Cancer as we Age
The News is Good and Getting Better

By John E. Morley, MB, BCh, and Rami Y. Haddad, MD

While cancer is still one of the most dreaded diagnoses, the good news is that the percentage of persons developing cancer is decreasing, as is the number of deaths from cancer. A cancer diagnosis is no longer an automatic death sentence. Early detection of cancers and dramatic advances in their treatments, coupled with a decline in tobacco use, have been the major reasons for these changes. However, this good news needs to be tempered with the realization that cancer occurs more commonly as we age. Persons aged 65-74 years have a two to three times higher chance of developing cancer than those 50 to 64 years old, and those over 75 years of age are at even greater risk for developing, and dying from, cancer. Cancer is the most common cause of death in persons 60 to 70 years of age and the second most common cause of death in persons over 80 years of age. Thus, despite the fall in the incidence of cancer, the increase in the aging population has resulted in an increase in total numbers of persons with cancer and cancer deaths. If this trend continues, the number of (continued on page 2)
patients with cancer will double to 2.6 million in the year 2050. Persons over 75 years of age will make up over 40% of those with cancer. There will be a four-fold increase in cancer in persons over the age of 85.

Overwhelmingly, lung cancer is the most common cancer in persons over 60 years of age. Colorectal cancer is the next most common. In women, breast cancer is slightly more common than colorectal cancer, and in men, prostate cancer occurs at almost the same rate. Pancreatic and non-Hodgkin’s lymphoma in men and pancreatic and ovarian cancer in women round out the top five. In persons over 80 years of age, cancers of the bladder and leukemia become more common in men.

Cancers come in many different forms. Some are relatively benign, such as a slow-growing skin cancer, while others grow rapidly. Cancer can remain localized to one area or it can spread through either the blood or the lymphatic system to distant parts of the body. When this happens, the cancer is said to be a metastatic cancer. It is more common for the cancer to spread by the lymphatic system than through the blood, and that is why lymph nodes near the cancer are checked to see if the cancer is present there.

Is cancer different as we age?

There are many reasons why cancer is more common in older than in younger persons. First of all, older persons have had a longer time during which they have been exposed to carcinogens, i.e., agents that produce cancer. At the same time, there is a decline in the body’s immune system with aging. The immune system and particularly the natural killer cells are important in destroying cancer cells before they can accumulate and take hold in the body. Loss of telomeres (the ends of chromosomes) that control the rate at which cells divide occurs with aging and is thought to play a role in cancer development. The decreasing ability of the body to repair genetic material (DNA) with aging can lead to alterations in normal cellular regulation.

Besides the increased propensity of older cells to develop cancer, when they become cancerous they often behave differently. Some, such as breast cancer, grow more slowly. Breast cancer in older women is more likely to respond to hormonal therapy because it is more likely to have receptors for estrogen and progesterone in the breast. On the other hand, acute myelogenous leukemia in older persons often responds less well to drugs and older persons may not tolerate high doses of the chemotherapy because of the lack of reserve capacity in their blood cells.

Cancer in older persons: taking an aggressive approach

Older persons often receive less prevention education, fewer screenings, and less aggressive treatment for cancer than do younger persons. Recent studies have suggested that this may be inappropriate because older persons have been shown to tolerate chemotherapy for breast cancer just as well as younger persons. While the outcomes of treatment in older persons may, in some cases, be not as good as in

Healthy older persons do very well with treatment.

PET scan courtesy PET Imaging Department, Saint Louis University Hospital

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Best Practices for Cancer Survivors

Cancer used to be a concern primarily of young people. Cancers of the brain, bone, kidney and especially acute leukemia, were, and still are, cancers associated with young people. Throughout most of the 19th century, people died of infections long before they were old enough to develop those cancers that are now most commonly associated with the elderly—colorectal, lung, breast, and prostate cancers. Modern medicine, in concert with improved sanitation, has been so successful at allowing people to survive to old age that, now, for every young person that develops cancer, 170 elders develop cancer. This makes cancer primarily a disease of the elderly.

This change in the percentage of older people who develop cancer, added to the recent advances in cancer research that allow greater numbers of people to be cured of cancer, has led to new challenges in medicine. As the number of cancer survivors grows, the practice of medicine has come to include oncologists who develop long-term relationships with their patients. One such oncologist at Saint Louis University is Dr. H. Joachim Reimers. We talked with Dr. Reimers about what advice he has for people who survive their battles with cancer. We share his wisdom with you here.

Common side effects

Common side effects of cancer treatment include temporary hair loss, inability to concentrate, and noticeable functional impairment. The most common side effect is chronic fatigue. This is true whether the cancer is treated with surgery, radiation therapy, bone marrow transplants, biotherapy, or chemotherapy. The body needs time to recover from the cancer and from the treatment. It is not uncommon for the patient to be fatigued for at least a year following the cure. Researchers are now looking for a key to how to reduce that fatigue. For example, cancer patients are treated differently in the USA and Germany. In the United States, people often continue to work while undergoing chemotherapy. In Germany, cancer patients are encouraged to stay home from work while undergoing chemotherapy and are then given a rehabilitative program before re-entering the workplace. Comparing the results from such different approaches will provide insight into which strategies are suitable for relieving the chronic fatigue experienced by cancer patients.

Early detection increases survival

If you are over the age of 50 and have no family history or other risk factors for a specific type of cancer, then you should follow the current standards of health care when deciding how often to be screened for cancer. The American Cancer Society (ACS) has published screening guidelines for many types of cancer and this information is (continued on page 20)
Saint Louis University Hospital is One of the Best in the Country
Listed Among the Top Ten Hospitals in Geriatrics

On July 22, 2002, US News and World Report issued its thirteenth annual rankings of America’s Best Hospitals. This ranking shows where to find the best care in 17 specialties including geriatrics. Saint Louis University Hospital has been placed in the top 10 in the national ranking of geriatric care for five years in a row.

The US News and World Report’s assessment of hospital ranking can assist patients in identifying medical centers with unmistakable expertise in various medical specialties. For geriatrics, these hospitals were given an institutional ranking, the US News Index, made up of three equal parts relating to quality of care: reputation, mortality, and a group of factors such as technology and nursing care. Saint Louis University Hospital had the best hospital-wide mortality ratio of all the hospitals listed in the top 10 for geriatrics.

Carol Peterman, Chaplain of National Health Care Nursing Home of Maryland Heights, Missouri, created a dying time protocol that validates the significance of one’s rite of passage. The protocol teaches all staff, regardless of department or role, how to establish and maintain an area in and near the dying patient’s room that is comforting and tranquil. The care plan is adapted to each family with emphasis on their particular world view, religion, or rituals.

