

thrive

BONE DEEP

Advice for keeping
bones healthy after
cancer treatment



thrive

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On the cover: Susan McDonald took her doctor's advice and improved her bone health by walking more.



Laura Galunas, Anne Marshall and Karen Hammelef discuss the Cancer Center's new Patient & Family Advisory Board.

Offering the Patient's Perspective

Patient & Family Advisory Board provides new opportunity for input

On the day of her first appointment at the University of Michigan Comprehensive Cancer Center, Anne Marshall remembers pulling into the parking lot, nervous and afraid. She had been to the center many times before with her mother, who was diagnosed with breast cancer in 2006; but pulling into the circle drive felt different when the breast cancer diagnosis was her own.

Then she met Cleon Abrams, a longtime parking attendant at the Cancer Center.

"I was surprised he remembered me," said Marshall, who is a social worker. "He just had this perfect smile and said, 'Be encouraged.'"

Those two words made all the difference to Marshall. Not only did they give her the boost she needed at that moment, but it led her to become more engaged in the Cancer Center and its efforts to provide the ideal patient care experience. Recently, Marshall was a member of a task force to establish bylaws for the Cancer Center's new Patient & Family Advisory Board. The board is designed to offer patients and families a formal role in providing input into the institution's initiatives and operations.


The new board furthers the Cancer Center's mission for providing patient-centered care—a movement whose motto is "Nothing about me without me"—said Karen Hammelef, R.N., M.S., director of Patient & Family Support Services. Beginning this fall, the board will provide input on a variety of Cancer Center issues, including policies, facility design and educational materials.

"We want to make sure we have patient voices represented in a formal way to ensure that we understand the patient experience and that we're not speaking for them," Hammelef said.

For example, said Laura Galunas, M.S.N., R.N., a nurse manager in an inpatient unit on Level 8B of University Hospital, the nursing staff would like to include patients in discussions that occur at the end of every nursing shift to ensure the incoming nurse is up-to-date on the patient's status. The Patient & Family Advisory Board could help the nursing staff learn how this change will impact families, Galunas said.

"Only patients have the first-hand experience to provide that kind of information to us," Galunas said.

Jim Morgan, a Patient & Family Advisory Board task force member, said he thinks the board will allow patients and families to use their unique talents to help improve the patient care experience. Morgan, who is global director of body and stamping engineering for Ford Motor Co. and a sarcoma survivor, said his background allows him to provide ideas to streamline information management. In the business world, he said, the companies that respond to customers' voices are the ones that succeed; the same holds true for health systems and patients.

"I have this desire to give back whatever I can to make other people's experiences as good as they can be," Morgan said. "Cancer treatment is an extremely tough thing to go through—not only for the patient but for the whole family. If there's something I can do to improve that experience, I'm motivated to do that." 



To learn more about the Patient & Family Advisory Board and how you can participate, call 734-936-0434, email Cancer-Support-Services@med.umich.edu or visit mCancer.org/Volunteer.

WHAT'S THE FALLOUT?

A U-M radiologist answers questions about the risks of commonplace exposure to radiation



For some cancer survivors, commonplace exposure to radiation induces pangs of worry. Will the chest X-ray ordered by a family doctor or a trip through the airport's new security scanner increase your chance of developing a secondary cancer? What can you do to reduce your risks?

We talked with Ella Kazerooni, M.D., University of Michigan professor of radiology, about what people with cancer should know about everyday radiation exposure. Here's what she had to say.

Q: RADIATION IS KNOWN TO CAUSE CANCER. AND YET MANY IMAGING TESTS, SUCH AS X-RAYS AND CT SCANS, EXPOSE PATIENTS TO RADIATION. SHOULD PATIENTS BE WARY OF THESE TYPES OF TESTS?

A: I wouldn't let the fact that a patient has had cancer in the past impact whether diagnostic imaging is appropriate. For every test, you have to weigh the risks and benefits. Patients should always feel empowered to ask their doctors, "Why is this test important and what are you trying to learn from it?" If the test is not likely to change a patient's treatment, then maybe it's not necessary.



