

bloom

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Reach to Recovery International (RRI)
RRI is committed to improving the quality of life of
individuals affected by breast cancer and their families.



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Reach to Recovery International, Inc. is a global non-profit organisation based in Baltimore, Maryland, USA.

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Our mission

Reach to Recovery International's mission is to:

- Unite organisations throughout the world which support individuals affected by breast cancer, including their families, in order to share ideas and best practices;
- Disseminate valuable information to support individuals affected by breast cancer throughout the world via bi-annual conferences, our website, our e-newsletter, and other forms of worldwide communications; and
- Assist our Member Organisations in achieving their goals of:
 - Improving the quality of life of individuals affected by breast cancer,
 - Providing psychosocial support to individuals affected by breast cancer, either through group meetings or activities or one-on-one peer support provided by carefully trained survivor volunteers,
 - Advocating on behalf of individuals affected by breast cancer,
 - Providing patient navigation to individuals affected by breast cancer.

What would you like to read about in the next edition of *bloom*?

Email your theme suggestions to info@reachtorecoveryinternational.org. A theme will be chosen by February 2023. Regardless of whether your suggested theme is chosen this time, it will remain under consideration for future editions.



SUBMIT YOUR ARTICLE



Bloom is published by Reach to Recovery International, Inc. The views expressed in Bloom's articles are those of the authors and do not necessarily reflect the views of RRI. For more information about RRI, go to www.reachtorecoveryinternational.org.

Celebrate the work being done by your organisation's volunteers!

Do your organisation's volunteers do outstanding work to support those touched by breast cancer in your community? Bloom wants to hear all about it! Send us articles about the projects your volunteers are working on, and be sure to include high resolution photos. Articles should be 200 - 400 words long and should be sent in Word format to info@reachtorecoveryinternational.org. It's a great way to thank your volunteers for a job well done, and to raise awareness about your organisation!

Upcoming events:

SEABCS SAVE THE DATE!!!

7TH ANNUAL SOUTH EAST ASIA BREAST CANCER SYMPOSIUM
Hue City, Viet Nam & Zoom

Breast Cancer in a Post-COVID World:
Lessons learned and pathways forward

Program Highlights:

- Global Policies to Accelerate Cancer Control in the ASEAN region
- IARC Atlas Screening Tools
- WHO Global Breast Cancer Initiative
- Decentralizing Cancer Care
- The Economics of Cancer
- ASCO Breakthrough APAC
- Regional updates/best practices
- Mental Health and Cancer
- Global Cancer Survivorship - beyond the silos

ORGANIZERS:
Bright Future Fund
Hue Central Hospital
Global Focus on Cancer

August 25-26, 2023

website/registration will be active soon: www.seabcs2023.com

7th Annual South East Asia Breast Cancer Symposium
25-26 August 2023
Hue City, Viet Nam & Zoom
seabcs2023.com
for registration details

2023
OCT 13-16, 2023

9th Global Chinese Breast Cancer Organizations Alliance Conference
WEAVE DREAMS, SPREAD LOVE, GATHER STRENGTH AND BLOSSOM

Conference Highlights:

Capacity Enhancement; Breast Cancer Prevention & Treatment, International Cooperation Forum, China Breast Cancer Postoperative Rehabilitation Forum, Technology projects, Exhibition, Xi'an City Wall Walk Inauguration of Pink Academy Hua Shan branch

Host Unit:

Co-organizer:

9th Global Chinese Breast Cancer Organisations Alliance Conference
13-16 October 2023
Xi'an, China
E: breastcancer.alliance@gmail.com
for registration details

ABC 7
Bridging the Gap

Advanced Breast Cancer
Seventh International Consensus Conference
9-11 November 2023, Lisbon, Portugal

Advanced Breast Cancer Seventh International Consensus Conference
9-11 November 2023, Lisbon Portugal
www.abc-lisbon.org

San Antonio Breast Cancer Symposium
5-9 December, 2023, San Antonio, Texas, USA
www.aacr.org/meeting/san-antonio-breast-cancer-symposium-2023



Reach to Recovery International is calling for applications to qualify to bid to host the next RRI Breast Cancer Support Conference!

Learn! Share! Collaborate! Interested in hosting a **Reach to Recovery International Breast Cancer Support Conference**? Now that travel is becoming safer, we are optimistic that we can safely gather together again soon.

Face-to-face RRI Conferences bring a vast global community together – women and men personally affected by breast cancer, including patients, caregivers, doctors, nurses, allied health professionals, advocates, volunteers, and many more.

The benefits for organisations and communities are many! RRI Conferences promote networking, awareness and advocacy, volunteerism, capacity building, and even tourism, and they foster international friendships that last a lifetime.

If your breast cancer support organisation is interested in hosting a Conference, please click [here](#) for more information.



Email: info@reachtorecoveryinternational.org



Message from Leonie Young

– President of RRI

In this first edition of Bloom for 2023, we are focusing on breast cancer research and will be looking at examples of prevention, risk factors, and breast density. We will hear from a variety of people involved in research and how their roles are vital to providing evidenced-based treatments worldwide. Importantly, we will hear from a woman who has participated in a clinical trial and from others who provide input in different ways.

In addition to the changes in RRI last year, when I was appointed President and Ann Steyn retired from the Board of Directors, this year we introduce you to two new members of our Board of Directors: Stephné Jacobs from South Africa and Joanna Grecos from Greece. Stephné lives in Pretoria, South Africa. She was diagnosed with breast cancer in 1999 and has been an active volunteer ever since then, supporting others and training volunteers not only in her country but also in neighbouring African countries. Stephné is Chairperson of the Board of Management of Reach for Recovery South Africa. Joanna lives in Athens, Greece. She was diagnosed with breast cancer in 1992 and, since 2006, she has been an active peer-support volunteer with Alma Zois in Athens. Joanna is a past member of the Board and a past Vice-President of Alma Zois.

Both Cathy Hirsch and Ann Steyn remain as valued members of our team, with Cathy as Vice-President and Treasurer and Ann as one of our experienced Special Advisers. Along with input from our Regional Representatives we hope that more and varied voices will ensure widespread awareness of RRI ideals.

We have also broadened our membership criteria, aiming to be as inclusive as we can for all areas of breast cancer support and advocacy. Individual members are those individuals who sign up for our email list via our website in order to receive *Bloom* and other periodic updates on RRI news and events. RRI also welcomes any programme, group, or organisation to submit an application to become a Member Organisation. Membership Organisation categories are as follows:

- **Peer-support providers** - Programmes, groups, or organisations that provide one-on-one peer support and connection by volunteers with a lived breast cancer experience who are carefully trained and align with RRI's Peer Support Training Guidelines
- **Breast cancer advocates** - Cancer-focused programmes, groups, or organisations that support, advocate, and raise awareness of issues relating to breast cancer and align with the aims and mission of RRI
- **Collaborators** - Non-governmental organisations, health professionals, advocacy organisations, and umbrella cancer organisations which align with the aims and mission of RRI

As we move away from the impact of COVID and toward reigniting our influence around the world, we hope you will encourage those in your networks to join us as individual members or Member Organisations.

Last September, we introduced our online webinar events. In the first of these events we focused on early breast cancer, and our second session in February 2023 focused on challenges and solutions in relation to advanced breast cancer. These events have been very successful in sharing appropriate and evidenced-based information from experts including doctors, nurses, and those with a lived experience. I'm sure you will agree it is a great privilege for the RRI community to be supported in this way. Remember, these sessions are recorded so any time the allotted time doesn't suit you you can always go back and listen when it's more convenient – all you have to do is register!

The online events were introduced to bring us together and to fill the gap otherwise fulfilled by our face-to-face conferences which have not been able to take place because of the impact of COVID. However, it is our intention to plan the online events as regular occurrences along with our face-to-face conferences which we hope can be hosted again in the near future. Expressions of interest for a face-to-face conference are being called for now!

