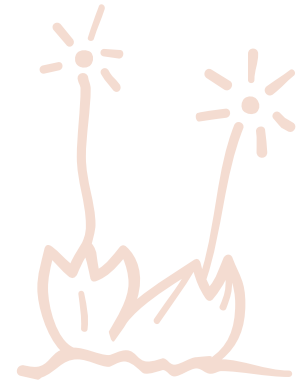


BREAST

CARE CENTER newsletter



A MOMENTOUS YEAR IN BREAST CANCER RESEARCH



Laura J. Esserman, MD, MBA
Director, Carol Franc Buck Breast Care Center

Welcome to the first issue of *Breast CARE Center Newsletter*, the newsletter of the Carol Franc Buck Breast Care Center at the UCSF Cancer Center. Many of you have asked for a summary of the most important news in the field of breast cancer. You've also asked to be informed of new programs at the BCC. In response, we have created this publication, which we will send out twice a year. Each issue will include summaries of important studies, programs and seminars at our Center, a Question & Answer column ("Analyze This!"), and various information of interest to our patients.

This issue features a review of last year's most newsworthy breast cancer research findings. Debu Tripathy summarizes the news from the San Antonio Breast Cancer Conference, featuring updates on Tamoxifen and Herceptin. Henry Kuerer reports findings from a study on Neoadjuvant Therapy in which he was involved, and Stanley Leong explains the importance of the sentinel lymph node. Other articles concern clinical trials and our own research.

We hope you enjoy the information in this newsletter. Your feedback is very much appreciated -- for suggestions and comments please contact the editor sarah_paris@quickmail.ucsf.edu / phone (415) 885-7323. Thanks!

HEALING TILES & STORY GARDEN

Shown here is one of the 550 "healing tiles" that line the entrance hallway of the Cancer Center. Each tile has been created by a patient, family member, or caregiver and contains a personal message or story, accompanied by images of plants from the garden or botanical remedies with their scientific and common names.

For more info on upcoming garden or tile projects for the Cancer Center, please contact the **Ida and Joseph Friend Cancer Resource Center** at 885-3693.



The drug **Tamoxifen** has been making headlines in the last year. The good news is that Tamoxifen will reduce the short-term risk of getting breast cancer and the chance of a DCIS recurrence, as well as breast cancer in the opposite breast (see Debu Tripathy's article on page 6). However, it also leads to a small increase in the risk of uterine cancer in woman who are post-menopausal. The important lesson here is one we have learned throughout breast cancer research: The relative benefit is not nearly as important as the absolute benefit. While tamoxifen can reduce your risk of getting breast cancer, in either breast or at a metastatic site, you must understand your original risk and how much benefit this treatment will bring you.

The same applies in relation to the news about **prophylactic mastectomy**. A report from the Mayo Clinic showed that prophylactic mastectomy reduced the risk of getting breast cancer by over 90%. Again, how much benefit you would receive from such a procedure would depend on your risk. If you have a hereditary mutation for breast cancer, and your lifetime risk of developing breast cancer is somewhere between 60% and 85%, a 90% risk reduction would be far more important than if your lifetime risk is somewhere around 5%.

Another drug in the headlines was **Taxol**, which promises a 20% relative reduction in the risk of recurrence, especially if the tumor is hormone-receptor negative. The trial results are early, and we will hear more about them in the next years. Once again, it is not the relative risk but the absolute risk reduction that is important. This is something you need to discuss with your physician, or you can bring your questions to our monthly "office hours" sessions (see page 9). ■

Laura Esserman. MD, MBA
(excerpted from a talk at Women's Health Grand Rounds at UCSF/Mt. Zion)

The diagnosis of DCIS (ductal carcinoma in situ) is increasingly common due to today's advanced mammographic technology. DCIS is microscopic cancer, confined to cells lining the milk ducts of the breast. While it is non-invasive, a significant proportion (30-50%) will probably progress to invasive cancer, if left untreated. The current therapy, which is generally the same as for invasive cancer, is effective but traumatic and expensive. For many patients, therapy other than surgical excision is probably unnecessary. The problem is, we have no clear idea which ones. The challenge is to establish a framework for decision-making that allows treatment tailored to the different types of DCIS and the extent of the disease. Individual risk can then be matched to treatment recommendation. The table below shows some of the statistics:

