

thrive

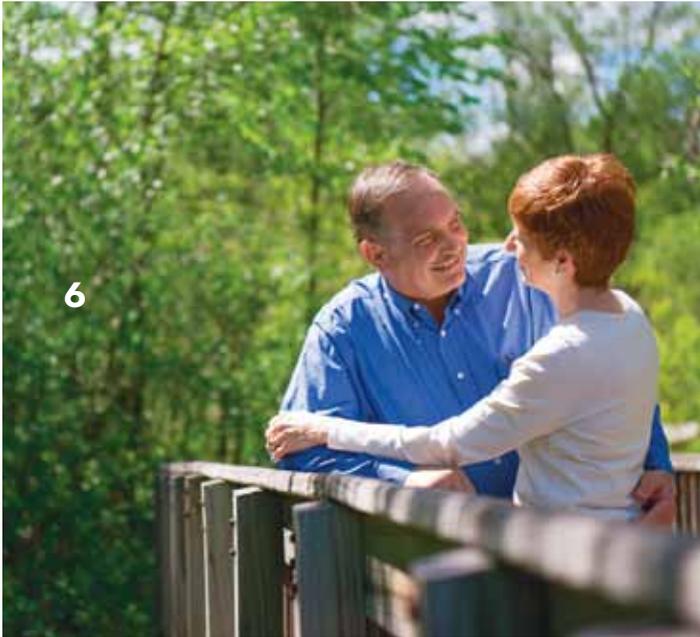


A PARTNER IN CARE

U-M research comes
to the community to
support caregivers



University of Michigan
Comprehensive Cancer Center



thrive

SUMMER 2012 CONTENTS

04 POWER IN NUMBERS

A U-M cancer doctor explains a tumor board and how multiple experts in one room can benefit patients.

06 CARE FOR THE CAREGIVER

U-M research comes to the Ann Arbor community to support cancer patients and caregivers.

09 THE NEW DINNERTIME BATTLE

Learn strategies for eating well and maintaining a healthy weight during treatment even when eating is a challenge.

*On the cover:
Richard Montmorency
attended a local support
group for cancer patients
and their loved ones. As
the primary caregiver
for his wife, Carol Rugg,
during her treatment,
the FOCUS program
gave the couple a new
perspective on caring
for one another.*

10 TIRED OF BEING TIRED?

The Symptom Management and Supportive Care Clinic helps patients fight fatigue and other side effects of treatment.

12 PAYING FOR CANCER

One couple finds U-M financial resources for medical treatment and other cancer-related expenses during tough economic times.

15 RESEARCH ROUNDUP

Check out the latest research at the U-M Comprehensive Cancer Center.



Published quarterly by the University of Michigan Comprehensive Cancer Center, 1500 E. Medical Center Dr., Ann Arbor, MI 48109-5944. If you do not wish to receive future issues of *Thrive*, please call Martha Towas at 734-936-0434.

Max S. Wicha, M.D., director

Marcy B. Waldinger, M.H.S.A., chief administrative officer

Karen Hammelef, R.N., M.S., director of Patient & Family Support Services

Nicole Fawcett, manager of cancer communications

Beth Johnson, editor and senior writer

Enrique Cruz Jr., art director, GLC Custom Media

Myrna Traylor, project manager, GLC Custom Media

Photography by Edda Pacifico

Executive Officers of the University of Michigan Health

System: Ora Hirsch Pescovitz, M.D., Executive Vice President for Medical Affairs; James O. Woolliscroft, M.D., Dean, U-M Medical School; Douglas Strong, Chief Executive Officer, U-M Hospitals and Health Centers; Kathleen Potempa, Dean, School of Nursing.

The Regents of the University of Michigan: Julia Donovan Darlow, Laurence B. Deitch, Denise Ilitch, Olivia P. Maynard, Andrea Fischer Newman, Andrew C. Richner, S. Martin Taylor, Katherine E. White, Mary Sue Coleman (ex officio).

The University of Michigan is an equal opportunity/affirmative action employer.

© 2012 The Regents of the University of Michigan.

For more information about the stories in *Thrive* or any other cancer-related information, please call the Cancer Answer Line at 800-865-1125.

Alexis Nees, M.D. (foreground), and Lisa Newman, M.D., read the results of breast imaging, a procedure recommended by ASCO to be discussed by patient and provider in some instances.

Photo by Michigan Photography, Scott Soderberg

More tests, not always best

Association of cancer physicians provides top five tests and treatments to reconsider

Patients facing a cancer diagnosis deal with anxiety about the future, not feeling well and the high cost of care. That's why the American Society of Clinical Oncology (ASCO) took a careful look at which tests and treatments that oncologists order aren't supported by evidence showing they help patients live longer and which, in fact, could be harmful.

