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## Question and Answer Session with Dr. Winer and Dr. Harpham

February 28, 2009

Eric P. Winer, MD

Wendy S. Harpham, MD, FACP

### WOMAN:

My question is for Wendy. [Regarding] your book [*When a Parent Has Cancer: A Guide to Caring for Your Children* and] getting the kids to talk—how did you do that? I'm a 16-year survivor. My son is very shy; I couldn't get him to talk to me. But every time I go back to the doctor, he comes and asks me, "Mama, are you okay? Is it back?" And, you know, this is something that all of us who have children go through—learning how to get your children to talk to you and discuss the problem.

### WENDY S. HARPAM, MD, FACP:

Excellent question . . . My short answer is to open lines of communication and to tell the truth. Our job as parents or aunts or uncles is to help these children through their world; to help these children adjust to the changes and the losses that are happening in their world, not in our world—to see it from their perspective and give them the tools and the confidence to cope and grow. There are a lot of reasons that parents often try to hide, to protect their children, from the crisis. But the problem is that children are smart; children are observant. They know something's up. And if we don't talk openly, if we don't share with them, we lose the opportunity to guide them toward accurate and healthy ways of coping with the world.

So the answer is to open lines of communication and to tell the truth so that you can go through it together.

### WOMAN:

This question is for Dr. Winer. First, I want to thank you for being one of the warriors [who] actually [helps us] live. Hopefully, one day I will be saying to my little babies, "That's the man that helped Mommy live for the rest of her life." (Applause)

I did want to ask you, since you are one of the most foremost people in the country—I'm triple negative, and I went from zero to stage III in three days. I had no idea about the

platinum-based chemo or PARP inhibitors. [My] tumors grew so large—[growing rapidly] in three days. [I] went through chemo—I had TAC every three weeks—and then [had surgery, during which] no evidence of cancer [was found], thank God. Would you recommend that I go to my oncologist and gently say, "What is this PARP," or the other treatment that I had mentioned? [Is that] something that I would be interested in doing?

### ERIC P. WINER, MD:

Those are treatments that, for the most part, should be done in the context of clinical trials. I'm going to get back to your situation in a second, but I do want to put in a plug for clinical trials. This is how we learn how to take care of people better in the future. Too often, patients with all sorts of cancers—and, to an even greater extent, their doctors—think of clinical trials as something to do when everything else fails, and that's probably not the best time to do one.

You, however, just told all of us some very good news. It turns out, particularly in patients who have triple-negative cancers, that it's an extraordinarily good sign when all the cancer in the breast goes away. I always put it like this: As goes the breast, so goes the patient. And, when you give preoperative therapy, that is largely the case. However, in women who have estrogen receptor-positive breast cancer, it's very unusual to see all the cancer go away, yet they can continue to do very, very well. That's because hormonal therapy adds so much. In women who have triple-negative breast cancer, if preoperative chemotherapy is given, and if there isn't any cancer left in the breast at the end of preoperative chemotherapy, that is a really, really, really good sign.

So you don't need to be thinking about other therapies. I mean, I can't give you a signed and sealed guarantee and, you know, none of us has

guarantees in this world. But my advice to you is to go on and live your life—and to carry this clinical trial message forward, if you will. (Applause)

### WOMAN:

I have a comment for Wendy and a question for [Dr. Winer]. When I was diagnosed almost ten years ago, a friend gave me *When a Parent Has Cancer*. [Wendy,] I want to thank you for writing that book. I also want to thank you for talking a little bit about the fact that there's a need to grieve in addition to being happy and optimistic, because I hear a lot of survivors saying— . . . they don't want to call themselves "survivors." They think [calling themselves survivors] means that they have to be positive and upbeat. And, you know, I don't want to wear pink—I don't want to do all of that because I'm not feeling that good.

