



CANCER OPTIONS

CANCER OPTIONS NEWSLETTER

June 2009



WELCOME TO THE BI-MONTHLY NEWSLETTER FROM THE CANCER OPTIONS RESEARCH TEAM.

Firstly apologies for the late arrival of this newsletter, not quite as bi-monthly as I intended!

As you may know (if you don't there is more information about us at the end of the newsletter) we take an impartial and receptive view of good quality information on all approaches to cancer.

Our newsletter contains the pick of the best information from both the orthodox and complementary worlds of cancer. There are frequently contentious issues particularly relating to Cam therapies, where possible we will bring you the balancing arguments so you can make your own mind up.

We are strong believers in people with cancer being able to access on the benefits of safe integration of different approaches. We don't believe that people who wish to take charge of their dealing with cancer and tackle it from a holistic and multi-dimensional approach are either naive or unable to rationalise the arguments from viewpoints that are diametrically opposed for many reasons.

We aim for people to be:

PROACTIVE! WELL INFORMED! DETERMINED! DECISIVE!

We always say at Cancer Options; we don't mind what you do as long as you are well informed and have made your own decisions.

When we are working with people through the vast amounts of confusing and contradictory evidence our three golden rules for surviving cancer:

❖ **KEEP YOUR OWN PERSPECTIVE**

❖ **BECOME AN EXPERT ON YOURSELF**

❖ **LEARN WHAT HEALS YOU**



CANCER OPTIONS

Contents

Page 4 – Yorkshire Laser Centre

Page 5 - Quotes of the month

Page 6 – Good news for melanoma sufferers

Page 8 – Concerns about breast screening information

Page 12 – Not good news for Avastin

Page 14 – Overuse of prostate cancer therapy

Page 17- Vitamin D (again I know but good stuff!)

Page 21 – Effect of healthy lifestyle on cancer survival

Page 24 – Complementary medicine causes more harm than good: A debate from opposing views on the subject

Page 27 – Orthodox German Oncologists hail Hyperthermia

Page 30 Advice on how to conduct your relationship with your doctor

Page 22 – About Cancer Options Services

Integrative Medicine

**The best of current science + The depth of holistic healing +
Multidimensional strategies and innovations**

EQUALS - Empowerment, Positivity and Purpose



YORKSHIRE LASER CENTRE

I recently had the pleasure of visiting the Yorkshire laser Centre to discuss their work with Professor Keyvan Moghissi

This Centre is working at the forefront of the use of lasers in the treatment of cancer and other life threatening conditions. It works in partnership with the NHS and is supported by a charitable trust established in 1984. The team has pioneered the development of photodynamic therapy (PDT) which combines the use of lasers with a photo-sensitive drug to provide highly targeted treatment.

Work continues to develop the effectiveness of PDT in different parts of the body and in the exciting new area of photo-detection (PD) which can identify abnormalities under laser light long before traditional techniques. Ongoing research, treatment and training is making a significant contribution to advances in effective laser therapies in the UK and overseas.

I personally find it a great shame that like so many teams that are developing breakthrough treatments that are not drug based and do not have the drug companies investment that they have to set up charities to enable them to make their work accessible to people. It is wonderful to see such innovation and dedication from small teams working within the NHS. Patricia



QUOTES OF THE MONTH

“The best information on cancer is coming out of the UK - more so than any other country”

Macmillan

We speak to colleagues in lots of different countries who have many innovative, and integrative programmes of care where holism, nutrition and natural therapies are viewed as being wholly sensible

I hope they are not going to start feeling jealous of us!!

Upon being told that she was consulting Cancer Options a client was told:

“You must not talk to people like that or read their web site, you must only read Cancerbacup and Macmillan sites for information”

Someone save us from this level of biased ignorance. There is a saying that 20 years experience may be 1 year of poor experience repeated 20 times!!



ALTHOUGH EARLY RESEARCH COULD BE GOOD NEWS FOR MELANOMA SUFFERERS WHO ARE VERY MUCH IN NEED OF IT

ASCO 2009: Investigational Targeted Therapy for Metastatic Melanoma Shrinks Tumors, Causes Stir at Meeting

June 4, 2009 (Orlando, Florida) — The targeted-therapy revolution in oncology could be coming to melanoma, especially if the results of a phase 1 trial of an investigational agent are followed by similar results in subsequent trials, according to melanoma experts attending the American Society of Clinical Oncology 45th Annual Meeting.

"We are on the verge of a paradigm shift for melanoma therapy," said melanoma expert Boris Bastion, MD, from the University of California at San Francisco, who was not involved in the trial. "This is a decisive step toward personalized medicine," he added.

Dr. Bastion was a discussant at a meeting session on melanoma at which studies of 2 targeted therapies for malignant melanoma were presented, 1 of which is the investigational PLX4032 (Plexxicon Inc). This oral agent targets the oncogenic *BRAF* gene mutation known as V600E, which occurs in about 60% of malignant melanoma patients, according to the study authors.

In a dose-escalation, proof-of-concept study, more than half of metastatic melanoma patients with this *BRAF* mutation who received high doses of PLX4032 had tumor shrinkage, said lead study author Keith T. Flaherty, MD, from the Abramson Cancer Center of the University of Pennsylvania in Philadelphia.

"We were able to give enough drug to block mutated *BRAF*, and that resulted in clinical benefit in a majority of patients treated at higher doses," Dr. Flaherty told *Medscape Oncology*. Specifically, 9 out of 16 patients with *BRAF* mutations had an objective response by RECIST criteria. Of the remaining 7 patients, 5 had tumor shrinkage, but not enough to count as an objective response, and 2 had growth, he added.

