with those who did not. Doctors believe that these encouraging results support the continued study of

denosumab for the prevention and treatment of bone loss in women taking aromatase inhibitors.

REDUCING RECURRENCE OF EARLY-STAGE BREAST CANCER

Even women with small HER2-positive breast tumors may benefit from treatment with trastuzumab (Herceptin).

In the past, women who had surgery for small HER2-positive breast tumors did not usually receive treatments, such as chemotherapy and trastuzumab, afterward. This is because it was thought that they were not at high risk of their cancer

returning. However, according to the results of a new clinical trial, cancer may indeed return in some of these women, and targeted treatment after surgery may help prevent that. (Treatment after surgery is referred to as “adjuvant.”)

At M. D. Anderson Cancer Center in Houston, Texas, and the Mayo Clinic in Jacksonville, Florida, researchers examined the records of nearly 1,000 women with small breast cancers. None of these patients had received any type of treatment after surgery.

Within five years of their surgery, women with HER2-positive breast tumors that were one centimeter (less than half an inch) or smaller had a surprisingly high risk of return—23 percent. This rate was three times higher than in women who had similarly sized HER2-negative tumors.

Based on these results, researchers now believe that women who have small HER2-positive breast tumors may benefit from treatment with medications after surgery to prevent the return of their cancer. Further clinical trials are needed to verify this.

Locally Advanced and Metastatic Breast Cancer

Locally advanced breast cancer is a term that refers to one of two situations: either the tumor is confined to the breast but is too large to be effectively removed or it has spread to nearby areas outside the breast, such as the lymph nodes in the armpit, neck, or chest wall.

Metastatic breast cancer is the most advanced stage (stage IV) of breast cancer. At this stage, cancer cells have spread past the breast and nearby lymph nodes to other areas of the body, where they continue to grow and multiply. The most common parts of the body to which breast cancer spreads are the bones, lungs, and liver.

DELAYING THE RETURN OF BREAST CANCER BY ADDING CAPECITABINE TO CHEMOTHERAPY

Adding capecitabine (Xeloda) to chemotherapy may help women live longer without their breast cancer returning.

Doctors have found that adding a newer drug called capecitabine to standard combination chemotherapy appears to stop cancer from returning in women with metastatic breast cancer. So they thought that giving the same treatment



might also stop the tumors from spreading in the body. According to the early results of a clinical trial known as the FinXX study, they may be right.

The Finnish Breast Cancer Group studied this new treatment with capecitabine in nearly 1,500 women. About 90 percent of these women had breast cancer that had spread to the lymph nodes. The lymph nodes are a linked system of small bean-shaped structures throughout the body that filter out and destroy bacteria and other foreign or

toxic substances. Women with breast cancer in their lymph nodes are at higher risk for their cancer coming back than are women whose cancer has not spread to the lymph nodes.

The women in the study were divided into two groups. One group was treated with the newer approach—capecitabine plus another anticancer drug called docetaxel (Taxotere) and then the chemotherapy combination called CEF (cyclophosphamide [Cytoxan and others], epirubicin [Ellence and others], and 5-fluorouracil [5-FU]). The other group was not given capecitabine; they were treated with just docetaxel and CEF.

Three years after treatment, women who had received the capecitabine combination were 34 percent less likely to have their cancer come back and were more likely to survive compared with women who had not received capecitabine as part of their treatment.

ZOLEDRONIC ACID COMBINED WITH CHEMOTHERAPY FOR BREAST CANCER

Zoledronic acid (Zometa) not only strengthens bones, it may also shrink tumors.

Zoledronic acid belongs to a group of medications known as bisphosphonates. These drugs help prevent loss of calcium from bone, strengthen the bones, reduce the risk of bone breaks, and reduce pain in people whose cancer has spread to their bones.

Now, according to the early results of a recent clinical trial, zoledronic acid may also shrink tumors. Researchers believe that this may be the first real evidence that this class of drugs may have the ability to directly fight cancer.

More than 200 women with locally advanced breast cancer, who were scheduled for surgery and/or radiation treatment, took part in this clinical trial. Half of these women received standard chemotherapy alone, and the others received chemotherapy plus zoledronic acid.

The tumor significantly shrank in more women who received the combination treatment than in those who received only chemotherapy. Also, the tumor completely disappeared (at least temporarily) in a higher percentage of women who received zoledronic acid than in those who did not (11 percent versus less than six percent).

Researchers were so impressed with these results they plan to study the cancer-fighting abilities of zoledronic acid in further clinical trials.