"The issue is that many of the things we do are based on things somebody thinks are best practice and, often, there are not data to support their use," says Kathleen A. Cooney, M.D., interim medical director at the U-M Comprehensive Cancer Center. "For example, excessive use of testing without adequate data can sometimes be dangerous to patients."

Cooney says patients often go through unnecessary tests and procedures that are invasive, stressful and otherwise negatively affect a person's quality of life (such as missing work). In some cases, patients receive false positive results that lead to further anxiety and over-treatment. ASCO's recommendation is not intended to deny any patient

care or treatment, but to protect patients by only providing care proven to help.

The ASCO study was conducted as part of a national effort called Choosing Wisely® that challenged the medical community at large to identify five practices that are expensive, are routinely used and for which there is insufficient proof that the practice helps patients.

Unnecessary and excessive spending in any area also drives up medical costs to patients. As cited in the ASCO study, the Congressional Budget Office estimates 30 percent of care delivered in the United States goes toward treatment that doesn't help patients' health. Cancer costs alone are increasing approximately 15 percent a year.

"These tests and treatment options should not be considered unless a patient and provider have worked together to discuss options," Cooney says. "The Top Five List doesn't trump a clinical assessment. Hopefully this list will help stimulate dialogues about individual goals of cancer treatment and appropriate diagnostic testing and follow-up." 

ASCO'S TOP FIVE LIST FOR ONCOLOGY

- Chemotherapy for patients with advanced cancers who have seen little or no benefit from prior treatment.
- PET, CT and radionuclide bone scans in low-risk prostate cancer patients.
- PET, CT and radionuclide bone scans in low-risk breast cancer patients
- Surveillance testing and imaging for breast cancer survivors with no symptoms
- White cell-stimulating factors for primary prevention of fever/infection associated with neutropenia (a low number of a type of white blood cells) in low-risk patients



Visit mCancer.org/thrive to learn more about these recommendations.

Power in numbers

A U-M cancer doctor explains a tumor board and how multiple experts help patients

Cancer patients tend to rely on their physicians for answers and treatment plans, but may not know how much is going on behind the scenes to help their cases. The U-M Comprehensive Cancer Center holds regularly scheduled meetings—called tumor boards—to bring experts together to discuss difficult cases and recommend the best course of treatment moving forward.

We sat down with Jorge Marrero, M.D., director of the U-M Comprehensive Cancer Center's Multidisciplinary Liver Tumor Clinic, for an introduction to tumor boards, why collaboration matters and how multiple experts in one room can help cancer patients obtain the best outcomes.



How would you define a tumor board to a patient or family member who isn't familiar with the term?

A tumor board is a multidisciplinary meeting where complex patient cases are discussed in significant detail. We concentrate on patients with difficult tumors or patients who have previously received treatment and, for various reasons, now need a different treatment plan.

All the disciplines are involved in this meeting. There may be a dozen experts or more in one room. Each patient's diagnosis is introduced, and the group reviews the patient's scans with the goal of coming up with the best treatment plan.

You mentioned that all the disciplines are involved. What exactly does that mean?

It means that every type of specialist with expertise in the specific cancer takes part in the meeting. For example, in liver cancer there will be two types of surgeons in the room: transplant surgeons and surgical oncologists. There will be a diagnostic radiologist and interventional radiologist. Others represented are hepatologists (liver specialists), medical oncologists and radiation oncologists.

Why is it important for our patients to have so many people reviewing their cases?

Tumor boards are great for patients because members of each specialty bring their own expertise to the table. They each have a unique view of the best approach to treat and care for a patient. It is great to have different perspectives according to the different specialties. We all complement each other, share knowledge and offer recommendations as far as the best strategy for the patient.

How can all these doctors and clinicians assess a case when they might not have met the patient they're discussing?

Typically, the patient's primary cancer physician will present the case at the liver tumor board after having seen the patient. What we try to do in the tumor board meetings is develop a strategy based on what we're seeing—right now—on a patient's scans. The tumor board isn't a substitute for quality patient care and thorough assessments by caregivers. For the most part, the benefit of the tumor board is that the patient has different experts commenting on his or her case, in addition to regular appointments with his or her doctor.

After the meeting, the patient receives a recommendation on how his or her treatment should progress.



More than a dozen experts participated in this meeting of the multidisciplinary liver tumor board.



Specialists share expertise and best practices to develop recommended treatment strategies for complex patient cases.