This year RRI celebrates a milestone achievement of 70 years of sharing and support. It all started when Terese Lasser was diagnosed with breast cancer and knew how important it was to meet others with a similar experience. A lot has changed around treatments and how support is provided, but the importance of peer support and connection has not and will not change. This is integral to RRI's Mission, and it is truly amazing in these modern times for a movement to be as relevant and important as RRI is. We should all feel proud to be a part of this unique global community through RRI.

So, as we move through 2023, I encourage all to unite our voices and continue to work towards better outcomes for people affected by breast cancer – you can do this in your communities and we can do it together through RRI!

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A tribute to Terese Lasser (1904 – 1979), founder of the Reach to Recovery movement



Ann Steyn

Ann Steyn, South Africa

Seventy years ago, in 1953, a remarkable lady named Terese Lasser founded a breast cancer peer support programme which she called Reach for Recovery. It was the first breast cancer peer-support programme in the world, and possibly the first peer-support programme for any type of cancer.

Who was this remarkable person, and what do we know about her and the history of the organisation she founded? From an editorial by Dr Arthur Holleb in "Cancer Journal for Clinicians," and from other articles and books, we learn that Ms. Lasser was a well-connected New York woman and a known feminist. She was married to tax expert J. K. Lasser and had two children and 5 grandchildren. She hated being patronised as a woman and could be domineering and arrogant. She was well groomed, loved swimming and dancing, and was a volunteer for the American Red Cross.

At the age of 48, she discovered a small lump in her breast. Not wanting to disturb her husband, who had recently had two heart attacks, she booked herself in to hospital for what she believed would be a minor procedure, a biopsy. The biopsy proved positive and her surgeon immediately performed what was the standard surgical procedure in those days, namely a Halstead Radical Mastectomy. She awoke from the anaesthesia to find herself bound from midriff to neck "like a mummy in surgical gauze." According to Barbara Seaman in her book "The Role of Advocacy Groups on Women's Health," Ted, as Terese was known, was devastated and radicalised by her hospital experience; it was a turning point in the direction her life took.

Ted was furious at the doctor's failure to state her options before the surgery and, being accustomed to getting answers to her questions, she resented the silence that resulted when she asked what she felt were quite reasonable questions: what sort of treatment would she require, where could she find a prosthesis, what should she tell her children, when could she resume sexual relations with her husband, and, very importantly, what exercises should she do to regain arm mobility? Receiving no answers to these questions, she set out to find the answers herself and, at times, created them. Having the courage to break with the accepted conventions of her time, she devised a programme of stretching exercises for her arms in order to regain mobility and strength. She was so keen that other mastectomy patients should benefit from these exercises



that she would slip into hospitals and encourage women “to crawl their fingers up the wall.” Her surgeon had a deeply depressed patient and he requested that Ted visit her. From that, the idea of Reach for Recovery was born. The visit was a success, and Ted then developed a one-on-one programme where women who had successfully recovered from a mastectomy would visit a newly-diagnosed breast cancer patient.

Ted expected her volunteers to demonstrate a “will to recover,” to be upbeat and to wear clothing that emphasised the bustline showing patients that they could not distinguish between a real and a missing breast. As well as demonstrating her reaching/stretching arm exercises, a temporary prosthesis was given and a letter to husbands urging them to make their wives feel feminine and desirable. The words “Reach” and “Recover” found their way into her name for the newly founded organisation: Reach for Recovery.

Certain surgeons reacted angrily to her programme and saw her volunteers as outsiders interfering with the doctor/patient relationship. Ted always tried to get permission prior to making a visit, but she was undeterred if she was refused and she was “often escorted out of the front door at Memorial Hospital.” The women she visited welcomed her visits and many became her first volunteers. The programme she founded enabled women to find the strength to return to living their normal lives again.

In the 1960’s, Ted travelled widely throughout the United States and the world to promote her programme. In 1967 she visited Johannesburg and as a result of this visit Reach for Recovery South Africa was started. We in Africa are proud to carry the original name of the organisation. No one seems to know when the name was changed to Reach to Recovery. The American Cancer Society (ACS) took over the running of the programme in 1969, with Ted serving as the National Coordinator and

overseeing the training of the volunteers until her retirement in 1977. She died in 1979 following complications from heart surgery and her obituary in the Toledo Blade spoke of Reach for Recovery. Perhaps the name was changed to Reach to Recovery after her death.

Until her retirement, Ted continued to lecture at numerous medical schools and hospitals and to promote the programme on TV. She received many awards. By 1970 it was reported that 50% of all women treated for breast cancer in the USA had been seen by a Reach to Recovery volunteer.

It was important to Ted that her programme moved with the times as the management of breast cancer changed. She knew that the programme needed to reflect the changing needs of women. When she developed her programme, she envisaged that all the patients would be visited in hospital and her reaching/stretching exercises demonstrated to them. That is not always possible today. She also had very definite ideas as to the content of the training and the criteria required by the prospective volunteer. I had the privilege of meeting Jack Skipkowski of the ACS at the RRI Conference in Athens (2005). As an intern at ACS, he had worked under Terese Lasser and described her as a formidable person who didn’t suffer fools gladly. He particularly recalled her training of the Reach volunteers where she expected everything to be carried out as she planned.

Whilst Ted was still running the programme for the ACS, her friend Francine Timothy, a breast cancer patient living in Paris, introduced the programme to Europe in 1974. The programme was taken up by hospitals throughout Europe and, twenty years later in 1994, the Geneva-based Union for International Cancer Control (UICC) united the various programmes under one umbrella and called it Reach to Recovery International (RRI). As a global organisation, the UICC was well placed to promote the RRI programme in the many countries

around the world in which its members organisations were found. In 2009 Cancer Council Queensland assumed management of RRI as an outsourced programme of the UICC, relinquishing this role at the end of December 2016 when RRI was incorporated in the USA as an independent global non-profit organisation. The first Board of Directors met on January 16th 2017, and the Articles of Incorporation and by-laws were ratified. Terese Lasser’s programme had done a global circle and returned to the country where it was founded for the next stage of its important development.

One of the legacies Ted left was empowering women to openly discuss both their breast cancer and its effects on their lives. If she was alive today, I think she would be fighting to ensure that support is available to all breast cancer patients wherever they live. She truly was a remarkable woman who turned a challenge into an opportunity to speak up for women on a topic that was not discussed at that time, and to build strong foundations for a peer support programme whose relevance continues to this day.

WE CELEBRATE 70 YEARS OF THE RRI PROGRAMME AND RECOGNISE THE CONTRIBUTION THAT TERESE LASSER MADE IN THE FIELD OF BREAST CANCER SUPPORT, EDUCATION AND ADVOCACY.

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- Barbara Seaman: The Role of Advocacy Groups on Women’s Health
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- Arthur I Holleb: A Cancer Journey for Clinicians. 1990

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ONE OF THE LEGACIES TED LEFT WAS EMPOWERING WOMEN TO OPENLY DISCUSS BOTH THEIR BREAST CANCER AND ITS EFFECTS ON THEIR LIVES. IF SHE WAS ALIVE TODAY I THINK SHE WOULD BE FIGHTING TO ENSURE THAT SUPPORT IS AVAILABLE TO ALL BREAST CANCER PATIENTS WHEREVER THEY LIVE.

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Breast Cancer Trials: a world leader in breast cancer research



"Trials Save Lives"

Anna Fitzgerald, *Communications Manager, Breast Cancer Trials Australia*

An overview of Breast Cancer Trials

Breast Cancer Trials (BCT) has been the quiet achiever in the research world. Chances are if you have been treated for breast cancer in Australia or New Zealand in the last 30 years, BCT has conducted a clinical trial that proved the benefits of that treatment.

