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Spirit & Breath

from the Alliance for Lung Cancer Advocacy, Support, and Education (ALCASE)

feature story

Lung Cancer Hot Topic in New Orleans ALCASE attends annual oncology meeting

Representatives from ALCASE were among the more than 25,000 cancer specialists who gathered at the 40th Annual Meeting of the American Society of Clinical Oncology to discuss the latest advances in cancer care, treatment, and prevention.

The program at the meeting, which was held June 5 to June 8 in New Orleans, included nearly 400 abstracts and presentations concerning lung cancer.

"This was a truly exciting year for lung cancer research," says Janet M. Healy, ALCASE Senior Program Manager.

Members of ALCASE's Medical Advisory Committee chose a few select findings presented at ASCO to highlight in this issue of *Spirit & Breath* (see pages 7 to 11).

Please visit www.asco.org to view the full text of each abstract related to lung cancer.

ASCO Highlights
 Check out our Medical Advisory Committee's review of key lung cancer findings presented at ASCO 2004.
page 7

Board of Directors Adopts New Strategic Direction for ALCASE

To better serve lung cancer patients and those at risk for the disease, the Alliance for Lung Cancer Advocacy, Support, and Education (ALCASE), is embracing a new strategic direction, which includes moving its headquarters to Washington D.C.

Following a recent independent review of our mission, operations, and services to patients, ALCASE's Board of Directors decided on several key changes aimed at strengthening our visibility and ability to influence key decision makers.

"We are at a critical moment to create significant progress in lung cancer detection, treatment and patient support," says Randolph Urmston, current president of the board of ALCASE and a lung cancer survivor. "We needed to change at this critical time, when increased attention is being paid to women's health, including lung cancer, and new treatments are on the horizon."

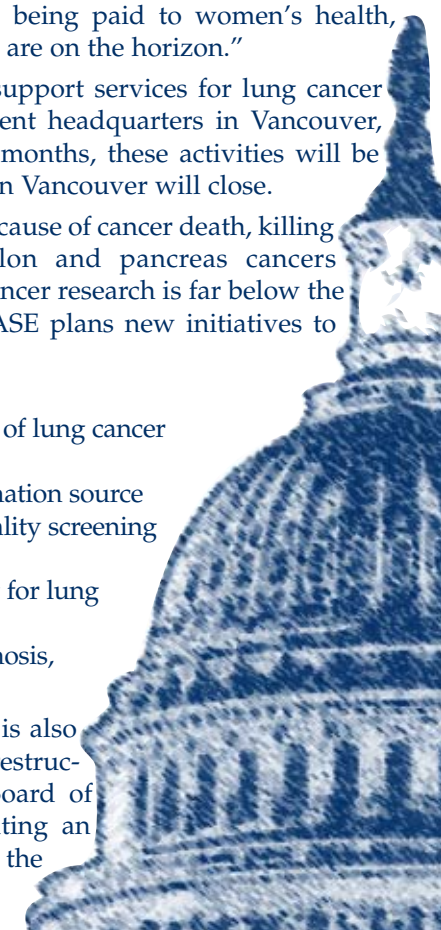
We will continue to provide important support services for lung cancer patients and their families from our current headquarters in Vancouver, Washington. Over the next six to twelve months, these activities will be moved to Washington D.C. and the office in Vancouver will close.

Lung cancer remains the nation's leading cause of cancer death, killing more people than breast, prostate, colon and pancreas cancers combined. Yet funding for national lung cancer research is far below the levels for these other malignancies. ALCASE plans new initiatives to address and call attention to this disparity.

Those initiatives include:

- Advocate for increased public funding of lung cancer research
- Become the leading lung cancer information source
- Advocate for evidence-based, high-quality screening for lung cancer
- Provide patient education and support for lung cancer patients and their families
- Advocate for access to screening, diagnosis, treatment and support

In addition to these initiatives, ALCASE is also recruiting an executive director to lead restructuring and relocation; restructuring its Board of Directors to broaden representation; creating an Emeritus Advisory Board; and renaming the organization to better reflect its mission.



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Tournaments Support ALCASE Ken Giddes, Mike Mallare and Mark Belanger Honored with Golf Events

Now that summer is upon us, the annual season of golf tournaments has begun. Several upcoming events (and one completed tourney) are expected to draw hundreds to increase awareness about lung cancer and help support ALCASE.

More than 100 golfers turned out for the *Third Annual Ken Giddes Memorial Golf Tournament* at the St. Marlo Country Club in Duluth, Georgia May 17. Giddes, who died of lung cancer, was a dedicated Phone Buddy and advocate for the interests of cancer patients. He helped start the "Caring Ambassadors" program through his employer, to connect people with information and personal support following a cancer diagnosis. Tom Simon, who was a friend and neighbor to Giddes, carries on that work and also serves on ALCASE's Board of Directors. ALCASE receives a portion of the proceeds from the tournaments.

At press time, two other golf tournaments to benefit ALCASE were on the calendar:

This is the fourth year for the *Mike Mallare Golf Classic*, in Salem, Virginia. The event celebrates the life and memory of Mallare, who was a pediatrician and father of two when diagnosed with metastatic lung cancer at age 38. Jennifer Mallare Turner (his widow) organizes the *Classic*, which also includes a cocktail party, dinner-dance, silent auction,



Above: Golfers relax after the Giddes tournament. Left: First place winners were Pete Jacques, Buddy Linton and Mike Zowine.

and a family picnic.

The first-ever *Mark Belanger Tournament* will be Monday, October 11, in Baltimore, Maryland. The longtime Baltimore Orioles baseball shortstop, died of lung cancer in October, 1998 and this event is expected to draw former teammates and many friends and family.

Belanger's son Rob and friend Chris Federico are organizing the tourney, which benefits ALCASE. For more information, email Chris at chris.federico@brickbodies.com

Pulmonary Rehabilitation: A New Approach to Treating Dyspnea

(Continued from page 14)

A team of physicians, nurses, psychologists, and social workers all join to help you cope with the psychological aspects of their disease. Initially you'll be assessed to determine your level of mental health and to construct a plan for assisting you. Group and individual sessions are employed to address everything from increasing dependence on others to fears about mortality. Rehabilitation sessions provide a unique opportunity for discussion of some of the more delicate issues such as Health Care Proxy and DNR status. You can build support groups and develop new ways of coping with your new life stressors. Behavioral, cognitive, emotional, and even pharmacologic therapy is used to maximize your potential for rehabilitation.

Creating a Life-Long Family

The final essential element of pulmonary rehabilitation is that of follow-up. You will never be left to feel alone and abandoned. Follow-up phone calls, re-visits to the rehabilitation center, meetings with fellow patients, comprehensive treatment reviews are all part of pulmonary rehabilitation. The pulmonary rehabilitation process creates a life-long family.

As a lung cancer patient, you can benefit greatly from pulmonary rehabilitation. Often, lung cancer patients suffer from tremendous physical and psychological stress. A majority of them are coping with shortness of breath, reduced exercise capacity, decreased ability to perform daily tasks, and increased dependence on others. These patients are often depressed, anxious, and have difficulty dealing with their mortality. As a comprehensive approach to patient care, pulmonary rehabilitation is an excellent tool in the arsenal against cancer.