Do other hospitals and health systems have tumor boards? What sets a tumor board apart?

Tumor boards are very standard at medical centers. The big difference at the University of Michigan Comprehensive Cancer Center is the depth of discussion and level of expertise.

For example, we're extremely unique in having a liver tumor board. Other hospitals might have an abdominal tumor board where they discuss all tumors of the abdomen, including the liver. Here, we separate them because of the expertise in liver and other gastrointestinal tumors.

Having tumor boards is also a way for U-M experts to be better educated because, for example, a non-surgeon might learn about the latest surgical approach or we might identify that a patient is a good fit for a research study. We learn from one another how to best treat the patient.

This is in contrast to community hospitals where all cancer cases are typically discussed at one single tumor board.

How often will a patient's case be discussed at a tumor board?

A patient's case will be discussed as often as is needed at the request of the primary cancer doctor. For example, a patient is treated with surgery and the tumor comes back, and the primary cancer doctor will now want to confer with the liver tumor board as to the best approach. This way, patients are treated as consistently as possible and may be eligible for newer therapies or clinical trials.

We always tell patients when their cases are going before the tumor board; we take notes and send patients and their referring doctors the details of the discussion.

What types of things might be discussed at a tumor board meeting?

We discuss the best treatment approach, especially pertaining to complex cases. One example is a patient who had a very large tumor that was surrounding a major vein in the liver. The patient was referred to our Cancer Center after not being able to have surgery at another institution, and the case was discussed at our liver tumor board.

The U-M transplant surgeon performed an auto-transplantation: taking the liver out, removing the tumor on the table and putting the liver back in without the cancer. That's an example of a case where you need the expertise of the members of the liver tumor board to provide exceptional care.

What clinics at the University of Michigan have tumor boards?

We have such a wealth of expertise that we basically have a separate tumor board for every tumor. **t**



Visit mCancer.org/thrive to see a list of all the Cancer Center's tumor boards.

Photos by Michigan Photography, Austin Thomason



Care for the Careg

iver

U-M research comes to the community to support cancer caregivers

When Carol Rugg was diagnosed with breast cancer in 1997, her fiancé Richard Montmorency thought they'd gotten the "in sickness" part of their marriage out of the way early. Rugg fought the disease with Montmorency as her caregiver, an experience they did not expect to repeat as the years passed with no recurrence.



Richard Montmorency says meeting other caregivers of loved ones with cancer helped him understand and accept the sacrifices he made to care for his wife during cervical cancer treatment.

It came as quite a surprise when, 14 years later, her doctors diagnosed her with stage two cervical cancer. Rugg knew she'd fight again and Montmorency, as her caregiver, would struggle through it, too.

"I was always very sensitive that the caregiver doesn't get very much attention," Rugg says. "The caregiver is like a secondary player in this game. That caregiver is stressed to the max and nobody is paying much attention to them."

Helping cancer patients and their family caregivers cope with the disease has been the focus of University of Michigan research led by Laurel Northouse, Ph.D., R.N., former co-director of the Socio-behavioral Program at the Comprehensive Cancer Center. With an estimated 4.6 million Americans providing care to patients with cancer, Northouse believes best practices are needed to allow for this group to receive education and support on providing cancer care.

"Patients are leaving the hospital sicker and sooner than ever before and when they go home, they may have drains or a pump or another medical need," Northouse says. "At that point, the family takes on the care. Patients often return home to a setting where the caregiver, for the most part, hasn't had preparation on how to be a caregiver."

Research indicates caregiver stress can lead to psychological upset and sleep disturbances, as well as changes in physical health, immune function and financial well-being. The extent to which the patient and caregiver can jointly deal with the stress of cancer is beneficial to the well-being of both.

"Carol's treatment was grueling and she could barely eat," Montmorency says. "Toward the end I almost had to carry her out of the hospital. I cooked her rice and peeled her bananas, got her saltine crackers and helped with her medication. It was scary because sometimes she seemed confused."

When the couple later learned about an Ann Arbor-area support group for cancer patients and caregivers, they signed up for the six-week program. The FOCUS Program, in a nutshell, is Northouse's research brought to the local community. Held at the Cancer Support Community, participants attend



TIPS

Tips for a strong patient and caregiver team:

- Support one another, even though only one person is ill
- Communicate openly
- Share worries and concerns
- Maintain an active lifestyle as much as possible
- Continue enjoyable activities
- Ask questions to understand and manage symptoms
- Help one another cope

weekly sessions to learn about how to live through and beyond cancer. The program is unique in that it addresses caregiver concerns and how patients and loved ones can work as a team to manage and cope with the illness.