A “Comfort Cart” is provided. The cart holds light refreshments to allow the family members to remain with the dying resident. Cards with spiritual verses and CDs of soothing music are available on this cart as well. A serene, framed picture is placed on a marble pedestal outside of the patient’s room to alert employees, guests, and other residents that death is imminent. This affords them the opportunity to honor that family with quietness and respect.

Country music was provided for one dying resident who had been unresponsive for several hours. Her daughters were certain they saw her smile when a CD of Johnny Cash began to play. Another family returned to pick up some belongings after their loved one had passed. They asked to see a particular employee from the dietary department in order to tell him that he would always be remembered for the care he provided. The employee is an immigrant from Africa. He replied, in broken English, “I care this is happening to you today. I pray for you.” Those simple, yet genuine words began a relationship that impacted this family’s grief journey.

Saint Louis University Hospital has a highly successful geriatrics program, not only in clinical care, but also in its research and educational programs. It has several supportive care programs including an acute care unit (Acute Care for the Elderly or ACE Unit), a sub-acute care unit (Life Care Center of St. Louis), a nursing home, home care, and outpatient and assisted living programs. Educational programs offered each year to healthcare professionals, as well as to the lay public, by the Division of Geriatric Medicine include conferences, newsletters, newspaper columns, television and radio interviews, workshops, and interactive Internet websites. All of these programs help make Saint Louis University Hospital an excellent place to receive geriatric care.

Giving Comfort

Carol Peterman, Chaplain of National Health Care Nursing Home of Maryland Heights, Missouri, created a dying time protocol that validates the significance of one’s rite of passage. The protocol teaches all staff, regardless of department or role, how to establish and maintain an area in and near the dying patient’s room that is comforting and tranquil. The care plan is adapted to each family with emphasis on their particular world view, religion, or rituals.

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present the

2nd International Meeting

International Academy on Nutrition and Aging

Albuquerque, New Mexico, USA
July 10-12, 2003

Sheraton Old Town
800 Rio Grande Boulevard NW
Albuquerque, New Mexico USA

The International Academy on Nutrition and Aging decided to organize the 2nd International Meeting in Albuquerque, NM, because it is the home of The New Mexico Aging Process Study (NMAPS).

The NMAPS, one of the first longitudinal studies on Nutrition and Aging, started in 1979 by James S. Goodwin, M.D., and Philip J. Garry, Ph.D., is supported by the National Institute on Aging. Since 1979, the NMAPS has produced over 180 publications examining the role of nutrition in the aging process. For more than 10 years, Rick Baumgartner, Ph.D., the principal investigator of the NMAPS, has been involved in this project, adding tremendous work on body composition and genetics.

This conference was organized in collaboration with the Saint Louis University Division of Geriatric Medicine, one of the major clinical and research centers in geriatrics in the world and a collaborator for many years with the NMAPS in Albuquerque.

Large portions of the symposium this year will be devoted to associations between nutrition and dementia, including Alzheimer’s disease. Dementia is one of the major health problems in the elderly, with more and more evidence that diet, vitamin intake, anti-oxidant status, diabetes, cholesterol, and apoE (E4) are related to cognitive decline in the elderly. Researchers from around the world will be presenting on subjects including DIAGNOSING AND TREATING DEMENTIA, AGING SUCCESSFULLY, HORMONE REPLACEMENT THERAPY, BODY COMPOSITION, SARCOPENIA, and NUTRITION IN THE LONG-TERM CARE SETTING.

FOR MORE INFORMATION ABOUT THIS CONFERENCE, CALL 505-272-3942 OR FAX 505-272-8604
cer was rarely cured; today cures abound. I have been fortunate to live through an era where I have seen the development of kryptonite-like medicines for certain cancers such as gleevec for chronic myelogenous leukemia. What was science fiction when I started my career is reality today.

Cancer is a disease of aging and how we handle it determines whether or not we age successfully. Recently Harvey Cohen and his colleagues at Duke University demonstrated that high quality geriatric care has a major impact in determining the quality of life of older persons with cancer. Saint Louis University has developed a Cancer Center which can work closely with the geriatricians in our “Top 10” geriatrics program to add quality years to the lives of older persons. Thus, oncologists working hand-in-hand with geriatricians can not only bring cutting edge advances in cancer therapy to older persons, but can also provide a focus on maintaining function at the same time. Together, when cure is no longer feasible, we can work to relieve pain and suffering, thus allowing the older person with cancer to face the final journey with equanimity and spiritual harmony.

This issue provides practical advice for those older persons facing a cancer diagnosis. In addition, it has heartwarming stories from some older cancer survivors. It is hoped that this issue will provide a useful learning experience for you just as it has for those of us who researched these articles. Certainly we wish all of you who have to face one of life’s greatest hurdles the best of outcomes. May God bless you all.

This special issue of Aging Successfully was made possible by a Grand Visions grant from the Saint Louis University Hospital Auxiliary. We extend our thanks to them for making it possible to provide this issue for our older friends and patients.

Finally, this issue of Aging Successfully is dedicated to two of our faculty members and my friends who faced cancer bravely: Douglas K. Miller, MD, who successfully became a cancer survivor and James Flood, PhD, who showed me what a “good death” truly is. These two magnificent people taught me more about cancer therapy and the role of positive attitudes than I could have learned from all of the books ever written on the subject.

John E. Morley

Saint Louis University Geriatric Care
Physicians Listed as Tops in America

Castle Connely Medical Ltd. compiles the 2002 America’s Top Doctors guide based on feedback from physicians who identify the most highly skilled and exceptional doctors. The firm follows a rigorous screening process that uses mail and telephone surveys, electronic ballots, an examination of educational and professional experience, and other research to choose the most outstanding physicians in the country.

*St. Louis Magazine* uses the information to select the “Top Doctors” in St. Louis, who are profiled annually in the publication. Three doctors specializing in providing geriatric care were selected this year. They are Douglas K. Miller, MD; John E. Morley, MB, BCh; and George T. Grossberg, MD. Congratulations to our doctors for a job well done.

**MOVING SOON?**

You won’t want to miss our next issue! Please fax the label from the back of this issue along with the new address to 314-771-8575. Allow 12 weeks for processing.
New Cancer Technique Offers Hope to Older Patients

Cancers of the blood, leukemia and lymphoma, carry a poor prognosis when they occur in older adults. This is because these types of cancer are normally treated with chemotherapy, followed by bone marrow transplantation, which is very toxic and not well tolerated in older patients.