<u>5-10 YR RISK OF RECURRENCE AFTER LUMPECTOMY</u>		
	Lo-grade DCIS	Hi-grade** DCIS
No Further Treatment	10% (5%*)	25% (12.5%)
With Radiation	5% (2.5%)	12% (6%)
With Radiation & Tamoxifen	3% (1.5%)	8-10% (4-5%)
Tamoxifen Only***	5% (2.5%)	12-15% (6-7%)
Mastectomy	1%	1%

* risk for recurrence to be invasive cancer.
** risk for low-grade DCIS may eventually be as high as for high-grade DCIS, but only after 10-20 years.
*** Tamoxifen also reduces the risk of breast cancer in the opposite breast from 5% to 2.5%.

The margin of normal tissue around the DCIS should also be a factor for decision-making (NEJM 1999).

A Dilemma Becomes an Opportunity

Another factor in DCIS is that because the cancer is not invasive, there is *no urgency* to intervene. This presents us with a window of opportunity to try out novel strategies, such as vaccines. Over half of DCIS lesions over-express a genetic marker, the HER2/neu oncoprotein. These lesions are the most likely to progress to invasive cancer in the first five years after diagnosis, if treated only with lumpectomy. In my laboratory at the Cancer Center, we are in the process of testing various potential HER2/neu vaccines. We are planning to start a phase I/II clinical trial next Spring to test a cell vaccine currently being developed. Patients will be vaccinated and followed for 3 months prior to surgical excision. We will use Magnetic Resonance Imaging (MRI) to demonstrate the extent of DCIS before and after treatment to assess the efficacy of the vaccines. ■

Henry M. Kuerer, MD

joined the Breast Care Center last year after completing a fellowship in breast surgical oncology at the M.D. Anderson Cancer Center. He has a special interest in the surgical management of breast cancer in women who have received chemotherapy before undergoing surgery. He is also strongly committed to helping women who have just been diagnosed with breast cancer to make sound treatment decisions based on their personal needs and to successfully adhere to the best and most appropriate treatments for their conditions. Dr. Kuerer will be helping to organize new trials at the Breast Care Center for women with stage III breast cancer.



NEOADJUVANT CHEMOTHERAPY ALLOWS FOR LESS RADICAL SURGERY FOR BREAST CANCER

In a new study, we found that chemotherapy that is given before surgery (called “neoadjuvant chemotherapy”) sometimes caused the tumor in the breast to completely disappear. This could potentially eliminate the need for radical surgery for these patients.

Until now, there has been limited research on a woman's response to neoadjuvant chemotherapy.

The study was done between 1989 and 1996. A total of 372 women (median age 47 years) with locally advanced breast cancer, who had not undergone breast surgery, participated in two clinical trials, during which they received four cycles of doxorubicin-based neoadjuvant chemotherapy treatment. Forty-three women (12 percent) had no evidence of cancer after receiving chemotherapy.

Says Dr. Kuerer: “Our study also found that the five-year overall and disease-free survival rates were significantly higher for those patients with no evidence of cancer than for those women whose tumors were not completely eliminated after receiving the neoadjuvant chemotherapy.” However, it's important to realize that there is still a risk of recurrence, even for patients with no evidence of cancer after neoadjuvant chemotherapy.”

The advantage of neoadjuvant chemotherapy is not only that it shrinks the tumor and allows for less radical procedures, but also that we can determine within three to four months to what degree a patient responded to the chemotherapy that was given. If a woman does not respond well to chemotherapy, we can start her on another treatment immediately, or we can proceed with surgery.

Traditionally, chemotherapy has been administered to cancer patients after surgery, and doctors had no way of determining for sure whether or not a particular treatment was actually effective. The sooner the effectiveness of a treatment can be assessed, the better a woman's chance of survival.

Dr. Kuerer performed this study with a team of researchers at the M.D. Anderson Cancer Center. The full results were published in the February 1, 1999 issue of the Journal of Clinical Oncology (www.jco.org). ■



INTRODUCTION TO THE PROGRAM FOR COLLABORATIVE CARE

by Karen Sepucha, Ashley Parsons, and Carrie Sanders

The goal of our new Program for Collaborative Care is to ease communication between patients and physicians so you can make better treatment decisions. The program has several components: One is to make sure we know what is of greatest concern to you. The next is to find better ways to communicate the risks and benefits of various treatments when there is uncertainty. Treatment decisions can be very complex and confusing, so it is very important that communication between patients and physicians is clear and concise. We are developing ways to structure your consultation when you have important decisions ahead of you, then give you a summary of the discussion when you leave.

