

CANCER CARE TODAY


Summer 2011

A publication from
Cancer Care Centers of South Texas

CARE TODAY



CANCER CARE CENTERS
of South Texas

 United in Healing with US Oncology

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- Beating Breast Cancer
- Oncology Emergencies for the Non-Oncologist
- “First, Do No Harm” — Alternative Cancer Treatments
- Screening and Early Detection of Colon Cancer

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ABOUT CANCER CARE CENTERS OF SOUTH TEXAS

Cancer Care Centers of South Texas (CCCST) is a comprehensive cancer care practice with 16 locations in San Antonio, New Braunfels, Seguin, Kerrville, Fredericksburg, Marble Falls, Boerne, Uvalde, Jourdanton, Hondo and Floresville. The physicians and staff members provide state-of-the-art treatment for cancer and disorders of the blood, as well as clinical trials. The highly-qualified physician staff is comprised of 27 board-certified physicians specializing in medical oncology, hematology, radiation oncology and gynecologic oncology and a skilled and compassionate team made up of RNs, nurse practitioners and physician assistants specializing in the care of patients with cancer and blood disorders. CCCST is "United in Healing" with US Oncology.



United in Healing with US Oncology

ABOUT US ONCOLOGY

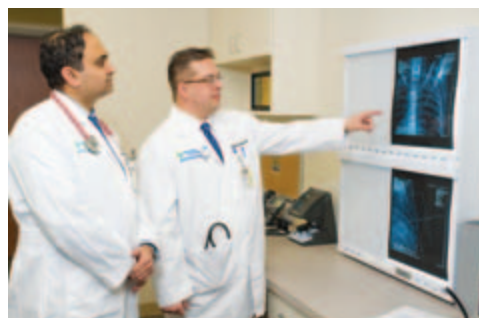
US Oncology, Inc. is the nation's leading integrated oncology company. By uniting the largest community-based cancer treatment and research network in America, US Oncology expands patient access to high-quality care and advances the science of cancer care. Headquartered in The Woodlands, Texas, US Oncology is affiliated with more than 1,300 physicians nationwide and works with hospitals, patients, payers and the medical industry across all phases of the cancer care continuum. Through the use of innovative technology, clinical research, evidence-based medicine and shared best practices, US Oncology improves patient outcomes and offers a better patient experience.

ABOUT THE PUBLISHER

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Production Manager: Shannon Patterson
Marketing: Wanda Bastert
Copy Editor: Michael Adkins

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Arun R. Rao, MD, Medical Oncologist/Hematologist, and Michael J. Gagnon, MD, Radiation Oncologist



Sridhar Beeram, MD, Medical Oncologist/Hematologist

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Gynecologist Oncologist and Robotic Surgeon, Antonio Santillan-Gomez, MD, MBA, FACOG



Ed L. Hesita, MD, Medical Oncologist/Hematologist

ON THE COVER

Front row, left to right: Glenn G. Preston, MD, PhD; Ed L. Hesita, MD; Thomas D Fisher, MD; Rebecca E. Barrington, MD, FACP; Sharon T. Wilks, MD, FACP; Sreedevi Daggubati, MD; Anu Dham, MD; Allyson L. Harroff, MD; Arun R. Rao, MD; and David H. Gordon, MD, FACP. Second row, left to right: Alexander Zweibach, MD, PhD; Mark C. DeLeon, MD; Michael J. Gagnon, MD; Suneetha Challagundla, MD; Roger M.

Lyons, MD, FACP; Jesse E. Medellin, MD; J. Dean McCracken, MD, FACP; Gregory J. Guzley, MD, FACP; Ather Siddiqi, MD; Sridhar Beeram, MD; and Jason B. Kaplan, MD. Not pictured: Gia Dice, MD; J. Brant Ellis, MD; David J. Friedman, MD, PhD; Vijay K. Gunuganti, MD; Manuel A. Santiago, MD; and Antonio Santillan-Gomez, MD, FACOG.

Message from the Executive Director



Deborah Gaeke, RN,
Executive Director,
Cancer Care Centers
of South Texas

Dr. Sharon Wilks and Dr. Allyson Harroff review the latest clinical research for promising new therapies for breast cancer including the exciting new targeted therapies. Colon cancer continues to be a dangerous disease, and Dr. J. Brant Ellis stresses the importance of prevention and early detection in the primary care office for the best treatment outcomes for patients exhibiting high risk factors and warning signs.

Cancer Care Centers of South Texas (CCCST) is a unique, comprehensive physician practice specializing in the care and treatment of patients with cancer or disorders of the blood. Through our 27 physicians and 16 sites of service, we provide a full spectrum of outpatient services in San Antonio and the surrounding Hill Country and South Texas areas. We are “United in Healing” with US Oncology, offering the knowledge and resources of American’s largest cancer-fighting organization and the understanding of an expert local practice. By offering state-of-the-art technologies, world-class clinical research trials and evidence-based treatment plans, we can offer patients the same approach to diagnosis and treatment offered in the largest metropolitan areas.