A bone marrow transplant involves the introduction of bone marrow from a closely-matched donor to replace the host bone marrow that has been destroyed by the chemotherapy used to eradicate the disease. Almost 1/3 of the patients die from the side effects of the transplant. Because of this, it conventionally has been believed that only young patients are strong enough to undergo this type of treatment. This is despite the fact that cancers of the blood are much more common in older adults than in younger adults or children. As a result, even though the median age of diagnosis of acute leukemia is 65, only 10% of patients diagnosed with leukemia have traditionally been considered candidates for transplantation.

The bone marrow is a person’s immune system. To transplant bone marrow is to transplant someone else’s immune system into a patient. One serious side effect of bone marrow transplantation is graft-versus-host disease (GVHD). This occurs when the donor’s immune system mounts an attack against the patient. Although GVHD can be severe, and even fatal, the transplanted immune system can also do something very unique which makes it worthwhile to take the risk of developing GVHD. It can attack the cancer. This is called graft-versus-leukemia/lymphoma (GVL).

A new technique has been developed to harness the power of GVL. This technique is called nonmyeloablative transplantation. The theory behind this approach is that, rather than destroy all of the bone marrow (myeloablation) of the patient, small amounts of donor bone marrow are added to the diseased bone marrow to compete with it (nonmyeloablation). This new technique is done while the patient is exposed to immune suppressing medications in order to prevent GVHD. Successful introduction of donor bone marrow should result in a condition known as chimerism. In this condition, both types of bone marrow work together to produce blood cells. Once chimerism results, the immune suppressing medications are withdrawn to promote GVL. Sometimes GVL can be augmented by infusing blood cells collected from the original donor. GVHD can still occur but the patient has a greater chance of surviving it because he/she has not been weakened by myeloablation. Cancer research in dogs has helped to clarify optimal dosages of both donor bone marrow and immune-suppressive drugs and the technique is now being used quite successfully in patients with cancers of the blood.

Dr. John Richart of the Saint Louis University (SLU) Cancer Center was quick to realize that older adults could benefit from this new technique. Because death caused from the side effects of myeloablation can be almost entirely eliminated, bone marrow transplantation can be offered to patients with cancers of the blood who would not normally be considered candidates for this potentially curative treatment. Dr. Richart’s most recent patient is a 60-year old man with lymphoma. His cancer has completely disappeared; he takes no medications, and he is living a healthy, normal life.

This new technique is not available at all transplant centers. Thanks to Dr. Richart, bone marrow transplant research at the SLU Cancer Center is raising the limit on how old is too old to receive effective transplant treatment.
Cancer as we Age (continued from page 2)

younger persons, this is often due to the fact that the person being treated has other diseases and may have a poorer level of function. Healthy older persons do very well with treatment. Also, elders who have a strong social network and/or who live with healthy and supportive family members often can better survive more aggressive treatments than can people who live alone or whose spouse is frail. Thus, it is important that as decisions about screening for cancer and its treatment are made, the person’s level of health, life expectancy, and social support are taken into account.

Cancer prevention

In 1950, smoking was shown to be the number one cause of preventable cancer. Since then, other lifestyle alterations have been shown to lessen the chances of developing cancer, although none is as powerful as smoking cessation.

Screening for cancer on a regular basis can result in early detection and treatment of the cancer, thus saving lives. Persons who develop symptoms suggestive of cancer as outlined in the CAUTION mnemonic (see page 13), or who have a higher risk of cancer than average, need to discuss appropriate approaches to screening and diagnosis with their doctor. While some of the screenings may be controversial, such as the recent arguments over breast self-exam and mammography, nevertheless they still appear to make sense for most people. (See page 20 for several screening recommendations.)

Making rational decisions about your cancer treatment

When discussing a diagnosis of cancer with the oncologist (cancer doctor), take a friend or relative along with you. This is a very emotional time and one does not always understand or later remember what is being said. Be careful to make sure you ask all your questions (write them down or use the questionnaire in this issue of Aging Successfully (see page 22).

Life expectancy in older persons

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(Based on NCMS Life Tables of the United States 1997, Adapted from Walter LC and Covinsky KE. JAMA 2001:285:2750-6.)

Lifestyle Factors for Preventing Cancers

Clear benefit
- Do not smoke or chew tobacco
- Use sunblock and avoid excessive sun exposure
- Avoid occupational exposure to cancer-causing toxins or use appropriate protective clothing
- Increase physical activity (colon and breast cancer)
- Avoid being overweight (colon, breast, and uterine cancer)

Probable benefit
- Eat fruits and vegetables (colon and lung cancer, and possibly others)
- Limit red meat intake (colon cancer)
- Limit alcohol intake (oral, esophageal, breast, and pancreatic cancer)

Possible benefit*
- Take folic acid and supplements (colon and breast cancer)
- Take selenium supplements (lung, prostate, and colon cancer)
- Take vitamin E supplements (prostate cancer)

*Note that eating a balanced diet with citrus fruit, broccoli, leafy vegetables, asparagus, and tuna is most probably as good as taking these vitamins and minerals as a supplement.
My Turn

Using this forum, we take this opportunity to share the stories of four cancer survivors. May their courage inspire you and their stories give you hope.

Don Cline’s mother had colon cancer years ago. Knowing there was a family history of colon cancer, he made sure his family doctor checked for it every year. Four years ago, when in his late 60’s, he had a little pain just below his navel and some slight constipation when he went for his annual check-up. His family doctor gave him a clean bill of health. But Mr. Cline was not convinced and insisted the doctor check again. That was why he got the colonoscopy that saved his life.

During the colonoscopy the doctor found a cancerous polyp that was just out of sight of what could be found with the proctoscope only. The polyp was removed by surgery which was deemed a total success. Eight months later, a chest x-ray performed during a routine physical exam detected a tumor in the left lung. A PET scan indicated that the tumor was not cancerous, but Mr. Cline’s common sense told him to get a second opinion.

He asked a neighbor who worked in the medical profession where she would go if she were in his shoes. She recommended Saint Louis University Hospital. There, he learned that PET scans detect only fast growing tumors, and this one was not fast growing. A CT scan revealed three tumors in the right lung also. These three tumors were removed in June 1999. The tumor in the left lung was treated with chemotherapy to attempt to shrink it, however, the tumor did not shrink. It was surgically removed in December 1999. He has been cancer free for 3 years. He returns to Saint Louis University Cancer Center for blood tests and a CT scan on a regular schedule: initially at 3 months, then at 6 months, and now, annually.

Mr. Cline attributes his success in fighting cancer to a number of things. When he first was diagnosed he went to his pastor and asked for readings from the Bible to help him understand and accept what was happening to him. Once he became at ease with his fate he was able to feel at peace with undergoing all of his treatments. He did what the doctor told him had to be done, always went through with the treatment, and never missed an appointment.