Consultation Planning, the first step, is ready to be provided to our patients free of charge. During a typical session, a Consultation Planner helps create a flow-chart of a patient's questions and concerns. Patients then take a print-out with them to their appointment to share with their doctor.

Over the past year, we have worked with 61 patients with breast cancer in Consultation Planning sessions. Their ages ranged from 31 to 79, and their diagnoses varied in severity from Stage 1 to Stage 4. These women were making treatment decisions, such as on the type of surgery (including the type of reconstruction) and the type of chemotherapy.

For example: Ms. A came to the BCC for a second opinion. She told us, "I scheduled an appointment here because I have gotten conflicting diagnoses, and I do not know which information to trust. I am frustrated with the lack of coordination and communication among my treatment team." Ms. A was anxious to make a decision and move forward with treatment. She felt Consultation Planning would help her communicate her priorities during her consultation at the BCC.

The figure below is the Consultation Plan we created for Ms. A. Each Consultation Plan is a unique picture of what is on an individual patient's mind. The arrows connect related questions and concerns, and the numbers reflect the priority of these items, according to this patient.

Dr. Esserman reviewed the Consultation Plan before seeing the patient and during the consultation. "I like having a Consultation Plan, because it helps me figure out where the patient is and what is important to her. I cannot find these things in the medical chart". For any number of reasons, patients sometimes don't raise all of their concerns during their office visit.

Whatever decisions you face when scheduling an appointment, a Consultation Planning session can help you prepare and stay focused during your consultation. The Consultation Planners at the BCC are available for appointments, which take between 45 and 60 minutes. If you would like to schedule an appointment for a Consultation Planning session before your next medical appointment, please call the Front Desk at 885-3700.

If you have questions about Consultation Planning or wish to share an experience making decisions about treatment, please call Karen Sepucha at (415) 885-7228 x2 or e-mail her at karen@onyourmind.com. Your input is appreciated!

Our fall newsletter will feature information about the next step in Collaborative Care, Consultation Recording. ■

CONSULTATION PLAN FOR DR. ESSERMAN AND MS. A

One surgeon recommended mastectomy based on the tumor size

I would like to make the decisions about treatment but want to strongly consider the doctor's opinion.

One surgeon said that breast conservation was an option for me

I am confused with the differing opinions. Do you feel I am a good candidate for a lumpectomy?

I have concerns about the side effects from radiation. Does it damage my lungs and heart?

I want to maximize my survival. I have two young children.

If breast conservation is an option, that's what I would choose.

ROLE OF SENTINEL LYMPH NODES IN BREAST CANCER

by Stanley P. L. Leong, MD., FACS



The sentinel lymph node received its name because it is the first node that is invaded by metastatic cells. The concept of the sentinel lymph node has been well-studied in melanoma and is now being applied to breast cancer. The standard treatment for patients with primary invasive breast cancer is the surgical excision of the primary tumor, either through a lumpectomy or a mastectomy, and the removal and dissection of all or most lymph nodes. However, this can result in complications for the patient, such as lymphedema (swelling) of the arm. If an analysis of the sentinel lymph node proves to be a reliable indicator of whether or not metastatic cells have progressed as far as the lymphatic system, then the removal of further lymph nodes could be avoided.

At the Breast Care Center, the sentinel lymph node program began in January of 1998. Our goal is to decrease post-operative problems for women who do not need an axillary lymph node dissection, yet provide appropriate treatment for those who have sentinel lymph nodes involved with disease.

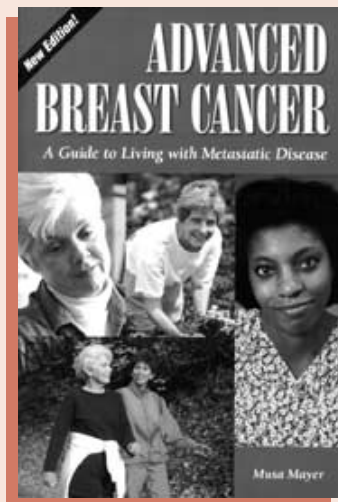
Reference: Leong SPL. The role of sentinel lymph nodes in human solid cancer. In: DeVita, VT, Hellman S and Rosenberg SA. eds. Cancer Principles and Practice of Oncology Updates Vol 12(4). Philadelphia: Lippincott-Raven; 1998:1-12.