“They helped me put my role as caregiver in perspective,” Montmorency says. “I can support somebody, but I can’t change anything. You have to be accepting, and it’s not your fault if things don’t go right. I felt and saw the sacrifices the other caregivers were making and it made my sacrifice more acceptable.”

Cancer Support Community hopes to have data and results from the FOCUS Program by the end of this year; in the meantime, verbal responses from participants have been positive with some groups bonding and exchanging information in order to stay in touch, says social worker Bonnie Dockman, L.M.S.W., who facilitates the program. Ideally, the program will expand to each affiliate of the Cancer Support Community across the United States to broaden the availability of caregiver support.

“This is a great community partnership because we both have an interest in providing high-quality care to patients and their caregivers,” says Northouse, who continues to research care for caregivers. She hopes to implement a web version of the FOCUS Program in the future, as well as further expand to more community agencies.

“People in our group discussed making plans for the future,” says Rugg, who is currently cancer-free. “We were talking about reasons to hope. At the time I couldn’t even imagine planning anything for the future. Now, we’re planning a trip overseas.” 



The FOCUS program encourages participants to make plans for the future. Montmorency and Rugg plan to go overseas now that she is well.



You can participate in the FOCUS Program for cancer patients and caregivers.

- **F**amily Involvement
- **O**ptimistic Attitude
- **C**oping Effectiveness
- **U**ncertainty Reduction
- **S**ymptom Management

Contact Cancer Support Community at
734-975-2500 or bonnie@cancersupportannarbor.org.

The new dinnertime battle

Strategies for eating (and eating well) when you don't want to eat

By Nancy Burke, R.D., Danielle Karsies, M.S., R.D., Melissa Shannon-Hagen, R.D., CSO
U-M Comprehensive Cancer Center Symptom Management and Supportive Care Program



If you've sat at a table with kids, you've probably said or heard these words of encouragement: "Eat your breakfast, it's the most important meal of the day," "Eat your broccoli, it's good for you," or "You have to at least try something." We know how important eating is to fuel our bodies, and some foods are better than others. We also know that eating may be the last thing on a kid's mind.

When cancer is diagnosed, a new mealtime battle may start—waged not with kids but with your husband, wife, mom, dad or friend. Depression, stress, lack of appetite, side effects of treatments and other factors can hinder one's desire and ability to eat. How can you force yourself to eat when you're nauseated, or get a loved one to eat when he or she has no interest?

Eating well and maintaining your weight during cancer treatment may help you:

- Feel better
- Keep up your energy and strength
- Tolerate your treatment better
- Lower your risk of infection
- Heal and recover faster

Think of your body like a car: Without gas, the car won't go. Without enough calories and protein to support your daily needs (which are increased during treatment), you'll lose weight and weaken an immune system already busy fighting cancer. Your body will break down muscle mass to make up the calories you aren't eating, leading to fatigue and weakness. 



To make an appointment for nutritional counseling, call 877-907-0859. For additional resources, visit mCancer.org/thrive.