Ella Kazerooni, M.D., addresses questions about radiation exposure and cancer risk.

Q: CAN YOU GIVE US AN EXAMPLE OF WHEN A TEST MIGHT NOT BE NECESSARY?

A: For example, take a primary care doctor treating a patient with a new cough. It may be that based on the patient's other symptoms, like a fever, the doctor would give the patient antibiotics regardless of what the chest X-ray shows. On the other hand, maybe the patient has had cancer in the chest and the symptoms could be related to a recurrence. Then the test becomes more important. The benefit of detecting cancer at an earlier stage when it's more treatable outweighs the risks of any radiation associated with the exam in this case.

Q: IS IT WORTH THE RISK TO UNDERGO ROUTINE TESTS TO MONITOR FOR CANCER RECURRENCE?

A: Cancer patients often undergo surveillance CT examinations after they have been declared disease-free to look for early signs



of recurrence. At some point, after being disease-free for several years, it may not be beneficial to continue to have these CT scans. Again, asking your physician about why the CT is being done is important.

Q: RECENTLY, THE U.S. TRANSPORTATION SECURITY ADMINISTRATION INSTALLED FULL-BODY SCANNERS AT AIRPORTS. SHOULD WE BE CONCERNED ABOUT RADIATION EXPOSURE EMITTED BY THE SCANNERS?

A: The American College of Radiology issued a very thoughtful statement about this. If the TSA is operating the equipment and performing quality control as required, the doses the machines deliver are extremely small. The radiation exposure from the airport screening scan is much lower than what you get when you travel by airplane.

Q: QUALITY CONTROL IS OBVIOUSLY IMPORTANT IN ANY CIRCUMSTANCE

WHERE RADIATION IS BEING DELIVERED. HOW CAN PEOPLE MAKE SURE THE MEDICAL FACILITIES WHERE THEY RECEIVE DIAGNOSTIC TESTS ARE MAINTAINING EQUIPMENT PROPERLY AND DELIVERING THE RIGHT DOSES OF RADIATION?

A: Patients can ask if their imaging facility has been accredited. The Centers for Medicare and Medicaid Services has approved three bodies to accredit diagnostic imaging programs: the American College of Radiology, the Intersocietal Accreditation Commission and The Joint Commission. These accreditation programs examine the equipment itself, the physicists who test the equipment, the technologists who operate the equipment and the physicians who interpret examinations. So far, this accreditation

process is mandatory for outpatient facilities only, but it is very likely to become mandatory for hospitals, too. The University of Michigan has received ACR accreditation for many of our facilities already, both in the outpatient setting and at the hospital. We expect that by the end of this year, all of our facilities will be accredited.

Q: WHAT'S INVOLVED IN THE ACCREDITATION PROCESS?

A: Accreditation requires everything from ensuring the machine works properly and delivers the proper level of exposure to the professional staff's credentials for running the machines, the doctors' credentials for interpreting the scans and the physicists' credentials for monitoring the machines. The process is rigorous. Regardless of whether the facility has undergone accreditation, we are dedicated to maintaining the same high standards for all of our radiology clinics. **T**



Susan McDonald has always incorporated a lot of dairy products into her diet to maintain bone health.

Bone deep

Learn how to keep bones healthy even if cancer treatment has increased your risk for osteoporosis



Normal Bone Matrix

The results of Susan McDonald's bone mineral density screening were troubling. Bone density had decreased 3 percent in her spine and 3.6 percent in her hips since a scan done two years earlier. Given her history of breast cancer and the potential that related treatments might further sap her bones' strength, McDonald needed a plan to improve her bone health.

Her oncologist, Catherine Van Poznak, M.D., outlined some options to address the thinning in her bones, which in the case of her hips had progressed to a precursor of osteoporosis called osteopenia. McDonald, a 72-year-old Ann Arbor resident, decided to make a concerted effort to increase her walks from 20 minutes to 30 minutes per day, covering about a mile-and-a-half to a mile-and-three-quarters during each outing.