Through our extensive clinical trial program, our practice is dedicated to providing the most treatment options by offering investigational therapies to eligible patients. We are dedicated to finding new and better ways to treat cancer and disorders

In our first issue of *Cancer Care Today*, we are pleased to provide you with several articles touching on some distinctive topics related to oncology. Many patients embrace alternative therapies and complementary medicine, and Dr. Gregory Guzley discusses the pros and cons of these types of therapies that some patients will embrace during treatment for cancer. Dr. Anu Dham provides thoughtful insight for primary care and emergency physicians as part of a patient’s cancer treatment team.



David H. Gordon, MD, FACP,
Medical Oncologist/
Hematologist, CCCST
Vice President

of the blood. As a member of the US Oncology Research Network, we participate in one of the most extensive clinical trial programs in the nation. At any given time, we have approximately 40 to 50 clinical trials open to eligible patients, many of which are prominent national trials and only available in Texas through CCCST’s clinical research program.

Every patient is unique, and our physicians provide personalized treatment options for each patient using evidence-based medicine. This provides a standard of care that relies on the best scientific evidence to define the treatment options that are the most reliably effective for any given cancer or blood disorder. Our patients can rest assured that they are receiving the most advanced and personalized care available.

And, to ensure the highest quality of patient care, all of the chemotherapy and therapeutic drugs we provide are supplied to us through the US Oncology safe and secure drug distribution program. In fact, Cancer Care Centers of South Texas is the only physician practice in the San Antonio area that provides this level of distribution safety for chemotherapy and therapeutic drugs.



Roger M. Lyons, MD, FACP,
Hematologist, Medical
Director of the Cancer
Care Centers of South Texas
MDS Center of Excellence,
CCCST President

We are very proud that Cancer Care Centers of South Texas has been recognized nationally for expertise in the diagnosis, treatment and research of myelodysplasia and is designated as a Center of Excellence by the Myelodysplastic Syndromes Foundation. As with this disease and the many other types of cancers and blood disorders, Cancer Care Centers of South Texas is a “Center of Excellence” for patients in the San Antonio, Hill Country and South Texas areas.

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If you have any questions about this information, be sure to discuss them with your doctor. You are encouraged to report negative side effects of prescription drugs to the FDA. Visit www.fda.gov/medwatch or call 1-800-FDA-1088.

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BRIEF SUMMARY OF PATIENT PACKAGE INSERT

Neulasta® (pegfilgrastim)

This brief summary of the patient package insert provides information and instructions for people who will be receiving Neulasta or their caregivers. This brief summary does not tell you everything about Neulasta. You should discuss any questions you have about treatment with Neulasta with your doctor.

What is Neulasta?

Neulasta is a man-made form of granulocyte colony-stimulating factor (G-CSF), which is made using the bacteria *E coli*. G-CSF is a substance produced by the body. It stimulates the growth of neutrophils (**nu**-tro-fils), a type of white blood cell important in the body's fight against infection.

Who should not take Neulasta?

Do not take Neulasta if you have had:

- A serious allergic reaction to Neulasta® (pegfilgrastim) or to Neupogen® (filgrastim).

What important information do I need to know about receiving Neulasta?

Occasionally pain and redness may occur at the injection site. If there is a lump, swelling, or bruising at the injection site that does not go away, talk to the doctor.

Neulasta should only be injected on the day the doctor has determined and should not be injected until approximately 24 hours after receiving chemotherapy.

The needle cover on the single-use prefilled syringe contains dry natural rubber (latex), which should not be handled by persons sensitive to this substance.

What should I tell my healthcare provider before taking Neulasta?

If you have a sickle cell disorder, make sure that your doctor knows about it before using Neulasta. If you have a sickle cell crisis after getting Neulasta, tell your doctor right away.

If you have any questions, talk to your doctor.

What are possible serious side effects of Neulasta?

- **Spleen Rupture.** Your spleen may become enlarged and can rupture while taking Neulasta. A ruptured spleen can cause death. The spleen is located in the upper left section of your stomach area. Call your doctor right away if you have pain in the left upper stomach area or left shoulder tip area. This pain could mean your spleen is enlarged or ruptured.
- **A serious lung problem called Acute Respiratory Distress Syndrome (ARDS).** Call your doctor or seek emergency care right away if you have shortness of breath, trouble breathing, or a fast rate of breathing.
- **Serious Allergic Reactions.** Neulasta can cause serious allergic reactions. These reactions can cause shortness of breath, wheezing, dizziness, swelling around the mouth or eyes, fast pulse, sweating, and hives. If you start to have any of these symptoms, call your doctor or seek emergency care right away. If you have an allergic reaction during the injection of Neulasta, stop the injection. Call your doctor right away.

- **Sickle Cell Crises.** You may have a serious sickle cell crisis if you have a sickle cell disorder and take Neulasta. Serious and sometimes fatal sickle cell crises can occur in patients with sickle cell disorders receiving filgrastim, a medicine similar to Neulasta (pegfilgrastim). Call your doctor right away if you have symptoms of sickle cell crisis such as pain or difficulty breathing.

What are the most common side effects of Neulasta?

The most common side effect you may experience is aching in the bones and muscles. If this happens, it can usually be relieved with a non-aspirin pain reliever, such as acetaminophen.

What about pregnancy or breastfeeding?