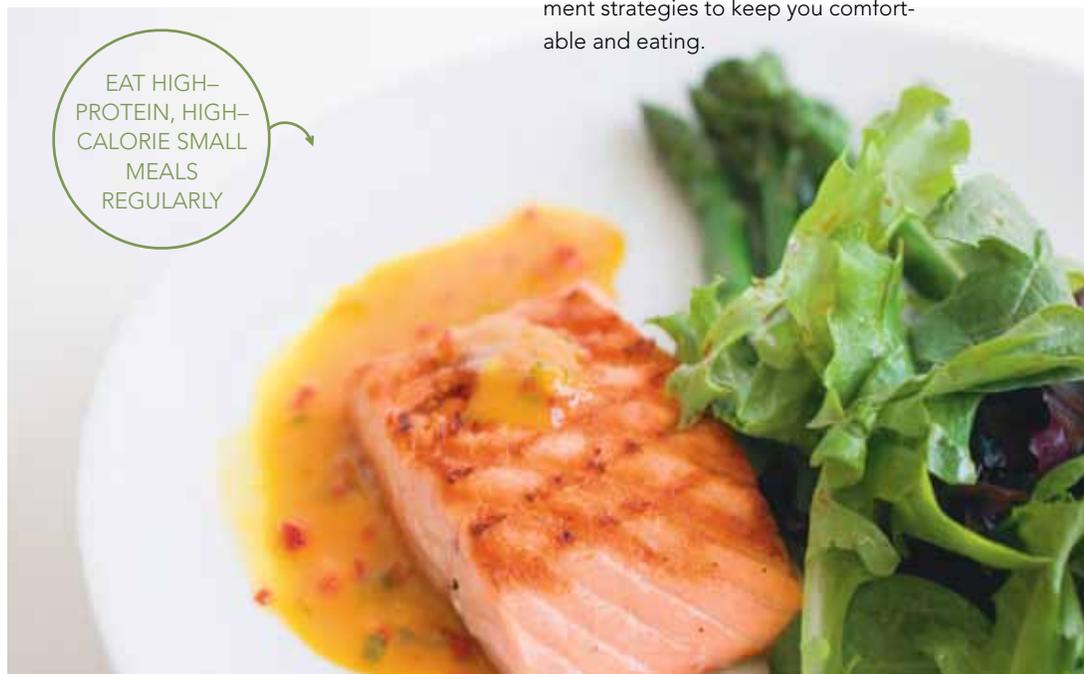
EATING TIPS

- Think of food as part of your medication regimen. Set meal times regularly and take time to eat.
- Eat small, frequent meals and snacks every 3-4 hours, whether you are hungry or not.
- Make every bite and sip count. Instead of calorie-free water, choose milk, soy milk, shakes, smoothies or 100 percent fruit juice.
- Eat more when you are feeling hungry.
- Increase your appetite before meals with light exercise such as walking.

EATING TIPS FOR TREATMENT-RELATED SIDE EFFECTS

- Eat high-calorie, high-protein foods. Stop using low-calorie, low-fat, low-sugar versions.
- Eat the higher-calorie, higher-protein foods on your plate first, saving low-calorie, high-fiber (filling) foods such as fruits and vegetables for last.
- If fruits and vegetables taste good, increase their calorie and protein content with healthy additions like olive oil, cheese, nuts and sauces.
- Make sure your clinician is aware of your symptoms and their severity. Medication could help.
- Ask for a referral to see a registered dietitian to review which foods are best tolerated and symptom management strategies to keep you comfortable and eating.

EAT HIGH-PROTEIN, HIGH-CALORIE SMALL MEALS REGULARLY



Tired of being tired?

Cancer Center's Symptom Management and Supportive Care Clinic helps patients fight fatigue and other side effects of treatment

At 84, Emanuel Tanay is far too busy to be tired. A retired clinical professor of psychiatry at Wayne State University and well-known forensics psychiatrist, Tanay's diagnosis of metastatic prostate cancer seven years ago has by no means stopped him from doing what he enjoys. He continues teaching in the University of Michigan's Lifelong Learning program, is writing another book and does what he can to stay active.

Nevertheless, symptoms and side effects from his cancer and treatment have slowed him down.

Tanay's treatment has included extensive radiation, surgery and a drug called Lupron that eliminates testosterone and is often used to treat symptoms of prostate cancer. In addition to playing a key role in the development of male reproductive tissue, testosterone is related to energy and cognition. Without testosterone, simply put, fatigue sets in.

"My resilience is very low," says Tanay. "In other words, it takes very little for me to get exhausted. I can get started on my computer and, if something doesn't go right, the next thing I know...[feigns sleep]."

Cancer-related fatigue is defined by the National Comprehensive Cancer Network as a distressing, persistent, subjective sense of physical, emotional and/or cognitive tiredness or exhaustion related to cancer treatments that is not proportional to recent activity and interferes with usual functioning.

Fatigue is rarely an isolated symptom and is perceived by cancer patients to be one of the most distressing symptoms of cancer treatment.

"People's self-worth is often tied up in what they were doing before they had

cancer," says Nurse Practitioner Suzette Walker, co-director of the University of Michigan Comprehensive Cancer Center's Symptom Management and Supportive Care Clinic. "Their sense of who they are is often their employment. When they're too tired, they feel like they're failing themselves and their families. It's a vicious circle of being tired and depressed as they seek a new normal."

In Tanay's case, fatigue has come with other side effects like difficulty walking and hot flashes. He visits the Symptom Management and Supportive Care Clinic around once a month for help.

"There is something I call 'emotional infection' you can transmit, and this group

has it," Tanay says. "They are such a benevolent group of people, so interested in your well-being. Whenever I go there, I feel somehow improved. I know someone has really put their mind to my distress."

Tanay has used medication and exercise to combat his fatigue, which is a direct result of the Lupron in his treatment program. Walker explains that factors such as anemia, low testosterone and thyroid issues are often identified and can be treated to help fatigue. If it truly is cancer fatigue, the clinic gets patients moving with walking and strengthening programs.