Like you, I have a great sense of humor. I goofed around all the time, and I thought it was very important to at least try to keep up the appearance of being strong and upbeat. And [then] I got the message that it was important to share the grief. Shortly after I had finished treatment, my beloved father-in-law was diagnosed with inoperable lung cancer. And he was going through chemo, and it wasn't going well. He knew he was going to die. When he turned to me and said, "I just wish I could have handled this as well as you did," I realized that it is important to let people know that it's hard; it's difficult. You can show that you're strong and upbeat and have those happy moments. But make sure that you're being real to yourself and to the people that you love.

[Dr. Winer,] you talked about how it's been shown that, with chemotherapy and treatment with tamoxifen, oophorectomy isn't necessarily all that advantageous. I had ER/PR positive cancer. I went through all of the treatment—had radiation; was on tamoxifen—and I recurred within three years. Then I was treated with oophorectomy. Are there



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any studies that have shown that that is beneficial? Because, obviously, I'm living with the lifestyle ramifications of that now.

**ERIC P. WINER, MD:**

Do you want to comment first?

**WENDY S. HARPAM, MD, FACP:**

Okay. I have to write myself some notes, because I do have some cancer-related cognitive deficits. (Laughter)

Think about it in this way: Our bodies are wired to help us live our lives and deal with challenges that happen. When a normal, healthy person exercises, [his or her] pulse goes up. And the reason for that is that the increased pulse helps distribute the blood to the parts of the body, the muscles and everything, that need the blood in order to work [under those circumstances]. Emotions work the same way. Why would we be wired to shed tears, to reach out to people, unless the reason is that doing so is healing, is healthy, is adaptive in some way?

That point about tears and sadness and anger being part of a positive attitude, being part of authenticity with our children, is absolutely true. I would never call my cancer a gift. I would never choose it. I would never want it, despite all the wonderful things that have happened because of my cancer experience. But one of the major things that I appreciate is that my kids get it. My kids have been brought up, through my cancer [experience], knowing that, when something that is not right, that's unjust, makes you angry, that anger has a purpose. It has a reason. It can be directed in positive ways. My children get that, if you lose something very important to you, or someone very important to you, you are going to experience grief. And they know that allowing that grief to surface and that sharing that grief will help them get through the loss, adapt to the loss and embrace their lives in healthy, hopeful ways.

The greatest gift we can give our children is not protection from the world, but [rather] the confidence and the tools to cope with and grow with all that life has to offer. We can use our unwanted, unwelcome cancer experience in positive ways to teach our kids the values and skills that will help them live more fully as young adults, as middle-aged adults and as old adults.

When I go home, I'm going to tell my husband that somebody at the conference said that I had a great sense of humor. I'm afraid he'd beg to differ. (Laughter)

**ERIC P. WINER, MD:**

Well, I don't have chemotherapy-related cognitive deficits. I just have them on my own. They happen as you get older, I'm afraid. (Laughter)

I just have to make a comment, as well, about tearing up and feeling emotions. This, of course, goes on in interactions with patients all the time. You know, there is no finer place to get upset than with the people taking care of you. And I manage to bring that on all the time. (Laughter) No, not because I'm delivering bad news, necessarily, but because I've asked a probing question, or maybe not so probing a question, but just a question. I'll confess to being one who tears up a little [bit] myself when that happens. And I don't think any of it is bad. I think it's just all part of dealing with it. And I think that you can go from feeling that way one minute to feeling much more positive the next. It's just the roller coaster we all go on as we go through these kinds of experiences.

Regarding the medical question—oophorectomy, or ovarian suppression, can be beneficial when breast cancer recurs. [There is still controversy] about its role in somebody who's newly diagnosed. Opinions in the United States and Europe differ greatly, and there are even a fair number of different opinions within the United States itself . . . It's a treatment that really does have some side effects, and it can be difficult for some people.

**WENDY S. HARPAM, MD, FACP:**

I'd like to add one brief comment, [since] you mentioned tearing up—I got an e-mail from a nurse whose son died of cancer. Throughout his illness he'd received superb care. She told me something that resonated with me, and I can't get it out of my head. She said, of physicians and nurses, "Only cowards are afraid to love their patients."