Neulasta has not been studied in pregnant women, and its effects on unborn babies are not known. If you take Neulasta while you are pregnant, it is possible that small amounts of it may get into your baby's blood. It is not known if Neulasta can get into human breast milk. If you are pregnant, plan to become pregnant, think you may be pregnant, or are breastfeeding, you should tell your doctor before using Neulasta. If you become pregnant during Neulasta treatment, you are encouraged to enroll in Amgen's Pregnancy Surveillance Program. You should call 1-800-77-AMGEN (1-800-772-6436) to enroll.

How should Neulasta be stored?

Neulasta should be stored in the refrigerator at 2° to 8°C (36° to 46°F), but not in the freezer. Neulasta should be protected from light, so you should keep it in its carton until you are ready to use it. Avoid shaking Neulasta. If Neulasta is accidentally frozen, allow it to thaw in the refrigerator before injecting. However, if it is frozen a second time, do not use. Neulasta can be left out at room temperature for up to 48 hours. Do not leave Neulasta in direct sunlight. For all questions about storage, contact your doctor, nurse, or pharmacist.

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Beating Breast Cancer

CCCST Clinical Research Trials Test Promising New Therapies

Clinical research is critical to the future of medicine. Though researchers work behind the scenes, their discoveries are essential to curing a myriad of illnesses. These innovations would still be for naught, however, if not for the brave patients who agree to participate in clinical trials designed to prove a treatment's efficacy and safety. As part of US Oncology, Cancer Care Centers of South Texas offers clinical trials for a wide range of malignancies, including numerous trials for breast cancer. By participating in these trials, patients not only receive cutting-edge treatments before they are commonplace, but they also make their mark on the future of cancer care.

For several years, physicians have treated breast cancer using methods that interrupt tumor growth by attacking

receptors that feed estrogen to the tumor. Though these medicines are highly effective, in many cases, the strategy only works for a limited amount of time. Recent research has explained why this form of therapy can fail. "There are many pathways that exist intracellularly that can influence growth in spite of receptor blockade at the entry site of cancer cells," explained Sharon Wilks, MD, FACP. "There may be some mechanisms that work in a direct path like an assembly line, and then there may be alternate paths that growth signals will take, that may lead to failure of cell death and resilience of tumor-cell survival. The complexity of tumor growth not only relies upon receptor activation/inactivation and intracellular pathways, but also on the microenvironment, including the bone environment, vascular growth patterns, intactness of the immune system and a multitude of other factors that promote tumor survival." As researchers learn more about the complexities of cancer growth, they can apply their newfound knowledge to create treatments that may ultimately cure cancer — but only through clinical testing can these new measures be proven effective.

CCCST often has 10 to 15 breast trials open at any given time. "Currently, depending upon the disease presentation, we have a clinical trial for almost every breast cancer type and breast cancer stage," Wilks noted.

However, the practice tries to keep the trial lengths



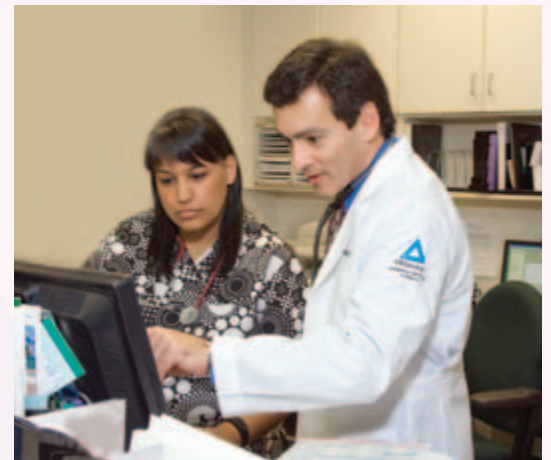
Sharon T. Wilks, MD, FACP



Allyson L. Harroff, MD

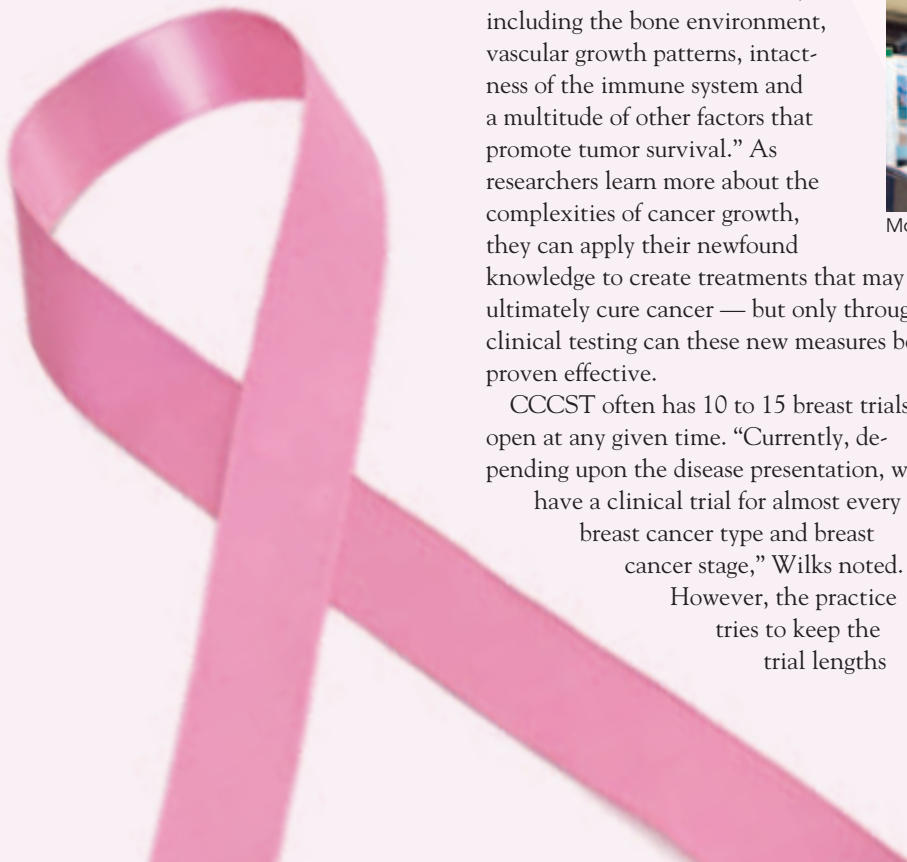
relatively short — ranging from several months to a year — in order to ensure the data's accuracy. "With trials that drag out over long periods of time, so many factors change," Allyson Harroff, MD, remarked. "The field of oncology moves so quickly that, over four or five years, standards of care may have dramatically changed, and the data may not be valid or useful."