Among the 16 patients with *BRAF* mutations, median progression-free survival "appears to be 6 months," said Dr. Flaherty, adding that the time period is "likely to change" as more data are collected.

"These early responses happen with remarkable reliability," Dr. Flaherty told the audience, adding that the agent is not useful for patients without the *BRAF* mutation.



CANCER OPTIONS

"The magnitude of response is better than we expected," he continued.

PLX4032 is important because it represents an advance in targeting *BRAF*, explained another melanoma expert, David Fisher, MD, PhD, from Massachusetts General Hospital Cancer Center in Boston.

"Others have attempted to use kinase inhibitors to block the *BRAF* gene. This agent was designed to specifically block the oncogenic mutated form of *BRAF*," Dr. Fisher, who was also not involved in the study, told *Medscape Oncology*.



CONCERNS ABOUT BREAST SCREENING INFORMATION

It has long been known by many people that the benefits of breast screening has been overplayed, very reassuring to see that prominent people in the NHS are prepared to stand up and do something about it.

Controversy Erupts Around Breast Cancer Screening Leaflet in the UK

February 26, 2009 — In the United Kingdom, a leaflet about breast cancer screening sent to women along with an invitation for a mammogram will be rewritten after fierce criticism from experts, who described it as inadequate and manipulative.

At the center of the controversy is the question of whether or not the leaflet fairly and accurately describes the balance of risks and harms involved with screening mammography.

The leaflet, *Breast Screening: The Facts*, was produced by the UK Department of Health. It was originally written in 2002, and was updated in 2006.

It will now be scrapped and rewritten, according to news reports.

Prof. Mike Richards, National Cancer Director, said a formal review is now in progress, and the new leaflet will likely be ready by Fall 2009.

The announcement was made this week, only days after severe criticism of the leaflet appeared online January 27 in *BMJ* and was highlighted February 19 in a letter to *The Times* newspaper. The letter was signed by 23 cancer experts, epidemiologists, family doctors, and patient representatives.

"None of the invitations for screening comes close to telling the truth," says Michael Baum, MD, emeritus professor of surgery at University College, London, United Kingdom, who headed the list of signatories to *The Times* letter.

None of the invitations for screening comes close to telling the truth.



CANCER OPTIONS

"As a result, women are being manipulated, albeit unintentionally, into attending," they write. It is "imperative" that this leaflet is rewritten.

Not Telling the Truth?

The UK breast screening program, started in 1990, invites all women between 50 and 70 years to undergo a mammogram, for free, every 3 years. The leaflet that has come under such criticism was sent out with this invitation, and sets out to explain what to expect from the screening.

The leaflet is "inadequate as a basis for informed consent," say Peter Gøtzsche and colleagues at the Nordic Cochrane Center, in Copenhagen, Denmark, writing in *BMJ*. It emphasizes the benefits of screening — inaccurately, in their opinion — but gives little information about harms, they write.

In particular, it makes no mention of the major harm of screening — that is, unnecessary treatment of harmless lesions that would not have been identified without screening, Dr. Gøtzsche and colleagues point out.

"This harm is well known and acknowledged, even among screening enthusiasts," they add. "It is in violation of guidelines and laws for informed consent not to mention this common harm, especially when screening is aimed at healthy people."

The leaflet does note that some women find mammograms to be painful and uncomfortable, and that recalls for further investigations "can cause worry." However, it does not elaborate on the fact that some of these recalls result in false-positive diagnoses, and makes no mention at all of the diagnosis of ductal carcinoma in situ (DCIS), which accounts for about 20% of the diagnoses made in the UK breast screening program. Fewer than half of these DCIS cases progress to invasive cancer, they note.

Dr. Gøtzsche and colleagues also take issue with how the benefits of screening are described. The leaflet proclaims that screening "reduces the risk of the women who attend dying from breast cancer" and estimates that it saves about 1400 lives in the United Kingdom each year.

But "it has not been proven that screening saves lives," they insist, and new evidence shows less benefit and substantially more harm from screening than previously thought.

In fact, this balance between risk and benefit has changed so much in recent years that nationwide programs of breast screening would be unacceptable, they say. "We believe that if policy makers had had the knowledge we now have when they decided to introduce screening about 20 years ago . . . we probably would not have had mammography screening."



Conflict of Interest?

A major problem with this information on breast screening is that it comes from the same organization that runs the screening program, and this represents a conflict of interest, say Dr. Gøtzsche and colleagues. Information about harms may deter women from participating, and high participation rates are pivotal for these programs to be successful.

The UK breast screening program is considered a success — during 2007/08, of the 2.2 million women invited for checks, 1.7 million were screened, *The Times* reports.

The Nordic Cochrane researchers have written on this issue previously, and have also criticized leaflets on breast cancer screening in 6 other countries that have publicly funded screening programs — Australia, Canada, Denmark, New Zealand, Norway, and Sweden (*BMJ*. 2006;332;538-541).

At that time, and now again, Dr. Gøtzsche and colleagues offer a template document that provides evidence-based information on breast cancer screening; it can be downloaded from The Nordic Cochrane Centre website.

In this document, they set out the benefits and harms, as follows:

- If 2000 women are screened regularly for 10 years, 1 woman will benefit from screening; she will not die from breast cancer.
- At the same time, 10 healthy women will become breast cancer patients and will be treated unnecessarily, many undergoing surgery, radiotherapy, and chemotherapy.
- About 200 healthy women will experience a false alarm.

