

WSCP Newsletter

Relay for Life

Every spring, all over the United States, the American Cancer Society conducts the Relay for Life. This year, I decided to volunteer to act as the team captain for the Wyoming Department of Health. Admittedly, I was not excited about this role. Raising money is not always an easy task and the prospect of exceeding the national team average of \$1,500.00¹ in a poor economy was less than thrilling. But I was lucky. I ended up with a handful of hard working, dedicated people who raised over twice the national average

Funds also pay for programs such as Quitline, support groups such as the Cancer Survivors Network plus other programs that help patients with cancer who are undergoing treatment. Funds help pay for political reform such as advocating for stronger smoking ordinances to protect the public from tobacco smoke, screening for breast and cervical cancer for low-income women and urging the Congress to support cancer research and programs.¹

When I attended my first captain's meeting, the first thing I noticed was how many teams there were for Cheyenne. There were 51 teams, some with just one member, but some with over 20 members. This is a "first glance" at how many people have been affected in some way by cancer. Each of those 51 teams, had persons on the track every hour for 18 hours, a second glance at how many people have been affected by cancer. The most profound glance is at the lighting of the luminaries. Each luminary surrounding the track

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or in the grandstands, represents a person (or pet) that has or is deceased from cancer. This is quite a visual impact, yet you begin to realize that the many luminaries represent just a small percentage of the cancer population in the community.

As tumor registrars, we enter names and diagnoses of cancer every day. We look at the totals and understand the percentages, but what are we doing to help besides just registering cases? As health professionals in the field of cancer, do we ever stop to see how this disease affects the local population? By actively participating in an event like Relay for Life, one begins to realize the enormity of this disease. Ask yourself what you can do to help. Are you offering to take a friend to support group, helping someone quit smoking or giving a cancer patient a ride to a treatment facility?

It is not just about dropping money in a can. If every central or hospital registrar did something to make a difference, what an awesome impact we could make.

It is September and you can start to think about how you too can make a difference by forming a team now and start to raise money for any cancer event.

¹American Cancer Society, Relay for Life team captain handouts, "Where does the money go?"

Submitted by : Deb Broomfield



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To Chemo or Not

Why do some Breast Cancer patients need chemo and others only need radiation, hormone therapy or observation?

As a Central Tumor Registrar I have abstracted many breast cancer cases. From my observation, 2 cases appear to be the same but are treated differently. My curiosity directed me to “Google” to find out why.

During my research the following factors seem to determine treatment choices: *the risk for recurrence*, age, menopausal status, lymph node involvement, stage and grade of the tumor, Hormone receptor status, HER-2 over expression, and Ki67.¹

The National Cancer Institute has classified 3 categories for the *likelihood of recurrence* for breast cancer without lymph node involvement:

1. Low Risk: tumor size 0-1 cm, ER/PR positive, tumor grade of 1.
2. Intermediate risk: tumor size 1-2 cm, ER/PR positive, tumor grade of 1-2
3. High Risk: tumor size over 2 cm, ER/PR negative, tumor grade 2-3

It has been found, through clinical trials, that certain adjuvant therapies (Chemotherapy/Hormonal therapy) benefit patients with either node negative or node positive tumors. Therapies are selected based upon the individual *risk for tumor recurrence* and the risks of the adjuvant therapies.¹

Per BreastCancer.ORG the general guidelines for who will benefit from chemo:

1. Cancer in lymph nodes, regardless of tumor size or menopausal status.
2. More aggressive treatment for premenopausal women with diagnosis of invasive breast cancer. Breast Cancer for premenopausal women tends to be more aggressive, so chemo is usually part of the treatment plan.

3. ER/PR negative and HER-2 positive. These are both indicators associated with more aggressive cancer.
4. Oncotype DX test for ER/PR positive breast cancer help to determine how likely the cancer will come back and if the patient would benefit from chemo.
5. Chemo is used to shrink some tumors prior to breast conservative surgery.
6. Non-invasive, in situ cancers are very unlikely to have spread to other parts of the body and chemo is usually not recommended.
7. Inflammatory Breast Cancer. Chemo is given prior to surgery to help shrink the cancer and bring down swelling. Following surgery more treatments are given due to the aggressiveness of the disease.
8. Advanced stage (stage III/IV) Breast Cancer. Chemo is used to destroy or damage the cancer cells as much as possible.
9. Metastatic Breast Cancer.