Two years later, McDonald's bone mineral density was much improved.

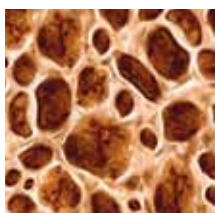
"I'm a small, fine-boned woman who's likely to get in trouble with bone problems," McDonald said. "But they were talking about osteopenia in my hips two years ago; they're not saying that anymore."

Bone health may be of particular concern for people with a history of cancer, said Van Poznak, a University of Michigan Comprehensive Cancer Center oncologist who specializes in breast cancer's relationship to bone. People with breast or prostate cancer who undergo treatments that block specific hormones may be at higher risk of thinning bones. Also, certain chemotherapy drugs used to treat these or other cancers may induce ovarian failure in younger women, causing bones to thin as a result of early menopause and estrogen deprivation. In addition, steroids may also accelerate bone loss in both men and women.

Although cancer treatment may increase the likelihood of developing osteoporosis—which may lead to painful bone fractures—many options are available to prevent it, Van Poznak said. The key is to talk to your doctor early to develop a plan of action. Here are six steps you can take to improve your bone health.

Talk with your doctor about your risk of osteoporosis. You may be at higher risk depending on your family history, diet and whether you have ever smoked. Women older than 65 and men older than 70 are generally at higher risk. White people also seem to have an increased risk.

A bone mineral density screening may be right for you, depending on your risk factors. An X-ray of your hip, lower spine and wrist will help establish your risk of fracture and guide your doctor in planning any follow-up treatment that may be necessary. Several medications are now available to treat osteopenia and osteoporosis. Some of these drugs—bisphosphonates and denosumab—are being studied in clinical trials to see if they can help to prevent cancer from spreading to the bones. These same drugs are used to decrease the risk of fractures when cancer involves the bones. When used to treat bone metastases, the dose and schedule of these drugs is more intensive than when treating osteoporosis.




Osteoporosis

Consider a vitamin D supplement. Vitamin D also plays a vital role in bone health and is often not as readily available in an average diet, unless you drink fortified milk or orange juice. Most people need between 400 IU and 800 IU per day.

Add weight-bearing exercise to your routine. Gravity helps encourage bones to become denser at areas that support weight, so make sure you incorporate weight-bearing exercise into your workouts. Walking is an excellent option, particularly when carrying hand weights.

Avoid tobacco and alcohol. Tobacco use and excessive alcohol consumption have both been associated with bone loss.

Get your daily dose of calcium. Recommendations vary based on age, but most people need between 1000 mg and 1200 mg per day of calcium. Ideally, calcium is consumed as part of a well-balanced diet that includes dairy products rich in calcium. However, many people benefit from the use of supplements. Calcium is best absorbed in portions of 400 mg to 600 mg at a time, so plan to take it in divided doses throughout the day. 



“ They were talking about osteopenia in my hips two years ago; they’re not saying that anymore.”

—Susan McDonald

RESEARCH SPOTLIGHT

KEEPING CANCER OUT OF THE BONE

Evan Keller, D.V.M., Ph.D., a professor of urology and co-director of the Prostate Oncology Program at the University of Michigan Comprehensive Cancer Center, is working with several other researchers to examine why prostate cancer spreads to the bones. The goal of their work is to develop drugs that can interfere with the biological processes that cause bone metastasis.

The team has already had some success: Keller’s group conducted early laboratory studies on denosumab, a drug now known commercially as Xgeva, that prevents bone fractures and other skeletal conditions in people with breast and prostate cancer that has spread to the bone. The drug alleviates bone pain and decreases the need for pain medication.

“If we can prevent cancer cells from getting into the bone, we could enhance cancer patients’ quality of life,” Keller said. “If we can slow down cancer’s growth and slow down bone destruction, we can increase survival.”





