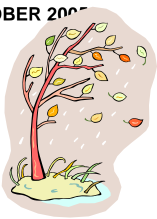

Touch of Courage

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Cedar Valley Breast Cancer Task Force

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Current Options in Breast Reconstruction

Deniz F. Batug, M.D., FACS

Breast Cancer affects one out of every eight or nine women and continues to be one of the most prevalent types of cancer among women. Although a cure for breast cancer has yet to be discovered, great advances have been made in recent years in both diagnosis as well as treatment, including possible preventative measures. Treatment of this disease involves a concerted effort by many specialists. The reconstructive aspect of care is performed by a plastic surgeon, and this article will present the various options available in breast reconstruction.

There are many factors to consider about breast reconstruction and many important questions a woman must ask. The first question should be "is reconstruction right for you?" Women choose to have breast reconstruction for many different reasons and the reconstruction option chosen depends on individual desire as well as one's unique physical and mental characteristics. Any type of breast reconstruction will typically involve multiple procedures, with the exact number varying with individual circumstances.

Breast reconstruction can be performed as an *immediate* reconstruction, that is, at the time of the mastectomy or on a delayed basis, which is performed weeks to years after the initial mastectomy. After determining whether to go under immediate or delayed reconstruction, the next important decision is selecting the type of reconstruction one will undergo. Reconstruction is performed using a variety of methods including use of a prosthesis (a breast implant), use of a women's own body tissue (a tissue flap), or by using a combination of the two. These procedures vary in complexity as well as recovery times and risks involved. Despite which reconstruction option is chosen, they all can give a very nice cosmetic result, and choice depends on many factors such as individual anatomy, type of cancer and life style.

The most common form of breast reconstruction procedure in the last ten to fifteen years is use of a breast implant to recreate the breast mound. Many times following a mastectomy there is deficient skin, and prior to placement of a permanent breast implant, a balloon like device called an *expander* may be placed as the first step in this type of reconstruction. The expander allows the surgeon to slowly stretch the skin and muscle creating sufficient space for placement of a permanent implant. At a second procedure the expander is removed and the permanent implant is placed. Both of these procedures can be performed on an outpatient basis with a fairly quick recovery time of one week to ten days. The time frame between procedures is determined by patient anatomy (how large a breast to reconstruct) as well as potential

(continued from page 1)

other factors such as need for additional therapy. The implant choice may either be a saline filled implant or a silicone filled implant. At this time, silicone implants are available for reconstruction purposes only if your surgeon is participating in ongoing clinical trials. Silicone implants have been shown in countless studies to be safe and not causative in any adjuvant diseases.

Flap reconstruction is a method of reconstruction that uses a women's own tissue. This can be taken from either her back, abdomen, or buttocks to create a breast mound. If the tissue is left attached to the blood supply this is known as a pedicled flap, or it may be completely separated from its blood supply and reattached to a new blood supply using microsurgical technique. This is known as a free flap.

There are a number of flap options that women can choose from. The *latissimus dorsi* flap utilizes the skin from the back attached to the latissimus muscle. This is then brought to the front of the chest to create the breast mound. Because this muscle is very thin, many times implants my be needed for creating the volume. This procedure typically takes approximately fours hours with a two to three day hospital stay. Recovery times are longer than implants alone and can range from three to four weeks. The advantage to this flap is its ability to provide needed missing skin in a reliable and consistent manner.

Other available options for flaps include use of tissue from the upper hip or buttock region. However, the most common type of flap in breast reconstruction is the TRAM flap. This stands for **T**ransverse **R**ectus **A**bdominus **M**usculocutaneous flap. This option utilizes skin from the abdomen with its underlying rectus muscle to allow sufficient volume and replacement of missing skin. Implants are usually not needed with this type of reconstruction and surgery can last from six to eight hours. Hospital stays may be up to three to five days with recovery time of approximately six weeks or greater. Patient selection is very important with this type of reconstruction and not all women are candidates for this procedure. Because we are utilizing skin from the abdomen, previous abdominal surgery may preclude the use of this flap. In addition, medical conditions as well as individual anatomy and lifestyle (smoking history, etc) may determine whether the flap may be used.

As mentioned earlier, reconstruction is typically not a one procedure event. Many times addressing the opposite breast must be taken into consideration. This is done in order to achieve symmetry between the reconstructed and non-reconstructed breast. Procedures such as breast lifts (mastopexy), breast reduction (reduction mammoplasty), or breast enlargement (augmentation mammoplasty) may be required on the opposite breast in order to achieve the best symmetry and results. Another consideration is whether to proceed with reconstruction of a nipple areola. This is typically performed three to four months after the initial reconstruction and is usually done on an outpatient basis.