Since 1978, BCT has been conducting a multi-centre clinical trials research program into the treatment, prevention and cure of breast cancer. This program involves 926 researchers across Australia and New Zealand, at 116 participating institutions. This research program plays a pivotal role in influencing breast cancer practice globally, contributing to better outcomes and treatments for thousands of women in Australia and New Zealand, and potentially millions more throughout the world.

BCT currently has seven clinical trials open to recruitment:

BRCA-P – a world-first trial that aims to prevent breast cancer in women with a BRCA1 gene mutation.

CAPTURE – aims to identify women and men with hormone-receptor positive metastatic breast cancer who may benefit from a novel combination of drugs that may improve progression free survival.

DESCRESCENDO – aims to identify patients whose early-stage, HER2-positive breast cancer may be sufficiently treated with a combination of pertuzumab and trastuzumab (anti-HER2 therapy) and taxane chemotherapy only and can avoid the need for treatment with traditional chemotherapy drugs.

DIAMOND – investigating if the addition of two immunotherapy drugs to Herceptin (trastuzumab) will improve treatments and outcomes for women and men who have HER2-positive metastatic breast cancer.

EXPERT – aims to improve personalized use of radiation therapy in early breast cancer patients by using a genomic test to identify women who can safely avoid this treatment after surgery and the possible side effects.

FINER – aims to find out if cancer will remain under control for longer in patients with advanced ER-positive and HER2-negative breast cancer.

TUGETHER – aims to find out if adding tucatinib and pembrolizumab to the usual treatment given to people with advanced HER2-positive breast cancer slows down the growth of the cancer.

To find out more about these breast cancer clinical trials, visit www.breastcancertrials.org.au.

Providing a patient perspective in research consumers play an important role in the research program of BCT, the largest independent clinical trials research group in Australia and New Zealand. Established in 1998, to recognize the value and importance of consumer input into the planning and conduct of clinical trials research, the Consumer Advisory Panel (CAP) provides a patient's perspective in the development and conduct of clinical trials.

Chaired by Ms Leslie Gilham, CAP has eight members from Australia and New Zealand who are committed to the BCT research program and its potential to benefit all those diagnosed or at risk of developing breast cancer. All CAP members have had an experience of breast cancer and many have participated in clinical trials. "CAP members are involved in all areas of the research program and they bring their own unique experience of breast cancer, networks, professional skills and advocacy experience, to the clinical trials research process,"

Leslie said. "Members participate on BCT committees, represent BCT on external committees and independently contribute to many breast cancer advocacy, research, fundraising and communication initiatives." All protocols and relevant research documents, particularly patient information, and consent forms, are reviewed by CAP members, who are staunch lobbyists for quality-of-life assessments in research. This means that patients participating in trials have improved patient resources that provide more clarity and understanding.



Leslie Gilham, Chair, BCT's Consumer Advisory Panel

Leslie was diagnosed with breast cancer in 2009 and she initially thought she had one tumour. Further investigations revealed, however, she had five tumours. "As part of my treatment I had a full mastectomy and that's when my oncologist brought up the idea of participating in a clinical trial that was called TEXT," said Leslie. "I had a really good experience being on the trial because I had a treatment team that was regularly monitoring me so I felt comfortable that I had the best care available. I also knew that even if I didn't benefit from the trial, this research may benefit future generations, so with a young daughter at the time, I didn't want her to go through what I did."

As it turns out, the TEXT trial as well as another clinical trial called SOFT, produced practice-changing results in the treatment of breast in young women, who often have a poorer long-term prognosis. The research showed that the aromatase inhibitor, exemestane, is more effective than tamoxifen in preventing breast cancer recurrence in young women who also receive ovarian function suppression. Worldwide, 2,672 women were enrolled in the TEXT trial, including 249 women such as Leslie in Australia and New Zealand.

"Survival rates have improved substantially in breast cancer over the last 30 years and that wouldn't be possible without breast cancer clinical trials," said Leslie.

For more information about the Consumer Advisory Panel and the achievements of Breast Cancer Trials, visit www.breastcancertrials.org.au.

My story as a research study participant in Australia

Kerry Powell, Brisbane, Australia



Kerry Powell

In December 2013, at the age of 58, I was diagnosed with advanced breast cancer. It was exactly eight years to the day after I had previously been diagnosed with breast cancer. I noticed I had blurred vision in my right eye and my general practitioner (GP) thought I had a detached retina. Emergency surgery was organised to reattach the retina but, on closer inspection, the surgeon diagnosed a metastasis. I will always remember the surgeon saying he was really sorry that I didn't have a detached retina but my cancer had spread and the operation was cancelled.

A PET scan revealed multiple liver and lung metastases, widespread skeletal metastases and bilateral adrenal metastases. A liver biopsy confirmed it was once again Oestrogen Positive, HER2 Negative. With such widespread disease my prognosis was not great. I commenced tamoxifen and monthly infusions of Zoledronic Acid in 2014 and I remained well with no symptoms of active disease. The eye metastasis had almost completely resolved within two months of treatment.

In early 2015, I noticed some unusual lesions on my scalp. In April 2015, my GP performed a biopsy and the report showed it was a metastatic carcinoma. My medical oncologist suggested a number of different treatments, including the Monarch 2 Trial. After investigating these treatments, I decided the trial was my best option and so began my eight-year journey on the Monarch 2 Trial.

I had been a primary school teacher for over 35 years and science was my passion, as I always believed in the value and effectiveness of science in our lives. The Monarch 2 Trial was a double-blind, placebo-controlled, Phase 3 study of fulvestrant with or without abemaciclib, a CDK4/6 inhibitor, for women with hormone receptor positive, HER2 negative locally advanced or metastatic breast cancer. The purpose of the trial was to help answer the research question: "Whether the combination of abemaciclib plus fulvestrant improves outcomes compared to fulvestrant

alone for women with a certain type of advanced cancer." After completing all the prerequisites, I began the treatment which consisted of taking three tablets in the morning and evening and receiving injections every 28 days. I had to complete a diary daily, recording the times and the dates when the medication was taken.

When you join a trial, you and your oncologist agree to adhere to the trial treatments but at the same time you possibly receive the newest and often very expensive drugs. You are very closely monitored by the research team, e.g., I had a CT scan every three months and a bone scan every six months, blood was taken and reviewed monthly, surveys were completed every few months, plus I saw my oncologist and research team every month – all at no charge. I found this close monitoring very reassuring and, as the years went by, it became my way of life. I planned my life around the trial requirements, in that I had to get permission to travel overseas, to change other medications I was taking, to have an operation, and to change the dates of the injections, among other things.

For nearly eight years, I participated in the Monarch 2 Trial and was the last participant in the trial in Australasia. I was what is called an outlier in the reports because my results were different than everyone else's, and my team and I thought that the only way I would stop being on the trial was when my results indicated that treatment was no longer working. However, in September 2022, I received a phone call from the research officer to say she had some good news and some bad news, which is something that a cancer patient never wants to hear. The bad news was that the trial had finished and the good news was that the trial had been unblinded and I had been on the placebo tablets and had not received the abemaciclib! No one could believe that the fulvestrant alone had produced such results, as in most cases patients receive only two or three years of positive outcomes. The result of the trial was negative in that it didn't prove that using abemaciclib along with fulvestrant improved outcomes, so it made

no difference to me that I had been receiving the placebo.

Fulvestrant was one of the original treatments suggested in 2014, but I felt the trial gave me the chance of a better outcome. The injections are not pleasant to give or receive as the drug has a high viscosity, meaning it is very thick and difficult to push through the syringe, and they take at least four minutes to inject into each buttock. They have caused nerve and muscle damage, but in the scheme of things with cancer treatment, that is fairly minimal. The drug company is presently investigating producing a tablet form of the drug which is great news for future patients.