Supply and demand

U-M pharmacists, doctors collaborate to ensure patients get drugs they need, despite shortages

After Shawn Burr became a patient at the University of Michigan Comprehensive Cancer Center, his doctor asked an unusual question: Would he be able to bring his own chemotherapy drug?

The Cancer Center—like many institutions throughout the country—was facing a daunting shortage of cytarabine, a generic chemotherapy drug that is instrumental in treating acute myeloid leukemia, the form of cancer Burr has. Two of the three companies that make cytarabine had run into manufacturing problems: One couldn't obtain the raw materials necessary; the other had to recall batches because of quality concerns. The third company couldn't keep up with the resulting demand.

And so, when it became clear to Sherry DeLoach, a pharmacist who coordinates drug purchasing for the U-M Health System, that stocks were running low, she notified the oncology pharmacists. They, in turn, met with the doctors whose patients use cytarabine to develop a strategy to ensure that every patient who needed the drug received it. One piece of this plan, among many others, was to ask newly referred patients if they could obtain the drug from their current health-care provider.

U-M would have provided Burr with the drug regardless of his answer. But Burr's care team at St. Joseph Mercy Port Huron Hospital was able to lend U-M enough cytarabine to accommodate his treatment.

"It's a pretty hopeless feeling," Burr said. "Usually, you think health care is all about money, but when it comes to generics, there's not a lot you can do if drug companies decide they aren't going to make a drug anymore. There needs to be some policy put in place to protect patients."

Drug shortages in all areas of medicine have become more common during the past several years, according to Erin Fox, chair-elect of the American Society of Health-System Pharmacists and manager of the University of Utah Drug Information Service. In 2001, 120 new shortages were reported; in 2010, there were 211. Twenty-three of the 2010 shortages—11 percent—involved chemotherapy drugs.

Although the Cancer Center has experienced several drug shortages since 2008, no patients have had to go without drugs that were essential to their care, said Kelly Wright, a pharmacist and manager of the Cancer Center's ambulatory infusion areas.

"We are doing all that we can to make sure our patients have the drugs they need," Wright said. "Every drug shortage has a different story; they're not all the same. But we are working closely with our clinicians—who in many cases are leaders in their fields—to develop ways to manage these shortages to ensure we are still providing the very best care possible."

Once doctors are notified of a potential shortage, said Jeffrey Smerage, M.D., Ph.D., medical director of the Cancer Center's infusion areas, the first thing doctors consider is who derives the greatest benefit from the drug. For some patients, the goal of treatment is to cure the cancer; for others, the goal of treatment is to control cancer for as long as possible. In most situations, more options and equivalent alternatives exist for patients undergoing treatment to control cancer than to cure it.

Next, doctors review what options are available for patients seeking a cure. Priority is given to those who have already started treatment with a given drug so that they can finish their regimen without interruption, Smerage said. Furthermore, doctors work with the pharmacy before starting any new patients on a particular drug to ensure that enough supply exists to allow a patient to complete a course of treatment.



Kelly Wright, a pharmacist and manager of the Cancer Center's ambulatory infusion pharmacy, works with doctors to develop plans to cope with shortages.



Cytarabine, a generic chemotherapy drug, recently was in short supply due to manufacturing problems.

Doctors also work with the pharmacy to ensure that no amount of drug is wasted, said Harry Erba, M.D., Ph.D., a Cancer Center oncologist who helped plan for the cytarabine shortage. If a vial is opened for one patient but the entire quantity is not needed, the team works together to figure out who else can use it so the excess does not go to waste.

In the case of the cytarabine shortage, Erba and his colleagues went a step further than typical conservation efforts. They reviewed the results of many studies to determine whether lower doses were equally effective. Lowering doses would allow more people access to the short supply of the drug. Given what they had found in recent medical publications, they found that they could cut doses in half in certain cases without any risk to patients.

"This was an opportunity to have a candid discussion about what is an adequate dose," Erba said. "We unanimously agreed that based on the most recent data, we could give patients the therapy they needed by limiting the doses by 50 percent of what we commonly give."