Breast reconstruction is a decision that is made based on many individual factors. By careful discussion with your plastic surgeon you determine the proper selection of reconstructive methods. With the current wide availability of reconstructive options mastectomy alone need not be the end point for breast cancer. It is now a federal law that all insurance companies must cover breast reconstruction following mastectomy for breast cancer, as well as covering procedures on the opposite breast to achieve symmetry. Through education and involvement in the decision making process, breast reconstruction can be a very fulfilling and satisfying option.

Touch of Courage Breast Cancer Support Group

The Touch of Courage Breast Cancer Support Group continues to meet on the first Monday of every month (unless it's a holiday), with the meetings being held at Covenant Cancer Treatment Center at 200 E. Ridgeway Avenue in Waterloo at 1:30 and 5:30 p.m.

For those of you who are long term survivors, please remember what a critical role you play in the journey of the newly diagnosed.

The Support Group invites any woman or man who is dealing with breast cancer to attend the support group meetings. Spouses and significant others are also welcome.

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A New Image

Era Of Hope

By Christine Carpenter

The Era of Hope meeting, held most recently in Philadelphia in June 2005, is a forum for review and reporting on breast cancer research that has been funded through the United States Department of Defense Breast Cancer Research Program (BCRP). It is a conference attended by researchers whose studies have been funded by the program, experts in breast cancer research and clinical oncology, and consumer advocates. The 2005 meeting included more consumers, representing more organizations than ever before, and their contributions during the meeting demonstrated that consumer involvement is key to the success of this important program.

The BCRP began as a result of the National Breast Cancer Coalition's 1992 campaign to dramatically increase federal funding specifically targeted to breast cancer research. Through the efforts of the hundreds of organizations that make up NBCC, this program created an unprecedented partnership that unites the military, scientific, medical, and breast cancer survivor and advocacy communities to develop and carry out research to end breast cancer. It is the federal government's only breast cancer research program that involves consumer advocates at vision setting, as well as both the scientific peer-review and the programmatic-review stages and at all levels of a scientific meeting.

The scientific peer-review panels that evaluate each proposal for merit and the programmatic-review panel have benefited from the voices (and votes) of 420 consumers, individuals who come from 240 separate organizations, providing an incredible nationwide reach into the world of breast cancer.

The Era of Hope Meeting

The Era of Hope meeting occurs every two or three years. Its purpose is to have all research funded by the program in a given funding cycle presented to the public through oral presentations and poster sessions. The Era of Hope program is designed by a Technical Planning Committee, which includes scientists and consumers who review the reports of the funded research, choose the meeting themes and select the presentations. Themes for each of the three meeting days of the 2005 meeting were: Understanding Risk – A Different Perspective; Understanding Who Needs Intervention and Understanding Treatments - Effectively Treating Primary and Metastatic Disease.

Advocate Involvement in Era of Hope

As in the rest of the BCRP program, consumer advocates were well represented at the 2005 Era of Hope meeting. There are few, if any, other forums in the scientific community in which such a diversity of scientific disciplines - basic scientists, clinicians, epidemiologists, nanotechnologists, mathematicians, physicists and more - come together on an equal footing with consumers to examine the complexity of breast cancer research, challenge each other, explore controversial issues, and learn and plan.

Consumers at every session challenged the status quo and conventional wisdom, and offered what was, in many cases, an eye-opening perspective to the researchers whose laboratory careers may be far removed from real world clinical applications.

Iowa was represented at the Era of Hope by consumer advocateChristine Carpenter of Cedar Falls (seen here in Washington, D.C at Lobby Day)

Other Unique Features of Era of Hope

Acceptance of Department of Defense Breast Cancer Research Program funding requires reporting of all findings, whether they are positive, negative or inconclusive. This is an important feature because it ensures that more efficient use of resources can be made when researchers are able to learn from the mistakes and false starts of others who are investigating similar questions; fosters development of collaborative relationships, when, for example, a researcher with a new idea is able to identify and join

forces with a researcher who has already started down a related path; and provides accountability to the public in terms of how research money is spent.

This meeting maintains a strong focus on the broad vision of preventing and curing breast cancer, rather than on narrow and esoteric questions. This focus was clear in all the plenary sessions. One researcher noted, for example, that she has worked in the field of metastatic breast cancer for over 20 years and has given hundreds of presentations, but before this meeting she had never been asked to speak on what it will take to prevent breast cancer metastasis.