The other good news was that, while the trial was underway, fulvestrant was approved to be on the Pharmaceutical Benefits Scheme (PBS) in Australia at a cost of only AU\$7.70 per monthly treatment. Also, when the injections stop working, because I was on the placebo tablets I will be eligible for one of the CTK4/6 inhibitors which are now also on the PBS.

Having been so heavily monitored for so long and believing the whole time that I was receiving the real medication, it took me a while to accept that I was just a 'normal' cancer patient receiving fulvestrant as my only treatment for advanced breast cancer. Six months after the trial finished, I am still getting the monthly injections. I have just received my 103rd injection and, yes, my butt is sore. I had a PET scan in February, 2023 for restaging purposes and the results show there is no progressive disease.

The trial has given me so much more than just treatment, including the opportunities to: meet and love my grandson; see my sons grow up into fine men; travel overseas, even to Antarctica; continue working as a teacher; volunteer at the Brisbane International Tennis Tournament and the Gold Coast Commonwealth Games; and simply live and enjoy life. Would I participate in another trial? Yes, I would if my doctors and I believed it would be beneficial to my health.

The importance of knowing your breast density

Professor Jacqueline Smilg, MBBCh, Dip Pec(SA), FFRad(D)(SA), PhD (Wits); Consultant – Breast Wellness Centre; Honorary Researcher, University of Witwatersrand; President Elect, BIGOSA (Breast Interest Group of Southern Africa) Johannesburg, South Africa

A breast is dense when the volume of the breast's dense, fibrous, and glandular tissue exceeds that of the fat. A person's breast density level is primarily determined by genetics and age.

Dense breast tissue can mask cancer on a mammogram and increase the risk for developing breast cancer. Assessing data from nearly 390,000 women, researchers noted that women with extremely dense breast tissue have more than double the risk for breast cancer in comparison to women with average breast density and nearly four times the risk of women with extremely fatty breast tissue.¹

Breast density cannot be determined by touch, feel or by the appearance of a breast during the physical examination - it can only be determined by evaluating a mammogram. But mammography is significantly less accurate in breast cancer detection in patients with dense breasts (50-60% sensitive)^{2,3}. On a regular mammogram, highly dense breast tissue appears white, the same as a potentially cancerous mass.

Breasts fall into four categories:

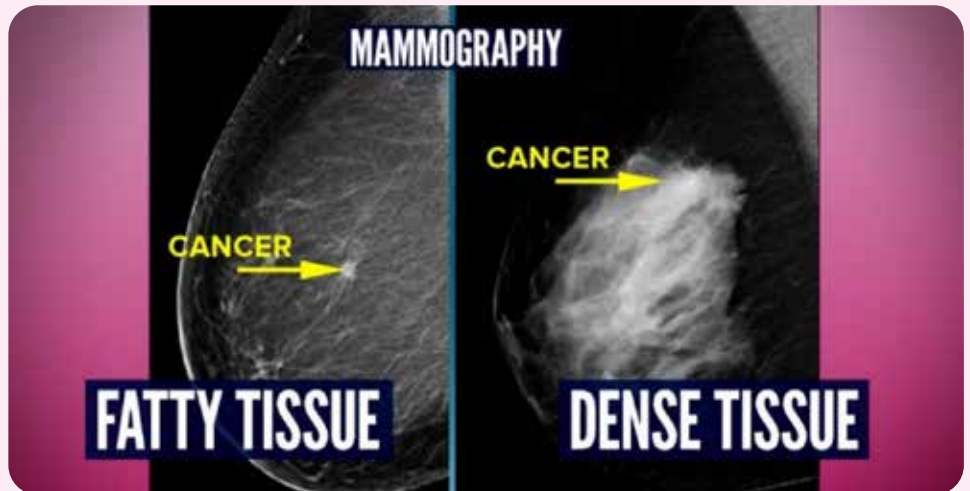
- fatty breast tissue
- scattered fibro glandular density
- heterogeneously dense
- extremely dense

It is important for women to understand the degree of density of their breasts to ensure they are breast aware and know what changes are normal for them.

In early March of 2023, the Food and Drug Administration in the USA announced new regulations requiring mammogram providers to inform patients about the density of their breasts.

So, you have dense breasts, now what? Knowing the following may be helpful:

- Dense breasts are normal.
- Your health care provider can assist in making a breast screening plan specific to your individual needs.



Source: <https://www.today.com/health/do-you-have-dense-breasts-you-may-need-more-mammogram-t104102> © DenseBreast-info, Inc. and Dr. Wendie Berg

- Mammography remains the gold standard for early breast cancer detection, but dense tissue may require the addition of other tests which could include:
- Tomosynthesis (3D mammography) involves taking multiple images which are then reconstructed by computer to create thin slices. These can be individually reviewed to reduce tissue overlap.
- Breast sonar uses high frequency sound waves to produce images.
- With Contrast Enhanced Mammography, the patient receives a contrast injection before the mammogram is taken. This is because cancers typically have more blood vessels and more leaky vessels than normal tissue. They tend to take up the contrast more than normal tissue do and thus stand out more on the mammogram.
- MRI – Magnetic Resonance Imaging (MRI) uses intravenous contrast injection and strong magnets to evaluate breast tissue.
- Molecular Breast Imaging (MBI) uses intravenous injection of radioactive material to image the breast. It is not appropriate for screening as it has higher radiation and there is still a relative lack of evidence to support its use for screening.

- Positron emission mammography (PEM) uses a short-lived radioactive sugar injected into body to detect metabolically active lesions such as cancer. Due to moderately high whole-body radiation, it not for screening.

Unfortunately, not everyone has access to all types of breast screening and if this is the case for you it is important that you seek out the best screening available for regular assessment.

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Why is breast density a risk factor for breast cancer?



Erik (Rik) Thompson

Erik (Rik) Thompson, PhD: *Professor in Breast Cancer Research, School of Biomedical Sciences, Faculty of Health, Research Lead, QUT Translation Research Institute, and Member, Centre for Genomics and Personalised Health, Queensland University of Technology (QUT) Brisbane, Australia*

Mammographic density (MD), also known as breast density, appears as the white area on a mammogram (Fig. 1 top right). It cannot be determined by feeling the breast but needs to be determined by x-ray mammography or, more recently, specific magnetic resonance imaging (MRI) or ultrasound protocols. When adjusted for age and Body Mass Index (BMI), MD is a strong and independent risk factor for breast cancer. The breast cancer risk of women with dense tissue comprising 75% of their breasts is 4 to 6 times higher than the risk of women with dense tissue comprising only 25% of their breasts, which is approximately 2 times higher than that of the general population. In determining whether an individual has an increased breast cancer risk, MD should be considered along with other well-established breast cancer risk factors such as family history, high-risk gene mutations, age at menarche, age at first childbirth, and breast-feeding history.

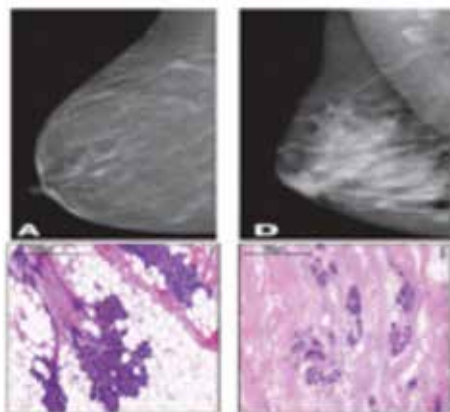
A number of methods are being developed to give a numerical score for MD. The scoring system most commonly reported is the Breast Imaging Reporting and Data System (BI-RADS), which classifies women in four categories: (A) almost entirely fat, (B) scattered density, (C) heterogeneously dense, and (D) extremely dense (see A and D on Figure 1). Dense breast tissue is common, with 35% of women between the ages of 40 and 74 having falling into category C, heterogeneously dense, with dense tissue comprising more than 50% of their breasts, and 8% falling into category D with extremely dense breasts.