And as a result, no patients went without. **t**



Harry Erba, M.D., Ph.D., a Cancer Center oncologist, worked to make sure the recent cytarabine shortage didn't interfere with patients' treatment.

“ We are doing all that we can to make sure our patients have the drugs they need. ”

—Kelly Wright

WHY ARE DRUG SHORTAGES OCCURRING?

A number of problems cause shortages, said Allen Vaida, executive vice president for the Institute for Safe Medication Practices. Consolidation among pharmaceutical companies has had a major impact. If only three companies manufacture a drug, and two of them merge, often the third company can't keep up with the resulting demand. Even if a company has additional production lines available to produce a drug in demand, they cannot be used unless those specific production lines have federal approval to manufacture that specific drug.

In addition, Vaida said, the U.S. Food and Drug Administration recently stepped up inspections to ensure drug quality. Some manufacturers had to halt manufacturing temporarily to improve processes; others decided it wasn't worth the cost, so they stopped manufacturing certain drugs altogether. And since pharmaceutical companies have no obligation to notify anyone that they plan to stop manufacturing a drug, shortages often occur unexpectedly.

To help prevent this, Sen. Amy Klobuchar (D-Minn.) recently introduced a bill that would require companies to provide six months' notice to the U.S. secretary of health and human services of any manufacturing interruptions that would likely lead to a drug shortage.

“We are trying to advocate for more transparency because then at least practitioners could plan for shortages,” Vaida said.

Would you like to learn more about drug shortages? Visit mCancer.org/thrive.



Organic curi

Is it worth the extra cost to buy organic?

By Nancy Burke, R.D., Joan Daniels, R.D.,
and Danielle Karsies, R.D., M.S.

A cancer diagnosis often makes people re-evaluate their eating habits, inspiring many to incorporate more organically grown foods in their diets. Some people buy organic because of concerns about the environment, pesticides or animal welfare. Others perceive organic foods to be more nutritious. But considering the higher cost, is there any evidence that organically grown food offers more health benefits than conventionally grown food?

The U.S. Department of Agriculture defines organic foods as those produced without the use of artificial fertilizers and pesticides. They also must be minimally processed without artificial ingredients, preservatives or irradiation. In organic animal products—including meats, eggs and dairy products—livestock are not given routine antibiotics or hormones.

But are organic or natural foods better for you? The evidence remains controversial. Some studies suggest that organically grown fruits and vegetables may contain slightly higher levels of vitamin C, trace minerals, antioxidants and polyphenols than their conventionally grown counterparts.

Other studies find no nutritional difference between organic and non-organic foods.

Many consumers choose organic produce because it's thought to be safer to eat. But it's not clear that this is true. Although organic farms may not use pesticides, their foods could contain trace amounts of pesticide residues if they are exposed to contaminated water, soil or chemicals carried by the wind. Furthermore, according to the American Institute for Cancer Research, no convincing scientific evidence exists to show that pesticide residues or additives increase cancer risk when used in accordance with federal regulations. The AICR also notes, however, that while produce grown in the United States is among the safest in the world, food grown in other countries may not follow the same strict standards for pesticide use.

We typically advise patients who are worried about pesticide residues to buy organic as long as the higher cost doesn't cause them to buy fewer fruits and vegetables. The goal is to eat at least five servings of a wide variety of fruits and vegetables daily—regardless of whether they are organically or conventionally grown. The advantages of eating a diet packed with colorful fruits and vegetables strongly outweigh any potential risk from pesticides.