Radiation therapy is recommended for breast cancer patients following lumpectomies or mastectomies to destroy any cancer cells that may have been left after the tumor was removed.²

Hormonal therapy is a treatment for hormone receptor positive breast cancers. (ER/PR positive). Hormone therapy lowers the amount of estrogen in the body and by blocking the action of estrogen on the cancer cells it reduces the *risk of breast cancers recurring* after surgery.²

Targeted biologic therapy is used for HER-2 positive breast cancer. Herceptin is an antibody that recognizes certain proteins on certain cells and signals the body's immune

System to destroy the cell and is generally combined with chemo therapy to lower the *risk of recurrence*.

Each patient's treatment plan is different. The Patient and their Cancer team work together to determine what treatment is best based upon the *risk of recurrence*, type of cancer, stage, and the patient's health.

Now I know.

¹[www.cancer.gov/cancer-topics/pdq/treatment/breast/Health Professional](http://www.cancer.gov/cancer-topics/pdq/treatment/breast/Health-Professional)

²www.breastcancer.org/treatment/chemotherapy/who_gets_it.jsp

³ www.herceptin.com

Submitted by : Vicki Moxley



Global Fear of Radiation

An 8.9 earthquake rocked Japan on March 11, 2011. The epicenter was off the shore of Sendai. Within minutes a tsunami caused extensive damage to nuclear plants closest to the epicenter of the quake. The main concern seems to be the Fukushima Daiichi nuclear power plant. On March 14, there was an explosion at one of the buildings housing a reactor on. Japanese officials have set up a 30km exclusion zone where residents within that area must leave or remain indoors due to radiation leaking.

People are concerned and making references to Chernobyl. Dr. James Cox, a radiation oncologist with the University of Texas MD Anderson Cancer Center, shared some insight about radiation exposure and the health risks involved. He claims not only can radioactive emissions be released into the air and inhaled but they can also fall to the ground. In the case of Chernobyl, the emissions fell to the ground and into the grass which was eaten by cattle that produced milk containing radioactive iodine. Thousands of children consumed the milk and later developed thyroid cancer. He adds that children are at risk because radiation targets rapidly dividing cells and they are growing and therefore have rapidly dividing cells. According to the American Thyroid Association, the younger the child is when they are exposed to radiation, the greater risk of thyroid problems. Radiation exposure can lead to hypothyroidism (underactive thyroid), or it can attribute to thyroid nodules and possibly thyroid cancer.

In the United States, thyroid cancer was the most common endocrine neoplasm in children with only 1-1.5% of all pediatric malignancies, and 5-5.7% of all malignancies of the head and neck region. 5% of the nation's thyroid cancers are in children and adolescents. While there are less thyroid nodules occurring in children compared to adults, 26.4% of these nodules are found to be malignant.

Now, let us compare the US numbers and talk about the disaster in Chernobyl, the Ukraine region of former Soviet Union. A nuclear accident happened in April of 1986 when a nuclear plant had a chain reaction of explosions that caused dangerous amounts of radiation exposure to people in the surrounding areas of Belarus and Ukraine, as well as other areas of Eastern Europe. In an article written in 2003, the World Health Organization reported that this disaster will cause 50,000 new cases of thyroid cancer in the younger population. Currently, the rates are three times higher in adolescents from age 15-18 years than those rates prior to the incident and the rates of incidence in children living in the Ukraine region rose 10-fold. Researchers estimate that 36.4% of children under the age of 4 at the time of the incident can expect to develop thyroid cancer. And recorded in the journal *Cancer* (2000;68:1470-1476), thyroid cancer is even more common and severe in those children younger than two years of age at the time of the accident living in Belarus. Again, presumably because of the rapid cellular growth that occurs in children of that age group.

Idaho, Nevada, New Mexico, Utah, and Wyoming have never had an operating nuclear power plant. The borders of these contiguous western states are more than 100 miles from any reactor. According to SEER data, from 1988 – 1997, these states had a 22.1% lower rate of cancer incidence in children ages 0-9 years. This incidence rate was 14.27 per 100,000 people, compared to the rate of 17.42 incidents per 100,000 in 49 counties near reactors. This reduced rate seems to be an ideal reason to live in Wyoming, or one of the other 4 western states listed.

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Upcoming Events

April

4/7 NAACCR Webinar- Collecting Cancer Data: Breast
4/5 - 4/7 Program Directors Meeting (NPCR)

May

5/5 NAACCR Webinar- Collecting Cancer Data: Prostate
5/15 - 5/18 NCRA Annual Conference - Orlando, Florida

June

6/2 NAACCR Webinar- Best Practices for Developing and Working with Survival Data
6/18 - 6/25 NAACCR Annual Conference - Louisville , Kentucky

July

NPCR Train the Trainer, Atlanta, Georgia

WCSP newsletter is a semi-annual publication of the Wyoming Cancer Surveillance Program (WCSP).

*This and previous issues are also available online at:
<http://www.health.wyo.gov/phsd/wcsp/news.html>*