In addition to being a strong biological risk factor, dense breast tissue both appears white on a mammogram just as breast cancers do and thus dense tissue can mask or hide a cancer, making early detection more difficult. Because of this, high MD is also associated with risk of discovering a breast cancer after a clear mammogram. The higher the percentage of MD, the less likely it is for an existing tumour to be detected by mammography. This is especially important because breast cancers that are found within 24 months of a "clear" mammogram tend to have poorer outcomes. In short, high MD puts a woman at a higher risk of developing breast cancer AND a higher risk of the breast cancer being missed at mammography screening — a double whammy! Many breast health professionals are utilising, or at least considering, targeted screening for women at higher risk of breast cancer, including those whose higher risk is due to MD, and are supplementing mammography with MRI and/or ultrasound. After a steady progression of state-wide legislation in the USA, where 38 states now require that women be told of their MD status, a very recent Food and Drug Administration guideline mandates that all USA states must provide MD notification and interpretation by mid 2024. Similar

notification laws have recently been passed in several of Canada's provinces, and the European Society of Breast Imaging also recommends that women be informed of their breast density and the prognostic and diagnostic implications of having dense breasts. These laws have provided abundant data on acceptability and utility of such MD information flow.

Our own research studies at QUT have aimed to understand why MD is associated with increased risk of breast cancer (separate to masking). Women of the same age and BMI vary greatly in their MD, and about 60% of this variation appears to be due to genetic factors, some of which are now known. The genes implicated in influencing MD include 10-12% of the genes that are implicated in driving breast cancer risk. Extrinsic factors are also known to modify MD over time. For example, MD reduces with childbearing. Similarly, other factors affecting MD, such as hormone replacement therapy, are also implicated in breast cancer risk.¹ The link between estrogen and MD has been highlighted by the observation that a significant decrease in MD was able to predict the protective effect of the anti-estrogen tamoxifen in the large-scale IBIS-I prevention trial. Since then, work by others has also shown that MD reduction also predicts whether women treated for breast cancer are protected from recurrences or new breast cancer events by anti-estrogen therapies such as tamoxifen and, in some studies, aromatase inhibitors.² Thus, in either the prevention or treatment settings, women on anti-estrogen therapy who experience a decrease in MD appear to be those that derive benefit. This finding could allow us to identify those women destined not to benefit from their current anti-estrogen therapy within their first year of treatment, possibly avoiding unnecessary toxicity and allowing a switch to a more effective treatment. Recent studies have also

Figure 1



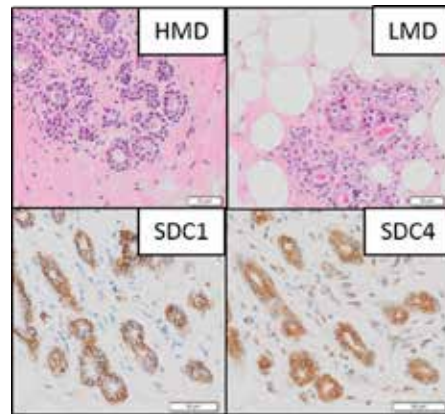
Representative mammograms (top) and histology images (below) of low (A; left) and high (D; right) breast density. Note more fat (white) and more ECM (pink) in histology images of low and high density, respectively. The dark purple structures are the actual mammary glands.

shown that MD change with lower doses of tamoxifen correlated with known endocrine side effects, suggesting that MD change could be used to determine the lowest dose of tamoxifen required for treatment. In some cases this could be 20-times lower than the standard dose, with significantly lower side effects.

Working closely with surgeons, pathologists and radiologists, initially at St. Vincent's Hospital in Melbourne, Australia and subsequently at the Princess Alexandra Hospital in Brisbane, Australia, and acknowledging our gratitude for the consent from women undergoing prophylactic mastectomy, our research team developed a pairwise comparison approach to study mammary tissue regions that had low MD versus those with high MD (MD was determined by taking a mammogram of a slice of breast tissue that was surplus to the pathologists needs.) As had been suggested by others, we found that the glandular structures in high MD regions were surrounded by dense connective tissue, separating them from the fat, whereas low MD tissues had very little dense connective tissue and in some regions directly abutted the fat.³

To study these tissues more closely, we have employed a patient-derived explant (PDE) model system, pioneered by our collaborator Dr Theresa Hickey, where small pieces of freshly removed mammary

Figure 2



Top: histological (microscopy) sections of High (HMD) and Low MD (LMD) patient-derived explants (PDEs) cultured for 21 days. Bottom: SDC1 and SDC4 levels (brown staining) in HMD PDEs.

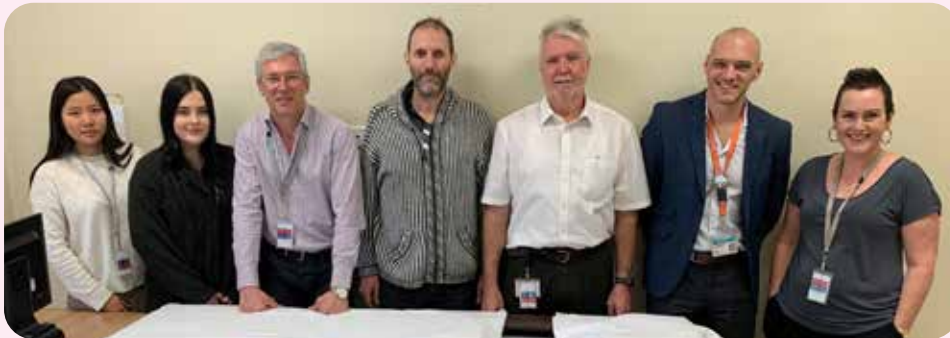
tissue are cultured on top of a piece of dental sponge at the air liquid (cell culture medium) interface. These PDEs are proving useful across many biomedical studies as they allow us to add treatments and assessed responses readily. We first ascertained that the differences between high and low MD tissues were maintained over a 3-week period (Fig 2).

The dense connective tissues surrounding the mammary glands in high MD tissues is comprised of a special class of proteins

and carbohydrates that we term extra-cellular matrix, one well recognized component being collagen. We and many others have shown that the collagen is abundant in high MD tissues, and in addition to being more abundant, it has a different structure.⁴ Collagen structure is governed by a variety of collagen binding proteins, and our early screening of all the proteins that were different between the low versus high MD tissues (we call this proteomics) identified that several members of one particular collagen-binding protein family – proteoglycans – were significantly higher in the high MD tissues. We have tested some inhibitors to these and are optimistic that this work will lead to ways to reduce MD therapeutically and thus reduce breast cancer risk, enhance the accuracy of mammography, and possibly enhance responses to breast cancer therapies.

Our team is working on a number of exciting ideas in our laboratory to better understand what controls MD and to enable us to target it more effectively. In particular, an area we are developing has the capacity to become a screening methodology for regular assessment of MD in the general population, especially in younger women, measuring the effects of lifestyle factors on MD, and/or measuring why high MD is linked to breast cancer risk. More broadly, it has the potential to be the next-generation tool for clinical imaging, including in rural and remote regions because it will be possible to use it outside of a hospital or screening clinic setting.

Most of what we have learnt about MD has come from analysis of clinical mammography, where the huge amount of data attached to clinical outcomes (breast cancer diagnosis) has provided a wealth of information. Ongoing collaborative studies are continuing to lead to better understanding of MD and how it develops.