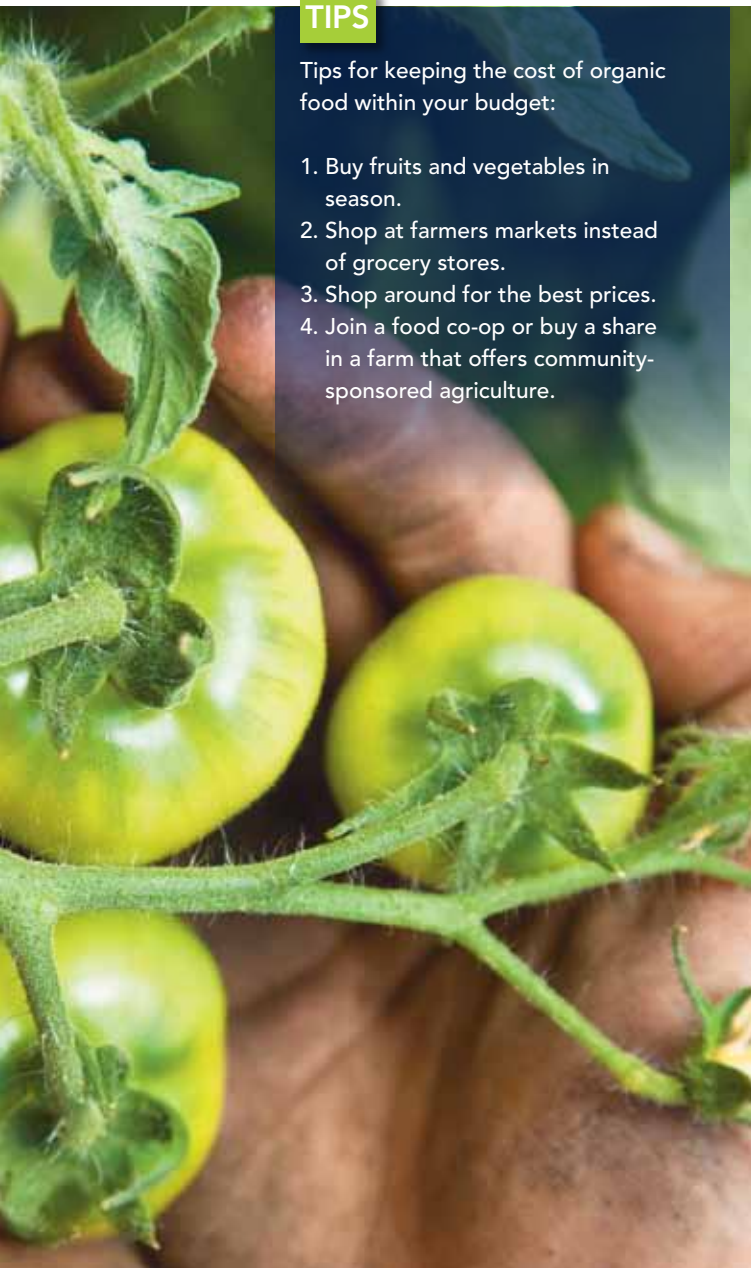


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TIPS

Tips for keeping the cost of organic food within your budget:

1. Buy fruits and vegetables in season.
2. Shop at farmers markets instead of grocery stores.
3. Shop around for the best prices.
4. Join a food co-op or buy a share in a farm that offers community-sponsored agriculture.



THE DIRTY DOZEN

If you'd like to incorporate more organic food into your diet, spend your money where it counts. The following fruits and vegetables typically contain the highest pesticide levels when grown conventionally, according to the Environmental Working Group, which makes them a good place to start if you want to go organic. Wash all produce well before eating it, whether it's organic or not.

- Apples
- Kale
- Bell peppers
- Lettuce
- Carrots
- Nectarines
- Celery
- Peaches
- Cherries
- Pears
- Grapes (imported)
- Strawberries



THE CLEAN 15

The following are fruits and vegetables that have been found to have the lowest levels of pesticides when grown conventionally. If you're budget-conscious, it may be less important to buy these organic.

- Asparagus
- Onion
- Avocado
- Papaya
- Broccoli
- Pineapple
- Cabbage
- Peas (sweet)
- Corn (sweet)
- Sweet potatoes
- Eggplant
- Tomatoes
- Kiwi
- Watermelon
- Mango



ORGANIC VS. NATURAL

Foods labeled "natural" aren't necessarily organically grown. According to the U.S. Food and Drug Administration, foods labeled "natural" do not contain synthetic or artificial ingredients. They are minimally processed, but animals may be given antibiotics or growth enhancers. **t**

Michael Daly is feeling better since consulting the PsychOncology Clinic to get his anxiety and depression under control.