"In educating our patients about fatigue, the No. 1 thing is exercise," says Susan Urba, M.D., who co-directs the clinic with

CONTRIBUTING FACTORS OF FATIGUE:

- Medication side effects
- Emotional distress
- Anemia
- Sleep issues
- Nutrition issues
- Co-morbidities



Learn everything you need to know about fatigue: causes, symptoms, coping and taking action. Visit mCancer.org/thrive.



Emanuel Tanay says beginning his day with a walk gives him more energy throughout the day.

Walker. “Resting is not always the best and patients often don’t know this. But just telling people to go out and exercise isn’t very helpful. We get more specific, like telling a patient to walk to the mailbox and back every day. General conditioning can often be most effective in a formalized setting so we’ll refer patients to physical therapy.”

Tanay took part in physical therapy at Briarwood MedRehab and liked it so much he asked for a second referral. “One of the things that bothers me most is my inability to walk briskly,” he says. “My physical therapy did help with flexibility and now I make an effort to walk outside, on my treadmill or at the rec center every day.” He recently began a second round of physical therapy at the Geriatrics Center.

“I think almost every single person we’ve referred to physical therapy has benefited from it,” Urba says. Other techniques used by the Symptom Management and

“There is something I call ‘emotional infection’ you can transmit, and this group has it.”

—Emanuel Tanay

Supportive Care Clinic to alleviate fatigue and other side effects include nutrition counseling, reviewing medications and ensuring healthy sleeping patterns. U-M resources are also available to help manage the significant emotional component of fatigue.

Walker says a person’s entire sense of well-being improves with exercise, but Tanay adds that, for him, adrenalin plays a big part, too. The influx of energy he gets from teaching reminds him daily of the importance of keeping active and doing the things he loves. 

GENERAL STRATEGIES TO MANAGE FATIGUE:

- Self-monitor your energy level.
- Limit naps so you can sleep at night.
- Structure routines.
- Use distractions like games, music or reading.
- Set priorities if you can’t do everything.
- Postpone non-essential activities.
- Drink adequate fluids.



Call the Symptom Management and Supportive Care Clinic at 877-907-0859 to make an appointment.

Paying for can

One couple finds U-M financial resources for cancer-related expenses during hard times



When Aracelli and Miguel Martinez left Mexico City for Michigan 30 years ago, health insurance was the last thing on their minds as the healthy couple and their two children began new lives in the Midwest. Fast forward to May 2009: their children grown, Aracelli worked as a caregiver to the elderly, Miguel managed the grounds and home of a family with a large property. The couple had lived in their Auburn Hills home for 10 years.

Michigan was in the midst of its second economic downturn when Aracelli fell ill, recalling a terrible headache and itching all over her body. An area hospital referred her to the U-M Emergency Department, which led her to the Comprehensive Cancer Center where she received a diagnosis of multiple myeloma, a cancer of the plasma cells in bone marrow that help our bodies fight infection.

Aracelli signed on to participate in a clinical trial and responded well to treatment, despite the possibility that her disease could be aggressive and she might have as little as six months.

“I was very scared at first, but then focused on getting well. I thought my life was worth it,” Aracelli says. “I thought I’d go back to work in a month or two, but a year passed and I still couldn’t go back. Then I needed a transplant and other problems came along.”

LIFE CAN BRING UNEXPECTED TURNS; WE HAVE RESOURCES TO HELP



cer

During that period, Aracelli lost her job. Then, Miguel lost his job, too, and the van that came with his employment. Over the next year, with Aracelli still in treatment, the couple lost their home.

“We were devastated,” Aracelli says. “We were almost on the street. I wasn’t able to spend one dollar on my medication.”

FINANCIAL SUPPORT

So, how did a couple without health insurance or employment in the midst of a recession manage to pay for treatment? According to Miguel, his wife’s treatment experience came with “the whole package,” including practical and financial resources for qualified patients.

Patient Financial Counselor Sue Thornton sees many patients newly diagnosed with cancer who are stressed about bills they cannot pay. In Aracelli’s case, a U-M social worker came to her when she began the clinical trial, was hospitalized and did not have health insurance.

“If it wasn’t for them, I wouldn’t have had treatment,” Aracelli says. “I was embarrassed in the beginning, to tell the truth. But they treated me like a good friend with such good care you don’t even realize how much they’re doing for you. They came to my rescue.”

“Often people come to me before they’ve even had a chance to accept a heavy-duty diagnosis,” Thornton says. “We screen patients for state assistance and, once we get through that criteria, for other programs like MSupport or

Continued on page 14



Social Service Technician Sarita Castro (right) helps patients like Aracelli Martinez connect with cancer-related resources.