**WOMAN:**

This question is directed to Dr. Winer. I want to know what the difference is between taking Herceptin every 21 days for an hour and a half [and taking it for] 30 minutes.

**ERIC P. WINER, MD:**

Are you asking about 21 days versus every seven days or about the difference between giving it for longer or shorter periods of time every 21 days? Both . . . I could have just guessed that. (Laughter)

Herceptin has a very long half-life. It's a big molecule. It stays in your body for a long time. It probably stays at reasonable levels in your body for up to three months and [at lesser levels] for quite a bit of time after that. So, in terms of its benefits, it actually doesn't matter whether you take it every week or every three weeks. When women are receiving weekly chemotherapy, they often get weekly Herceptin as well—not for any particularly good reason; it's just simple to do it that way. After that weekly chemotherapy is done, or if it's not given, we usually give Herceptin every three weeks.

The standard duration of the infusion is an hour and a half. I have no doubt that there are some treatment centers that speed that up, and I'm not aware that there's a problem [with doing that]. But I think that the label that comes in the package says that, if you're going to give an every-three-week dose, you should give it over an hour and a half.

**WOMAN:**

For Dr. Winer: I guess I'm triple positive. It's a bastard to say. And I had a relatively large tumor. I had the preoperative chemotherapy, so it's hard to say exactly how big it was because all the scans couldn't tell for sure. It was four to five centimeters, maybe, and there was at least one positive node. I had chemotherapy, radiation and mastectomy, and next week I have an appointment with my oncologist to talk about hormone therapies. I think he's [considering] ovarian suppression and [an] aromatase inhibitor. In what circumstances would you go with that blend?

**ERIC P. WINER, MD:**

You were relatively young when that—

**WOMAN:**

I was 33.

**ERIC P. WINER, MD:**

So, clearly, you were premenopausal at that time.

**WOMAN:**

Yes, before chemo.

**ERIC P. WINER, MD:**

The only real data that we have on the use of aromatase inhibitors in women who are premenopausal at diagnosis comes from a study [done in] Austria, in which women who didn't get chemotherapy were randomized to receive either ovarian suppression plus tamoxifen or ovarian suppression plus an aromatase inhibitor [Abstract: <http://content.nejm.org/cgi/content/short/360/7/679>; LBBC story on this trial:



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[http://www.lbbc.org/content/news/premenopausal-women-taking-zoledronic-acid-with-hormone-therapy-may-live-longer.asp?section\\_tag=G](http://www.lbbc.org/content/news/premenopausal-women-taking-zoledronic-acid-with-hormone-therapy-may-live-longer.asp?section_tag=G)]. In that study, the two treatments were [shown to be] entirely equal [in terms of outcome]. Actually, numerically, women who were on the tamoxifen arm did a tiny bit better. But it was not a significant difference.

All of the other data [we have] are in women who are postmenopausal at diagnosis. There is little question in my mind that ovarian suppression plus an aromatase inhibitor is a much harder treatment for a 33-year-old woman to tolerate than ovarian suppression plus tamoxifen. And, again, it hasn't been shown to be better. So I can't imagine wanting to use it unless you, for some reason, couldn't take tamoxifen. The big reason for that is a history of blood clots.

## WOMAN:

[Inaudible] blood clot in my heart. I'm on a blood thinner.

## ERIC P. WINER, MD:

If you're on a blood thinner, you probably still could take tamoxifen. But that might be a reason to think about an aromatase inhibitor. If you have trouble tolerating it—and I'm sure there are people in the audience who have been on an aromatase inhibitor and who have had trouble tolerating it—then, rather than [just stopping all treatment], it would be much, much better to talk to your doctor about taking tamoxifen with a blood thinner, because, you know, you can't benefit from the drug if you don't take it. And a fair number of people just go off these drugs because they make them uncomfortable.

## MODERATOR:

Let's thank Dr. Winer and Dr. Harpham.  
(Applause)  
[END OF TRANSCRIPT]