CCCST is currently involved with several trials that implement targeted therapies to control cancer. Particularly



Manuel A. Santiago, MD

promising are the practice's trials targeting patients with HER2 breast cancer. "Research in this type of breast cancer is moving very quickly," Harroff said, noting that patients with HER2/neu-positive cancer tend to have very aggressive forms of the disease. One of these trials uses everolimus, a pill with minimal side effects, to treat patients who have acquired resistance to Herceptin®. "With the use of everolimus, which bypasses the resistance to Herceptin inhibition of the HER2 signal, the tumor cells become sensitive to Herceptin again," Wilks explained. "If our Phase III study shows

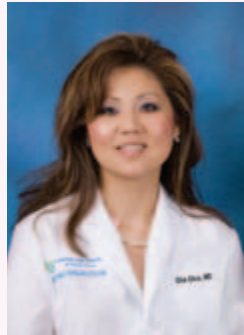


value, this will be an extraordinary move in improving the treatment of aggressive and lethal cancers.” Another promising treatment for HER2/neu-positive breast cancer is trastuzumab-DM1 (TDM-1). CCCST is currently conducting the only TDM-1 study for adjuvant use in South Texas, as well as a TDM-1 study for metastatic HER2/neu disease.

Other clinical trials that CCCST is proud to be part of include a trial examining the use of dasatinib — a form of chemotherapy currently approved for patients with chronic myelogenous leukemia — in treating breast cancer patients with estrogen receptor-positive tumors that seem to be resistant to anti-estrogen therapy. “It appears that dasatinib blocks Src pathways that are known to induce resistance in estrogen receptor-positive pathways,” Wilks noted.

The practice is also currently participating in a Phase III study examining potential uses for denosumab, a drug known to be a RANK ligand inhibitor. “Osteoporosis remains a big problem

for women with breast cancer,” Wilks explained. “Though this drug appears to work on the bone tree, there are observations that it may also prevent tumor growth, and so the aim of this study is to look at prevention of bone fractures and to determine if there are less breast cancer relapses in patients who receive this drug.”



Gia Dice, MD

Though every trial has inclusion and exclusion criteria, and subjects must have good performance status to participate, patients with an interest in research are often the most excited about the practice’s wide variety of available clinical trials. Harroff also noted that patients with an atypical form of breast cancer, as well as young patients, may benefit the most from the trials. “That way, we can gather more information about them rather than lumping them in with all breast cancer patients,” she explained.

Harroff cited patients with triple-negative breast cancer as a specific subgroup that tends to find clinical trials

particularly beneficial. Triple-negative breast cancer, which refers to an absence of receptors for estrogen, progesterone and HER2/neu, metastasizes quickly and is frequently unreceptive to traditional chemotherapy drugs. “It’s very difficult to treat, but sometimes, through clinical trials, we have treatment options that are effective but are otherwise not available,” Harroff explained. Today, CCCST is one of the only sites in South Texas that offers a trial for patients with recurrent triple-negative disease, testing a drug called BSI-201 (iniparib).

Patients who participate in the clinical trials offered by CCCST tend to be highly satisfied with their experience. “The patient has to be very motivated to do a trial, so those who are motivated to participate in an initial trial are often motivated to continue to participate,” Harroff said. “They feel like they personally get enough out of the experience to participate in multiple trials.”

For more information about CCCST’s extensive clinical trial program, please visit www.CancerCareSouthTexas.com.

Article written by Alexandria Lopez

A Patient’s Perspective

In December 2010, Vicky Ishihara decided to participate in one of CCCST’s clinical trials of TDM-1. Initially, Dr. Wilks had discussed the possibility of participating in two different trials with Ishihara. “She said I was a good candidate for both trials because I’m very healthy. I exercise and I try to eat healthy,” Ishihara said.

Ishihara ultimately decided to participate in clinical trials in order to help future patients. “Anything that’s going to help anyone else and keep them from going through what I went through, I think we need to go in that direction,” she said, noting that she believes TDM-1 will be a major player in the future treatment of breast cancer. “If it’s a better medicine than what’s out there already, then we’ve made progress.”