Better days

PsychOncology Clinic offers patients tools for coping

After Michael Daly was diagnosed with cancer, he felt alone. He didn't know what to expect with his treatment and, in the early days, some of his doctors didn't offer much encouragement about his prognosis.

Daly was prescribed a medication to treat his anxiety and depression, but after a while, it stopped working.

"I found myself not wanting to get involved in my life and just vegetating," Daly said. "I wanted to get back into control of it, because I didn't want to spend my days waiting to die. I needed to get over that hump."

By then, Daly had chosen a new approach to treatment that brought him to the University of Michigan Comprehensive Cancer Center. His oncologist suggested he consult with the Cancer Center's PsychOncology Clinic.

Staffed by social workers, psychiatrists and nurse practitioners, the PsychOncology Clinic provides assessments to Cancer Center patients to determine their level of distress and individual needs. The team then develops an action plan to help patients get the assistance that's right for them.

In 2007, the Institute of Medicine issued a report stating that every cancer patient should be evaluated for psychological distress. Michelle Riba, M.D., director of the Cancer Center's PsychOncology Program, said as many as 25 percent to 30 percent of people with cancer will have a psychological problem at some point during their care. The problems depend on the person and may include general anxiety or depression, personality issues or substance abuse.

Cancer treatment also may impact patients psychologically, Riba said. For example, certain medications may cause patients to become anxious.

The goal of a PsychOncology Clinic visit is to develop a care plan that might involve medications or referrals for longer-term therapy, community support groups or in-house Cancer Center resources, such as art therapy. Often, if someone has a past history of psychological problems, a cancer diagnosis and its treatment may cause the problems to recur or worsen, Riba said. For others, cancer may cause overwhelming emotions unlike

any they've experienced, so they may benefit from having additional support.

"No one should be suffering with this," Riba said. "It's sort of like pain: If you break your arm, you might be in pain only temporarily, but it doesn't mean you shouldn't be treated for your pain. The same should be true in addressing psychological concerns. People should seek help when they're feeling emotionally overwhelmed."

For Daly, the PsychOncology Clinic suggested an adjustment in medication and provided an opportunity to talk periodically with Patty Miller, a nurse practitioner. The result has been a better state of mind, he said.

"I do have my highs and I do have my lows, but you can't appreciate the highs without the lows," Daly said. "I see the good in what the clinic has done for me, and I'm very happy with it. I think I'm doing well." 



To make an appointment with the PsychOncology Clinic, talk to your health-care team or call 877-907-0859.



Learn more about the latest cancer research at the University of Michigan at mCancer.org/thrive.



SUPPLY OF HOSPICE SERVICES TIED TO MEDIAN HOUSEHOLD INCOME, U-M STUDY FINDS

Wealth, population size, race and age are associated with the supply of hospice care available in a county, according to a study published in the *Journal of Pain and Symptom Management* recently.

Local availability is an important predictor of use of hospice programs, which are end-of-life services that have been shown to improve pain control, maintain patients' independence and even extend life, said lead author Maria Silveira, M.D., M.P.H., a University of Michigan assistant professor of internal medicine.

The researchers found that for every \$1,000 increase in median household income in a county, the supply of hospice services increased by 3 percent. Hospice supply also was larger in counties with larger populations, more African-Americans and more people over the age of 65. But hospice supply decreased in larger geographic counties and those with more Hispanic residents.

These study results indicate the traditional model for structuring and financing hospice needs to be re-designed, Silveira said. Community hospices are often funded by charity; the fact that wealthier communities may be more likely to support such charities may be one possible explanation for disparities.

While the amount of hospice use has increased tremendously in the last 20 years, most Americans die without using hospice care. In 2002, only 28.6 percent of Medicare beneficiaries who died had enrolled in hospice.