Many lung cancer patients also suffer from COPD, and benefit from the traditional approach of pulmonary rehabilitation. In addition, many of these patients are being put through a battery of stresses on their bodies. Pulmonary rehabilitation is ideal for patients undergoing chemotherapy as it helps to strengthen them both physically and mentally.

Often, patients are found to have a respectable stage of their lung cancer, but are too physically weak to be considered good candidates. Pulmonary rehabilitation can be used prior to surgery to strengthen a patient and increase chances of a favorable outcome. Post-operative patients have obviously been through significant trauma and rehabilitation is readily used to help those patients reach their fullest potential. Because pulmonary rehabilitation is a team effort, often the patient's oncologist becomes inte-

grated into the planning and execution of the essential elements of pulmonary rehabilitation.

Pulmonary rehabilitation is a multidisciplinary approach to patient care. It is a team effort that strives to improve the mental and physical health of patients with pulmonary diseases. The essential elements of assessment, training, exercise, psychosocial improvement, and follow-up all create an environment that fosters improvement in a patient's quality of life.

Though initially conceived for patients with primary issues, pulmonary rehabilitation has grown to encompass many different subgroups of patients and is perfectly suited for patients with lung and other types of cancers.

reconditioning stage, you may be helped to perform your everyday activities more easily.

Suggested Reading

- Guidelines for Pulmonary Rehabilitation Programs. American Association of Cardiovascular and Pulmonary Rehabilitation. Human Kinetics. 1998.
- American Thoracic Society. Pulmonary Rehabilitation. *Am Rev Respir Dis* 1981; 124:663-66
- Kyprianou A, Russo R. The Role of Pulmonary Rehabilitation for Patients with Non-COPD Lung Disease. 2004.

Dr. Russo is the director of Pulmonary Rehabilitation for the Division of Pulmonary & Critical Care Medicine at North Shore University Hospital. She is also an Assistant Professor of Medicine at New York University School of Medicine. Lawrence D. Shulman, DO is a Fellow in Pulmonary & Critical Care Medicine at North Shore University Hospital.

How & Why rehabilitation

Why Get Pulmonary Rehabilitation?

It will help you understand why your lungs are not working as well as they once did. The more you understand about your disease and treatment, the less frightening symptoms like shortness of breath and fatigue are. By performing exercise regularly during the

Getting Pulmonary Rehabilitation

Most physicians will refer you to rehabilitation services if you need them; be sure to ask if you think you might want them. Also, check to see if these types of services are covered under your insurance plan (some may be, others may not). Additionally, some cancer or social service organizations may provide you with free rehabilitation services if you are not insured for them.

Spirit & Breath

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RESOURCE
financial assistance

Patient Advocate Foundation's Patient Assistance Program

The Patient Advocate Foundation (PAF) has introduced a financial assistance program for patients (including those with **lung cancer**) who meet certain qualifications to help them pay for the prescriptions and/or treatments.

The assistance lets patients who have chronic, life threatening and/or debilitating illness afford the out-of-pocket costs for these items that their insurance companies require.

The PAF Patient Assistance Program is designed to help patients who have insurance (including Medicare and Medicaid). Once approved for the program and depending on the level of help needed, payments are made:

- to the doctor
- to the pharmacy
- to the patient directly

To find out if you are eligible, please contact a PAF program call counselor — either via the phone at 866.512.3861 or via email at pap@patientadvocate.org. The counselor will screen for eligibility by asking for financial and medical information.

Symptom Management

Pulmonary Rehabilitation: A New Approach to Treating Dyspnea

Adapted with permission from *Pulmonary Rehabilitation for Patients With Cancer*, an article written by Roseann Russo, MD and Lawrence D. Shulman, DO

Shortness of breath, or dyspnea, is one of the most common symptoms for lung cancer patients. Studies have shown that 50 percent of cancer patients in general complain of shortness of breath with 20 percent rating it as moderate to severe. It is estimated that 60 percent of lung cancer patients have some dyspnea at the time of diagnosis.

While pulmonary rehabilitation has typically been used to treat patients with chronic obstructive pulmonary disease (COPD), recently its use has been extended to patients with all types of lung disease, including lung cancer.

Using pulmonary rehabilitation, patients strive to improve their quality of life, while decreasing their anxiety and depression related to their illness — and perhaps to increase their survival. Other goals of pulmonary rehabilitation include reducing the number of hospitalizations and decreasing the use of medical resources.

There are many studies and trials that support the use of pulmonary rehabilitation to improve dyspnea by teaching breathing techniques, strengthening arms, and improving how a patient feels emotionally and mentally.

A Customized Approach

The key to pulmonary rehabilitation is in its individually tailored, multidisciplinary approach. There are five essential components to a successful pulmonary rehabilitation program — assessment, patient training, exercise, psychosocial intervention, and follow-up. Not every patient will need help

in all five areas, but each component should be assessed.

Ideally, a team of medical professionals — physicians, nurses, technicians, a pharmacist, psychologists, respiratory specialists, nutritionist, and social workers — orchestrate the care of each patient.

Care begins with the initial assessment. There may be certain conditions for enrolling in a rehabilitation program. Prime among these is that the lung cancer or other respiratory disease or the side effects of treatment has reduced the quality of your life, including the ability to work or perform activities of daily living. Sometimes this means that you're dependent on others to perform tasks.

If you are considered eligible for rehabilitation, you will probably complete a detailed interview including medical history and diagnostic testing. Questionnaires are employed to assess the patient's physical, nutritional, educational, exercise, and psychosocial status. In the end, all the preliminary processes culminate in the creation of individualized goals for each patient.

As a patient, you understand your disease best and can control your lives the best. Because of that, the next essential element in pulmonary rehabilitation is training for you — the patient. After assessing the level that you understand your disease, an individual education program is created. Because every person learns differently, a combination of lectures, reading materials, and one-on-one information sessions should be used. All facets of the disease processes will be discussed, including pathophysiology, medication use, and interpretation of diagnostic testing. You will be taught the basics of breathing retraining and bronchial hygiene. Nutrition, exercise, and psychosocial issues also receive a great deal of focus and attention.

Exercise assessment and training are among the most readily recognized components of pulmonary rehabilitation. Assessment usually involves basic exercise modalities with a variety of monitoring parameters including blood pressure and pulse oximetry. Often, full pulmonary exercise stress tests are performed to determine baseline function. Facilities contain a variety of exercise equipment and training devices.

As a patient, you may participate in aerobic exercises, upper and lower extremity muscle and strength training, and respiratory muscle training. To enable continued rehabilitation, you will be instructed in unsupervised training and are prescribed a home exercise maintenance program.

Psychological Treatment

The impact of disease on an individual is greater than just physical disability. The process of psychologically accepting and adjusting to a "different" lifestyle is complicated and difficult. The psychological element of pulmonary rehabilitation is an essential part of treatment.

Inside ALCASE

Cheers to ALCASE Volunteers

Thanks to many dedicated volunteers, ALCASE is able to reach across the country to provide support, education and advocacy to lung cancer patients and those who love them. Thanks to these and the many other volunteers, whose efforts and contributions support ALCASE and advance our shared cause!

Speaking About Lung Cancer

Gail Matthews, of New Hampshire, had never smoked but the unexplained fatigue and bronchitis she'd had over several years finally led to a scan in 2000 that revealed lung cancer. Soon, she noticed there was a blaming attitude about the disease. "It is quite disturbing to listen to people who call lung cancer 'the selfish disease,'" she told a local newspaper reporter last November. "Even a smoker does not deserve to get lung cancer." Gail continues to be vocal about lung cancer issues and recently spoke before the Rotary Club. She also distributes ALCASE's brochures and lapel pins.