Though Ishihara will continue to participate in the study until December 2011, so far, she’s had no problems related to the clinical trial. “The side effects have been really mild — maybe a little fatigue, but that’s the extent of it,” she remarked.

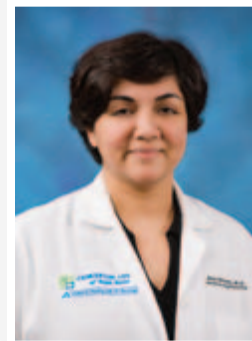
Her experience working with the CCCST clinical research team has also been positive. “I’m very satisfied,” she said. “The doctors and nurses are wonderful. It’s very exciting.”

Ishihara recommends that other patients should consider participating in CCCST’s clinical trials, adding, though, that a healthy lifestyle also helps in battling cancer. “I was fortunate to be in pretty good condition when I got this disease,” she acknowledged. “Physically and emotionally, that’s really helped — not just a little bit, but by leaps and bounds. I think there’s a tendency for people to hunker down when they get cancer, and they should really do the opposite: get ready for it mentally and physically.”



WHAT PRIMARY CARE AND EMERGENCY PHYSICIANS NEED TO KNOW:

Oncology Emergencies for the Non-Oncologist



Anu Dham, MD

According to an article in the November 2009 edition of *Community Oncology*, the number of cancer patients in the United States is projected to increase from 11.8 million in 2005 to 18.2 million in 2020 — a jump of more than 35 percent in just 15 years.

As the populations of cancer patients and cancer survivors continue to grow, it becomes more important than ever before for physicians on the front lines of health care — such as primary care physicians and physicians in hospital emergency departments — to be able to recognize symptoms related to their patients' cancers as well as symptoms that manifest as a result of their cancer-treatment regimens.

WHAT IS AN ONCOLOGIC EMERGENCY?

Frequently, when a cancer patient seeks medical attention from a non-oncologic medical professional, he or she is experiencing an oncologic emergency. As written by John C. Morris, MD, and James F. Holland, MD, in the "Oncologic Emergencies" chapter of *Holland-Frei Cancer Medicine, 5th Edition*:

An oncologic emergency is defined as any acute, potentially life-threatening event, either directly or indirectly related to a patient's cancer or its treatment. This event, if not anticipated, quickly recognized, and effectively treated, may rapidly result in permanent morbidity or the death of the patient.

Anu Dham, MD, medical oncologist at Cancer Care Centers of South Texas, said cancer patients are at a unique risk of serious complications. "Oncological emergencies are common conditions associated with significant morbidity and mortality," she noted. "Cancer itself, cancer-related hormones or cytokines, or treatment effects can cause emergency problems."

HOW ARE PRIMARY CARE AND EMERGENCY PHYSICIANS INVOLVED?

Despite the ever-present need for cancer patients to be seen by their oncologists, non-oncological medical professionals are often greatly involved in these patients' ongoing medical care.

According to a study published in the *Journal of General Internal Medicine* in 2009, 90 percent of primary care physicians directly managed or co-managed various aspects of the general medical care of their patients with cancer, including comorbid conditions, chronic pain and do-not-resuscitate orders. In addition, more than 50 percent of these physicians participated in their patients' choices of treatment and surgeries, and 19 percent reported heavy involvement with patients during the course of cancer treatment.

WHAT ARE COMMON SYMPTOMS RELATED TO CANCER AND/OR TREATMENTS?

As with any patient with a complex medical condition, not every symptom will be directly related to a cancer patient's disease or treatment regimen. However, non-oncologic medical professionals should be aware of the patient's cancer diagnosis and treatment plan before treating symptoms in order to most effectively aid the patient.

Patients with cancer may develop the following symptoms as a direct result of their disease:

- Headache
- Fever
- Back pain
- Pain
- Weakness
- Changes in mental status (confusion, disorientation, delirium, etc.)

Common symptoms that arise as a result of cancer-treatment regimens are the following:

- Neutropenia
- Diarrhea
- Vomiting

For more detailed information on common cancer-related medical emergencies, please see the table on page 10.

COMMUNICATION IS KEY

For the cancer patient to receive the best care possible, everyone involved in his or her medical care must be on the same page. The primary care physician, the emergency-room physician, the attending physician in the hospital, the oncologist — all of these individuals must actively communicate to tailor the treatment plan to the patient’s needs.

Dham pointed out the difficulties of maintaining the lines of communication while emphasizing the need to do so. “Health care delivery becomes more complex at the end of life, and cancer patients may make several visits to the emergency room and may receive fragmented and ineffective care,” she explained. “Important issues regarding the stage of cancer, the response to treatment, prognosis, and the wishes of the patient and family should be effectively communicated to the health care team by the oncologist and may prevent futile intervention in advanced disease.”

Unfortunately, according to an article by Eva Grunfeld, a member of the Division of Medical Oncology at Dalhousie University’s Department of Medicine, in the May 2008 edition of the *Journal of Clinical Oncology*, a lack of this sort of communication between the aforementioned medical team members is a recurring trend in medical literature. However, Grunfeld also writes that recent advances in medical technology, such as the growing use of electronic medical records, may help increase the frequency and effectiveness of such communication.