"The question of whether the benefits of screening outweigh the harms is a value judgement that needs to be made by invited women," Dr. Gøtzsche and colleagues conclude. In order to make that decision, the woman needs to be informed — and they hope that their leaflet provides sufficient information to enable women, together with their doctors, to decide whether to participate.

But Numbers Are Disputed

In their letter, Dr. Baum and colleagues urge the British authorities use this template to rewrite the current leaflet. It gives a clear overall picture of how the benefits and harms stack up, they say, although they admit that there is some debate about the exact numbers; some data suggest that more women benefit and fewer are treated unnecessarily.

These numbers are disputed by government-appointed experts. Julietta Patrick, director of the National Health Service (NHS) Cancer Screening Programmes, says the estimated numbers are nearer to 4 to 5 lives saved



CANCER OPTIONS

and 4 to 5 women being unnecessarily treated, so the ratio is closer to 1:1. Her comments appear in an article about the recent reports on the NHS website, and these same figures were used by the head of cancer policy, Prof. Richards, when talking to the press.

"There are no doubts in my mind about the benefits," Prof. Richard said.

Although the presentation of information can be debated, it is "dangerous to scare people away from a program that has brought substantial benefits," said Peter Johnson, MD, chief clinician at Cancer Research UK.

The NHS website article points out that the Nordic Cochrane group previously published a systematic analysis, which concluded that "screening likely reduces breast cancer mortality," with about a 15% relative risk reduction.

It also explains that most of the harms associated with screening relate to the uncertainty about DCIS. Although only about half of these cases go on to develop invasive cancer, it is not possible to predict which ones will, so all women with screen-detected DCIS are treated in the same way, with surgery/ radiotherapy or chemotherapy. For those women who would not have developed invasive cancer, this treatment would have been unnecessary.

Complete Rethink Needed?

Dr. Baum argues that there is no evidence of large benefits. "The number of invasive breast cancers being detected is not falling, despite the number of cases picked up by screening rising dramatically," he told *The Times*. "You would expect serious cancers to drop because the early detection means the DCIS cases are not progressing. It just doesn't add up."

The policy of screening every women should be revised to focus on those most at risk, factoring in family history and demographic trends, he suggested. In addition, he questioned the current trend for aggressive treatment, and suggested that there may be room for a "watchful waiting" approach such as in prostate cancer.

"It is complacent and arrogant to think we should carry on regardless with screening services," Dr. Baum said. "It is time we had a complete rethink, but anyone who dares challenge the sacred cow of screening has a terrible time."

BMJ. Published online before print January 27, 2009.



NOT GOOD NEWS FOR AVASTIN

There's more trouble for Avastin (bevacizumab). On April 22, 2009 the US manufacturer, Genentech, Inc. announced that the drug had failed to prevent colon cancer in a large National Cancer Institute (NCI)-sponsored clinical trial. A successful trial would have been a big boost for Genentech, and for its Swiss parent company, Roche, which acquired Genentech in March.

Genentech, however, continues to sound optimistic about Avastin. "Our initial review of the data leads us to continue to believe Avastin may be active in patients with early-stage colon cancer," Hal Barron, the company's chief medical officer, said in a statement. The data will be presented at the late May meeting of the American Society for Clinical Oncology (ASCO). All the company is saying for now is that Avastin did not "meet its endpoint," i.e., did not reduce the risk of cancer returning by the targeted amount.

Avastin had sales of \$2.7 billion in the United States alone last year. It is currently approved for late-stage colon, breast and lung cancers. According to the *New York Times*, "in that use, trials have shown the drug can prolong life by up to a few months." That was true in colon cancer clinical trials. (The drug's results in the community setting remain unknown.) For breast cancer, however, the drug does not actually improve survival. In fact, in 2007, the FDA's Oncology Drug Advisory Committee (ODAC) recommended against approval, but was overruled by the director of the FDA. In the case of brain cancer (glioblastoma multiforme), ODAC recommended approval in early April 2009, but again without proof of increased survival.

The new early-stage colon cancer trial was an attempt to use the drug earlier in the course of the disease, right after surgery had been performed to remove the tumor. Presumably, the drug would prevent cancer from recurring, in effect curing the patient of the disease. To test this hypothesis, about 2,700 patients received either six months of standard chemotherapy or six months of the same chemotherapy plus a year of Avastin. The study then measured how many patients were alive and free of cancer over time. Apparently the results were not significantly different, although the oncology world eagerly awaits the ASCO meeting disclosures, which will be scrutinized for any sign of benefit from the drug. Not one to be discouraged,



CANCER OPTIONS

Roche is running another trial of Avastin, this one for early-stage colon cancer. Results of that trial are expected in 2010. Roche and Genentech are also testing the drug for use in early-stage breast and lung cancers. A lot of money is riding on this determination since Genentech has said that Avastin sales could quadruple - to \$10 billion by 2015 - if it could get the drug approved for early-stage colon, lung and breast cancer. Unfortunately, the drug does not seem to be cooperating in that effort.



OVERUSED: ANDROGEN-DEPRIVATION THERAPY IN PROSTATE CANCER

June 11, 2009 — Androgen-deprivation therapy (ADT) for prostate cancer is overused, according to experts who have written recent editorials in 2 major journals.

"It's becoming increasingly clear that androgen-deprivation therapy is overused in treating prostate cancer," writes William Dale, MD, PhD, in an editorial accompanying a new American study that indicates that ADT contributes to the development of diabetes. The study and editorial were published online June 8 in the *Journal of Clinical Oncology*. Dr. Dale is from the geriatrics and palliative medicine and hematology/oncology sections at the University of Chicago in Illinois.