SPORE Patient Representatives

Also in the Northeast, Debbie Violette of Maine continues to be a lung cancer advocate. She was recently invited to be a patient representative with a new lung cancer Specialized Program of Research Excellence (SPORE) at Dana-Farber Cancer Institute in Boston. The National Cancer Institute to speed development of cancer detection and treatment research funds SPOREs. Debbie's also working toward her Master's degree in Public Health. Anita Johnston, of New York, is active with the lung cancer SPORE at the University of Texas' Southwestern Medical Center in Dallas. Besides her volunteer work with ALCASE and CancerCare, she has a busy summer schedule, including attending the annual SPORE meeting and keeping up with clinical trial matters for several cooperative research groups. See <http://spores.nci.nih.gov/current/lung/lung.html> for details on research at the seven lung cancer SPOREs.

Talking, Golfing, and Run/Walking for Lung Cancer

Elaine Lombardo, of Louisiana, and her husband Vincent, volunteered many hours with the telephone support network at M.D. Anderson Cancer Center in Houston. After his death last year, she decided to get even more active and this spring she became an ALCASE Phone Buddy. Elaine wants to help ALCASE reach more people with lung cancer in Louisiana and use some of her skills and contacts to bring more attention to issues facing people with the disease. In late April, ALCASE staff and New York volunteers Matt Blank and Moti Asif attended the second annual TGL Classic in Central Park, New York City. The lung cancer run and health walk honors the memory of Thomas Labrecque, a former executive of Chase Manhattan Bank who died of lung cancer. We had a booth and gave out our pins and brochures. At this year's Revlon Run/Walk for Women in New York City in May, there wasn't an official lung cancer team but Susan Jarrett persuaded friends and family to participate anyway. After the race, she sent ALCASE the donations she'd collected.

Valued Volunteer Loses Long Battle With Lung Cancer

It is with great sadness that we note that Marilyn Sonenshine, of Atlanta, Georgia, passed away from lung cancer in early May. Marilyn and her husband Bill were a true team throughout their long and happy marriage. Active in their synagogue, they shared a life guided by purpose, family, and service to others. Following Marilyn's diagnosis nearly five years ago, Bill turned his engineer's mind to finding the best medical care and he endlessly researched treatment options for his wife. Two years ago, they won our annual Phone Buddy award for their compassion and availability to callers. Not shy about public exposure, they gave newspaper interviews and even welcomed a video crew into their home for a lung cancer story. Bill remains a Phone Buddy, especially for spouses and those curious about tracking down medical research reports.

Lung Cancer News

The last few months have been chalk full of exciting lung cancer news.

A quick and easy way to keep up on the latest lung cancer research, or read inspiring profiles of lung cancer survivors is to visit the ALCASE Web site.

Bookmark the link: www.alcase.org/news/lung_cancer_news.html to always keep updated on lung cancer news.

Honor/Memory Donations

We are grateful for the many private donations we receive. These contributions, which are often in memory of someone who has died of lung cancer or to honor someone living with the disease, help us continue to provide information and personal support.

Frankly Speaking

ALCASE recently collaborated with the Wellness Community and CancerCare, on the "Frankly Speaking About Lung Cancer" kit and related materials.

Medicare Iressa Coverage

Patient groups, including ALCASE successfully lobbied for coverage oral cancer drugs, like Iressa, before full Medicare drug coverage starts in 2006. Applications for the program will be accepted until September 30. Go to: http://www.cms.hhs.gov/researchers/demos/drug_coveragedemo.asp

QuickShot definitions

Dyspnea: Difficult, painful breathing or shortness of breath. Dyspnea is a common side effect of lung cancer.

Pulmonary Rehabilitation: The art of medical practice wherein an individually tailored, multidisciplinary program is formulated which through accurate diagnosis, therapy, emotional support, and education, stabilizes or reverse both the physio- and psychopathology of pulmonary diseases and attempts to return the patient to the highest possible functional capacity allowed by his pulmonary handicap and overall life situation.

— From the American Thoracic Society

Volunteer Appreciation

Amy Dixon: Phone Buddy Enthusiast Providing peer support for those with lung cancer

Amy (whose given name is Armida, from her Italian heritage) was considering retirement from her work as a buyer for hospital products when she was diagnosed with non-small cell lung cancer eleven years ago.

“Anytime I wake up in the morning, it’s a good day. I’m delighted to get out of bed, make my coffee, read the newspaper—and do other simple, daily, marvelous things!” Amy Dixon says.

She’d gone to the doctor with what she thought was a simple viral infection. “I didn’t understand what the cancer diagnosis meant. I had no idea what was going on. After that first surgery, there was no rehabilitation but I walked and did my usual things and recovered in about two months.”

Little did she know she’d face two more surgeries and then chemotherapy for recurrent lung cancer. Her most recent scan showed that the remaining cancer has not grown. “Waiting for those CT scan results is tough,” Amy admits. “It’s the closest I get to feeling depressed.”

Each person has his or her own way of coping with lung cancer. “I admit I am definitely *not* someone who believes that knowledge is power!” she says. “I’m more an ‘ignorance is bliss’ kind of person. For me, knowing too much about lung cancer would just give me more to dwell on.”

Amy lives in New York City and receives her medical care at a highly respected medical center and, when she wants to get more information (including contacting ALCASE), she knows where to look.

In high school, decades ago, Amy took a fashion illustration and design class. Now, she enjoys painting watercolors and making doll clothes. She also likes to cook and to host parties, especially potlucks with foods from different countries.

She lives alone but her adult children and young grandchildren are a big part of her life and she travels to be with them. “My seven-year old grandson has seen me sick and recovering and he’s quite clear that when he grows up, he’s going to be a scientist and find a cure for cancer and then childhood diabetes,” she chuckles.

Amy volunteered to be a Phone Buddy last fall. “As a result of going through my diagnosis and treatment, I hope I can help—I think I’ve become kinder and more considerate, too,” she reflects.

“Being a Phone Buddy makes me feel good. Talking to callers, I’m able to explain that their diagnosis is not a ‘sentence’ and that, in a way, we are all on borrowed time.”

The good-natured lung cancer survivor enjoys life’s simple pleasures. She’s had to admit that some physical tasks are beyond her now, and she gets help with housecleaning and grocery shopping.

“I focus on what I *can* do and I’m more thankful and happy for anything I get!”



Left: Amy Dixon before chemotherapy. Above: Amy Dixon and her grandson — Michael.
The ALCASE hat of hope can be purchased for \$20 at www.alcase.org.



QuickShot phone buddy

The Phone Buddy Program is thriving! It has grown to 220 Phone Buddies nationwide.

The staff at ALCASE would like to announce our new promotion of Hats of Hope, which was funded by AstraZeneca. Our Hats of Hope is a thank you to our volunteers for their time and compassion they give to newly-diagnosed patients and their families facing lung cancer. The hats are printed with quotes about the program.

We welcome our newest volunteers: Agnes Pringle, John Grzesiak, Betty Cameron, Terry Earp, Phyllis Goldstein, Carol Hawes, Venise Leach, Lillian Mack, Ann Mason, Allen Melsness, Judy Moyer, Matt Mugglebee, Shirley Powers, Joan Rogers, Eve Samuel, Mary Shipard, Reiley Smith, Katherine Shultz, Amman Williams, and Elaine Lombardo.