Consumer advocateCheryl Wheaton of Cedar Falls (seen here being honored at the CVBC task force annual celebration) also represented Iowa at Era of Hope

Scientific Themes That Were at the Heart of Several Presentations in 2005

While the research funded by the BCRP covers an enormous range of approaches, several scientific themes were common among the many presentations at the 2005 Era of Hope conference.

Breast cancer as a heterogeneous disease: Gene expression profiling technologies have allowed researchers to identify several breast cancer "types" that include those often referred to as Luminal A and Luminal B (tumors that arise from luminal cells and distinguished from one another in terms of hormone receptor status); HER2 (tumors that test positive for HER2 and negative for hormone receptors); BRCA (tumors that arise from mutations of the BRCA1 or BRCA2 genes); and Basal (tumors that arise from basal cells and are negative for estrogen and progesterone receptors and for HER2/neu). Recognition of the heterogeneous character of breast cancer will allow for better selection of patient subgroups for clinical trials testing targeted therapies. Without taking this into account, we dilute risk among our test populations, and we obscure recognition of real risk factors and effective treatments.

Tumor progenitor cells: Several researchers presented on their investigations of the role of tumor progenitor or breast cancer stem cells. This line of investigation hypothesizes that a tumor is an abnormal organ growing within the breast from abnormal progenitor cells. The implications of this research are that the cancer cannot be finally arrested unless and until the stem cells underlying it are killed or forced to differentiate and behave like normal cells. Choosing stem-cell specific targets for future treatments therefore may prove far more effective in stopping cancer from progressing. This type of hypothesis could explain: why tumor regression does not correlate with survival if chemotherapy is killing differentiated cells but sparing cancer stem cells; why the real disease is carcinogenesis, not cancer; why some micro-metastatic cells never develop into metastasis and others - the ones that are stem cells - do; how negative environmental exposures during late puberty (such as atomic bomb fallout after World War II) can lead to breast cancer 20, 30 or 40 years later; and why a small percentage of ER positive tumors - those that arise from ER negative stem cells - remain refractory to tamoxifen treatment, while others - those that arise from ER positive stem cells - are completely arrested. This model could explain why even "early diagnosis" is, in fact, late diagnosis in terms of the time that the disease processes have been developing in the breast. If it proves correct, it would suggest that drugs that specifically target breast cancer progenitor cells might be more effective than some of the more traditional approaches to breast cancer treatment such as surgery followed by systemic chemo-toxic treatments.

Individual Presentations

Scientific abstracts summarizing the individual research projects funded by the Breast Cancer Research Program can be accessed at: http://cdmrp.army.mil/bcrp/era/default.htm.

For more program abstracts and additional information about the Breast Cancer Research Program and Era of Hope, visit the Congressionally Directed Medical Research Programs website at: http://cdmrp.army.mil/bcrp/era/default.htm.

A Survivor's Story

Mammography Does Save Lives!
By Pat Kutz

Five years ago, at the age of 44, I decided it was time to schedule an appointment for a mammogram. Although I had had a baseline mammogram at the age of 35, I hadn't taken the time to schedule follow-up mammograms. So in the fall of 2000, I scheduled a routine physical and mammogram. A few days later, I received the results.

The news was a little frightening. I had calcifications in my right breast that required further tests and a biopsy. The results of the biopsy? I had breast cancer, ductal carcinoma in situ.

I began seven weeks of radiation treatment and tried to keep life in proper perspective and somewhat normal. This was my youngest son's senior year of high school and I wanted him to have good memories, not memories of a sick mother. My husband lost his mother to breast cancer his senior year of high school and knew the difficult times that lay ahead, but my family was wonderful.

My father and mother took me to doctor appointments, both my sons took me to radiation appointments, and my co-workers at the pre-school picked up the slack from my fatigue. My husband was always there, making sure I was resting and eating enough.

I finished radiation and life was beginning to feel normal. I did miss my new friends at the Cancer Treatment Center but I really felt I was cancer free. Follow-up treatment consisted of tamoxifen, doctor checkups and another mammogram four months after radiation. While I felt cancer free, I also understood the importance of follow up care and I would not miss an appointment! I did, however, cry a few tears when thinking that I was a cancer survivor and I would be nervous about test results.

I received the news that there were more suspicious areas, necessitating a trip to my surgeon. Then I heard the news that I feared most – more DCIS in my previously radiated breast. I knew I would need a mastectomy and decided to have a bilateral mastectomy to finally put my life on track to be cancer free.

My family was ready to care for me and I wanted to be ready for my son's graduation ceremony and reception. The week after my surgery I attended ceremonies honoring my son and classmates with surgical drains pinned inside my clothes. My husband emptied my drains, measured and recorded the data, and helped me get dressed. He always told me I looked great!