BEVACIZUMAB COMBINED WITH DOCETAXEL FOR ADVANCED BREAST CANCER

Combining bevacizumab (Avastin) and docetaxel may help women with HER2-negative tumors go longer without their advanced breast cancer growing.

Sometimes, when two cancer treatments are used together, they are more effective or safer than either treatment alone. This seems to be the case with the chemotherapy docetaxel and the targeted treatment bevacizumab, which were tested in a clinical trial called AVADO.

More than 700 women with HER2-negative breast cancer that had returned or spread took part in AVADO. Patients received either docetaxel plus bevacizumab (two different doses were tested) or chemotherapy and placebo (a pill or liquid containing no active ingredient).

Researchers found that women who received chemotherapy and placebo went two-and-a-half months before their cancer started to grow again. The women who received docetaxel plus either dose of bevacizumab went four months without their cancer growing.

Overall, the AVADO results of combining docetaxel and bevacizumab represent a small improvement over docetaxel alone. However, doctors are encouraged by this benefit.

TRASTUZUMAB FOR LOCALLY ADVANCED OR METASTATIC BREAST CANCER

Adding trastuzumab to chemotherapy before surgery for locally advanced HER2-positive breast cancer may become a standard treatment.

In the United States, trastuzumab has been approved for adjuvant treatment—use after the main treatment (often surgery)—in women with HER2-positive breast tumors. Based on the recent results of a clinical trial called NOAH,

trastuzumab also may benefit women as a first step before the main treatment, which is known as neoadjuvant therapy.

More than 200 women with newly diagnosed, locally advanced HER2-positive breast cancer took part in the NOAH clinical trial. Approximately three years after treatment, the women who had received chemotherapy plus trastuzumab before surgery survived longer than the women who had received chemotherapy alone.

Researchers believe that these results establish neoadjuvant and then adjuvant trastuzumab with chemotherapy as a standard treatment option for women with locally advanced HER2-positive breast cancer.



Combining trastuzumab with a new medication called DM1 appears to shrink HER2-positive metastatic breast tumors.

A new treatment option has shown impressive early results for women with metastatic HER2-positive breast cancer. Doctors are now combining trastuzumab with DM1 to create a new medication called T-DM1, a treatment that blocks the growth of cancer cells and causes less severe side effects.

In a recent clinical trial, more than 100 women whose HER2-positive breast cancer did not respond or no longer responded to treatments that included trastuzumab or lapatinib (Tykerb) in some cases, were treated with T-DM1. Nearly four-and-a-half months after treatment, researchers reported their early results: in 40 percent of the women, the tumor had completely disappeared or had shrunk by more than 50 percent. The final results of this study are expected later in 2009, when all the patients have been followed for at least six months.

T-DM1 also is being studied in several other ongoing clinical trials for women with HER2-positive breast cancer.

COMBINATION TREATMENT WITH LETROZOLE AND LAPATINIB FOR METASTATIC BREAST CANCER

The combination of letrozole and lapatinib is another new, promising option for women with HER2-positive metastatic breast tumors.

Doctors continue to search for effective treatments for women whose metastatic breast cancer tumors are both HER2-positive and hormone receptor-positive. More than 1,200 postmenopausal women took part in a clinical trial in which they received daily treatments with letrozole plus lapatinib or letrozole plus a placebo. All of the women had



hormone receptor-positive breast cancer that had spread; in addition, 219 of the women were also HER2-positive. None of the women had been treated for metastatic breast cancer before this clinical trial.

It took longer for the cancer to grow in the women who received

letrozole plus lapatinib than in those who received letrozole plus a placebo (more than eight months versus three months in the women who had HER2-positive breast cancer). This means that letrozole plus lapatinib reduced the risk of cancer growing by nearly 30 percent in women with HER2-positive tumors.

Although these early results do not prove that adding lapatinib to letrozole increases survival, researchers believe that future studies may show that this combination does help women with

both HER2-positive and hormone receptor-positive tumors to live longer.

FULVESTRANT FOR METASTATIC BREAST CANCER

Doubling the usual dose of fulvestrant (Faslodex) may help women with hormone receptor-positive tumors go longer without their cancer growing.

In a clinical trial known as FIRST, researchers are studying another promising option for postmenopausal women who have metastatic breast cancer. For women with hormone receptor-positive breast cancer that is locally advanced, higher-than-usual doses of the hormonal treatment fulvestrant may shrink their tumors. This medication may also help the women go longer without their cancer growing.