PART OF AN ONGOING TEAM EFFORT

The growing number of cancer patients and survivors and the well-documented lack of medical professionals necessary to treat them indicate a growing need for the involvement of more than just the treating oncologist in successful cancer-treatment plans, Dham said. “As the incidence of cancer increases and the focus of

SUMMARY OF ONCOLOGIC EMERGENCIES

Emergency	Associated Cancer or Cause	Signs and Symptoms
Metabolic		
Hypercalcemia of malignancy	Lung, breast, and kidney cancers; multiple myeloma	Fatigue, anorexia, nausea, vomiting, constipation, mental decline, renal failure, coma, myalgia, headache, altered sensorium
Syndrome of inappropriate antidiuretic hormone	Bronchogenic carcinoma	Anorexia, nausea, vomiting, constipation, muscle weakness, myalgia, polyuria, polydipsia, severe neurologic symptoms (e.g., seizures, coma)
Tumor lysis syndrome	Hematologic malignancies; cancers with rapidly growing tumors, particularly acute leukemias and high-grade lymphoma	Azotemia, acidosis, hyperphosphatemia, hyperkalemia, acute renal failure, hypocalcemia
Hematologic		
Febrile neutropenia	Chemotherapy-associated bacterial or fungal infections	Temperature greater than 101° F (38.3° C), absolute neutrophil count less than 500 per mm ³ (0.5 X 10 ⁹ per L)
Hyperviscosity syndrome	Waldenström’s macroglobulinemia, multiple myeloma, leukemia	Spontaneous bleeding, “sausage-like” hemorrhagic retinal veins, neurologic defects, serum viscosity levels greater than 5 cP
Structural		
Epidural spinal cord compression	Breast, lung, renal, and prostate cancers and myeloma	New back pain that worsens when lying down, late paraplegia, late incontinence, and loss of sensory function
Malignant pericardial effusion	Metastatic lung and breast cancer, melanoma, leukemia, lymphoma, chemotherapy to the chest wall	Dyspnea, fatigue, distended neck veins, distant heart sounds, tachycardia, orthopnea, narrow pulse pressure, pulsus paradoxus, water-bottle heart
Superior vena cava syndrome	Lung cancer, metastatic mediastinal tumors, lymphoma, indwelling venous catheters	Cough; dyspnea; dysphagia; head, neck, or upper extremity swelling or discoloration; development of collateral venous circulation
Side Effects from Treatment Agents		
Diarrhea	Chemotherapy	Dehydration, poor skin turgor, dry mucous membranes, weight loss
Extravasations	Current chemotherapy infusion	Pain and erythema at infusion site, swelling, necrosis, contractures
Obstipation	Narcotic medications, chemotherapy (specifically neurotoxic agents)	Abdominal pain, constipation, hard stools every three to five days

COMMON ONCOLOGIC EMERGENCIES

- Metabolic complications: hypercalcemia, hyperuricemia, SIADH, hyponatremia, renal failure, tumor lysis
- Neurological emergencies: cord compression, brain metastasis, increased intracranial pressure, leptomeningeal disease
- Cardiovascular: pericardial effusion and tamponade, SVC syndrome
- Hyperviscosity due to monoclonal protein or hyperleucocytosis and leukostasis
- Coagulopathy, pancytopenia, bleeding secondary to thrombocytopenia, acute hemolytic anemia, TTP
- Infectious: neutropenic fever, line sepsis, typhillitis



David J. Friedman, MD, PhD

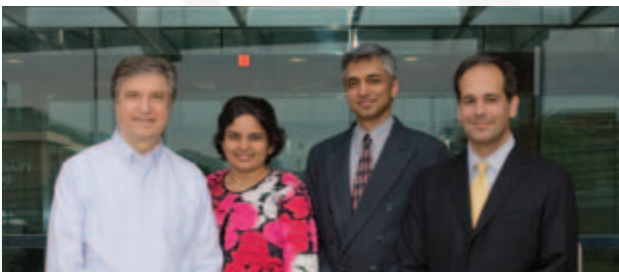
care shifts to outpatient practice, all physicians involved in the care of cancer patients must be sensitive to life-threatening conditions that require urgent action to avoid morbidity," she added.

This approach is of the utmost importance to Cancer Care Centers of South Texas. As stated on the practice's website, "Our practice of skilled physicians offer a consultative, multi-specialty team approach.

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With Cancer Care Centers of South Texas providing the best oncological treatment services available, combined with the ongoing care and expertise of non-oncological medical professionals, patients have the best possible chance of successfully treating — and beating — their cancer.

Article written by Michael Adkins



CCCST – New Braunfels: Alexander Zweibach, MD, PhD; Sreedevi Daggubati, MD; Ather Siddiqi, MD; and Jason B. Kaplan, MD



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Gregory G. Guzley, MD, FACP

“First, Do No Harm”

ALTERNATIVE CANCER TREATMENTS AND THEIR EFFECT ON PATIENT WELL-BEING

The poet Emily Dickinson once famously described hope as “the thing with feathers that perches in the soul — and sings the tunes without the words — and never stops at all.” Dickinson’s depiction of unceasing hope offers encouragement to people who are faced with seemingly insurmountable challenges, including cancer and other major illnesses. But just as hope can strengthen people in the face of adversity, it can also be dangerous. Unfounded hope that is not tempered by knowledge may lead cancer patients to seek healing from a wide range of alternative treatments that are ineffective at best and may be harmful.