IN THE NEWS THE BONE MARROW CONTROVERSY

Early study results show that undergoing bone marrow transplantation does not appear to improve the survival of women with metastatic disease. There may be a group of women with a great response to chemotherapy that might benefit; this needs to be looked at in the context of a clinical trial. For women diagnosed with stage II/III disease (many positive nodes), bone marrow transplantation seemed to improve survival modestly, in the range of 7%. However, this came at a cost: the complications were significantly higher; in the largest trial, the mortality was high (7%). The critical factors that determine complications are the combination of drugs (regimen) used for the transplant, and where it is performed. At very experienced, high-volume treatment centers, trials show a mortality of 1% or less.

Bone marrow transplantation cannot be considered the standard of care for women with high-risk or metastatic disease; but further investigation will continue through clinical trials at high-volume centers with demonstrated low mortality rates. In our next newsletter, we will devote a longer article to bone marrow transplantation.

More on Bones: Clodronate, a bisphosphonate drug that promotes bone growth and prevents bone destruction, may also reduce the risk of developing new bone metastases, as shown in 2 out of 3 recent European studies. Results from one of the studies suggest that it might even reduce the risk of developing other metastases. These studies are controversial, but extremely intriguing, and will be followed up by national trials. This is a very exciting new area of research, and we will keep you updated on further developments. ■



This newest edition of Musa Mayer's book "Advanced Breast Cancer: A Guide to Living with Metastatic Disease" (formerly entitled: Holding Tight, Letting Go) is reissued as part of a series of "Patient-Centered Guides". And indeed, this is an excellent resource for patients and their care-givers, with much practical information, sound advice, and many stories of real patients and their experiences.

While many other books on breast cancer focus on newly diagnosed patients and on the issue of being a "survivor", this book acknowledges the reality that for some breast cancer patients, the disease will reoccur. All aspects involved in such a recurrence are covered here, including coping with the news, making informed treatment decisions, managing side effects, getting emotional support and finding new ways to keep hope alive and discover meaning in adversity. ■



Debu Tripathy, MD
*Director of Clinical Research
& Breast Oncology
Carol Franc Buck Breast Care Center*

ADVANCES IN RESEARCH

Several important advances were covered at the San Antonio Breast Cancer Symposium held in December of 1998.

Tamoxifen

Findings from the NSABP P01 Prevention Trial now confirm that in the short term (over about 5 years), patients who are at high risk for getting breast cancer can reduce their risk by almost one half by taking tamoxifen. Based on this information, the Food and Drug Administration has approved tamoxifen as a drug that can lower the short-term incidence of breast cancer.

It is important to recognize that tamoxifen may not in reality be preventing cancer. In the opinion of most scientists, breast cancer takes as many as 5 to 15 years to develop. Therefore, it is likely that what tamoxifen is doing is actually treating established breast cancers that are microscopic and undetectable.

There are many questions about the long-term effects of tamoxifen prevention and the optimal time for a woman to take it. Trials showed a higher risk of uterine cancer, blood clots, and the development of cataracts, especially in women over 50. So even though tamoxifen can now be prescribed as a "prevention" drug, it remains unclear for which women the benefits of the treatment will actually outweigh the risks.

There is a trial planned to compare tamoxifen to raloxifene as a preventive agent for breast cancer. Raloxifene has the advantage that it may not increase the risk of uterine cancer.

HER2/neu

Reports in San Antonio included further information on the HER2/neu genetic marker and its use to identify who might benefit from different types of therapy -- hormonal or chemotherapy -- for early stage breast cancer.

Patients whose tumors overexpressed HER2/neu (i.e., made high amounts of the protein encoded by the HER2/neu gene) seem to benefit more from the chemotherapy Adriamycin. A study of older women compared tamoxifen alone to a regimen of tamoxifen and Adriamycin-containing chemotherapy. Results suggested that only patients whose tumors overexpressed HER2/neu obtained significant benefits from the addition of chemotherapy.

Herceptin

Further presentations included an update from the clinical trials using Herceptin, the HER2/neu antibody. In one trial, women received Herceptin as the only treatment if they had metastatic breast cancer which overexpressed HER2/neu and which had progressed after one or two chemotherapy regimens. 14% of the 222 women had a response. It remains unclear why a majority of women do not respond to Herceptin, but certainly for those that do respond, there is a clinical benefit, even though the responses were temporary.