The U. S. Food and Drug Administration (FDA) has approved fulvestrant for postmenopausal women with hormone receptor-positive metastatic breast cancer that has returned or grown after treatment with tamoxifen or aromatase inhibitors. However, the more than 200 women who took part in the FIRST study had not yet received treatment for their cancer.

The women were divided into two groups. One group of women received two shots of fulvestrant a month—twice the approved dose. The other group of women received the standard dose of another medication—the oral aromatase inhibitor anastrozole.

For women who received fulvestrant:

- The tumor completely disappeared, shrank by at least half, or did not grow in 73 percent.
- A recent evaluation showed that the tumor continued to grow in 29 percent.

For women who received anastrozole:

- The tumor completely disappeared, shrank by at least half, or did not grow in 67 percent.

- A recent evaluation showed that the tumor had continued to grow in 42 percent.

Researchers will try to confirm the encouraging results on fulvestrant in another ongoing clinical trial, aptly called CONFIRM.

NERATINIB FOR METASTATIC BREAST CANCER

The new oral drug neratinib may help shrink tumors in women with HER2-positive breast cancer.

More than 125 women with advanced HER2-positive breast cancer received neratinib daily as part of a recent clinical trial. All of them had received no more than four prior chemotherapy treatments for their metastatic breast cancer. Approximately half of the women had already been treated with trastuzumab, and the others had not.

Beginning at 16 weeks after treatment with neratinib, the researchers evaluated the women in the study.

Among the women who had received trastuzumab previously:

- After 16 weeks, the tumor had not continued to grow in 60 percent of the women.
- It took about 23 weeks for the tumor to continue growing.
- The tumor shrank in 26 percent of the women.

Among the women who had not received trastuzumab previously:

- The tumor had not continued to grow in 77 percent of the women.
- It took 40 weeks for the tumor to continue growing.
- The tumor shrank in 56 percent of the women.

These promising results must be verified in further clinical trials.

IXABEPILONE AND CAPECITABINE FOR METASTATIC BREAST CANCER

Early results with the combination of ixabepilone (Ixempra)

and capecitabine show that it shrinks tumors and may prolong survival for women whose cancer returns quickly and for those who do not recover very well.

Some women who are treated with chemotherapy before or after surgery experience a return of their breast cancer, often within 12 months. Therefore, more effective treatments are needed for these women whose cancer does not respond or no longer responds to chemotherapy. Researchers may have found a new treatment combination for these patients—ixabepilone plus capecitabine.

In October 2007, the FDA approved ixabepilone for metastatic and locally advanced breast cancers. This medication belongs to a new class of drugs known as epothilones, which treat breast cancer that is resistant to other chemotherapy. Ixabepilone is designed to block the growth of cancer cells.

In two large clinical trials, one group of women received ixabepilone combined with capecitabine. This combination was given as a first-time treatment for metastatic breast cancer that had returned within 12 months of the patients' original adjuvant treatment. The ixabepilone was given intravenously (through a vein), and capecitabine was given orally. The other group of women received capecitabine alone.

In the group that received ixabepilone plus capecitabine, the tumor did not grow for an average of about five-and-a-half months. In the group that received capecitabine alone, the tumor did not grow for an average of nearly three months.



In addition, the tumors shrank in more of the women treated with the combination than in those who were treated with only capecitabine (46 percent versus 24 percent).

Ixabepilone plus capecitabine may also extend survival, but final results are not yet available.

There are similar promising results with the combination of ixabepilone and capecitabine in women with metastatic breast cancer who have a lower performance status. Performance status is a way to measure (by percent) the ability of patients with cancer to perform ordinary tasks. For instance, a person with a performance score of 95 percent is better able to carry out daily activities than a person with a performance score of 70 percent.

Women with metastatic breast cancer and a lower performance status (between 70 percent and 80 percent) who received ixabepilone and capecitabine survived longer than similar women who received only capecitabine (12.3 months versus 9.5 months). Researchers believe this is a significant improvement in survival.

Interestingly, women with a higher performance status (between 90 percent and 100 percent) did not appear to survive longer from the combination treatment than those who received capecitabine alone. Ultimately, information like this may help doctors pinpoint the patients who would benefit most from a particular treatment.

Personalizing Treatment

In a new approach to treating breast cancer, doctors are moving away from “one-size-fits-all” treatments. Today, researchers are trying to determine the best approach for each patient based on her tumor’s genes, or genetic makeup.