One instruction, in particular, was hard to follow. He was told to avoid people while undergoing chemotherapy. The support of family and church members was critical in his recovery. People wanted to help in any way they could, but they would sometimes forget he was ill because people with cancer often don’t look particularly weak or ill. Instead of avoiding people, he compromised and continued to interact with them but was very particular about washing his hands carefully after shaking hands and he did avoid people while they had colds. This way he received the support of loving family and friends but he didn’t take any chances about contacting germs he couldn’t fight.

Mrs. Cline was Mr. Cline’s greatest weapon against his cancer. She maintained her cool through every procedure and diagnosis and kept a positive attitude. She even washed his toothbrush in the dishwasher every week to help him keep germs at bay. And, she helped him search the Internet for ideas and suggestions about what might help in his treatment. They found that the Mayo Clinic had a very helpful website (see page 21).

Finding information on the Internet gave them confidence that their doctor was doing the right thing. It also helped them feel they had some control over the process of getting better.

Mr. Cline has one final piece of advice he would like to share about evaluating the information available on the Internet: if you find something that you want to talk to the doctor about, print it out and take it to your next appointment. That helps the doctor understand exactly what was said and it tells him/her where the information was posted. That makes it possible for the doctor to evaluate the accuracy of the information and ensure you are getting the best of care.

More stories from survivors can be found on page 10
Five years ago, at the age of 55, Arlie “Smoke” Daugherty was too busy working for a living and playing golf to notice that he had one of the classic warning signs of cancer. It took the sharp eye of his wife to notice that he had a pimple on his chest that would not heal. A trip to their family doctor confirmed her suspicions. The pathology report came back with a diagnosis of stage IV, non-Hodgkin’s lymphoma that had spread to the bone marrow.

They immediately asked Dr. Paul Petruska at Saint Louis University to manage Mr. Daugherty’s fight against this cancer. The cancer was too close to the aorta to risk radiation therapy. Radiation close to the heart could damage the valves and muscles of the heart. Instead, they opted to treat the cancer with chemotherapy for a year. The chemotherapy put the cancer into remission. They felt fortunate but they did not let their guards down.

The Daughertys returned for a check-up in 3 months, then at 6 months and finally once every year. They never missed an appointment, even though he had no symptoms. He continued to work, he was not tired, and he had no reason to be suspicious that the cancer was back.

Then, 5 years later, during his annual screening it was discovered that the cancer was back. This time the cancer was caught before it had spread to the bone marrow. This allowed Mr. Daugherty to have an option he had not had before; this time he could donate his own bone marrow for a transplant. His insurance covered bone marrow transplants, and it was his best chance for either curing the cancer or putting it into remission.

He underwent another round of chemotherapy which succeeded in shrinking the cancer by about 70%. Mrs. Daugherty was able to give him many of his chemotherapy shots at home. He didn’t mind the hair loss but the nausea and the sensation of burning in his feet were difficult to live with. The chemotherapy also made him anxious, but his wife did a search on the Internet and found others who had suffered from the same symptoms. Following the advice she found from other cancer patients, she talked to the doctor about prescribing something to help control the anxiety. It worked so well that Mr. Daugherty recommends it to others who now call him for advice on how to deal with their cancer.

Mr. Daugherty had a bone marrow transplant in May and was back on the golf course 3 weeks after the transplant. He doesn’t have as much energy as he once had, but so far his check-ups have given him a clean bill of health. Even if he isn’t completely cured, he expects to be in remission for at least 10-15 years. By then he will be 75 and he hopes that chemotherapy will be available in a single shot, rather than as a series of shots which take weeks to complete. Right now, Medicare does not cover the costs of bone marrow transplants, but if Mrs. Daugherty’s lobbying efforts bear fruit, that will change soon. The Daugherty’s attribute his recovery to a few simple rules: ■ Have a positive attitude ■ Keep your appointments ■ Follow the doctor’s instructions ■ Eat a good diet and avoid saturated fats ■ Surf the Internet regularly for new information. More stories from survivors on page 11.
Mrs. Novelite Allen did not get to be 77 by ignoring her health. Five years ago she felt soreness on her left breast. She examined it and thought it was just a small pimple. Two days later, when the soreness got worse and the pimple got larger, she ran (her exact word) to her doctor to get a mammogram. The mammogram showed that the pimple was, in fact, the surface of a tumor. She got a second mammogram, which confirmed the suspicion of cancer, and her internist referred her to Saint Louis University Hospital for a biopsy. The biopsy showed that the tumor was cancerous.

Because Mrs. Allen had found the cancer so early she had several options about how to treat this cancerous tumor. She rejected radiation therapy because she had heart problems and did not want to take any chances of radiation damaging the heart muscle. The cancer had not spread to any of the lymph nodes and the tumor was small enough that chemotherapy was not needed to shrink the tumor. She decided it was best to remove the whole breast, tumor and all. The surgery removed all of the cancer and she has been free of cancer for five years.

Like every other cancer survivor, she went back for check-ups every three months, then every 6 months, and now she returns every year. The only side effect she suffers from the surgery is lymphedema, swelling in her left arm and hand. Her husband wraps her left arm and hand in a pressure sleeve and glove every night and she sleeps with the arm on a pillow. By doing this she manages to keep the swelling down. She credits her husband with her success at beating cancer. He stood by her side through it all, he gave her encouragement when she needed it, and he stayed positive at all times.

Mrs. Allen is not sure why the Good Lord gave her breast cancer but she thinks she is supposed to help others who may get it too. Every chance she gets, she gives female friends this advice:

❖ Go to the doctor if you see anything suspicious.
❖ Get a mammogram every year
❖ Examine yourself every month

Women are not the only recipients of Mrs. Allen’s good advice. She encouraged her husband to get screened for cancer on a regular basis too. Because of this advice, doctors found that Mr. Allen had an early stage of prostate cancer. Because they found the cancer so early, Mr. Allen was able to avoid surgery. He received a new form of radiation implant therapy, radioactive pellets that are so small they are called seeds. This radiation therapy cured his cancer, and he now has a clean bill of health.

But being cured of one form of cancer does not make a person immune to another form. Both Mr. and Mrs. Allen continue to follow their doctor’s advice on getting regular screens for colon cancer, as well as breast and prostate cancer. They want everyone else to do the same.

More survivor stories on page 16.
Aging is associated with increasing numbers of new cancers and cancer deaths.