"No doubt there is gross overuse of androgen-deprivation therapy in the treatment of prostate cancer," said Peter Albertsen, MD, MS, in an interview with *Medscape Oncology*. Dr. Albertsen is the author of an editorial published in the June 11 issue of the *New England Journal of Medicine* that accompanies a new European study on the use of ADT in men with locally advanced prostate cancer. He is professor of surgery and chief of the Division of Urology at the University of Connecticut Health Center in Framingham.

Both Dr. Albertsen and Dr. Dale note that ADT has been shown to improve survival in men with metastatic prostate cancer, but that its survival benefits are mostly uncertain or unproven in other stages of the disease.

What's Driving the Overuse?

The overuse of ADT has been driven, in part, by clinicians in the United States overestimating the effectiveness of ADT, suggests Dr. Albertsen. "If it's good for advanced disease, there's a good chance it will work for localized disease — that's probably been the thinking," he explained.

Money has also been a driver. "Overuse was probably worse a few years ago when clinicians were making a lot of money off of it," Dr. Albertsen said about the administration of ADT and related follow-up care.

The desire to take action is another driver, said Dr. Dale. "There is a propensity to 'do something' about cancer that leads to starting a therapy that is not justified. This is particularly true for older men," he told *Medscape Oncology*.

Dr. Dale cited 2 "do something" settings in which data don't support the use of ADT. "Starting it early when PSA [prostate-specific antigen] first rises following surgery or radiation — versus waiting until later to start it — has



CANCER OPTIONS

not been shown to extend life. It is also being used increasingly in older men as primary therapy rather than surgery or radiation therapy," he noted.

Dr. Dale, who is trained as a geriatrician and has an appointment in oncology, spent a month in an oncology clinic talking to clinicians and patients about their decisions to start ADT. "I was struck by men who had their PSA rising and were going out of their minds with worry," he noted. In a study coauthored by Dr. Dale (*J Clin Oncol* 2009; 27:1557-1563), patient anxiety was shown to be the primary reason men with rising PSA counts, or biorecurrence, decided to start ADT .

ADT for Some, But Not All, Advanced Localized Disease

In the treatment of prostate cancer, ADT should be "primarily be limited to men with advanced localized disease undergoing radiation therapy and to men with clear signs of systemic disease," writes Dr. Albertsen in his editorial.

"These are the patients most likely to benefit from either symptom relief or increased survival that would justify the compromise in quality of life that is associated with androgen-deprivation therapy," he notes.

Dr. Albertsen reached this conclusion based on the available literature, which now includes the European study of men with advanced localized disease published in the *New England Journal of Medicine*.

In the study, the definition of locally advanced disease was either tumor stages T1c to T2a–b and nodal stage N1 or N2, or tumor stages T2c to T4 and clinical nodal stages N0 to N2. Patients with clinical evidence of metastatic spread were excluded.

The study indicates that, following external-beam radiation for locally advanced prostate cancer, 6 months of ADT does not provide survival superior to 3 years of treatment; the now-published results were originally presented at the ASCO annual meeting in 2007 and reported on by *Medscape Oncology* at the time.

In short, the study says that 3 years of ADT, which is the standard in this setting, should remain the standard.

Balancing the Risks for Therapy and Disease

According to Dr. Dale, the best candidates for early use of ADT are, in addition to patients with overt metastasis, younger patients (under 65) with "high-risk" disease (high-grade prostate cancer, local spread of disease into lymph nodes) receiving external-beam radiation. His comments, in effect, echoed Dr. Albertsen's

Dr. Dale also suggested that otherwise healthy men with very high-risk features (Gleason grade of 8–10, PSA doubling times of less than 3 months, short time between primary therapy and rising PSA) could be started early.



CANCER OPTIONS

However, older patients with moderate-grade or lower disease and long PSA doubling times should definitely not be started on it right away, he emphasized.

"We have to balance the risk of the prostate cancer with the risks of the therapy when making these decisions," said Dr. Dale, adding that mixed information exists about the role ADT plays in worsening cardiovascular disease or diabetes.

However, the new American study "convincingly supports the conclusion that ADT contributes to the development of [diabetes mellitus]," writes Dr. Dale in his editorial.

J Clin Oncol. 2009. Published online ahead of print June 8, 2009.

N Engl J Med. 2009;360:2516-2525 and 2572-2574.



Vitamin D Again, apologies for going on about it but the constant stream of information warrant a mention

COLORECTAL CANCER PATIENTS ON CHEMOTHERAPY LACK ENOUGH VITAMIN D

Patients receiving chemotherapy for colorectal cancer are likely to have severe vitamin D deficiency and may need high-dose vitamin D supplements to bring their levels up to normal, according to a study published online October 2 in the International Journal of Colorectal Disease.

Vitamin D has an important link to colorectal cancer. A number of studies have found an association between vitamin D deficiency and an increased risk of colorectal cancer, as well as a worse prognosis in people who have the disease. "We know there's an association between vitamin D levels and increased risk of adenomas (tumors), as well as an increased risk of colon cancer," says lead study author Marwan G. Fakih, associate professor of Oncology at the Roswell Park Cancer Institute in Buffalo, New York. "And at least two studies have linked improved outcome with higher levels of vitamin D."

People get vitamin D from dietary sources (such as milk), as well as from being outside (vitamin D is produced in sun-exposed skin). Although researchers are not exactly clear how vitamin D might protect against cancer, they believe that it reduces cancer cells' ability to grow and enhances cellular differentiation, Dr. Fakih says.