Every cell in the body contains approximately 30,000 genes. These genes create a blueprint for the human body and its

functions. In the same way, each type of breast cancer has a different pattern of genes. As doctors learn more about these patterns, they are better able to predict which treatment will work for each patient. The study of how genes affect the way a person responds to medications is being used to predict which drug and dose will be best.

PREDICTING RECURRENCE OF BREAST CANCER WITH GENETIC TESTING

Oncotype DX, a widely used genetic test in women with early-stage hormone receptor-positive breast cancer, has now been shown to predict whether anastrozole, an aromatase inhibitor, will prevent the spread of tumors in individual patients.

Identifying gene patterns that are specific for certain types of breast cancer is one of the fastest growing areas of cancer research. By evaluating 21 genes in women with estrogen receptor-positive breast cancer, the *Oncotype DX* test is used to predict whether a woman will benefit from chemotherapy. The test is also a powerful predictor of metastasis in women receiving the anti-estrogen treatment tamoxifen and now anastrozole as well.



This important finding came from a large clinical trial called the ATAC study, which used *Oncotype DX* on tumor samples of more than 1,200 women who were treated for five years with either tamoxifen or anastrozole. Increasingly, doctors are prescribing aromatase inhibitors for postmenopausal women with hormone receptor-positive breast cancer to help prevent their cancer from returning after treatment.

A simple blood test checking for CYP2D6 can show whether tamoxifen or an aromatase inhibitor might be best for women with breast cancer.

When considering whether to prescribe tamoxifen or an aromatase inhibitor such as anastrozole for postmenopausal women who have breast cancer, doctors may suggest a blood test first. The point of the test is to check proteins that may affect the levels of active medication in the blood. Although several of these proteins may be important when it comes



to tamoxifen treatment, the one that has received the most attention is CYP2D6, which breaks down tamoxifen.

Seven to eight percent of white women have a mutation, or abnormal change, in the gene that makes CYP2D6. This means that tamoxifen may or may not work properly for them. But such a mutation does not matter when it comes to aromatase inhibitors, making these drugs useful alternatives.

In a clinical trial called ABCSG 8, more than 100 postmenopausal women with breast cancer took part. After surgery, approximately half of the women received tamoxifen for five years. The others received tamoxifen for two years followed by anastrozole for three years.

Women who had extensive mutations in the CYP2D6 gene and received only tamoxifen were almost four times as likely to have their breast cancer return compared with women who had minor or no mutations in this gene. Further study is needed of CYP2D6 and other genes that may help predict treatment benefit.

BIOMARKERS HELP PREDICT RESPONSE TO TREATMENTS FOR BREAST CANCER

Testing for two gene changes may predict whether tumors in women with HER2-positive breast cancer will resist trastuzumab and respond to lapatinib.

Biomarkers are characteristics of certain genes used to measure the spread of a cancer and to help predict how well a person might respond to a particular treatment for that cancer.

Two biomarkers—low levels of a gene called PTEN and mutations in a gene that makes a protein called PI3K—were the focus of two recent clinical trials conducted at Baylor College of Medicine in Houston, Texas. Both biomarkers seem able to predict how women with HER2-positive tumors might respond to treatment with two different targeted cancer drugs: trastuzumab and lapatinib.

In the first clinical trial, 35 women who had locally advanced breast cancer were treated with trastuzumab. In the second study, nearly 50 women who had locally advanced breast cancer were treated with lapatinib.

Of the women with low levels of PTEN:

- Most women (85 percent) who received trastuzumab did not benefit from treatment.
- All of the women benefited from treatment with lapatinib.

Of the women with mutations in the PI3K gene:

- Most women (80 percent) who received trastuzumab did not benefit.
- Sixty percent of the women benefited from lapatinib.

Researchers concluded that, as a biomarker, mutations in PI3K are a little less accurate than low levels of PTEN in predicting response to treatment with trastuzumab and lapatinib.

Managing Side Effects

Breast cancer and its treatments can cause a number of side effects. A key to managing these side effects is to be aware of them and communicate with your health care team if they arise. In that way, you can maintain the best possible quality of life.

FERTILITY AND CHEMOTHERAPY

Breast cancer treatment can affect the menstrual cycle and the ability to have children, but the combination of doxorubicin (Adriamycin and others) and docetaxel may help preserve fertility.

A clinical trial known as NSABP B-30 focused, in part, on the fertility of more than 2,300 women who had breast cancer. None of these women had reached menopause.