Our deepest thanks to you for being there for others.

Survivor Profile

12 Years After Lung Cancer Diagnosis: Doctor Walking Strong

In April of 1992, Doug Hammer was the Medical Director and Chief of Emergency Medicine of the Rex Hospital Emergency Department in Raleigh, North Carolina. In addition to being an avid runner (he ran the Boston marathon in 1969), Doug enjoyed spending time with his wife Susan, and their seven-year-old daughter, Molly.

While drinking his morning coffee on April 17, 1992 his wife thought he had something in his throat. “I cleared my throat and it didn’t go away,” says Doug. “I then let out a breath and heard a little wheeze in my right upper chest.”

Because of his training as a physician and epidemiologist, Doug immediately knew what it was. Susan asked what it was. He thought for a minute and said, “It’s probably an endobronchial carcinoma of my right upper lobe”. His wife said “I hate when you do that”. “My wife wanted to know if it could be anything else and I told her it was unlikely,” says Doug. “I had a really bad feeling.”

Doug was diagnosed with nonsmall cell lung cancer. “I had smoked from age 19 to 29 – averaged about a pack a day – but I hadn’t smoked for 26 years. It was a real surprise to say the least,” says Doug of his diagnosis. “Because I was a doctor, I knew lung cancer generally had a poor prognosis. At the time it was scary and depressing.”

“In the grand scheme of things, I am really grateful to be alive, to still be working,” says Doug, who now works in family practice. “I didn’t spend a lot of time feeling sorry for myself. I’ve lived a full life, have a wife, a daughter, a strong religious faith and I’ve accomplished a lot of stuff.”

Following the diagnosis, Doug scheduled surgery for April 28. Although his lung cancer was con-

tained to the upper lobe of his right lung, its proximity to the main-stem bronchus required removing the whole lung (pneumonectomy). He did not require any follow-up chemotherapy or radiation.

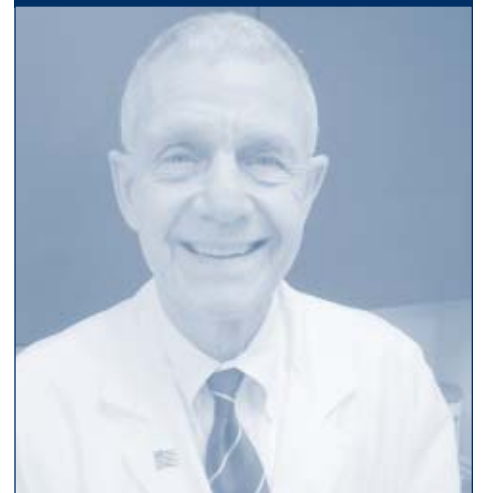
Doug and Susan didn’t share the seriousness of Doug’s illness with their daughter Molly. They likened the pain after the operation to when Doug had broken some ribs several years before. “Kids are real insightful,” says Doug. “She had chicken pox at the time I had my surgery, so she wasn’t able to come to the hospital. But afterwards, we were home talking about my surgery, and she said, ‘If you didn’t have your lung out, you would have died.’ So she knew.”

It took Doug more than two years to get his full energy back. “I woke up after the surgery with the brain of a runner and the lungs of a 100 year old man,” says Doug. “I didn’t know about how people should behave after a pneumonectomy – I tried to do everything. I couldn’t run, so I walked.”

Although Doug was able to regain much of his physical strength, he still can’t run, and had to give up playing the guitar and singing, a personal pastime he enjoyed (he said that other people probably enjoyed his playing more than his singing). He was unable to return to Emergency Medicine because it was so physically demanding.

Fortunately he was also board certified in Family Practice, so he was able to continue practicing Family and Occupational Medicine. He feels strongly that he wants to keep helping others since his life has been spared. He said that, “Every physician learns early that although we cannot always save people, we can always comfort them.”

Profile from where i stand



Name: Doug I. Hammer, MD
Cancer: Non-small Cell Lung Cancer, Stage I
Diagnosed: April 1992
Current Age: 67
Treatment: Pneumonectomy (Right Lung)

Another challenge Doug faced was tackling the first few years after his surgery – years when the cancer could recur. “It was scary. I felt like a sitting duck. I spent two years wondering some everyday if the cancer was going to come back. After that I thought about it less frequently. Now I almost never think about a recurrence.”

Faith, family and friends were vital to helping Doug manage his cancer and recovery. “Getting strength and sustenance from my family, my friends and my faith, really made a difference,” says Doug, who also credits prayer for helping to support and uplift him through his situation.

For more survivor stories, visit Stories of Hope at www.alcase.org. If you would like to submit your story, email us at info@alcase.org.

Alternative Therapy

Spirituality and Well-Being in Lung Cancer Patients

By Martha Meraviglia, RN, CNS, PhD

When I was in high school my grandfather was diagnosed with lung cancer. I lived in the same town so I had the opportunity to visit him daily both at home during treatment and for several months in the hospital before his death. He was a man of great faith and it was his love for God that set the tone for his life with lung cancer. He was full of life throughout his illness and he was very willing to share his life with us. My experience with him and with other relatives with cancer introduced me to my current interest and involvement with people with cancer. I have learned from many people with cancer that their spirit can shine brightly even when their body is struggling with the disease.

Spiritual concerns are important for people with cancer and include spiritual needs for love, meaning, purpose in life, faith, and hope. Spirituality though is an abstract term defined in the dictionary as an attachment to the values of the spirit. The human spirit is described as the immaterial aspect of a person, which never dies. The vast majority of published writings on spirituality focus primarily on the theoretical aspects of the term. Most people agree though that spirituality is an ongoing, dynamic process that reflects and expresses the human spirit. For the purposes of the study on spirituality, it was defined as the experiences and expressions of one's spirit in a unique and dynamic process reflecting faith in God or a supreme being; connectedness with oneself, others, nature or God; and integration of the dimensions of mind, body, and spirit.

The research examined the effects of spirituality on sense of well-being in people with lung cancer through a descriptive, relationship study. Sixty people from around the country with mainly non-small cell lung cancer participated by completing research instruments on meaning in life, prayer activities, prayer experiences, symptom distress, and psychological well-being as well as personal information.

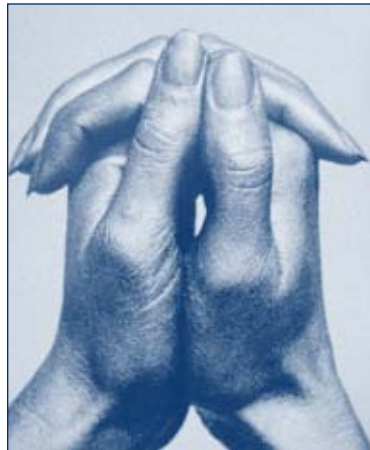
The study findings provide early evidence that people with lung cancer are unique in their responses to the impact of cancer. For example, people who were unmarried, in need of income to meet their daily needs, experiencing poor physical health or functional status, and currently receiving cancer treatment reported more symptom distress. These findings emphasize the importance of an individualized approach to care based on a thorough and ongoing assessment.