“They treated me like a good friend with such good care you don’t even realize how much they’re doing for you. They came to my rescue.”

—Aracelli Martinez



Martinez says the Practical Assistance Center eased worries about costs and allowed her to focus on getting well.

PAC RESOURCES
ARE AVAILABLE
FOR YOU



The PAC provides patients with free literature and a quiet place to find solutions.

Medicaid.” Thornton can then help patients navigate the processes and procedures required for whatever assistance is available, from individualized payment plans to discounted payments.

PRACTICAL SUPPORT

Medical bills aren’t the only costs that come with cancer. According to social worker Katie Schneider, L.L.B.S.W., from the Guest Assistance Program, medication costs and transportation are key areas of stress for many cancer patients. For these practical matters, the Cancer Center’s Practical Assistance Center (PAC) offers a range of services, like helping patients get wigs or figuring out which national and local programs offer aid for various expenses.

The Martinez family was fortunate to be able to borrow a car from family members in order to make the drive from Auburn Hills to Ann Arbor. For those without transportation, the PAC works with individual patients to find ways to obtain transportation and cover the expense, whether

through insurance, community agency programs or other methods.

Social Service Technician Sarita Castro works with Schneider to find solutions for patients’ needs—making phone calls, communicating with physicians and nurses, and keeping patients informed on progress.

“I’m always learning about new cancer resources and they’re changing all the time,” Castro says. “I connect patients with the resources out there. A number of patients need help with medication co-pays. There are a lot of foundations that help with different cancer diagnoses. I help facilitate applying to co-pay relief foundations.”

Schneider says many patients aren’t prepared to learn their medications could cost thousands of dollars per month. For Aracelli, whose condition is stable, taking a chemotherapy pill is part of her daily regimen. She utilizes PAC resources to help with those costs.

“They help me coordinate my medication,” Aracelli says. “Right now, Sarita and Katie are trying to get me one of the most

expensive drugs. They are talking directly to the pharmaceutical company to see what they can do.”

KEEP TROUBLESHOOTING

Thornton stresses there are many different ways to problem-solve and think outside the box in order to help patients with expenses. Her role, as well as Schneider’s and Castro’s at the PAC, is to understand the resources out there for cancer, understand each patient’s needs and facilitate those connections to help ease the financial burden so the patient can concentrate on healing. 



Contact the Practical Assistance Center at **877-907-0859**, or visit the center on Level 1 of the Cancer Center.

Financial Services:
877-326-9155

Guest Assistance Program:
800-888-9825

ANTIDEPRESSANT HELPS RELIEVE PAIN FROM CHEMOTHERAPY, STUDY FINDS

The antidepressant drug duloxetine, known commercially as Cymbalta, helped relieve painful tingling feelings caused by chemotherapy in 59 percent of patients. This is the first clinical trial to find an effective treatment for this pain.

Chemotherapy-induced peripheral neuropathy is a common side effect of certain chemotherapy drugs. The tingling feeling—usually felt in the toes, feet, fingers and hands—can be uncomfortable for many patients. For about 30 percent of patients, the sensations are painful.

In the current study, researchers looked at 231 patients who reported painful neuropathy after receiving the chemotherapy drugs oxaliplatin or paclitaxel. Patients were randomly assigned to receive duloxetine or a placebo for five weeks. They were asked to report on their pain levels weekly.

The researchers found that 59 percent of patients who received duloxetine reported reduced pain compared to only 39 percent of those taking placebo.

“The good news is it worked in the majority of patients. We need to figure out who are the responders. If we can predict who they are, we can target the treatment to the people it’s going to work for,” said lead study author Ellen M. Lavoie Smith, Ph.D., A.P.R.N., A.O.C.N., assistant professor at the University of Michigan School of Nursing and a researcher at the U-M Comprehensive Cancer Center.

Duloxetine has previously been shown to help relieve painful diabetic neuropathy. This type of antidepressant is believed to work on pain by increasing neurotransmitters that interrupt pain signals to the brain.

In this study, participants received a half-dose of duloxetine initially before ramping up to a full dose of 60 mg. Few severe side effects were reported with this approach, the most common being fatigue.

Treating painful peripheral neuropathy is critical because, if the pain becomes too severe, doctors might limit the patient’s chemotherapy dose.



KIDNEY CANCER PATIENTS DO BETTER WHEN WHOLE KIDNEY IS NOT REMOVED, U-M STUDY SHOWS

Kidney cancer patients who had just the tumor removed had better survival rates than patients who had their entire kidney removed, according to a new study from researchers at the University of Michigan Comprehensive Cancer Center.