Cancer in Men and Women Aged 75 and Over

**Deaths**

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<td>Lung</td>
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</tr>
<tr>
<td>Prostate</td>
<td>20%</td>
</tr>
<tr>
<td>Colorectal</td>
<td>15%</td>
</tr>
<tr>
<td>Pancreas</td>
<td>4%</td>
</tr>
<tr>
<td>Non-Hodgkin Lymphoma</td>
<td>4%</td>
</tr>
<tr>
<td>Leukemias</td>
<td>4%</td>
</tr>
<tr>
<td>Bladder</td>
<td>4%</td>
</tr>
<tr>
<td>Stomach</td>
<td>3%</td>
</tr>
</tbody>
</table>

**New Cases**

<table>
<thead>
<tr>
<th>Cancer Site</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prostate</td>
<td>28%</td>
</tr>
<tr>
<td>Lung</td>
<td>17%</td>
</tr>
<tr>
<td>Colorectal</td>
<td>15%</td>
</tr>
<tr>
<td>Bladder</td>
<td>9%</td>
</tr>
<tr>
<td>Non-Hodgkin Lymphoma</td>
<td>3%</td>
</tr>
<tr>
<td>Leukemia</td>
<td>3%</td>
</tr>
<tr>
<td>Pancreas</td>
<td>3%</td>
</tr>
<tr>
<td>Stomach</td>
<td>3%</td>
</tr>
</tbody>
</table>

Incidence and Mortality rates per 100,000 people.
Cancer Prevention

Don’t smoke or chew tobacco

Use sunblock and a hat

Increase physical activity

Eat fruits and vegetables

Avoid being overweight

Check stool for blood yearly

Check breasts for lumps and have regular mammograms

Have regular prostate checks

Have regular pelvic exams and discuss with your doctor the need for Pap smears.

Signs of Possible Cancer

Change in bowel or bladder habits

Sore that does not heal

Unusual bleeding or discharge

Thickening or lump in breast or elsewhere

Indigestion or difficulty in swallowing

Obvious change in wart or mole

Nagging cough or hoarseness

If you have any of these symptoms, talk to your doctor.

CAUTION is From the American Cancer Society.

Questions? FAX: (314) 771-8575 • email: agingsuccess@slu.edu
eralities (i.e., the best case scenario). If you are uncertain of what treatment you want, do not be rushed into a decision. Go home, think about it, and talk it over with friends, your family physician, and other patients who have had the same kind of cancer. In most cases, a delay of a few days is unlikely to make a difference to your health. Do not be embarrassed to ask for a second opinion and, if you want to, search the Internet for updates on your type of cancer. Be aware that many Internet sites may not be accurate (see page 21 for advice in assessing information on the Internet). Discuss your findings with your doctor. Understand that every cancer and every person is individualistic and therefore, your case may be very different from the quoted averages.

Remember that many cancer doctors talk about a remission (a period of time when the cancer is under control) and one can continue to enjoy life for several disease-free years following treatment for cancer.

Cancer therapies

Many cancers are treated first with surgery. The surgery may be a local incision or may require removal of lymph nodes in the area as well. Other common treatments are drugs (chemotherapy) and radiation therapy. Many people require a combination of two or more therapies. Ask your oncologist to discuss your case at a formal tumor board meeting so that other doctors can have input into your care.

If you are to receive chemotherapy, discuss whether you can receive the same dose as a younger person. Many older persons can and should do so.

Immunotherapy is a special form of therapy that increases your own body’s ability to fight off the cancer. In some cases, a bone marrow transplant may allow you to receive higher doses of chemotherapy. Proton or neutron beam therapy is a specialized form of radiation therapy offered at some cancer centers.

Ask about clinical trials. Are you eligible? Often these trials use new therapies that would otherwise not be available to you. Older persons have been less often included in these trials. Be aggressive about being included if your physician believes that the trial is appropriate for you.

Before and during treatment, discuss with your physician when you might want therapy to stop. This is an individual choice that needs to be discussed often between you and your physician.

Get involved with cancer support groups whenever you can. They can be a great help.

Side effects of therapy

Most persons undergoing cancer therapy will have some degree of fatigue. In addition, older persons tend to have a greater deterioration in function than younger persons when they are treated for cancer but this need not be so. Keep as active as you can and exercise regularly to maintain your function. Also, while some degree of unhappiness is understandable, older persons actually have fewer psychological problems when diagnosed with cancer than do younger persons. If you become depressed, discuss this with your doctor because you (continued on page 17)
Cancer Therapies

The number and types of therapies used to treat cancer is constantly increasing. Therapies differ with the type of cancer, the location of that cancer, and how advanced the cancer is. The goal of cancer treatment may be to cure the cancer, to keep the cancer from spreading, to kill cancer cells that have already spread, to slow the cancer’s growth, or to relieve symptoms (palliative care).

The different types of therapies that are now commonly used to treat cancer include surgery, radiation, chemotherapy, hormone therapy, bone marrow transplantation, and biotherapy. Gene therapy is a promising treatment which is currently being studied in clinical trials to determine its usefulness and safety and, therefore, it is not used routinely. Each of these therapies may be used alone or in conjunction with another type. How many of these different therapies a patient receives is decided upon by the patient and his/her cancer care team. Factors that will affect the decision include:

- the type of cancer
- the stage of cancer
- the health status of the patient
- the personal preference of the patient.

Before deciding which therapy or therapies to use, the patient should ask the cancer care team several questions. They include:

- What are my options for treatment?
- Can I take other medications while receiving this treatment?
- How can I tell if the treatment is working?
- Is there a support group for people receiving this treatment?
- How will I pay for this treatment?
- How can I tell if the treatment is working?
- Is there a support group for people receiving this treatment?
- How will I pay for this treatment?

These and other questions are listed in a convenient form on page 22.

Surgery is used for cancers that are localized and easily accessible. It is the first treatment choice for many cancers. About 60% of cancer patients choose to have surgery and half of them are cured with surgery alone.

Radiation therapy, like surgery, is used for localized cancers (cancers that have not spread). More than half of all cancer patients opt to have radiation treatment as part of their therapy. This therapy may be delivered in one of two ways: either with a focused, high-energy ray or with radioactive implants. The energy ray is painless and is often repeated several times a week, for several weeks. Individuals are not “radioactive” or dangerous to other people when they receive this type of therapy. The implants allow for a more concentrated dose of radiation to be administered to a smaller area for a shorter period of time. They are placed in or near the tumor while the patient is under local or general anesthesia. Once the implants are surgically removed, no radioactivity remains in the body.

Chemotherapy is used to treat cancer that has spread (metastasized) to other parts of the body or as a secondary line of treatment following surgical removal of a tumor to treat cancer that may not be seen on an x-ray or scan. It is delivered to all parts of the body through the bloodstream following injection of (continued on page 19)
Carolyn Theusch is looking forward to living to age 96. Her mother died at that age, despite having been diagnosed with cancer at age 46. If her mother could live 50 years after developing cancer, she thinks she can too.