The participants received one of the following chemotherapy combinations:

- AT: doxorubicin and docetaxel
- TAC: docetaxel, doxorubicin, and cyclophosphamide
- AC-T: doxorubicin and cyclophosphamide followed by docetaxel

During the first 24 months of treatment, many of these women experienced at least six continuous months with no menstrual periods. Of those taking AT, 69 percent did not menstruate. Of those taking TAC, 82 percent did not menstruate. And of those taking AC-T, 86 percent did not menstruate.

Of the women taking AT, half of those younger than 40 experienced a return of their periods within 24 months. Only about 20 percent to 30 percent of those receiving other types of chemotherapy had their periods return in the same amount of time.

Researchers concluded that for women who want to preserve their fertility, AT may be the option to consider. However,

doctors do caution that among the women who received four doses of AT, more had their cancer return than women who received AC-T.

PHYSICAL ACTIVITY AND FATIGUE

Staying physically active may improve quality of life and reduce the side effects of breast cancer treatment.

Quality of life is one of the most talked-about topics in breast cancer support groups. Women want to continue with their usual activities and responsibilities as much as possible. According to a clinical trial known as TEAM, one way to do this may be to remain physically active. This ongoing study is being conducted in nine countries with nearly 10,000 postmenopausal women who are receiving either exemestane or tamoxifen.

Researchers have found that women being treated for breast cancer who have a high level of physical activity may have a much better quality of life and even fewer symptoms related to treatment than women being treated for breast cancer who have a low level of physical activity. Active women had fewer symptoms such as fatigue, shortness of breath, constipation, and menopausal complaints.

Although it may be difficult for many women being treated for breast cancer to maintain a physically active lifestyle, even small amounts of time spent walking, bicycling, or gardening may be beneficial.



Coping With Breast Cancer

The information contained in this booklet can be valuable when discussing treatment options with your health care team. However, breast cancer and its treatment can also give rise to difficult emotions and day-to-day challenges. CancerCare® can help.

We are a national non-profit organization that specializes in helping people cope with cancer. Our staff of professional oncology social workers has developed the following tips for coping with breast cancer:

Acknowledge your emotions. When you are diagnosed with breast cancer, it's normal to feel sad, angry, afraid, or frustrated. Consider joining a support group to connect with others going through similar situations. CancerCare offers free telephone, online, and face-to-face support groups for people



with cancer and their loved ones. Individual counseling from our oncology social workers is also available to help you.

Take steps to look and feel your best.

Many women feel uncomfortable with their appearance after having surgery or

chemotherapy. If you had breast surgery or are experiencing hair loss and changes in your physical appearance, learn about the options available, such as breast prostheses and wigs.

Be specific. When reaching out to others, be specific about the kind of support you want or need. Saying something such as “It would help me a lot if you could shop for groceries this week” gives people a clear way to help.

Get help for lymphedema. Sometimes when lymph nodes are removed from the armpit during breast cancer surgery, a swelling known as lymphedema can develop in the affected arm. It happens when the body’s lymphatic fluid doesn’t circulate properly and builds up in the soft tissue instead. There are several ways to help manage lymphedema. Your doctor and nurse can make suggestions on how to prevent and reduce the swelling.



Talk to your spouse or partner about the physical closeness you need.

Share how you feel about your body, and talk about what you think or worry that your partner is feeling. Your partner is most likely waiting for your signal to know what to do, how to act, and what you need.

Learn about available resources. In addition to counseling and support groups, CancerCare provides educational programs, financial assistance to those who qualify, practical help, and referrals. Other organizations that help people with breast cancer are listed at the end of this booklet.

To learn more about how CancerCare helps, call us at 1-800-813-HOPE (4673) or visit www.cancercares.org.

Resources

CancerCare

1-800-813-HOPE (4673)

www.cancer.org

American Cancer Society

1-800-227-2345

www.cancer.org

Cancer.Net

Patient information from the American Society of Clinical Oncology

www.cancer.net

National Cancer Institute

1-800-422-6237

www.cancer.gov

National Library of Medicine (MedlinePlus)

www.medlineplus.gov

Breast Cancer Network of Strength

1-800-221-2141

www.networkofstrength.org

Living Beyond Breast Cancer

1-888-753-5222

www.lbbc.org

Susan G. Komen for the Cure

1-877-465-6636

www.komen.org

To find out about clinical trials:

Coalition of Cancer Cooperative Groups

www.CancerTrialsHelp.org

National Cancer Institute

www.cancer.gov/clinicaltrials



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the difference comes from:

- Professional oncology social workers
- Free counseling for you and your loved ones
- Education and practical help
- Up-to-date information

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