He and his colleagues looked at vitamin D status in 315 colorectal cancer patients, half of whom had been receiving chemotherapy. Patients in the chemotherapy group were about three times more likely to have very low vitamin D levels (15 nanograms per milliliter (ng/ml) or less) than patients who weren't receiving chemotherapy. Only about a quarter of the chemotherapy patients in the study had vitamin D levels within the recommended range of 32 to 100 ng/ml.

The authors say this deficiency may occur because chemotherapy

patients are less likely to get outside in the sunlight, or they may limit vitamin D-fortified milk products in their diet to prevent chemotherapy-



CANCER OPTIONS

induced diarrhea. It's also possible that chemotherapy might affect the body's ability to absorb vitamin D or use it in its active form.

Dr. Fakhri cautions that the association between low vitamin D levels and cancer risk does not necessarily mean that vitamin D deficiency causes colon cancer or shortens the lifespan of those with the disease. "True, we see low levels of vitamin D, but that does not mean that if you replace it these patients will do better," he says. He and his colleagues are currently studying how well colorectal cancer patients on chemotherapy respond to a daily 2,000 IU vitamin D supplement.

For now, Dr. Fakhri believes chemotherapy patients should have their vitamin D levels regularly tested—a practice that is not common in the United States. "The reason we test them is that there really is not a whole lot to lose here," he says. "Replacing vitamin D in patients with vitamin D deficiency may also have positive effects on bone health, as well as on the cardiovascular and immune systems."

How well vitamin D supplements might protect healthy people against colorectal cancer is still uncertain, because this and other studies have focused specifically on patients who already have colorectal cancer. More research is needed to determine the benefit—and optimal dose—of vitamin D for cancer prevention.



Also

We thought you might also be interested in this. Obviously only a theory but interesting!

RESEARCHERS STUDYING THE PREVENTIVE EFFECTS OF VITAMIN D ON CANCER HAVE PROPOSED A NEW MODEL OF CANCER DEVELOPMENT THAT HINGES ON A LOSS OF CANCER CELLS' ABILITY TO STICK TOGETHER.

The model, dubbed DINOMIT, differs from the older model of cancer development, which suggests genetic mutations as the earliest driving forces behind cancer.

The first event in cancer is loss of communication among cells due to, among other things, low vitamin D and calcium levels," said epidemiologist Cedric Garland. "This loss may play a key role in cancer by disrupting the communication between cells that is essential to healthy cell turnover, allowing more aggressive cancer cells to take over."

Garland suggests that such cellular disruption could account for the earliest stages of many cancers. Previous theories linking vitamin D to certain cancers have been tested and confirmed in more than 200 epidemiological studies, and understanding of its physiological basis stems from more than 2,500 laboratory studies.

Each letter in DINOMIT stands for a different phase of cancer development – disjunction, initiation, natural selection, overgrowth of cells, metastasis, involution, and transition.

While there is not yet definitive scientific proof, Garland suggests that much of the evolutionary process in cancer could be arrested at the outset by maintaining adequate vitamin D levels.

According to another study, getting more of the "sunshine vitamin" may also help you stay mentally fit as you age.

Researchers compared the cognitive performance of more than 3,000 men aged 40 to 79, and found those with low vitamin D levels performed less well on a task designed to test mental agility. The findings are some of the strongest evidence yet of such a link, because of the size of the study and because the



CANCER OPTIONS

researchers adjusted for a number of lifestyle factors believed to affect mental ability.

The researchers do not know exactly how vitamin D and mental agility may be connected, but it could be connected to the vitamin's role in increasing certain hormonal activity, or it could have a protective effect on brain neurons.



HEALTHY LIFESTYLE BEHAVIORS SLOW DECLINE IN LONG-TERM CANCER SURVIVORS

Breakthrough research for the orthodox world, how long now before health care providers start realizing investment in long term care after treatment reaps benefits for everybody

May 13, 2009 — Older long-term survivors of colorectal, breast, and prostate cancer might be able to stave off functional decline by changing dietary and physical-activity behaviors. After participating in a home-based tailored program of telephone counseling and mailed materials, cancer survivors experienced modest weight loss and clinically meaningful improvements in physical function and other health-related quality-of-life domains, researchers report in the May 13 issue of the *Journal of the American Medical Association*.

The mean baseline Short-Form (SF)-36 physical function score was 75.7, but at the 12-month follow-up, the researchers noted that mean function scores declined less rapidly in the intervention group (-2.15; 95% confidence interval [CI], -0.36 to -3.93) than in the control group (-4.84; 95% CI, -3.04 to -6.63; $P = .03$).

There was a statistically significant difference in basic lower-extremity function between the 2 groups. Function changed negligibly in the intervention group, whereas a decline in function was observed among the controls.

The 5-year survival rates for early-stage colorectal, breast, and prostate cancer are increasing, and currently exceed 90%, but cancer survivors remain at greater risk for second malignancies, chronic diseases, and accelerated functional decline. Even though lifestyle interventions might reduce the risk for disease and functional decline, the authors note, many older cancer survivors report poor lifestyle behaviors, and few meet the recommendations in health-promotion guidelines. Their dietary and physical-activity behaviors are frequently suboptimal, even though most patients are nonsmokers.

Older Adults Not Targeted

There is great interest in exercise- and diet-related approaches among cancer survivors, but the majority of these interventions for cancer patients have targeted younger individuals, those undergoing treatment, and those with recent diagnoses, the authors write. However, older adults are an important group because cancer and its treatment are associated with accelerated functional decline, and maintaining mobility and functional independence in at-risk older individuals has been established by the Centers for Medicare & Medicaid as the sole priority in aging research.