The first symptom of cancer that Mrs. Theusch had was a slight tingling in the ear. Then she developed difficulty swallowing. At first she thought it was sinus trouble or an allergy, but when the symptoms kept recurring over a 4-week period she decided to consult an ear, nose, and throat specialist. The doctor found a suspicious lump in her throat and referred her immediately to an oncologist at Saint Louis University Hospital. The oncologist enrolled her in a clinical trial in an effort to see if two strong doses of a then new chemotherapy drug called taxol would remove the tumor. The taxol treatments did reduce the tumor to half its original size but her difficulties with swallowing did not go away and neither would the tumor.

After consultation with her oncologist, Mrs. Theusch decided that her best chances for a complete recovery from cancer required an aggressive approach. She opted for a radical laryngectomy which required the removal of her voice box. When, 17 months later, a suspicious spot appeared on her lung, she asked the surgeon to treat that aggressively as well, and she had part of the lung removed. Seven years after her initial surgery, at the age of 72, she remains cancer-free but vigilant against its return. She alternates between getting a PET scan or a CT scan every 6 months. If anything suspicious is found, she has more tests to make sure the cancer has not returned. She listens to, and follows, her doctor’s advice. Even though she had smoked since college, she has not smoked since her surgery. She has even convinced two of her children to quit smoking and she is working with a third one to curtail his smoking.

When she isn’t working part time, she is helping others cope with their throat cancer, just as others helped her. Before her surgery, the oncologist gave her the phone number of a woman who had had the same surgery that she was about to undergo. Learning first hand that this woman could still make herself understood, even by phone, after having her voice box removed, reassured Mrs. Theusch that she could also learn to communicate after her surgery. She now provides similar encouragement to others who are referred to her by her speech therapist.

Mrs. Theusch believes everyone who has had cancer, or who has a loved one with cancer, should join a support group. She goes once a month. Once there, she offers advice to others about such things as how to adjust to the reactions of strangers to their new voices and, in return, she receives advice from others about any concerns she may have. While at the support group, she particularly enjoys hearing guest speakers talk about new techniques for treating cancer or new insights into dealing with the side effects of cancer. She is intrigued by the new trend she heard about of increased rates of throat cancer in people who are in their 40s and who have never smoked.

Being active in her support group allows her to reach out to others in need. She also goes out to high schools to talk to students about her cancer and to encourage them to quit smoking. Knowing that she has an important message to deliver gets her up every day and out there making a difference. That attitude will go a long way towards getting her to age 96.
may benefit from supportive therapy or an antidepressant.

The major side effects of radiation or chemotherapy may include:

- Nausea and vomiting
- Infection (fever)
- Low white cell count
- Diarrhea
- Loss of appetite
- Ulcers of the mouth
- Candida (a fungal infection)

Many of these can be treated with drugs. Make sure you tell your doctor about any side effects you may be experiencing. Nausea and vomiting can occur on days that you are receiving chemotherapy. This is called anticipatory nausea and needs to be treated before you come in for treatment on that day. Cancer and its therapies cause loss of appetite and weight loss. Eating multiple small meals in a day may help prevent this.

Pain is commonly associated with cancer. Where possible, pain should be treated before it occurs. This means you should take pain medication on a regular schedule and not just when you are hurting. Do not be afraid of opiates (morphine). It is an excellent pain medication and you are unlikely to become addicted when you have pain. If you are anxious or cannot sleep, tell your physician because there are medications to treat these conditions as well.

Some persons with cancer believe smoking marijuana decreases their discomfort and cures nausea. Marijuana is illegal and unavailable in most of the United States. Fortunately, a highly potent extract of marijuana called marinol (dronabinol) is available for medical use in persons with cancer. This drug decreases nausea, improves appetite, calms you, and decreases pain. Ask your doctor if this drug is appropriate for you. It is also excellent in preventing anticipatory nausea and vomiting.

**Alternative therapies**

Many persons, when they develop cancer, seek a variety of alternative therapies or healers. While in some areas of medicine alternative therapies are very effective, this is not the case in cancer treatment. Although numerous alternative therapies are often touted for the cure of cancer, in most cases, these are really “drugs in disguise” and need to be avoided.

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**Carcinogens: Agents that might cause cancer**

<table>
<thead>
<tr>
<th>Environmental Risk Factors</th>
<th>Cancers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fertilizers/Pesticides</td>
<td>Bladder</td>
</tr>
<tr>
<td>Asbestos</td>
<td>Lung</td>
</tr>
<tr>
<td>Ultraviolet radiation</td>
<td>Skin</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lifestyle Risk Factors</th>
<th>Cancers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>Mouth, esophagus</td>
</tr>
<tr>
<td>Tanning booths</td>
<td>Skin</td>
</tr>
<tr>
<td>Tobacco</td>
<td>Head, neck, lung, esophagus, bladder</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medical Risk Factors</th>
<th>Cancers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ionizing radiation</td>
<td>Thyroid, blood</td>
</tr>
<tr>
<td>Diethylstilbestrol</td>
<td>Liver, vagina</td>
</tr>
<tr>
<td>Estrogen, progestin</td>
<td>Breast</td>
</tr>
</tbody>
</table>

*Discuss YOUR risk factors with your physician.*

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A Grand Vision Grant (GVG) from the Saint Louis University Hospital (SLUH) Auxiliary funds this special issue of Aging Successfully. The SLUH Auxiliary is a not-for-profit organization whose mission is “to promote and advance the welfare of patients, their families, and the community served by Saint Louis University Hospital.” In addition to the GVG Initiative, some other service projects of the Auxiliary are the Saint Louis University Community Cancer Resource Center, short-term funding for prescription medication, and resident services at the Auxiliary Hospitality House.

Fundraising projects include the Fleur-De-Lis Gift shop, a gold jewelry sale, a golf tournament, and the sale of holiday greeting cards. For more information about the Auxiliary, their office is on the first floor of Desloge Towers, 3635 Vista Avenue at Grand, St. Louis, Missouri, 63110. The phone number is 314-577-8029.
Cancer as we Age  (continued from page 17)

If you are considering one of these alternatives, discuss it with your doctor. If you decide to pursue such a therapy, let your doctor know because some of these therapies are extremely toxic and can interact dangerously with conventional drugs you may already be receiving.