Prof. Thompson and his QUT research team

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The challenges of drug research in India

Rama Sivaram, India

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Rama Sivaram

Women with advanced breast cancer have told me all too often they know that drugs that might help them are available in other countries but they do not have access to them or cannot afford to pay for them. They ask if equivalent, more affordable drugs are made in India, as these are their only hope. This brings to mind the recent petition of a breast cancer patient in Kerala who sought judicial intervention for a compulsory license — a provision of Indian patent law — to allow the manufacturing of the generic drug ribociclib¹ at a much lower cost. Unfortunately, it was too late for the petitioner by the time price regulation of the drug occurred, and the generic replacement was still way too expensive for many.

Another young HER-2 positive patient was faced with a very difficult decision where she could use what she had saved for her young daughter's future for 18 cycles of Herceptin (trastuzumab) or opt out of treatment and keep the savings for her daughter. She cried, "I am not asking for the moon, just to stay alive for my 6-year-old daughter until she passes high school." This is not unique to my country but is common in all low- and middle-income countries, where large numbers of patients contribute as research participants in clinical trials for testing safety and efficacy of new and approved drugs yet are not beneficiaries of the latest research and technology. How do we explain the complexities of research, development, and the exorbitant pricing and funding when women ask: "Why doesn't India make its own drugs; why does the government have so little funding for this; and what are our own doctors and scientists doing about it?" They are not asking for the moon, just for life and a cure!

Budget, population, infrastructure, skill sets, cutting-edge science and technology, and federal funding along with private/public partnerships all contribute to progress in cancer research, especially breast cancer research, in the US² and other high-income countries. In contrast, in India and other low- and middle-income countries, there are many gaps in breast cancer research due to regional and ethnic relevance, lack of high quality clinical trials,

availability of open-source and reliable data, limited academic/clinical/pharma collaborations, insufficient infrastructure, and not enough clinician researchers.³ The recent COVID-19 pandemic has acutely highlighted issues in the Indian public health system and the extent to which it can respond to a public health crisis. This has led to a positive response to invest and increase the budget for health research. The recent budget speech for 2023-24 highlighted that facilities in select Indian Council of Medical Research (ICMR) Laboratories will be made available for research by public and private medical college faculties and the private sector.⁴ However, the major question is what percentage of cancer research will be geared toward basic drug discovery and translational research? Challenges to the plan will be the number of non-communicable diseases that compete for funding, the large population, the actual fluctuations in gross domestic product and therefore health spending, and the fact that most funding will be governmental rather than philanthropic funding. Added to this is the burden of addressing intellectual property and patents.

With the Indian Patents Act, 1970, we saw new hope as active pharmaceutical ingredient (API) manufacturing came into existence and the first generic drugs for cancer, vincristine and vinblastine, were made in 1983 by CIPLA, Ltd. Another major step forward occurred in 2007, when Novartis

lost a landmark case against the Indian government whereby Novartis had sought to patent the anti-cancer drug, Gleevec, for blood and other cancers. Recently, a Johnson & Johnson patent for a prostate cancer drug, zytiga, was invalidated. With the drugs palbociclib, ribociclib, and trastuzumab going off patent, we now have generic versions of these drugs that are used for treating some breast cancers available at almost half the price. This reflects opportunities for generic pharma, yet many challenges remain. There is a delicate balance between the public good and private good when pricing generics. Having to procure active pharmaceutical ingredients from foreign sources, mainly China, can drive costs and limit availability of needed generic drugs. India needs to overcome the challenges that prevent domestic companies from competing in the generic drugs field by becoming end-to-end pharmaceutical manufacturers. Currently, India has little in the pharma pipeline other than a handful of drugs in pre-clinical trials with only a few of those reaching phase 2 trials.⁵

In trying to understand why drugs cost so much and why some die for want of a needed drug or while waiting for it, I have asked doctors, scientists, and researchers, about drug development. Not all of them know that the principal investors or funders for drug development differ at each stage. "Kite-flying" ideas, or putting forward ideas to gauge a reaction rather

than being serious about them, typically don't attract funding unless a very small amount is funded through philanthropy or comes from internal institutional funding. Public and private institutions involved with basic research and discovery receive government or philanthropic funding, while late-stage development is funded mainly by pharmaceutical companies or venture capitalists. Of hundreds of new chemical entities, perhaps only a few will be discovered with a beneficial outcome. There is much uncertainty in the market and, as a result, we have low investments in our research and discovery. On the brighter side, India does have its own not-for-profit Biotechnology Industry Research Assistance Council, as well as the Department of Science and Technology's National Initiative for Developing and Harnessing Innovations Seed Support System, which provide financial assistance for potential start-ups with promising ideas, innovations, or technologies.⁶

The shortage of funds is obvious in low- and middle-income countries like India, and the lack of collaboration and understanding of each other's capabilities and

limitations between industry and academia erode India's potential. As a curious advocate and an editorial board member of the annual report and newsletter at the hospital research centre where I consult, I read about many clinical trials. I see drug development and the approval chain as a game of snakes and ladders. The steps bring a drug to market seem exceptionally long and burdensome, and it can be many years between the discovery of a new chemical entity that can be harnessed into an effective drug and actual approval of the drug. Imagine the frustration of patients with cancers requiring immediate attention when there is nothing to do but wait and hope that a drug that could help will be available in time.

The pharmaceutical climate is changing. Our experiences before and during the COVID-19 pandemic – being involved in global outreach, rolling out vaccines, being members of the Global Alliance for Vaccines and Immunization – can serve as models for us to enter into the field of drug discovery. India is making small but meaningful acquisitions of smaller US companies,

research and development facilities, start-ups, and collaborations. Industry is willing to invest in new drug research and in generics, and India is emerging strong and resilient. The amount allocated to the Indian Council of Medical Research from the budget of the Department of Health Research for 2023-2024 is up 7.4 per cent from the previous year. Furthermore, the initiative of ensuring that select ICMR labs will be made available for research is expected to encourage collaborative research and innovation.⁷ Hopefully, these small steps will continue and, one day, India will be among the global leaders in the development and distribution of cancer drugs.

My special thanks to my husband Sivaram, the “3 km-walk-educator,” who listens to my patient experiences, answers all my questions, and clears my doubt.

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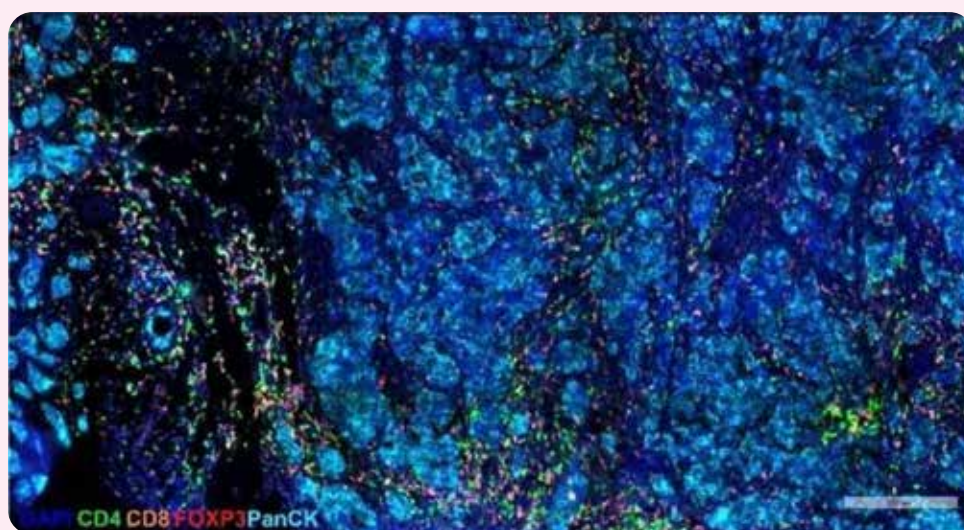
Improving breast cancer outcomes in India: comprehensive clinical, surgical, and translational research with a focus on triple-negative breast cancers.