It has been four years and counting and I hope and pray that I can be a role model for women to exercise proper breast care. Please take the time to schedule regular physicals, perform self examinations and get a mammogram. It really can save your life, sometimes twice.

How Aware Are You?

By Dee Hughes

Since women are still being diagnosed with breast cancer daily, we are again recognizing October as Breast Cancer Awareness Month.

There is probably no one who is not aware of breast cancer. We see pink ribbons on products all year, with proceeds (although usually minimal) going to breast cancer research. So we are aware of breast cancer, aren't we?

Did you realize that 31% of all new cancers in women are breast cancers? The second most common is colon at 15%. Uterine cancer makes up 6% and ovarian only 4% of all new cancers. That is why we must be concerned about breast cancer.

Many women believe because they have no family history of breast cancer they do not need to worry. Unfortunately, 80% of women diagnosed with breast cancer **do not** have a family history. We all need to be concerned.

Did you know that 10-20% of all breast cancers do not show on the mammogram? Most cancers are seen on the mammogram 2-3 years before they are felt, but some will never be seen. Why? We don't know. If you tell the technologist you have a lump, and nothing is seen on the mammogram, the radiologist will then order an ultrasound of the breast. Sometimes a lump can be seen by ultrasound that is not seen on the mammogram. Regardless of what imaging tests are done, a lump you can feel needs to be checked by your physician, and not ignored.

Mammograms are not perfect, but they are the best test we currently have to detect breast cancer. We need to find out what causes breast cancer and end this epidemic. That can only be done with research, and it is vital that we all support research. The best way to get involved is through the National Breast Cancer Coalition and the Iowa Breast Cancer Alert Network. Visit our websites for more information:
www.iowabreastcancer.org
www.cedarvalleybreastcancer.org.

Iowa Breast Cancer Edu-Action

Who Are We?

Iowa Breast Cancer Edu-Action includes breast cancer survivors and their supporters. We are members of the Cedar Valley Cancer Committee. **Our mission** is to serve as a catalyst for the prevention and cure of breast cancer.

What We've Done

- Visited with our congressional representatives to secure their commitment to breast cancer research.
- Participated in fax and letter campaigns o Congress for a commitment to a national strategy for the fight against breast cancer.
- Created the Iowa Breast Cancer Resource Guide, secured funding and distributed 4000+ copies
- Iowa Breast Cancer Edu-Action is a subcommittee of the Cedar Valley Cancer Committee

We Meet:

When: 7:00 p.m. on the 4th Thursday of each month.

Where: Area Education Agency 7
Special Education Building
Conference Room 5

Need more information?

Call Christine Carpenter
319-266-0194

Support and Rehabilitation Programs

Care and Share	Support group for anyone dealing with cancer. Meets the 1st Tuesday of every month at 1:30 p.m.
Touch of Courage	Breast cancer support group. Meets the 1st Monday of every month at 1:30 p.m. and 5:30 p.m.
Reach to Recovery	Provides information and support for women who are faced with breast cancer. Visits available before and after surgery.
Look Good…Feel Better	Consultation with a trained cosmetologist to help a cancer patient feel more comfortable with the physical changes that occur during treatment.

For more information call the American Cancer Society at 319-272-2880 or 888-266-2064.

Resources Available:
Information, support, counseling, and educational materials are available from the following:

Allen College of Nursing
Library and Media Center
1825 Logan Avenue
Waterloo, IA 50703
(319) 235-2005

American Cancer Society
2101 Kimball Avenue, Suite 130
Waterloo, IA 50702
319-272-2880 or 888-266-2064
1-800-ACS-2345 (available 24 hrs)

Breast Care Center
at United Medical Park
1753 West Ridgeway
Waterloo, IA 50701
319-833-6100

Covenant Cancer Treatment Center
200 E. Ridgeway Avenue
Waterloo, IA 50702
319-272-2800
Include Cancer Information Library

National Cancer Institute
1-800-4CANCER

National Coalition for Cancer Survivorship 1-505-764-9956

National Lymphedema Network
1-415-923-3680

Y-Me
1-800-986-8228

Covenant Lymphedema Therapy
319-272-7894

Physical Therapy Partners
Lymphedema Therapy
319-233-6995

Connect with us…
A donation for Touch of Courage is both needed and appreciated. All donations go to support the services of the Cedar Valley Cancer Committee and are tax deductible.

Name: ____
Address:____
City:__________________ Sate:_________ Zip:_____________
$______ amount of donation
❍General Donation ❍Newsletter Donation ❍NBCC Scholarship Fund

Make checks payable to the Cedar Valley Cancer Committee and send to 1067 Heath Street, Waterloo, IA 50703