People who reported more meaning in life had better psychological well-being. Moreover, as people's level of meaning in life increased, their symptom distress decreased. Prayer was also positively related to psychological well-being. In addition, the findings demonstrate mediating or buffering effects of meaning in life and prayer on sense of well-being.

The holistic view of the theoretical framework was supported by the findings. Participants who were married reported less symptom distress and more psychological well-being than those who were not married. Higher levels of participant satisfaction with income were associated with higher psychological well-being. Additionally, the majority of the participants reported good or very good physical health and functional status even while receiving cancer treatment.

In conclusion, aspects of spirituality, meaning in life and prayer, had positive effects on psychological and physical responses in this group of people with lung cancer. The research provides knowledge of spirituality and sense of well-being to guide people with lung cancer.

Dr. Meraviglia is an assistant professor of clinical nursing at the university of Texas at Austin. This article is taken from The effects of spirituality on well-being of people with lung cancer, which was published in the January/February 2004 issue of the journal Oncology Nursing Forum.



Note: To read an abstract of Dr. Meraviglia's study, visit <http://www.ncbi.nlm.nih.gov>. Using the search function, type in the full title —The effects of spirituality on well-being of people with lung cancer. It will be brought up under PubMed

Volunteer Activity

RFL Team – Running Steady and Strong

Run for the Lungs (RFL) is a team program that raises money for ALCASE and increases public awareness of lung cancer. Team members choose a race and meet a fundraising minimum. ALCASE provides training tips and fundraising support, plus team shirts. We cover airfare, lodging, and race entry.

Most RFL members enter half or full marathons, but **Marc Arkovitz**, a pediatric surgeon in New York, prefers a different challenge. At press time, he was in the final week of preparation for swimming, biking, and running his second New York City Triathlon — on his 40th birthday. Marc does this in memory of his mother, who died of recurrent lung cancer in February.

"Her courage and warmth were an inspiration to me and my sister and the doctors who took care of her," says Marc. "I think her fight would have been in vain if some good did not come of it."

Another repeat athlete is **Becky Garcia**, of Hawaii, who ran the Flying Pig Marathon in Cincinnati, Ohio in 2002 in memory of her mother. Becky's training for the U.S. Air Force Marathon in Dayton, Ohio this September. **Kimberly Campbell** is also back—she completed a half-marathon last year and has her sights on the Chicago Marathon this October, traveling from her New York home to run in memory of her stepfather.

Holli Graham, of Alabama, ran a half marathon and completed a half ironman (swim/bike/run) event before finding out about RFL. She joined, trained, and ran the Mercedes Marathon in Birmingham last February.

"I have always been athletic and played varsity sports in high school and college," says Holli. "My dad really encouraged me in my athletic pursuits, and he and my mom would drive all over the Southeast and come to as many games as possible. He was a great dad."

Sadly, Holli's father died of lung cancer last summer. Holli used Hal Higdon's marathon training method (we send the booklet to all RFL runners). "I looked forward to the runs. [I] got in a rhythm, and it was kind of like meditation. I did the run-walk-run method."

New to the team are: **Diana Boehm** is gearing up for one of the nation's premier marathons — New York City in November. She's coming from Texas to honor her mother. **Lisa Moore**, of Wisconsin, has her sights on the Dutchess County Classic half marathon in New York in September. **Eric Yates**, of Ohio, is a novice marathoner who's determined to complete the Chicago Marathon. We welcome, cheer on, and thank all of our runners!

For more information, visit www.alcase.org/runforlungs/index.html **Join the Team!**

LCAM 2004: Get Involved!

Get energized, get excited, get involved and get aware! ALCASE needs volunteers in each of the 50 states to help with this year's campaign for Lung Cancer Awareness Month (LCAM).

Held annually in November, LCAM strives to increase visibility about the disease, which is America's top cancer killer. This year, ALCASE is working with many other nonprofit lung cancer groups to coordinate efforts for LCAM. We need volunteers to help in that effort. The following is a list of areas, where we could use help. If you are interested in helping, please contact Courtney Santo at courtneysanto@hotmail.com. She is helping to coordinate LCAM activities.

Volunteer Positions:

1. **Web site design:** ALCASE hopes to have one central internet site to publicize all awareness activities. We've got the address: www.lcam.org, but need a simple site design.
2. **Media Spokespeople:** We would like to have at least one person in each state who will speak with the media (on camera and off) about his/her personal experience with lung cancer.
3. **Write Your Governor:** We would like everyone who gets this issue of *Spirit & Breath* to sit down on Monday, November 15 and write the governor of your state a letter. Tell him/her why raising awareness about lung cancer is important to you and ask for action! Then stamp it and mail it!

"I don't care who you are, if you're reasonably healthy and without joint problems, you can do a marathon. You just have to take small steps. When I first started training for long distance events (about a year and a half before I did the marathon), I was in awful shape and really hated running. My workout partner and I started run-walking for 20 minutes at a time. We would run for one minute and walk for four, and gradually we built up our running times. You need to set goals and start small ... After you finish, you're glad it's over, but you're already starting to think about the next one. It really is a great feeling of accomplishment that's very addicting."

—RFL Team member
Holli Graham



Volunteer Activity

Raise Awareness – Walk *An Excerpt from Lung Cancer Walk: Yes, You Can Do It, One Step at a Time!*

A walk can be big or small, simple or complex. It is all up to you. However you spin it though, a walk can be a great occasion to get together to raise awareness about lung cancer. Walks often bring more publicity and awareness than other functions, and help people feel like they are doing something important. It takes time, and a little patience and hard work, but anyone can do a walk.

The first thing to do is start! Decide that, no matter what, you will have a walk for lung cancer. Five people are better than none, and you certainly can pull five people together for a walk around the neighborhood, can't you? Use the following information to get started!

Where?

Find a venue. Try calling your local government officials to ask about having a walk on public streets. Some cities require permits and insurance, but some may not. You could also contact local schools, including colleges that may have a track. Many will allow use of a track for a charitable cause — just ask! Make the calls and be flexible on the date.

Who?

Get volunteers — the more help you can get, the better. Start by asking your friends and family members to help, and ask them to reach out to their loved ones. Some volunteers can assist with sponsors, publicity, and speakers, while others may just want to assist on the day of the walk. However each wants to help — be sure to take their assistance with gratitude.

Find sponsors. So many people have been touched by lung cancer that it is easier than one may imagine to get sponsors to assist with the costs of the walk. For most walks, you will want some food, beverages, signs, tables, and chairs. You should also have a sound system, unless there will be fewer than 20 people at the walk. Some people may choose to get t-shirts, entertainment and goodie bags as well. Once you have decided what you need, start by asking your own employer, and asking your volunteers and friends and family to reach out to their employers. If you still need sponsors, start calling local businesses.

What's Happening?

Send letters and emails to your local newspapers telling them about your walk. Likely, it will be the first-ever walk devoted to lung cancer in the area, which is definitely a newsworthy story for the local papers. Also contact your local news agencies and radio stations. And don't forget to post signs about the walk all over town! Contact area schools, churches, and other community groups to inform

Spotlight

Last November, Renee Kosiarek, whose family had experienced lung cancer, organized the first-ever Lung Cancer Walk and Rally in the Chicago area. Using that experience, Renee wrote *Lung Cancer Walk: Yes, You Can Do It, One Step at a Time*. Get in touch with us for a copy, or see www.alcase.org

Chicago Lung Cancer Walk and Rally

Renee will hold the second-annual Lung Cancer Walk and Rally on November 6, 2004. "Our goal is to get 500 walkers this year. We will be giving walkers the option of paying the \$20 registration fee, or getting pledges from others," says Renee. "We have great ideas for publicity, and great contacts as well! We are hoping to get some attention from politicians, and gain support from more businesses! It should be a great event!"