CANCER OPTIONS

"Older adults are just as motivated as younger adults," said lead author Miriam C. Morey, PhD, associate professor of medicine at Duke University School of Medicine in Durham, North Carolina. "I believe any nonacute-care visit is an appropriate time to approach cancer survivors about practicing healthier lifestyles."

But reaching out to long-term survivors can be challenging, explained Dr. Morey, because many long-term cancer survivors are no longer under the care of their oncologists.

"The primary-care setting might be a more ideal setting [to approach patients] — one in which primary-care providers serve as the referral source for potential participants who stand to benefit from this type of intervention," she told *Medscape Oncology*. "We need to find ways to improve provision of lifestyle changes in standard primary care or, alternatively, to develop methods of facilitating self-enrollment, perhaps over the Internet, for programs providing ongoing lifestyle-modification programs."

Thus far, it has been unclear whether long-term cancer survivors could modify their lifestyle behaviors sufficiently to improve functional status. Dr. Morey and colleagues evaluated whether a telephone counseling and mailed print-material-based diet and exercise intervention would be effective in reducing functional decline in older overweight cancer survivors.

Improvement Seen in All Measures

Reach Out to Enhance Wellness (RENEW) is a randomized controlled trial that evaluated the efficacy of a home-based diet and exercise intervention aimed at reorienting the functional trajectory of older long-term survivors of breast, prostate, and colorectal cancer. Included in this cohort were 641 overweight (body mass index, ≥ 25 and < 40 kg/cm²) individuals who were diagnosed with cancer at least 5 years previously, who were 65 years or older at enrollment, and who had no evidence of progressive disease or secondary cancers. Trial recruitment took place from July 1, 2005 to May 17, 2007.

The intervention consisted of a personally tailored workbook and a series of quarterly newsletters, combined with 15 telephone counseling sessions and 8 automated prompts over the course of 12 months. The control group received no intervention during the same time period.

In addition to changes in physical function as measured by the SF-36, the researchers observed significant differences between the intervention and control groups for all targeted behaviors except endurance-exercise frequency. Duration of strength-training exercise increased in the intervention group and remained stable in the control group (mean, 18.7 vs 2.7 minutes per week, respectively), and the duration of endurance exercise also increased for the intervention group (mean 36.3 vs. 23.4 minutes per week). The average intake of fruits and vegetables increased by 1.24 daily servings in the intervention



CANCER OPTIONS

group and by 0.13 daily servings in the control group.

Individuals in the intervention group decreased their daily consumption of saturated fat by 3.06 g, compared with 1.07 g in the control group. An average weight loss of 4.5 pounds was also reported by participants in the intervention group, which is more than double the 2.03-pound weight loss in the control group.

The researchers reported that overall health-related quality of life decreased on every subscale among participants in the control group during the study period, whereas decreases in subscale scores were of lower magnitude and were sustained for overall health and mental health in the intervention group.

"Future studies should not only assess the effect on health and well-being, but also should address cost-related outcomes, especially given that the economic burden associated with functional decline and loss of independence is exceedingly high," they conclude.

**'THIS HOUSE BELIEVES THAT COMPLEMENTARY
MEDICINE DOES MORE HARM THAN GOOD'**



CANCER OPTIONS

That was the title of a debate at Guy's hospital in April 2009. Speaking for the motion were cancer specialist Professor Michael Baum and science writer Simon Singh.

'This house believes that complementary and alternative therapies do more harm than good'.

Professors George Lewith and David Peters spoke in defence of complementary therapies.

This event provoked considerable interest and we reproduce the arguments for and against in some detail. Got a comment? Add your own thoughts below.

Homeopathy is promoted for all sorts of lethal diseases.

Professor Michael Baum: for the motion

Professor Baum began by defining what he thinks patients with life threatening diseases need. He said 'patients need to get better and that is where medical science leads the way.

Once they're getting better they need to feel better, and that's where complementary medicine has its role... and finally patients with life threatening disease need to live better, and to help them live better they need some kind of spiritual support, and in this area, this grey area. For the secular amongst us I believe the arts play in that role, and for the religious amongst us I believe the faith communities plays that role. I also believe it is a plausible hypothesis that helping patients with their spiritual concerns and making them feel better through complementary care may indirectly help them get better'.

He added that in the 1990s he had been instrumental in getting art therapy introduced to the Royal Marsden Hospital. His objection is to 'alternative' therapies which claim to treat major disease. 'I have a series of horrific photographs of patients with advanced breast cancer, horrible ugly stinking ulcers which would shock you and each one of these had chosen to have natural cures'. He says of websites which promote curing cancer by diet and vitamins alone 'this is cruel, this is evil and this should be illegal'. He adds that homeopathy is sometimes promoted for 'all sorts of lethal diseases'. Hence Professor Baum has come to the conclusion that CAM does more harm than good.

Professor George Lewith: against the motion

Responding, Professor George Lewith first talked about risk: 'Distorting the



CANCER OPTIONS

reality and deliberately misleading patients is bad stuff and there is good and bad in complementary and conventional medicine.' However it was misleading to draw a line portraying complementary medicine as unsafe and unproven and conventional medicine as working smoothly. 'If you look at some studies from the US, they suggest that the death rate from adverse reactions to some drugs is greater than the death rate from cancer'.

He criticised Professor Baum and others for implying that complementary medicine was not even worth researching. 'Michael and some of his colleagues have argued that we should stop teaching complementary medicine in some of the modern universities like Westminster and Thames Valley, and secondly that we shouldn't invest in research. We won't get any further unless we do invest in research'.