Another randomized trial compared chemotherapy alone to chemotherapy with Herceptin, also for women with metastatic, HER2/neu-positive breast cancer. This study showed convincingly that the addition of Herceptin improved the effectiveness of chemotherapy. The average time after which patients had progression of their tumor was significantly prolonged. The number of patients who had a response in the first place was also improved, and the one-year survival was improved.

These changes were not as dramatic as one would like to see, but clearly demonstrate the biological effectiveness of Herceptin at least in some women.

The important message is that though we don't have a cure yet, we are seeing the beginning of success for treatments which actually target the genetic and biochemical pathways of cancer. In the coming years, we will explore many other strategies. These include drugs that target angiogenesis (the formation of blood vessels that tumors require to grow); drugs that boost the immune system (such as vaccines), and drugs that actually introduce or alter the expression of a specific gene. It will take not only laboratory research but large and well-conducted clinical trials to move potential biological therapies towards a major impact in breast cancer.

For more details, check out the Breast Care Center Clinical Trials website at <http://bcc-ct.his.ucsf.edu> ■

BREAST CARE CENTER STAFF

Left to right: Annette Ramos, *Medical Assistant*; Laurel Bray, *Practice Manager* (kneeling); Sabrena Taylor, *Front Office* (standing); Claudia Castro, *Front Office*; Michelle Jones, *Front Office*; Sonia Stallworth, *Front Office*; Christine Del Rosario, *Medical Assistant*; Jenny Aquino, *Front Office*. Not depicted: Sandra Rodriguez, *Front Office*, and Mary Garlit, *Surgery Scheduler*



Carol Franc Buck
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newsletter

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"A New Vision For Integrated Breast Care"

ANALYZE THIS!

Our next newsletter will feature a patient Q & A column... Please send us your questions, and we'll publish a selection along with the answers in the fall issue.

Questions can be sent to Sarah Paris, UCSF Box 1728, San Francisco, CA 94143, e-mail: sarah_paris@quickmail.ucsf.edu.

FROM THE ADVOCATES

The two sidebars on this page are excerpts from letters written to patients by former patients who have become advocates in the fight against breast cancer.

For the full text of these letters, please contact Deborah Collyar at Collyar@worldnet.att.net, or at (925) 736-8155; or Peggy Devine at pdevine@pacbell.net, or at (415) 502-2986.

Clinical Trials

Virtually all of the improvements in cancer care have occurred because of something called a "clinical trial." The term "clinical trial" may sound a bit intimidating, but it is simply a research study that carefully tests new ways to prevent, diagnose, or treat diseases like breast cancer. There are advantages and disadvantages to participating in a clinical trial. Advantages might include receiving treatment that is not commercially available, undergoing more rigorous follow-up care, or experiencing treatment that is given in a more effective way than with standard therapies. Disadvantages might include more doctor visits, additional tests, or increased costs (although such costs are usually covered by the trial budget or by insurance).

We believe it is important for you to understand all of your options as you decide upon a treatment plan. We want you to make the best decision for your particular condition and invite you to learn more about cancer research. If you want information about a specific clinical trial, please call Liz Wieland at the UCSF Breast Care Center at (415) 353-7213. ■

LINKS IN THE CHAIN



Selected links of interest to our patients (for a comprehensive list of websites please check the "links" section of the Cancer Resource Center site below):

<http://cc.ucsf.edu/crc> - the Ida & Joseph Friend Cancer Resource Center at the UCSF Cancer Center

<http://bcc-ct.his.ucsf.edu/> - the Breast Care Center's Clinical Trials website.

www.ucsf.edu/ocim/ - website of the Osher Center for Integrative Medicine at the UCSF/Mount Zion. The Center's mission is to search for the most effective treatments for patients by combining non-traditional and traditional approaches that address all aspects of health and wellness - biological, psychological, social and spiritual.

www.cancerlinks.org - one of the most comprehensive, organized and user-friendly sites, with links to numerous topics related to cancer.

www.breastcancer.net - provides very complete information on breast cancer: current news articles, indexed reference articles, support groups, treatment options, and related websites.

www.canceranswers.org - what makes this site unique are the personal stories and artwork in support of women receiving treatment for breast cancer.