Gregory Guzley, MD, has been studying alternative cancer treatments since the early 1980s. Though the terms are often incorrectly used interchangeably, there is an important distinction between alternative treatments and complementary treatments. “Alternative treatments are treatments that people use in place of more standard treatments. Complementary treatments are used in association with more standard treatment options for cancer, usually for symptom control,” Guzley explained, citing the use of ginger and peppermint for post-chemotherapy nausea relief as an example of a complementary treatment.

Alternative treatments fall into multiple categories, including, as examples, nutritional support, immune stimulation, detoxification programs and spiritual

healings. “There’s such a huge variety of alternative treatments out there that I can’t say there’s one specific treatment that’s most prevalent, but a lot of people do ask me about nutrition and nutritional support,” Guzley acknowledged. One of the best-known forms of nutritional support promoted as an alternative treatment for cancer is the macrobiotic diet, a regimen that originally encompassed 10 increasingly restrictive diets. In Guzley’s 1992 article, “Alternative Cancer Treatments: Impact of Unorthodox Therapy on the Patient with Cancer,” published in the *Southern Medical Journal*, he writes that some variations of the diet were severely nutritionally deficient, such as “Number 7,” which consisted of brown rice and minimal liquids. These more restrictive versions often worsened patients’ overall condition and could cause their health to deteriorate rapidly.

Today, adherents to a macrobiotic diet are encouraged to primarily eat organic whole grains, accompanied by organic and locally produced fruits and vegetables. Meat, sugar, dairy, coffee and processed foods are discouraged. According to the American Cancer Society, there is no available scientific evidence suggesting that the macrobiotic diet is an effective cancer treatment, and no randomized clinical studies have been published to support this claim. “I think physicians are more aware of good nutritional practices in the

sense of helping the patient feel better, not as a way to cure cancer,” Guzley said.

Patients who adhere to the belief that metabolic balance is an effective means of fighting cancer may also be tempted to undergo dangerous detoxification treatments, such as enemas or high colonics. “With colonics, there are three big risks that come to mind,” Guzley explained. “You could perforate the colon, you could get water intoxication, and you could get an infection without proper sterilization of the colonic equipment.” There is no scientific evidence that points to colonics or enemas as viable methods of treating cancer.

One of the most infamous alternative cancer treatments, laetrile, a derivative of amygdalin, has been a source of medical controversy for decades. According to Guzley, amygdalin belongs to a class of compounds known as cyanogenic glycosides and contains 6 percent hydrogen cyanide by weight. Found in the seeds of apricots, peaches and plums, it is claimed to shrink tumors. Of the treatment, he writes, “Laetrile is not a nontoxic compound. In human beings, it has induced agranulocytosis, neuromyopathy and fatal acute cyanide toxicity.” Though the National Cancer Institute has performed repeated clinical trials of laetrile, the treatment, not approved by the U.S. Food and Drug Administration (FDA), has not proven beneficial. However, it is still manufactured and used as a cancer

treatment in Mexico, where it is given intravenously and orally.

The use of herbs and supplements to treat cancer is another alternative treatment method that is commonplace. It is critical that physicians remain aware of any herbs or supplements their patients may be taking to avoid potential drug interactions and dangerous side effects. "Most people think that 'natural' equals 'good,' but that's not necessarily true, and it's certainly not necessarily safe," Guzley stressed. Under current federal law, the FDA is prohibited from testing herbs and supplements for safety and efficacy before they go on the market; instead, it is limited to pulling these products from shelves if problems arise for consumers. "They are drugs — they aren't regulated or labeled as drugs — but they have effects on different parts of the body, and some of those effects are bad," Guzley explained.

If physicians are not aware of every treatment a patient has undergone, serious complications caused by treatment interactions can easily occur. "I've had patients who've had horrendous post-operative bleeding problems from the use of specific supplements," Guzley said. "Lots of people take St. John's Wort, and it neutralizes some types of chemotherapy, as well as medicines we use to prevent rejection of organ transplants, and can even neutralize some forms of birth control pills. I tell my patients, 'If it goes in your body, I have to know about it. I want to know absolutely everything you're taking.'"

Makers of alternative treatments do not routinely submit their products for clinical trials, "There are testimonials

and reports where people claim there's a benefit from certain alternative treatments, but these results haven't been reproduced in clinical trials," Guzley explained.

When patients ask Guzley about alternative treatments, he encourages them to show him data proving the treatment's efficacy. "I tell them, 'If you can show me the data that this stuff works, I'm happy to look at it and evaluate it. If you can't, it's going to be really difficult to justify making it a standard part of treatment.'"

Sadly, alternative cancer treatments are not only ineffective and potentially dangerous, but they also steal a precious resource from patients: time.

"Patients may have a curable cancer at their initial diagnosis, and then they can allow it to spread well beyond a curative state by delaying effective treatment," Guzley said. It's easy for patients to get blindsided by false promises of "miracle cures" when battling cancer. Hope can be found in the proven treatments offered by mainstream medicine, proven through clinical research at reputable centers to be safe and effective, but not in the unsubstantiated claims of alternative treatments.