He argued that although there are problems with complementary therapy safety and some herbs in particular have been rightly withdrawn, the risks often tend to get overstated. 'I remember having a debate about ten years ago about acupuncture. It was very dangerous, very harmful. Now we've now got prospective studies with over half a million acupuncture consultations, we know it's safe.

'Simon [Singh's] been on about how dangerous chiropractic is. Now just because stroke has sometimes happened after manipulation doesn't mean the two are causally linked. There's good evidence that the incidence of stroke is the same whether visiting a GP or a chiropractor with the same problem.'

Now this debate that we are having polarises the patient, they get stuck in the middle.

Professor George Lewith

He believes that some opponents of complementary approaches don't present a balanced view to patients, who sometimes respond by pursuing alternative health options in secret because they can't talk to their main healthcare provider about it.

He added that what patients want to do is 'trade off' and get the best of both methods. He agreed with Professor Baum that mistreating cancer with alternative medicine was suicidal, but argued that 'right wing oncologists', not miracle cure websites were the main reason for abandonment.

'I just systematically reviewed 26 papers looking at why people use CAM for complementary medicine and we focused very clearly on abandonment. We didn't find a single case in 26 papers, not one case which someone had gone to have their alternative cancer treatments because of what they read on the web, that is pure fiction, it is not supported by systematic science, it is



scaremongering.'

He pointed to places where there's a growing evidence base for complementary approaches. 'CAM helps with a range of illnesses, there've been some good systematic reviews of irritable bowel, depression and back pain'

He believes that RCTs can't work in acupuncture because there's no good placebo. 'What we know about acupuncture and pain is it doesn't matter necessarily where we put the needle, but when we put the needle in, for chronic arthritic problems, painful conditions like migraine, we get twice the effect that you do without using that method. Now there are two conclusions from that, one conclusion might be that acupuncture doesn't work, the other conclusion, probably a more reasonable one, given that it's twice as effective as conventional medicine, is that we don't have a very good placebo and that it's very difficult to design a placebo in acupuncture'.

Simon Singh: for the motion

Simon Singh, by contrast argued that newer acupuncture trials showed smaller and smaller effects. He added 'But the really important point here is, is this as good as it gets for my opponents? - acupuncture for pain and nausea is as good as it gets. We're going to acupuncture for everything from depression, to hay fever, high blood pressure, solving liver disease, mental problems, rheumatism, diabetes and so on. All these treatments are claimed for acupuncture, but there's virtually zero clear evidence. So in that case I would say for the majority of conditions acupuncture does more harm than good.

He went on to say that there's no compelling evidence for 'spiritual healing, homeopathy, crystal therapy, magnet therapy, reflexology, reiki and many others'.

He argued that while these do no direct harm, they may be used as an alternative to proper treatment, or lead to a delay in seeking proper treatment. For instance, he said 'only three per cent of homeopaths in a 2002 survey believed that the MMR vaccine was good for children.'

David Peters: against the motion

David Peters said that healthcare costs were spiralling because of chronic disease coupled with longevity. 'It has industrialised in the face of this onslaught. Michael's a very experienced and caring doctor and I don't believe he is typical by any means of what's happened to doctors in industrialising processes. But I think many begin to downgrade the time spent



on compassion'.

Summing up, he said: 'If you believe complementary practitioners are all conmen with an anti-science agenda, then actually campaigns are justified. I'm not going to get into conspiracy theory, but whose interest is it to entirely ration healthcare according to what you can force through the randomised controlled trials designed for drugs.

They're designed for looking at mass effects, they're designed - in general and with success - to tell us what happens when an enormous number of people are treated by a single drug. It's very hard to research something complex in that way. If we insist in national healthcare working that way, what we'll get from the NHS is a drug service.

'Complementary medicine has its place but if we support those who practice it badly, fraudulently, carelessly, in an unregulated way without being properly educated, then we will end up with a system where complementary medicine is no longer available to us, I don't think we want that. In its essence complementary medicine does far more good than harm, but it has to be done in context, it has to be done well, if and ideally it has to find its way into integrated relationships with mainstream medicine.

Integrated medicine is not 'what works mixed with what doesn't work', as Michael suggests. We have a problem with all kinds of medicine, part of it works and part of it doesn't but we often don't know the odds.

We need integration because we have the crisis of cost, care and profession. We need medicine which begins to create health, not just wage war against disease. Somewhere in there, there may be some very interesting and important knowledge to be gaining by diving in deeply to research. So I oppose the motion that complementary medicine does more harm than good.'

A personal view on this - I get pretty fed up with every debate on complementary medicine focusing on homeopathy. When advising people with cancer there are many different approaches that are viewed by us as being of greater efficacy. To keep bringing the public and media debate down to what they sneeringly described as watered down therapy does not give the other approaches an opportunity to be fairly heard



ORTHODOX GERMAN ONCOLOGISTS HAIL HYPERTHERMIA

We have for a long time appreciated the benefits of hyperthermia, most research is done in combination with radiation, but there are benefits to be gained in most situations. Patricia

On the topic of German cancer treatments, the orthodox German Cancer Society has praised hyperthermia for "putting the heat on advanced cervical cancer." Two trials have now documented a good rate of success using a combination of radiation therapy along with deep hyperthermia for treating advanced cervical cancer.

One treatment option for advanced cervical cancer, the Society explains, is a combination of radiation and chemotherapy. But chemotherapy is not feasible for all patients because of general health or other reasons. Also, if a tumor has already spread beyond the cervix and penetrated the surrounding tissues, it is often impossible to eliminate through the use of radiotherapy alone. In such cases, the German oncologists say, "combining radiotherapy with deep hyperthermia can produce better results."