Laleh Busheri

Laleh Busheri, CEO, Prashanti Cancer Care Mission
Pune, India

Breast cancer is a complex disease with different molecular subtypes which respond differently to therapy and have varying prognoses. Triple-negative breast cancers (TNBCs) comprise approximately 20-30% of all breast cancer cases in India, which is high compared to Western populations where TNBCs account for only 10-15% of all breast cancer cases. TNBCs are also associated with poorer prognoses with high rates of recurrence and metastasis. Despite recent advances in breast cancer treatment, TNBC remains a significant clinical challenge and there is an urgent need for the development of new therapeutic strategies.



The Centre for Translational Cancer Research's Breast Tissue Biobank and Utilizing State-of-the-Art Research Techniques:

The Centre for Translational Cancer Research (CTCR) is the research arm of Prashanti Cancer Care Mission (PCCM) in Pune, India. CTCR is on the forefront of streamlining resources like clinical data and has established a breast tissue biobank with annotated data, the first of its kind in Pune city. The biobank currently holds more than 1500 patient tissue samples which have helped CTCR develop novel molecular markers for prognosis as well as treatment,

keeping long-term survival of the patients in mind. It is also working towards the identification of germline mutations that may be specific to the Indian population.

CTCR utilizes the biobank samples to perform state-of-the-art translational research. Its latest significant study examines the use of multiplex immunofluorescence (mIF) to specifically investigate the TNBC issue in the Indian context. mIF is a powerful tool for analyzing the expression of multiple markers simultaneously in tissue sections. mIF allows for identification of specific cell types and how they are distributed within the tumor microenvironment,

enabling a more detailed measurement of the immune response which is how the body protects itself against harmful components.

Investigating the Immune Microenvironment of TNBCs in the Indian Context:

CTCR is currently measuring the variation of immune cells that break into a tumor and determining their association with overall survival (OS) and breast cancer-specific survival. This is done by examining tissue from a group of patients already diagnosed with TNBC. The findings from this study can provide clinically useful prognostic information to identify subgroups of patients with good or poor prognoses and guide treatment decisions in TNBC. This ongoing study will add to the growing body of evidence suggesting that the immune microenvironment plays a critical role in TNBC and that immune cell phenotypes or the immune cell's unique and visible characteristics and how it is distributed throughout the cell are important determinants of response to therapy and prognosis. CTCR's efforts have important clinical implications and highlight the potential of mIF as a tool for biomarker discovery and personalized medicine in TNBCs.

How research and customer insights inspire the Amoena product range

Heidi Flaherty, *Marketing and Education Manager, Amoena Australia Pty. Ltd Australia*

Amoena is the world's leading breast care brand and the developer of the first silicone breast form. With more than 45 years of experience and a commitment to quality and innovation, our goal is to support women through breast cancer and back to everyday living. Amoena offers a holistic solution including Recovery Care, Breast Forms and Breast Care Apparel.

With 70% of breast cancer-affected women undergoing breast-conserving surgery, there are increasing incidents of secondary lymphoedema in the breast, chest and thorax occurring. Seeing this emerging trend, Amoena expanded its recovery care range to include compression bras specifically designed to help manage the impacts of lymphoedema. The CuraLymph range includes two styles of compression bras, a silicone lymph pad plus three additional comfort garments giving customers more choice when it comes to managing their lymphoedema symptoms. The Lymph Flow Soft Bra features a 3D printed raised texture that provides a light massage effect when worn. The garment is created with an innovative bonding technique, with no raised seams or hems to irritate sensitive skin.

Research continues to inform how we have developed our range of breast forms. A breast from being "too hot" or "too heavy" is one of the most common reasons why a woman will avoid wearing a breast form. With this in mind, we add Comfort + to our breast forms, a technology that is also used by NASA, which absorbs excess heat from the body, stores it in the breast form, slowly releasing it as the body cools. When it comes to breast form weight, we can reduce the weight of the breast form by 20-40% without compromising balance. We also know that a close fitting breast form provides the most comfort. How could we create a breast form that could adjust to each unique chest wall? An adjustable air chamber provided the solution and so the Adapt Air breast form was developed. Through a simple adjustment with a compact pump, women can now adjust their breast form to find their ideal fit, which is especially useful for those who may have fluctuating weight or swelling from lymphoedema.

We know the value of keeping up to date on the latest research in breast cancer, especially when it is combined with the feedback and insights of those who wear Amoena products. By working closely with medical experts and breast cancer survivors, we will continue to create quality product that meets their needs and supports their confidence.

For more information, go to www.amoena.com



Spotlight on: Malaysia!

Learning the art and science of empathetic listening

Ranjit Kaur, Malaysia

A three-day Reach to Recovery training course was conducted for 15 applicants at the Breast Cancer Welfare Association Malaysia on 28-30 April 2023. The participants were women with breast cancer experience who expressed an interest in volunteering to offer Reach to Recovery support to newly diagnosed breast cancer patients.

They learnt and practised empathetic listening when supporting the patient and at the same time working on their own blocks to effective listening. Among other important points that the participants learnt were the ability to articulate effective coping strategies, having unconditional positive regard and being non-judgemental. They also had the opportunity to learn

the basics of screening, diagnosis and treatment of breast cancer from an oncologist and breast surgeon.



Spotlight on: Palestine!

Hear the voices of patients in Palestine

*Suhiela Hijazi and Carol El Jabari
Palestine*

The "patient's voice" comes from patients' experiences and perspectives during their healthcare journeys. It includes their needs, expectations, and the challenges they experience. The voice of the patient is critical to ensuring patient-centered care is improved.

In Palestine, it is rare or even unheard of for patients to be participants in discussions about their healthcare. National strategy formulation does not include their voice and, on the personal level, physicians and other practitioners talk to them, not with them. Often the patient isn't even part of the conversation about their disease, care plan, etc., which is ultimately between a relative and the patient. According to Nawal, a cancer survivor, "[t]he patient's voice is not important, so governmental institutions do not give attention to them."

Kate Niehaus, MBA, a patient advocate for the Patient Family Advisory Council for Quality at Memorial Sloan Kettering Cancer Center in New York City, says it is understood and accepted in many parts of the world that "the patient voice adds a different perspective to everything that goes on in health care and can point out real gaps in the system." There are movements underway in many low-resource countries advocating for patients, but organizers face many difficulties and challenges such as lack of access to health care and limited infrastructure and resources for health care, such as insufficient health care providers, facilities, treatments, medical equipment, and more. In Palestine, additional obstacles

include economic instability and restrictions on movement, such as checkpoints, imposed by the Israeli occupation.

What is the benefit of listening to the patient's voice in the field of health? One surgeon, Dr. Yusef, says, "It can help service providers to identify gaps and to communicate better, which improve feelings and raises patients' satisfaction and motivates the patient to complete treatment and follow-up leading to a greater goal, which is to involve patients in decision-making. More communication and understanding of the relationship between patients and health care providers through consultative sessions between the two parties and work on implementing the outcomes in institutions, not just theory, is very important."

At the Patient's Friends Society, Jerusalem (PFS) we work to encourage patients to raise their voices by holding meetings with health care providers and decision makers. We regularly engage with patients and survivors in our centres and on social media, and online patient groups to provide psychological and moral support. Our non-profit has been working for more than 35 years to raise awareness, engage with key stakeholders and educate with the goal of improving health care at all levels. Thanks to the Union for International Cancer Control (UICC) we were able to hold two meetings, bringing together more than 70 patients, health care providers, academics, volunteers, and medical students to listen and learn from each other.

In conclusion, the patient's voice is a critical component of patient care. By listening to and integrating patients' perspectives and experiences, healthcare providers can improve the overall quality of care and promote better health outcomes. We look forward to engaging with more patients, decision makers, practitioners and students. It is important to keep up the momentum to raise awareness about the gaps, needs and solutions if we are to improve patient care.