www.cancersupportivecare.com - information for patients and caregivers on topics such as Nutrition, Exercise, Pain Control, Sexuality, and Spirituality.

www.noah.cuny.edu - the N.Y. Public Library, City University of N.Y., and the N.Y. Academy of Medicine have joined forces to produce the ultimate resource on cancer and other diseases. Primary devoted to educating underserved populations, the website is totally bilingual (English and Spanish), and includes exhaustive information on breast cancer clinical trials, diet, diagnosis, prevention, causes, risk factors about cancer, and even includes questions to ask your physician. ■

CALENDAR



Monthly Office hours

with Drs. Laura Esserman, Debu Tripathy, and other BCC and visiting MDs

*These are open discussion sessions **for our patients** to discuss concerns and ask questions on important topics, such as hormone replacement, herbal medicine, exercise and nutrition, and new treatments. They are open Q & A sessions, where patients can bring up issues specific to them. The sessions are geared towards patients in follow-up care.*

“Office Hours” are held Monday evenings from 5:15pm to 6:15 pm at the Resource Center on the First Floor of the Cancer Center. The following dates have been set for 1999:

July 19
August 23
September 13
October 11
November 8



Bay Area Breast Cancer Forum

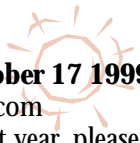
Sessions are open to the public. Upcoming dates for the BABCF are September 7, October 13, and November 10. Topics for discussion may include hormonal therapy, diet & exercise, sexual problems, and environmental factors. For more information, please contact Fern Hassin at 885-3738



October is Breast Cancer Awareness Month!

1999 San Francisco Race for the Cure: **October 17 1999**
on-line information at www.raceforthecure.com
If you'd like to be on our BCC team for next year, please contact Sarah Paris @ (415) 885 7323 or sarah_paris@quickmail.ucsf.edu to be put on our list.

In conjunction with the Race, we are planning to organize “Taste for the Cure”, a gourmet event featuring celebrity chefs. Please check back with us as the date gets closer for more information! ■



FEATURED

Clinical Trial at the BCC:
The Micrometastasis Study

Micrometastasis (MM) occurs when cancer cells break loose from their original tumor site and circulate in the bloodstream. This process goes undetected until the cells invade other organs and grow large enough to cause symptoms. Our study will test three ways of detecting micrometastasis, and will study the relationship between MM and clinical outcome.

This study will help to achieve the following:

- improve care for future patients
- learn more about how to predict whether breast cancer will spread and whether a woman needs chemo or hormonal therapy
- predict which cancers will respond to different types of therapy
- find potential genetic markers for metastasis

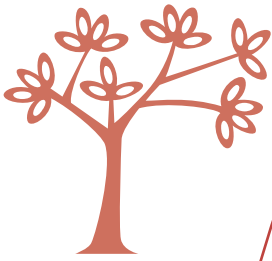
If we find a reliable, easy method of detecting circulating cells (MM) in the blood and bone marrow, we can, in the future:

- tailor therapy
- use mm to follow response to therapy
- follow the genetic markers for MM

The “Micrometastasis Study” is open to any woman who has been diagnosed with breast cancer, but has not yet had breast cancer surgery. It will necessitate having a bone marrow aspiration during surgery, while under anesthesia. A decision to participate or not in this study will not affect the quality of care you receive from UCSF.

Although you may not experience a direct benefit from participating in this study, your willingness to donate bone marrow will help researchers in their efforts to treat breast cancer more effectively in the future.

If you want information about this or other clinical trials, please call Liz Wieland at the UCSF Breast Care Center at (415) 353-7213. ■



SUPPORT GROUPS AT THE BCC



Personal Support and Lifestyle Intervention Trial of UCSF and CPMC. Women with breast cancer are invited to participate in a research program studying the benefits of two types of psychosocial and lifestyle interventions on well-being and quality of life. Women will be asked to participate in one of two groups, both lasting for 12 weeks. Interested people can call the program at 885-7877.

Young Adults with Cancer Support Group 1st and 3rd Monday of each month, 5:30-7:30 pm. To register or for more information, contact Keren Stronach, MPH at the Cancer Resource Center, 885-3693.

Support Group for Husbands & Significant Others 1st and 3rd Tuesday of each month, 6:30-8:30 pm, Cancer Center. To register or for more information, contact Andrew Kneier, PhD, 885-7585.