The papers in question were published in the *International Journal of Radiation Oncology, Biology, Physics* in 2008 and 2009. They showed that tumor growth was better controlled, and survival rates increased, using the combination of hyperthermia and radiation therapy. The heat was generated by electromagnetic radiofrequency (RF) waves. By using modern computer technology, doctors can closely target the cancer, while adversely affecting surrounding healthy tissue to a minimum degree.

Women who participated in these trials had either locally advanced disease or had disease that had already spread to lymph nodes, other organs in the pelvic area, and internal organs adjacent to the pelvic area (stages II through IVA). When compared to those patients receiving radiation therapy alone, the combination of radiation therapy and deep hyperthermia produced dramatic improvements in both response rates and tumor control. Furthermore, long-term survival rates improved. In the 2008 paper, overall survival was "persistently better" after 12 years: 20 percent for radiotherapy alone vs. 37 percent for the combination, a near doubling, which was also statistically significant (Franckena 2008). So while hyperthermia doesn't exactly "cook cancer while you nap," the way some



CANCER OPTIONS

Internet sites claim, it certainly does improve one's chances of being alive at 12 years (and therefore probably cured) than with radiation therapy alone.

But here's the part that I find really encouraging: the aforementioned organization of orthodox German researchers now recommends that its members offer "the option of combined radiotherapy and deep hyperthermia to patients who cannot undergo chemotherapy." In fact, they point out that at Dutch radiotherapy centers, this combination of radiation therapy plus hyperthermia is already standard practice. "In Germany so far, this treatment option is only offered in specialized centers," they say. I applaud their willingness to now endorse this treatment, which has been pioneered at German CAM clinics for decades.



ADVICE ON HOW TO CONDUCT YOUR RELATIONSHIP WITH YOUR DOCTOR

Do not expect your doctor to share your discomfort. Involvement with the patient's suffering might cause him to lose valuable scientific objectivity.

2. Be cheerful at all times. Your doctor leads a busy and trying life and requires all the gentleness and reassurance he can get.

3. Try to suffer from the disease for which you are being treated. Remember that your doctor has a professional reputation to uphold.

4. Do not complain if the treatment fails to bring relief. You must believe that your doctor has achieved a deep insight into the true nature of your illness, which transcends any mere permanent disability you may have experienced.

5. Never ask your doctor to explain what he is doing or why he is doing it. It is presumptuous to assume that such profound matters could be explained in terms that you would understand.

6. Submit to novel experimental treatment readily. Though the surgery may not benefit you directly, the resulting research paper will surely be of widespread interest.

7. Pay your medical bills promptly and willingly. You should consider it a privilege to contribute, however modestly, to the well-being of physicians and other humanitarians.

8. Do not suffer from ailments that you cannot afford. It is sheer arrogance to contract illnesses that are beyond your means.

9. Never reveal any of the shortcomings that have come to light in the course of treatment by your doctor. The patient-doctor relationship is a privileged one, and you have a sacred duty to protect him from exposure.



CANCER OPTIONS

10. Never die while in your doctor's presence or under his direct care. This will only cause him needless inconvenience and embarrassment.

Of course it's a joke.....isnt it?



ABOUT CANCER OPTIONS

Cancer Options is a private, cancer consultancy where you can obtain consultancy, research and coaching for all the different cancer treatments and therapies.

You will find the best of orthodox and complementary approaches evaluated by Britain's leading experts in the integrative field.

Only Cancer Options brings this unique and unbiased appraisal of both orthodox and complementary approaches.

We are the only professional service with the knowledge and experience of all approaches to cancer to guide you to safe and effective treatment choices

THE CANCER OPTIONS TEAM

Patricia Peat
RGN Dip Pall C Dip UTR

The Founder of Cancer Options

After many years as an oncology nurse Patricia saw the need for people to have access to good quality information about all approaches to treatment so they could take charge of their cancer decisions.

Passionate about encouraging the safe integration of complementary treatments with orthodox, she has developed Cancer Options into a renowned service at the forefront of cancer treatment developments.



CANCER OPTIONS

Dr. Christopher Etheridge

**PhD BSc(Hons) Chem, BSc (Hons) Herb Med, MCPP, MRSC CChem,
DolC, ARCS**

Director of Research

Dr. Christopher Etheridge trained at Imperial College London, and later at the Department of Biochemistry and Molecular Genetics at St. Mary's Hospital, Paddington and Department of Chemistry, Imperial College, where he holds three patents in Gene Therapy.

Christopher now holds a degree in the practice of Herbal Medicine (Phytotherapy).

Dr. Etheridge directs our research from his background as a medical researcher and junior lecturer at Imperial College, and from his knowledge of Complementary and Alternative Medicine.

He also now has his own thriving herbal practice, and is fast gaining a reputation of one of the most knowledgeable practitioners in his field.

www.drchrisetheridge.co.uk

SERVICES AVAILABLE

- ✦ Consultancy and information on all orthodox treatments.
- ✦ Recommendations for second opinions.
- ✦ Personal dietary, supplement and herbal regimes.
- ✦ Supportive regimes compatible with your chemotherapy and radiotherapy programmes.
- ✦ Consultancy and information on all complementary treatments for cancer.
- ✦ Analysis of underlying holistic elements contributing to ill health and identification of approaches to deal with them.



CANCER OPTIONS

- ✚ Organising treatment programmes both here and abroad.

We have a very eclectic service to suit the individual, both personal and telephone consultations call us to see how we can help you with your cancer programme