As the voice of the patient movement continues to grow, it is important for providers to prioritize patient engagement and work collaboratively with patients to achieve their healthcare goals.

PFS is a Palestinian independent, non-governmental organization (NGO) founded in 1980 by Palestinian academics and health professionals. PFS is a registered non-profit charity located in Jerusalem. PFS has been a member of the UICC since 2005 and has been a proud member of Reach to Recovery International (RRI) since 2007, a member of the Mediterranean Task Force for Cancer Control (MTCC), the ABC Global Alliance and the MAX Foundations. For more information: www.pfsjerusalem.org/, +970 59-992-2310 or email us at: info@pfsjerusalem.org, or find us on Twitter (@PFSJerusalem) or Facebook (Patient's Friends Society- Jerusalem).



©PFS team and survivors at Hebron University



©PFS conducts Patient Voice meeting at Ahli Hospital, Hebron



©PFS, patients and physicians at Ahli Hospital

Spotlight on: South Africa!

Help and healing for breast cancer survivors

A collaborative article by Reach for Recovery South Africa and the South African Mushrooms Farmers Association

The medicinal benefits of mushrooms have been used for centuries, and, in the modern era, one notable health link has been identified between cultivated mushrooms and breast cancer risk.

Studies conducted at the Beckman Institute at the City of Hope Cancer Centre in California as well as several Asian population studies over the years connected lower risk of some breast cancers with eating button mushrooms.

It's one of the many reasons The South African Mushroom Farmers' Association (SAMFA) is a staunch advocate for Reach for Recovery South Africa (R4R), whose volunteers reach out to underprivileged breast cancer survivors year after year, supplying silicone breast prostheses free of charge to those recovering and offering

counselling and community to those undergoing treatment.

The financial muscle

SAMFA runs the yearly Power of Pink campaign to fund R4R's Ditto Project. This means that each October, one South African Rand from every pink punnet of fresh mushrooms bought at Pick n Pay stores across South Africa goes to their uplifting work.

In 2022, a total of R587,262 (30,576 USD) was raised this way and, since 2011, more than 8,350 silicone prostheses, costing in excess of R7.45 million (387,889 USD), have been distributed through the Ditto Project to South African women who could not afford them. The Power of Pink campaign contributed 99.3% of the total project costs.

R4R has done its work in SA for over 50 years, making it in many ways ahead of its time when viewed through the lens of the World Cancer Day 2023 directive to "close the care gap."

By focusing on South Africa's disadvantaged breast cancer survivors, R4R has consistently shown it actively cares, in 2022 fitting 562 women with individually colour- and size-matched external silicone breast forms. Stepné Jacobs, Chairperson of Reach for Recovery in South Africa, says throughout 2023 R4R will be providing "even lighter weight silicone prostheses which will offer more comfort to women." The new forms are also softer and more natural looking.

(left to right, Edith Venter, R4R Ambassador; Ross Richardson, SAMFA Chairperson; Stepné Jacobs, R4R Chairperson; Mari Villiers, Pick n Pay



Stepné Jacobs and members of the RFR team

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WE LOVE THAT WE CAN CONTRIBUTE TO THE DITTO PROJECT AND HAVE THE CHANCE TO TRANSFORM THE LIVES OF WOMEN,” SAYS ROSS RICHARDSON, CHAIRPERSON OF SAMFA. “WE WISH REACH FOR RECOVERY EVERY SUCCESS FOR THEIR AMAZING WORK.”

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Mushroom Baguette Pizza

Global Kitchen



SERVINGS: 4-6 / MAKES 4 PIZZAS

Ingredients:

4 large portabello mushrooms / 400g
large brown mushrooms
100g (3.5 oz.) baby portabellini
mushrooms, sliced
2 baguettes
1 x 375ml (12.5 fl. oz.) tomato based
pasta sauce of choice (*tomato & basil
works very well or use arabiata for
a chilli kick*)
250g (8.5 oz.) mozzarella cheese, grated
200g (7 oz.) mixed olives, sliced
1-2 Tbsp capers
1 tsp dried Italian herbs
Olive oil
Salt and pepper, to taste
Chilli, for serving

Method:

To prepare topping:

Place oven rack towards the top 3rd of the oven
Preheat oven to 200°C, fan on
Place the portabellos on a baking tray. Season lightly with salt and pepper
Dry roast for 7 minutes until just tender but not fully cooked through
Allow to rest skin side up and release their liquid
Slice
Place pasta sauce in a small saucepan and reduce until slightly thickened
and a good spreadable consistency

To prepare pizza base:

Halve each baguette lengthways
Place on a baking tray and brush with a little olive oil
Bake in the oven for 5 min to crisp up

To assemble pizzas:

Spread a few tablespoons of pasta sauce onto each baguette half
Top each half with cheese, sliced portabellos, raw baby portabellinis,
olives and capers
Finish with a sprinkle of Italian herbs, salt and pepper
Return to the oven and bake for 6-8 min, until the cheese is bubbling
and golden brown

Serve straight away with some chilli on the side.

Dairy-Free Creamy Chicken and Mushroom Casserole

**Global
Kitchen**

SERVINGS: 4



Ingredients:

4 free-range chicken breasts
250g (9 oz.) porta bellini mushrooms, sliced
1 white onion, diced
2 cloves garlic, minced
1 Tbsp ground almonds (almond flour)
4 Tbsp nut butter, e.g. cashew or almond
175ml (6 oz.) almond or oat milk, warm
375ml (12.5 oz.) chicken stock, just boiled
1 tsp dried herbs
1 bunch Tuscan kale (Cavolo Nero)
100g (3.5 oz.) sun-dried tomatoes, roughly chopped
Salt and pepper, to taste
Olive oil, for cooking

Method:

Heat a drizzle of olive oil in a large buffet casserole or sauce pan
Season the chicken breasts with salt and pepper and then sear until golden brown all over
Remove from the pan and set aside
Add the mushrooms to the pan and cook until golden brown
Remove from the pan and set aside
Add the onion to the pan with a pinch of salt and cook until soft
While the onion is cooking, combine the nut butter, almond milk and chicken stock in a large jug. Whisk until well combined and smooth
Add the garlic to the onion and cook until fragrant
Sprinkle in the almond flour and mix well
Pour in the nut butter and stock mixture
Sprinkle in the dried herbs
Bring to a gentle simmer and add the kale
Simmer until thickened
Return the chicken to the pan to cook through
When the chicken is almost done add the mushrooms back into the mix and stir to heat through
Finish with the sun-dried tomatoes for a pop of colour and acidity
Serve the saucy creamy casserole with a fresh green salad on the side and enjoy!

**Spotlight on
our members!**

Salomé Meyer and Stephné Jacobs

Reach to Recovery International extends sincere thanks to two of our members who recently celebrated their birthdays by setting up Facebook fundraisers to benefit RRI!

Salome Meyer is a cancer advocate based in Cape Town, South Africa. Those of you who attended the 2013 RRI Conference in Cape Town may well remember her for the vital part she played in organising it. She now heads up the Cancer Alliance, an advocacy group for all cancers.

Stephné Jacobs of Pretoria, South Africa, chairs the Board of Management of Reach for Recovery South Africa and is a new member of RRI's Board of Directors.

Happy birthday to Salomé and Stephné, and thank you both for your dedication to Reach to Recovery International! Thanks also to those of you who generously contributed to their fundraisers!

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**REACH TO RECOVERY
INTERNATIONAL EXTENDS
SINCERE THANKS TO TWO OF
OUR MEMBERS WHO RECENTLY
CELEBRATED THEIR BIRTHDAYS
BY SETTING UP FACEBOOK
FUNDRAISERS TO BENEFIT RRI!**

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Salomé Meyer



Stephne Jacobs