Some forms of alternative therapy have been shown to be sound. A positive attitude may enhance the body’s immune system, thereby decreasing the aggressiveness of the cancer. A positive attitude also makes it easier to cope with the variety of adverse factors that a cancer patient needs to deal with. Similarly, spirituality can have positive effects. Prayer may help the healing process, and religion provides tremendous support. However, these supportive approaches should not replace appropriate medical therapy, but rather should be fellow travelers alongside one another on your road to becoming a cancer survivor.

The good death

Our journey through life is one that eventually must end. Cancer is one of the more common ways this happens and therefore no discussion of cancer can be complete without mentioning death and dying. For those of us with religious convictions, life is a journey of trials and tribulations from which we will ultimately escape to a better place. In 1491, William Caxton suggested that we should think about the end of life while we are healthy in order to be ready for the great moment when death approaches. He went on to say, “The time of departing shall be better than the time of birth, for now all sickness, sorrow, and trouble shall leave forever. Be not angry with your sickness, but take it not with grudging but rather all by gladness.” The Dakota Indians had a similar philosophy encapsulated in their daily greeting: “Let it be a good day to die.”

Dying can be a wonderful experience as I have seen in many older persons who have mastered the “ars moriendi” (art of dying). They have held my hand as they composed themselves and told me their time is now, and I have felt the tremendous power in the room as a soul gracefully ascends from this earth to heaven. There is no greater moment to be present than at a “good death.”

To allow a “good death” to occur, the patient and family must assert their rights. The patient should be pain free. The environment should be hospitable to both patients and family. Patients and family need to be aware of the services offered by hospice. Entering hospice during the final six months of life often allows people to end their lives at home, if this is their wish. Hospice workers are trained to aid both the patient and family members in this process. Good care is an essential component of the “good death.”

Summary

A diagnosis of cancer, although frightening, is not reason to lose hope. Instead, it is a time to explore options, to gather friends, family, and faith about you, and to make a plan to get the best care you can in an environment in which you are most comfortable. The more allies you have on your road to recovery, the more likely you are to survive the cancer. May you have a safe journey.

Dr. Thomas Receives Award

Dr. David R. Thomas of the Division of Geriatric Medicine at Saint Louis University has been awarded the Osler Award this year. This award is presented annually to the physician voted as the best teacher of the year by his students, the residents and interns. Named after perhaps the most important figure in medical education in the United States, Sir William Osler, the award is given to one who knows and teaches that “medicine is learned by the bedside and not in the classroom.” Osler was a common-sense teacher; he loved books and emphasized that a patient, a library, and a notebook were the tools of medical education.
the drug into a vein or after being taken in pill form by mouth. Chemotherapy is given in repeated cycles of drug delivery followed by recovery periods. It is not unusual for a course of chemotherapy to take 3 to 9 months.

**Hormone therapy** involves the use of chemicals that are either naturally produced by the body or that resemble hormones that are used by the body. They include corticosteroids, estrogens, progesterone, tamoxifen and androgens. Therapy often requires the administration of larger doses of hormone than are normally produced by the body and result in side effects that are temporary (see table below).

Either **bone marrow transplants** or **peripheral blood stem-cell transplantation** may be used to replace bone marrow destroyed by high doses of chemotherapy.

**Biotherapy**, also called immunotherapy, biologic therapy, or biological response modifier therapy, uses the body’s own immune system to fight cancer or to decrease the side effects of other types of cancer treatments. This treatment may interfere with cancer growth or it may help to repair normal cells that were damaged by the other cancer treatments. Drugs such as interleukins, interferons, or tumor necrosis factor are being studied in several ongoing clinical trials.

All standard cancer treatments have side effects (see table). Many are temporary, but some can be permanent, and some are even life threatening. People fortunate enough to survive cancer may suffer a reduced length of life or a reduced quality of life following recovery because of these side effects. Oncologists are constantly trying to reduce the number of adverse side effects and improve the quality of life of cancer patients by making improvements in the types of cancer treatment available. These improvements come about through clinical trials.

Clinical trials are research studies designed to test new, heretofore non-validated, ways to treat specific types of cancer. All of the currently used treatments underwent clinical trials before they became part of the standard treatment.

Clinical trials have several components or phases. Before a new drug is tested on people it must first be tested on animals to determine whether it is safe and effective. Those treatments that pass that phase must then undergo rigorous testing on people who have cancer that has not responded to conventional treatments: first on a small number of people to answer questions about what a safe dosage is (Phase I trials), then on a larger number of people to study the side effects and effectiveness of the drug in humans (Phase II trials). If the new therapy is determined to be safe and effective then it is compared to the standard therapy in the final phase of the clinical trial (Phase III trials). Large numbers of patients with cancer are then recruited into the clinical trial. Some receive standard therapy and others the new treatment and

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**Side Effects of Standard Types of Cancer Therapy**

<table>
<thead>
<tr>
<th>Cancer Therapy</th>
<th>Temporary or Permanent Side Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery</td>
<td>Pain, infection, fatigue, loss of mobility, loss of organs or limbs</td>
</tr>
<tr>
<td>Radiation</td>
<td>Fatigue, local irritation of the skin, loss of appetite, hair loss at the irradiated site</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>Increased risk for infections, temporary loss of body hair, nausea, vomiting, fatigue</td>
</tr>
<tr>
<td>Hormone therapy</td>
<td>Mood changes, fluid retention, difficulty sleeping, osteoporosis</td>
</tr>
</tbody>
</table>

These two therapies are currently being used in clinical trials for treatment for several types of cancer.

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available on their website at www.cancer.org. (See page 21 for additional websites.) Screening has proved beneficial for reducing mortality with breast and colon cancer although there is no evidence yet that early detection reduces mortality with prostate cancer. Screening recommendations for people over age 50 are shown below. As of now, there is no recommended test for the screening of lung cancer. Two types of screening tools have been developed for lung cancer, the chest radiography and sputum cytology, but ACS guidelines state a specific recommendation against using either of these tests. They have not proven to be cost effective. Therefore, research continues to look for tests [such as screening computerized tomography] that will detect lung cancer at earlier stages and, thus, improve survival rates.

**Will my cancer come back?**

There is no standard of care yet about how often you should be screened if you have already had cancer. Researchers are currently reviewing cancer data from veterans treated at Veterans Administration Medical Centers in order to develop those recommendations. In the absence of those guidelines, Dr. Reimers recommends for a majority of his patients to be screened every 3 months for 2 years for the return of their cancer. The goal of this increased surveillance is to find the cancer before the symptoms return. This increased rate of screening applies to only the type of cancer the patient had. If the cancer does not return within 2 years, then the schedule for screening returns over the next few years to the frequency recommended for people who have never had cancer. Patients who have had one kind of cancer should continue to be screened for all other kinds of cancer at the recommended rate for each cancer. Getting one kind of cancer does not make you immune to another kind of cancer.