Virginia Beach Lung Cancer Walk

The first-ever Lung Cancer Walk in Virginia Beach, Va. will be held in early November. Kelly Burke Jennings, a physical education teacher, is organizing the event in memory of her mother, who died of lung cancer in March. The event will also honor all women and men with lung cancer. For details, contact Kelly at 757.227.5618, or email her at kb@md@aol.com.

them about the walk and lung cancer in general. Meet with the local wellness houses and hospitals, and ask each to help promote the walk.

Plan the day

You should have someone give a short speech about lung cancer and the importance of the walk. If you combine the walk with a rally, then you may also want a singer or other entertainer. Use the internet to search in your area for singers and ask them to volunteer their time. The worst they can say is no. You may want to have a table devoted to education — ask ALCASE to provide you with fact sheets and other material. Additionally, ask local wellness houses and hospitals to provide other literature

Walk Day

Post signs so people can easily find the event. You will need some volunteers to help you set-up. You also need a couple of people to assist with registration (assuming you have more than 20 people). These people can also pass out the t-shirts and any other material you may want to provide. In addition, you should probably have a couple of people standing by the food/beverage area. After that, enjoy the walk, and soak in the marvelous accomplishment you have made.

Research Supplement



Radiation Therapy Continued From Page 7

were surprisingly poor (median survival of only 11.4 mo).

Huber (Abstract 7075) reported a German trial of induction chemotherapy followed by RT with or without concurrent single agent paclitaxel. Progression-free survival was significantly better in patients receiving concurrent chemoradiation after induction than those who received radiation therapy without concurrent chemotherapy. Survival favored the arm with concurrent chemoradiation although not to a significant degree. Both this trial and that of the CALGB were probably somewhat small and underpowered to detect small differences between the compared regimens.

Several key issues in lung cancer radiation therapy were not addressed at this meeting.

It is clear that the conventionally used doses of 60-63 Gy are woefully inadequate to control the typical bulk of disease in patients with Stage III NSCLC. Concurrent chemotherapy helps but has not solved the problem. Prospective trials of higher radiation doses are needed in this setting.

The use of PET scanning in conjunction with CT alters radiation treatment planning in a substantial proportion of patients, often by including otherwise unsuspected lymph node regions. Does this alter outcomes, and should it be the new standard of care?

A variety of means for dealing with the fact that lung tumors are moving targets during the respiratory cycle are becoming commercially available. How will such technologies impact our ability to accurately target and treat both small early lung cancers in medically inoperable patients and those with unresectable disease?

The Fall meeting of the American Society for Therapeutic Radiology and Oncology in Atlanta GA this October should provide updates on these and other pertinent questions in lung cancer radiation oncology.

Henry Wagner Jr., M.D. is Director, Division of Radiation Oncology at Penn State Cancer Institute Milton S. Hershey Medical Center in Hershey, PA. He is also a member of ALCASE's Medical Advisory Committee.

More NSCLC Research Noted at Lung Cancer Congress

Some drugs still in clinical trials that might show promise for previously-treated non-small cell lung cancer (NSCLC) were discussed at the Fifth International Lung Cancer Congress, held June 30-July 3 in Kauai, Hawaii. The U.S. Food and Drug Administration (FDA) has not yet approved these drugs for treating lung cancer (and some may be in trials for a variety of solid tumors). To find out more about current clinical trials with these or other compounds, see the National Institutes of Health website <http://www.clinicaltrials.gov> or the National Cancer Institute's search feature at <http://www.cancer.gov/clinicaltrials>. Or, call the NCI's Cancer Information Service at 1-800-422-6237 (1-800-4-CANCER).

bortezomib (Velcade™): blocks some of the signals cancer cells rely on, resulting in a buildup of proteins that hastens cell death.

CT-2103 (Xyotax™): a new, more water-soluble form of paclitaxel (Taxol™) with a unique way of entering cancer cells.

Epothilone B compounds (such as ixabepilone): interfere with mitosis, the cell division process of cancer cells.

GW572016: targets certain receptors inside the cell associated with cell reproduction, tumor progression, invasion and metastasis.

pertuzumab (Omnitarg™): blocks several key receptors in the cancer cell's signaling pathway, interfering with cell growth and causing death of the cancer cell.

TLK-286 (Telcyta™): stimulates apoptosis (programmed cell death) when activated by an enzyme in cancer cells.

ZD6474: targets blood vessel growth (angiogenesis) necessary for tumor growth.

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conventional q 3-week schedule. Nearly 450 patients with advanced NSCLC were enrolled on this phase III trial. Those with no evidence of progressive disease after four cycles of treatment were then randomly assigned to maintenance therapy with low-dose weekly paclitaxel versus observation. Patients enrolled on the weekly arm experienced significantly less arthralgias and myalgias (aches and pains in the bones and muscles), and less sensory neuropathy (numbness and tingling in the feet and hands). There was no difference in response rates, time to disease progression, or survival rates. Both groups fared a bit better than historic controls with respect to survival, suggesting a possible benefit to maintenance therapy.

The Japanese (FACS) spearheaded a randomized phase III trial comparing four separate, commonly used chemotherapy combinations: irinotecan and cisplatin (the standard in Japan); gemcitabine and cisplatin; vinorelbine and cisplatin; and paclitaxel and carboplatin. There was no statistically significant difference in outcome between the investigational arms. The gemcitabine and irinotecan combination yielded the best survival rates, though these two regimens were associated with substantial toxicity. The gemcitabine arm caused a significantly higher incidence of platelet toxicity; the irinotecan arm resulted in significantly more diarrhea.

An intriguing common arm analysis conducted by Gandara and colleagues evaluating carboplatin and paclitaxel suggests pharmacogenomics difference in therapeutic results; in other words, the ethnic background of certain patient populations may be associated with different response rates or survival results because of differences in drug metabolism and or clearance. Gandara evaluated patients enrolled on the paclitaxel/carboplatin arm in both the Japanese study and in a previous Southwest Oncology Group effort. The baseline patient characteristics were virtually identical with respect to histology, gender and stage. However, identical doses in the Japanese study resulted in a three month higher median survival time compared to the US trial, strongly suggesting ethnic difference. This observation needs to be investigated further.

Bronchoalveolar Carcinoma

Bronchoalveolar carcinoma (BAC) is a distinct clinical subtype of adenocarcinoma. Its clinical behavior distinguishes itself from other NSCLC histologies. This malignancy often remains confined to the lungs throughout the course of the illness, occurring in multiple lobes, often mimicking pneumonia. It tends to occur in younger patients, non-smokers, and more often in women; compared to other histologies, it tends to be chemotherapy-resistant.

West and colleagues from SWOG reported the results of single agent gefitinib 500mg daily in 138 patients with BAC.

Just over half of the enrollees were female. The overall response rate at 21 percent was at least as good, if not better than results generally seen with chemotherapy. Median survival exceeded a year whether patients were previously treated, or had received prior chemotherapy. Prognosis was better in women and in those who developed a rash.