UCSF/Mt. Zion Department of Psychiatry offers the following support groups to cancer patients. To register, or for more information, contact Debra Marks, PhD, 415-885-3770.

-Family & Friends Support Group - A group for family members and friends of people dealing with cancer.

-DCIS - 12-week support group for women with Ductal Carcinoma In Situ.

The Cancer Support Community is an 11 year-old free-standing community-based agency. UCSF/Mount Zion is proud to co-sponsor the groups situated at Mount Zion.

-African American Group 1st and 3rd Monday of each month, 6-8 pm at the YWCA, 1830 Sutter St. Contact Jane Gainer 765-7677, 207-5958 pager.

-Breast Cancer Support Group For more information contact Carol Kronenwetter, PhD 885-3785.

-Cantonese Support Group 1st and 3rd Sat., Chinatown District, Health Center, 1490 Mason St., SF. To register, or for more information, call 788-2131.

-Family and Friends Support Group Meets on the 2nd and 4th Friday of each month, 12-1:30 pm. To register or for more information, call Carol Kronenwetter, PhD 885-3785.

-General Cancer Support Group - all stages Wednesdays 5:30-7:30 pm, Resource Center. Contact Carol Kronenwetter, PhD 885-3785.

-Group for Children Whose Parents Have Cancer To register or for more information, call 788-2131.

-For Support Groups in other languages contact the Resource Center, 415-885-3693

Ida and Joseph Friend Cancer Resource Center Programs and Services:

Exercise Class for Cancer Patients

Tuesdays, 12:15-1:45 pm and Thursdays, 9:45-11:15 am, Mount Zion Cardiac Care Gym, first floor, room C101. Entrance is at 2200 Post at Scott. To register, please contact the Resource Center at 885-3693 and Kathleen Dzuber at 510-597-1189.

Restorative Movement

Wednesdays, noon - 1:00 pm in Mount Zion Cardiac Care Gym, first floor, room C101. Entrance is at 1600 Divisadero. For more information, contact the Resource Center at 885-3693.

Gentle Yoga Class

Thursdays, 12:15 - 1:30 pm. Mount Zion Medical Building, 1701 Divisadero. Registration required. To register, contact the Resource Center at 885-3693.

Individual and Couple's Counseling

Individual and couple's counseling/psychotherapy with a sliding scale fee can be arranged by calling Debbie Marks, PhD, at 885-3770.

Support for Russian-Speaking Women and Their Family Members

Raya Smail, MA, (Russian-speaking) at 831-4339.

Smoking Cessation & Relapse Prevention Course

A month-long course, Wednesdays, 5:30 -7 pm. To register, contact the Resource Center at 885-3693.

Art for Recovery

Mondays & Thursdays at the Cancer Center Infusion Center, 2nd floor, or by appointment. Contact Cindy Perlis, 885-7221.

Healing Garden and Tile-Making Workshops

Call the Resource Center for more information at 885-3693.

Look Good, Feel Better

Workshops to improve appearance during chemotherapy. Call the Resource Center for dates and locations at 885-3693.

Spiritual Counseling and Guidance

Chaplains are available in the department of Pastoral Care to provide patients with spiritual counseling and guidance, and to assist in coping with bereavement. Please call 353-7681.

The Cancer Resource Center contains books and audio tapes & video tapes which may be checked out by the public. The Center can help you locate information about your condition, treatment options, nutrition, pain management, stress reduction or other health matters. All Resource Center support groups and activities are free. Stop by and visit us at 2356 Sutter Street, First Floor or call us at (415) 885-3693. Web page: <http://cc.ucsf.edu/crc> ■





Franking Code #2096

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San Francisco, CA 94143-1710



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NUTRITION CONSULTATIONS

*Now Available in the
Breast Care Center
with registered dietician
Alison Horton*

One Hour Consult Can Include:

- dietary assessment
- current information about diet and breast cancer
- information on phytoestrogens in soy
- answers to your nutrition questions
- supplementation needs
- weight loss suggestions

To book an appointment with Alison, simply ask the Breast Care Center front desk staff, or call the *Breast Care Center* at 885-3700

OPPORTUNITIES FOR VOLUNTEERS!

Have you ever considered volunteering some of your time? Do you think our efforts here at the BCC are worth supporting? Would you like to gain some hands-on experience in healthcare?

***Please contact Meridithe Mendelsohn
(415) 885-7558***