**Is there a “cancer personality”?**

There is no personality type that is associated with an increased risk for a particular type of cancer. Some cancers seem to run in families but those cancers usually express themselves when people are young. The single greatest risk factor for getting cancer is growing old. The older you become, the greater your chances of getting cancer. No one knows why that is true but there are several contributing factors. As we age, we have a decline in the efficiency of the immune system, an increased exposure to cancer-causing agents, an accumulation of random genetic mutations, a decrease in our ability to repair injuries, and we undergo repeated hormonal changes. Whatever the reason or reasons, the importance of early detection through screening and quick treatment following detection cannot be over-emphasized. A vigilant patient/doctor team is necessary to ensure a successful recovery if we do develop cancer.

### How Often Should I Be Screened for Cancer After Age 50?

<table>
<thead>
<tr>
<th><strong>Men and Women</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Colorectal Cancer</strong></td>
</tr>
<tr>
<td>■ Fecal occult blood test yearly.</td>
</tr>
<tr>
<td>■ Colonoscopy every 10 years starting at age 50 and until at least 80 years of age.</td>
</tr>
<tr>
<td><strong>Skin</strong></td>
</tr>
<tr>
<td>■ Do monthly skin self-exam.</td>
</tr>
<tr>
<td>■ Have your physician look at any new growths or changing moles at least yearly.</td>
</tr>
<tr>
<td><strong>Other</strong></td>
</tr>
<tr>
<td>■ Your physician should check lymph nodes, thyroid, and mouth yearly.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Men</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prostate</strong></td>
</tr>
<tr>
<td>■ Prostate specific antigen and digital rectal exam yearly until at least 75 years of age.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Women</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Breast</strong></td>
</tr>
<tr>
<td>■ Have your physician examine your breasts yearly.</td>
</tr>
<tr>
<td>■ Do monthly self-exams.</td>
</tr>
<tr>
<td>■ Mammograms yearly until at least 80 years of age.</td>
</tr>
<tr>
<td><strong>Gynecological</strong></td>
</tr>
<tr>
<td>■ Have a yearly pelvic exam.</td>
</tr>
</tbody>
</table>
There has been an information explosion about cancer and treatment options in the past ten years. With a bit of imagination, trial and error, and luck, much of that information can be found on the Internet. Determining whether that information is useful or correct, however, can be daunting. In this time of information overload it is sometimes useful to review how to assess information for reliability, if not accuracy.

Here are several websites that the editorial staff of Aging Successfully has reviewed and feels might be useful to cancer patients and their families. These are only a few of the available websites and the absence of a website does not imply disapproval of the site. Cancer care team members often have further recommendations to make to interested consumers and should be asked to identify their favorite sites. Information for some of the more common cancers, like breast or prostate cancer, can be found on many websites and it may be best to ask for some help when getting started.

Have a trained librarian assist you in finding sites. Check the site’s address (its URL) to learn which type of agency maintains the site. Sites maintained by universities and government agencies tend to be the least biased. .edu is a university site; .gov is run by a government agency; .com is the site of a commercial company; .org designates a not-for-profit organization.

For insight into why that site was created, read the “About us” section on the home page.

Until you can confirm the information by finding it on at least 2 credible sites, treat the information as anecdotal. Print the information out and take it in to your next appointment in order to discuss it with your doctor.
Questions to Ask Your Doctor About
Cancer
Saint Louis University
Cancer Center
Division of Geriatric Medicine

Take a friend with you. Write the answers down or circle the answer.

1. What kind of cancer is it? ________________________________

2. Is it a fast- or slow-growing cancer? FAST SLOW DON'T KNOW

3. Has it spread beyond where it started? YES NO DON'T KNOW

4. What kind of therapies are available?
   Surgery Radiation Chemotherapy Combination

5. Where can I get printed material on each treatment? ________________________________

6. How much longer can I expect to live with this cancer? ________________________________

7. What percentage of people are alive at 5 years after diagnosis? ________________________________

8. How much longer will I live with therapy versus no therapy? ________________________________

9. Do I need to go into the hospital for therapy? YES NO

10. Are the costs of all treatments covered by my medical plan? YES NO SOME

11. How long will treatment last? ________________________________

12. How do I get to speak to other patients with my kind of cancer?
   Name: ________________________________ Telephone #: ________________________________
   Name: ________________________________ Telephone #: ________________________________

13. What support group should I go to?
   Name: ________________________________ Contact: ________________________________

14. What side effects does the therapy have?
   Nausea Vomiting Fatigue Pain Infection Mouth Ulcers Hair Loss
   Diarrhea Sexual Dysfunction Other ________________________________

15. When I have questions or side effects, who should I contact?
   During working hours: Name ________________________________ Telephone # ________________________________
   For emergencies: Name ________________________________ Telephone # ________________________________

16. How can I tell if the treatment is working? ________________________________

17. Can I take my other medications while I am getting treatment for cancer? ________________
tests are run to determine whether the new therapy is better than the standard treatment. People who take part in clinical trials are not denied regular treatment and, if the new therapy is better than the standard therapy, then once the trial is ended, the new treatment may be made available to people in the trial who received the less effective, standard treatment. This is the process whereby new, better forms of therapy are adopted.

During the course of a patient’s treatment, the cancer care team may suggest that the patient consider joining a clinical trial. This does not mean that the patient’s cancer cannot be cured or that the case is hopeless. It may mean that there is a promising, new therapy that may allow the patient’s cancer to be treated more effectively or with fewer side effects. However, this treatment may still be seeking final regulatory approval before it is accepted by oncologists and by medical insurance plans as being preferable to the standard treatment.

Participation in clinical trials is completely voluntary and the patient should consider his/her options carefully. People considering entering a clinical trial must discuss several questions with their cancer care team. These include:

- What is the purpose of the trial?
- What are the side effects?
- What kinds of tests are involved?
- What are the advantages and disadvantages of this new treatment?
- Is the treatment given in a hospital or in an outpatient setting?
- How long will the study last and will there be follow-up care after the study has ended?
- What will be the costs of this treatment and who will pay for it?
- If the research causes harm, what treatment is available to repair the damage?

If all of these questions plus any other concerns they may have are satisfactorily answered, then patients should consider entering a clinical trial. Treatments for cancer are constantly improving and procedures do not enter into clinical trials unless they have been shown to be an improvement over the standard treatment. Patients who participate in a clinical trial are helping others who will develop similar cancers in the future and may well be helping themselves should they be unfortunate enough not to have their cancer cured with the standard therapy.
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