After an average of five years, 25 percent of patients who had a so-called partial nephrectomy, in which only the tumor and a small amount of healthy tissue is removed, had died, while 42 percent of patients who had radical nephrectomy, in which the entire kidney is removed, had died, the study found.

“For patients who are candidates for partial nephrectomy, it should be the preferred treatment option. We found that patients who were younger or had pre-existing medical conditions benefited most from partial nephrectomy,” said lead study author Hung-Jui Tan, M.D., a urology resident at the U-M Medical School.

The researchers looked at 7,138 Medicare recipients with early stage kidney cancer up to eight years after treatment. The study found that patients from each group were equally likely to die of kidney cancer, which suggests each procedure is equally effective at curing the cancer. The survival discrepancy was found in the number of patients who died from any cause, including complications related to surgery.

The study showed that if seven patients chose partial nephrectomy over radical nephrectomy, one extra life would be saved.

The question, though, is whether partial nephrectomy—which is a more technically challenging procedure and potentially associated with more short-term complications—is preferable to radical nephrectomy. Removing a kidney can increase the risk of chronic kidney disease, which is associated with lipid disorders, cardiovascular disease and renal failure.

The debate is similar to breast cancer surgery, in which studies have found that lumpectomy plus radiation is comparable to mastectomy. While that choice often comes down to a cosmetic trade-off, the trade-off with kidney cancer is a potential higher risk of short-term complications with partial nephrectomy vs. avoiding chronic kidney disease in the long term.

Results of the study appear in the April 18 *Journal of the American Medical Association*.



For information about clinical trials at U-M, call the Cancer AnswerLine at 800-865-1125.



Do you have a question for the pharmacist? Email us at **Thrive Magazine@med.umich.edu**.

WEB EXCLUSIVE

Visit mCancer.org/thrive for more information about medical management of diarrhea, including foods to avoid, foods to try and supplements that might help.

JUST A PHONE CALL AWAY

Art Therapy:
877-907-0859

Cancer AnswerLine:
800-865-1125

Clinical Trials:
800-865-1125

Development:
734-998-6893

Fertility Counseling:
877-907-0859

Financial Counseling:
734-647-5120

Guided Imagery:
877-907-0859

Music Therapy:
877-907-0859

Nutrition Services:
877-907-0859

Patient Education Resource Center:
734-647-8626

Pharmacy:
734-647-8911

Practical Assistance Center:
877-907-0859

PsychOncology:
877-907-0859

Social Work:
800-888-9825

Skills Lab:
877-907-0859

Smoking Cessation Counseling:
734-998-6222

Symptom Management and Supportive Care:
877-907-0859

DON'T LET DIARRHEA SLOW YOU DOWN

By Elizabeth Koselke, Pharm.D., and Emily Mackler, Pharm.D., U-M Comprehensive Cancer Center Symptom Management and Supportive Care Program



Undergoing cancer treatment with chemotherapy or radiation often leads to diarrhea, a significant and unpleasant side effect. Not only can diarrhea affect your quality of life, but if left untreated, diarrhea can lead to dehydration, malnutrition, delay in chemotherapy or radiation therapy or even hospitalization. Treating diarrhea as soon as it occurs is crucial in preventing possible complications. It is important to contact your health care provider, especially if you are having difficulty drinking and retaining enough fluids.

Q: Besides medications prescribed by my health care team, what can I do at home to help treat my diarrhea?

- **STAY HYDRATED!** Drink 8–10 glasses of fluid per day. Try Pedialyte™; clear broth; tea; or non-carbonated, decaffeinated soft drinks.
- Eat smaller, more frequent meals and snacks.
- Avoid foods that may trigger diarrhea, including fatty, greasy or spicy foods; alcohol; caffeine; high-fiber foods or milk products.

Q: When should I contact my health care provider?

If you are unable to stay hydrated or have multiple episodes unrelieved by anti-diarrheal medications, contact your health care provider. Report any symptoms of dizziness, confusion or fever.



The Cancer Center Symptom Management and Supportive Care Clinic works with patients along with their oncologists to help manage the side effects of cancer treatments. To make an appointment, call 877-907-0859.

mCancer.org/thrive

THRIVE ONLINE



Thrive doesn't end here! Visit mCancer.org/thrive for more. Here's what you'll find:

- Opportunities to improve quality and value in cancer care
- A full list of tumor boards at the U-M Comprehensive Cancer Center
- More information about being a cancer caregiver
- Resources on careers, costs and cancer
- Links to U-M Cancer Center patient resources
- How to use food as medicine: healthy summer recipes
- Frequently asked questions about cancer-related fatigue