To improve the feasibility of hospice in poorer communities, Silveira suggested that Medicare provide assistance or incentives for building hospices in poorer communities, in addition to making sure that reimbursement for hospice services matches its cost.

Silveira stressed that more research is needed to find out how patient preferences influence access to hospice by underserved communities.

"The relationship between community affluence and supply of hospice services could reflect community values about hospice and indicate that hospice, as a business, merely follows the demand for its services," Silveira said. "Given the tremendous, proven benefit of hospice programs, supply of these services needs ongoing study."

PRESENTING CANCER TREATMENT OPTIONS IN SMALL DOSES YIELDS SMARTER CHOICES

Women who choose among different breast cancer treatment options make smarter choices when getting the information and making decisions in small doses rather than all at once, as is customary, a University of Michigan study found.

It's long been known that people who aren't good with numbers have a harder time understanding the risk information they need to make good medical decisions, says Brian Zikmund-Fisher, Ph.D., assistant professor at the U-M School of Public Health and a research assistant professor at the U-M Health System.

Zikmund-Fisher tested whether asking women to make a series of simpler choices rather than one complex decision would help the women understand when aggressive post-surgery therapies, such as chemotherapy, actually yield larger benefits.

The researchers found that the group of women in the study who weren't good with numbers became confused when faced with as few as four treatment options at once, and chose chemotherapy regardless of whether their benefit would be 1 percent or 5 percent.

A different group of women in the study received the same treatment options divided into two separate decisions. They first decided whether to take hormonal therapy, and if they said yes, they then decided whether or not to add chemotherapy. More of the women who made decisions incrementally chose the chemotherapy only if it gave them a large benefit.

"It's obvious that you should be more interested in chemotherapy if you're going to get a 5 percent benefit vs. only a 1 percent benefit," Zikmund-Fisher said. "What that tells me is that it doesn't take very much information to be too much, especially with patients who have trouble with numbers. When we try to provide patients with full and complete information, we often end up overwhelming them."

Even women who are good with numbers benefit from having information presented piece-by-piece because they can better understand how much benefit comes from each treatment option, Zikmund-Fisher says.

He says that parceling out information to make decision-making simpler doesn't necessarily mean more work for doctors or longer visits.

"I believe that having patients make decisions one at a time might make doctors' visits shorter rather than longer," Zikmund-Fisher says. "When you make things simpler, you don't have to explain it again and again."



Danielle Karsies and Emily Mackler

To learn more about soy, visit mCancer.org/thrive to watch a videocast with Mackler and Karsies.

Art Therapy:
877-907-0859

Cancer AnswerLine:
800-865-1125

Clinical Trials:
800-865-1125

Fertility Counseling:
877-907-0859

Financial Counseling:
734-647-5120

Guided Imagery:
877-907-0859

Music Therapy:
877-907-0859

Nutrition Services:
877-907-0859

Pharmacy:
734-647-8911

PsychOncology:
877-907-0859

Social Work:
800-888-9825

Skills Lab:
877-907-0859

Smoking Cessation Counseling:
734-936-5988

Symptom Management & Supportive Care:
877-907-0859

SOY: BENEFIT OR RISK?

Some laboratory studies suggest eating soy may increase breast cancer risk for some women, but other studies show eating soy from an early age may protect against breast cancer. So what's a woman to do?

For most people, eating about two to three servings per day of soy foods—such as soy milk or tofu—is safe, according to pharmacist Emily Mackler and registered dietitian Danielle Karsies, both of the University of Michigan Comprehensive Cancer Center's Symptom Management & Supportive Care Program. However, for some women—particularly those with hormone-receptor-positive breast tumors and those receiving tamoxifen therapy—the issue is more complicated.

To learn more about soy, visit mCancer.org/thrive to watch a videocast with Mackler and Karsies. Learn more about:

Who should consider eating soy?

What medications require limitation or avoidance of soy foods?

Are supplements of soy protein safe?

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



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