A similar phase II trial conducted by Kris and colleagues assessed the role of erlotinib in BAC. 69 patients ultimately received treatment. Nearly 30 percent of protocol participants were "never smokers." Response rate in pue BAC was relatively low (7 percent), but turned out to be as high as 30 percent in those with mixed adenocarcinoma/BAC. As with the gefitinib trial, the median survival exceeded one year.

The results of these efforts strongly suggest that BAC may be best approached with non-cytotoxic therapy. Upcoming studies will evaluate the role of monoclonal antibodies, as well as combinations of EGFr TKI and vascular inhibiting agents. This year has proven a watershed year with the respect to adjuvant trials and the role of EGFr inhibition in the second and third line setting. It is hoped, that the advances observed at ASCO (2004) will translate into improved survival rates in the lung cancer population at large.

References: Winton, ASCO 2004, A-7018; Strauss, ASCO 2004, A-7019; LeChevalier, IALT, ASCO 2003; Shepherd, ASCO 2004 (A-7022); Lynch, NEJM 2004; 350; Gatezemeier, ASCO 2004 (A-7010); Herbst ASCO 2004 (A-7011); Belani, ASCO 2004 (A-7017); Kubota, ASCO 2004 (A-7006); Gandara, ASCO 2004 (A-7007); West, ASCO 2004 (A-7014); Kris, ASCO 2004 (A-7062)

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Key Highlights from ASCO 2004

This issue of our Research Supplement will focus on noteworthy lung cancer results presented at ASCO 2004.

Radiation Therapy Update

by Henry J. Wagner, MD

While the major excitement in lung cancer presentations at this year's ASCO meeting dealt with successful adjuvant chemotherapy for patients with resected NSCLC and the emerging story of the role of tyrosine kinase inhibitors, with erlotinib showing a prolongation of survival in patients with metastatic disease compared with best supportive care, there were also several reports of trials clarifying the role of radiation therapy, either as a single modality or combined with chemotherapy and surgery.

Onishi (Abstract 7003) reported an update of a multi-institutional experience with stereotactic high dose irradiation (STI) for patients with medically inoperable NSCLC, stage I. From 1993 to 2003 273 patients with T1N0 and T2N0NSCLC were treated with STI to total doses from 57 to 160 Gy. With a median follow-up of 24 months, the local failure rate was 12.5 percent for all patients, 8.0 percent for those treated to 100Gy or more and 26.4 Gy for doses <100 Gy. Three year survival of medically operable patients treated to the higher doses was 95 percent. While further follow-up is in order as well as full reporting or survival for all patient groups, this report further demonstrated the substantial curative potential of higher dose small volume image guided radiation therapy for selected patients with early stage NSCLC who may not be optimal candidates for surgery.

The North American Intergroup trial reported last year that, for patients with Stage IIIA NSCLC with biopsy proven mediastinal lymph nodes, pre-operative radiation therapy followed by surgery and definitive chemoradiation gave similar overall survivals. The inclusion of surgery gave better disease-free survival, but in this trial this was counterbalanced by a higher rate of early toxic deaths. The search for safer ways to combine modalities in lung cancer treatment remains a high priority. Thomas (Abstract 7004) reported a trial conducted by the German Cooperative Lung Cancer Group which randomized patients with N2 NSCLC to preoperative chemoradiation or chemotherapy only. Between 1995 and 2003 558 patients were randomized, of whom 94 percent were eligible. Early toxicity such as esophagitis was, as expected, more severe in those patients receiving radiation. However treated related mortality did not differ between the arms (5.6 vs. 5.3 percent), nor did respectively, the proportion of patients undergoing complete resection, or three-year survival (24 percent /23 percent). The authors concluded that the addition of RT to

the preoperative regimen did not add to progression free survival but did add to toxicity.

The three-year survival for both arms was rather low and compares poorly with the North American Intergroup trial as well as several newer reports of chemoradiation alone. This may in part reflect the fact that about 2/3 of patients in this trial had Stage IIIB disease. Also, one would expect that radiation therapy, while contributing relatively early to increased in treatment related morbidity and mortality, would, if it improved local control, exert a beneficial effect on the tail of the survival curve rather than on earlier times. It thus may require longer follow up to properly evaluate whether or not the inclusion of pre-operative RT has a role for these patients. The RTOG is coordinating an Intergroup trial testing this question in patients with potentially respectable IIIA disease, with a randomization between chemotherapy only (carboplatin/docetaxel) or the same chemotherapy with concurrent radiation therapy. This trial is scheduled to open in the next year.

Rischin (abstract 7077) reported early results of a Phase I-II trial investigating the addition of gefitinib to concurrent chemoradiation using carboplatin/paclitaxel and radiation therapy to 60 Gy in 6 weeks. An initial group of five patients continued to receive gefitinib following completion of chemoradiation, but this was stopped after reports from other centers of interstitial pulmonary disease in patients receiving gefitinib. Overall acute toxicities were acceptable, but Grade 2 interstitial pneumonitis was seen in 5 of 15 patients, 4 of whom were treated with long term gefitinib. The effectiveness of Cetuximab in combination with RT in patients with locally advanced head and neck cancer, as also reported at ASCO this year, suggests that further investigation of combinations of inhibitors of EGFR signaling, both antibodies and low-molecular weight kinase inhibitors in conjunction with thoracic radiation warrant further exploration but should not be adopted for general use without much more data on safety and efficacy.

Several groups reported trials investigating optimal sequencing of radiation and chemotherapy for patients with unresectable Stage III NSCLC. Vokes (Abstract 7005) reported a CALGB trial of concurrent chemoradiation with or without induction chemotherapy. Both median and one year survival favored the arm using induction chemotherapy prior to concurrent chemoradiation, but the differences were not significant and the survival results in the concurrent only arm without induction chemotherapy (see page 11 for continuation of article)

Surgical Oncology Update

By Eric Vallieres, MD

ASCO 2004 was exciting for lung cancer patients and surgeons treating them. The results of two North American clinical trials, which evaluated the role of adjuvant (post-operative) chemotherapy, reinforced previous research (1) showing survival benefits to such chemotherapy.

NCIC Trial Shows Survival Benefits

Dr Tim Winton, on behalf of the NCI Canada Clinical Trials Group, presented results of NCIC's Br 10 trial. (2) In this Intergroup phase III collaborative trial, 482 patients who had undergone complete resection (surgery) of stage IB, IIA and IIB NSCLC were randomized to observation alone or to 4 cycles of cisplatin and vinorelbine, starting within 40 days of their surgery. Adjuvant vinorelbine/cisplatin chemotherapy was completed as intended in 49 percent of patients. Of the 123 patients who did not complete their four cycles of chemotherapy as planned, 30 did not because of toxicity, nine because of disease progression, three died and 72 refused for other non-medical reasons. Quality of life was assessed during and after treatment in both groups and was decreased during adjuvant therapy but very similar after treatment completion. Recurrence-free survival at five years was 48 percent in the surgery only arm and 61 percent in the chemotherapy arm. These results translated into a very impressive overall survival advantage for the adjuvant chemotherapy-treated patients, whose median (half the patients less, half more) survival was nearly two years longer. Absolute overall survival at five years was 69 percent for the adjuvant group vs. 54 percent for the control group. Further analysis of tumor characteristics is pending. Investigators concluded that adjuvant cisplatin/ vinorelbine chemotherapy could be safely given to patients recovering from resection of stage IB and stage II NSCLC and that it provided a significant improvement in disease-free and overall survival, compared to observation alone.