Article written by Alexandria Lopez



Vijay K. Gunuganti, MD



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J. Brant Ellis, MD

Colon Cancer

SCREENING AND EARLY DETECTION ENSURE BEST OUTCOMES

For cancer that affects both men and women, colon cancer is the second-leading cause of cancer-related death in the United States. With thousands of Americans diagnosed each year, it is important for physicians to properly screen patients and identify those who are most at risk for the disease. Although treatment for metastatic colon cancer is available, the best outcomes for patients rely on treating the disease before metastasis occurs.

BASIC INFORMATION

Colon cancer typically begins as a polyp that emerges in the colon or rectum. These polyps are usually benign, but their presence can lead to an increased risk of colon cancer. According to J. Brant Ellis, MD, oncologist with Cancer Care Centers of South Texas, “Polyps are a predecessor of the primary carcinoma of the colon, and decreased risk can be obtained by removing polyps that could become malignant at a later date.”

RISK FACTORS AND WARNING SIGNS

Like many other cancers, advanced age plays a role in colon cancer risk. Colon cancer is most common in patients ages 50 and older, with incidence rates peaking at age 65. Early detection and treatment are important, as the disease’s progression from precancerous polyp to malignant tumor can take between 10 and 20 years.

Patients’ risk factors for developing colon polyps and/or colon cancer include:

- A family history of colon polyps or colon cancer
- Past history of cancer in the patient, particularly cancers of the ovary, uterus or breast in women
- Inflammatory bowel diseases
- Genetic syndromes like familial adenomatous polyposis or hereditary nonpolyposis colon cancer

In early-stage colon cancer, an in-office physical examination may show nothing more than fatigue or weight loss — or nothing at all. In advanced cases, the patient may exhibit:

- Iron-deficiency anemia
- Bleeding from the rectum

- Abdominal pain
- Bowel-habit changes
- Intestinal obstructions/perforations
- Palpable abdominal mass
- Hepatomegaly
- Ascites

If these symptoms are present, a referral to an oncologist is warranted.

SCREENING

According to the U.S. Preventive Services Task Force, physicians should begin screening patients for colon cancer at age 50 and continue through age 75. Patients at higher risk because of any of the factors noted above should be screened at a younger age and more frequently than the average patient. These patients should be screened regularly using high-sensitivity fecal occult blood testing (FOBT), flexible sigmoidoscopy and/or a colonoscopy.

Fecal Occult Blood Testing

Guaiac FOBT checks for the presence of heme in stool, and immunochemical FOBT uses antibodies to detect hemoglobin protein. The CDC recommends conducting this test annually.

Flexible Sigmoidoscopy

The CDC recommends conducting this test every five years on its own or every three years in conjunction with an FOBT. Finding a polyp larger than 1 centimeter in diameter indicates a need to examine the entire colon with a colonoscopy, because 30 percent to 50 percent of patients with a polyp of this size will have additional polyps.

Colonoscopy

Ellis suggested that colonoscopy is the most efficient screening method, “because not only is the full colon evalu-



Suneetha Challagundla, MD

ated, but if polyps are present, they may be removed.”

The CDC recommends conducting a follow-up colonoscopy every 10 years for at-risk patients whose colonoscopies are negative. After removal of a large polyp — larger than 2 centimeters — a repeat colonoscopy should be performed in three to four months. If multiple benign polyps are removed, another colonoscopy should be performed in one year. If only one polyp is removed, or if the first colonoscopy after removing multiple polyps is negative, a follow-up colonoscopy should be scheduled every three years.

METASTATIC COLON CANCER

If a polyp or cancer is discovered early enough in a patient, the condition can be treated through surgical removal of the growth, removal of the cancerous section of the colon, chemotherapy and radiotherapy as directed by an oncologist. However, as Ellis noted, treatment of metastatic colon cancer is primarily palliative in nature.



J. Dean McCracken, MD, FACP

The historic survival time for patients with metastatic colon cancer was approximately nine months, Ellis said, but he added that the development of fluorouracil associated with leucovorin and subsequent chemotherapy medications, added to a regimen including oxaliplatin and

irinotecan, has significantly improved patients’ response rates and survival times.

“In addition, even more recently was the development of the VEGF antibodies,” Ellis continued. “These are antibodies to vasoactive endothelial growth factor, which is made by the tumor to stimulate blood vessel growth toward it.” Ellis noted that using drugs that block angiogenesis, such as Avastin®, has “significantly increased the long-term response and survival of patients with metastatic colon cancer.”

THE BOTTOM LINE – KEEPING PATIENTS SAFE AND HEALTHY

Treatments for metastatic colon cancer have improved in recent years, and patients whose cancer has spread now have more options than ever before. However, effective screening methods and treating colon cancer early is still the best way to keep patients living active, healthy lives for many years to come.

For more information about referring patients to an oncologist at Cancer Care Centers of South Texas, visit www.CancerCareSouthTexas.com.

Article written by Michael Adkins



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Sharon T. Wilks, MD, FACP

Radiation Oncology

Michael Gagnon, MD

North Central

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Vijay K. Gunuganti, MD
Allyson L. Harroff, MD

Southeast

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Thomas D. Fisher, MD
Ed L. Hesita, MD
Arun R. Rao, MD

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J. Dean McCracken, MD, FACP
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Medical Oncology/Hematology

David J. Friedman, MD, PhD

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