Results from CALGB 9633 Phase III Trial

These exciting results were followed by a presentation by Dr. Gary Strauss on behalf of the CALGB, RTOG and NCCTG reporting the results of CALGB 9633, a phase III trial of adjuvant chemotherapy with paclitaxel and carboplatin following resection in Stage IB disease.(3)

In CALGB 9633, 344 patients were randomized to either observation or to four cycles of the carboplatin/paclitaxel doublet, starting four to eight weeks after the complete resection of their T2N0 NSCLC. The mean (average) tumor size of these lesions was 4.7 cm (range 0-15 cm); 89 percent of patients were treated by lobectomy. There were no chemotherapy-related deaths and grade 3-4 neutropenia (low number of neutrophils, or white blood cells) was noted in 36 percent of patients in the chemotherapy arm.

Delivery of the chemotherapy was quite good, with 85 percent of patients receiving all four cycles of chemotherapy, and 55 percent of patients receiving all four cycles at full-intended dose. Median (half of patients less than, half more than) follow-up was 34 months. Failure-free survival was significantly increased in the chemotherapy arm, leading to an absolute overall survival of 71 percent at four years, versus 59 percent with observation alone.

Sites of first recurrences were in the primary lung in a significant number of patients in both groups. This will be studied in more detail. Death from lung cancer was reduced by 49 percent in the adjuvant chemotherapy group. Mortality from other causes was similar, resulting in an absolute reduction in all-cause mortality of 38 percent. Dr Strauss and colleagues concluded that four cycles of adjuvant chemotherapy with paclitaxel and carboplatin were well tolerated in their patients and should be considered, following resection of stage IB NSCLC.

Japan Trial Weights in on Adjuvant Chemo

A meta-analysis (statistical review) of published studies from Japan was also presented and concluded in favor of adjuvant chemotherapy after resection of T1N0 adenocarcinomas larger than two centimeters and stage II adenocarcinoma, using the oral agent UFT (not yet available in North America).(4)

Significant Impact Expected From Results

The results of these trials will have a significant impact on the role of combining different types of therapy in the treatment of NSCLC in early stages. Correlative studies (further analysis of the tumors and patient characteristics) from these trials, are pending. Potentially, they could allow better identification of groups of patients who are likely to benefit the most from such an approach. Bringing novel biologic therapies into the adjuvant cytotoxic (cell-killing) strategy will be studied in future trials. Finally, whether induction (preoperative) chemotherapy offers an advantage over more conventional adjuvant therapy remains unanswered. Future trials comparing the two strategies are being designed.

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Dr. Vallieres is on ALCASE's Medical Advisory Committee and is Surgery Director, Thoracic Oncology Program, at the Swedish Cancer Institute in Seattle, WA.

Medical Oncology Update

by Corey Langer, MD

For the first time in many years, we have observed major headway in the treatment of advanced non-small cell lung cancer (NSCLC). Two separate randomized trials have demonstrated a clear cut benefit for adjuvant treatment with chemotherapy after surgical resection. In addition, we finally have evidence that new agents such as the epidermal growth factor receptor inhibitors can improve survival in patients whose tumors have progressed on standard treatment. Changing the schedule of standard chemotherapy drugs may potentially reduce toxicity, without compromising efficacy. Finally bronchoalveolar carcinoma, an entity that behaves somewhat differently from most other NSCLC, appears to be particularly sensitive to EGFr inhibitors.

Adjuvant Therapy: A New Model

By definition, adjuvant treatment constitutes additional treatment given after definitive surgery, to help prevent or delay relapse. Two separate presentations during the thoracic plenary session underscored the usefulness of chemotherapy after surgical resection. The NCI-C mounted a randomized phase III trial testing the benefit of combination vinorelbine and cisplatin after resection in stage Ib/II NSCLC. Patients were randomized after surgery to either chemotherapy or observation. Nearly 500 patients were accrued to this study over a 5-year period. The group receiving chemotherapy enjoyed a statistically significant improvement in 5 year survival rate: 69 percent versus 55 percent. While the majority of individuals on the treatment arm were able to complete at least three cycles of chemotherapy, just over half were able to receive all four. This trial, in the context of the IALT effort presented last year by LeChevalier, which showed a similarly significant, though numerically more modest, improvement in survival, has helped reset our therapeutic thermostat when it comes to treating resected NSCLC patients in the adjuvant setting (additional treatment given post resection to help prevent or delay relapse).

A similar trial presented by Strauss and colleagues from CALGB focused on resected stage IB NSCLC. 344 patients were randomized to either standard therapy (observation post-resection), or to combination paclitaxel and carboplatin for four cycles. The intervention arm was administered every three weeks. Compliance was excellent, with over 80 percent of patients completing all scheduled therapy. As in the NCI-C study, the investigators observed a double-digit improvement in survival: 71 percent at 4 years for the adjuvant group versus 59 percent for the control group. The analysis in both studies was conducted on an intent-to-treat (ITT) basis.

The standard treatment approach has clearly been influenced by these efforts. Fit patients of any age, who undergo surgical resection for early stage NSCLC, can benefit from adjuvant treatment using a combination regimen, with platinum as its backbone.

EGFr Tyrosine Kinase Inhibitors

Epithelial cancer cells like NSCLC are generally lined with epidermal growth factor receptors (EGFr). Increased concentrations of these receptors have been associated with an increased likelihood of metastatic progression, as well as poorer prognosis. Gefitinib (Iressa, ZD 1839) and Erlotinib (Tarceva, OSI 774) are two prototypical EGFr inhibitors. In advanced NSCLC patients whose tumors have progressed on two or more prior regimens and who would otherwise have refractory disease, each agent has demonstrated clear activity and relatively promising survival rates. In a critical, placebo-controlled phase III randomized trial presented by Shepherd and colleagues which compared erlotinib to best supportive care (BSC), the use of erlotinib led to a two month improvement in median survival (the point at which 50 percent of patients have succumbed to the underlying cancer); more importantly, it has generated a nearly 10 percent improvement in one year survival rate. Side effects included acne-like rash and diarrhea, which, though common, was seldom severe. The usual side effects associated with chemotherapy, including reduction in blood counts, hair loss, nausea and vomiting, were extraordinarily rare. Those most likely to benefit included women, non-smokers, or those with relatively little cigarette exposure, and those with adenocarcinoma histology.

Unfortunately, the addition of erlotinib (Tarceva, OSI 774) to standard chemotherapy in two other, large, randomized phase III efforts, failed to show a survival advantage over chemotherapy alone. These results were disappointing, but scarcely surprising. Other, recent studies evaluating targeted agents in this setting (e.g. gefitinib, and lonafarnib), had similar results.

Lynch and colleagues have identified an "activation mutation", which seems to correlate with response to single agent (monotherapy) in patients who have previously had disease progression despite conventional chemotherapy drugs. At this year's ASCO meeting, multiple other groups verified the existence and predictive nature of this mutation. The vast majority of patients with this mutation responded to treatment. But this mutation provides no explanation for patients with stable disease, who still derive a clinical benefit response. Nor are kits to detect this mutation commercially available as of the summer of 2004.

Conventional Therapeutic Agents

Belani and colleagues evaluated the role of weekly paclitaxel in combination with carboplatin versus the more