



## San Antonio Breast Cancer Symposium

By Galina Tash

The 29th Annual San Antonio Breast Cancer Symposium (SABCS) took place December 14 – 17, 2006. 8,200 people representing 71 countries attended this international scientific symposium in San Antonio, Texas. Scientists, doctors, and clinicians had an opportunity to interact and exchange their knowledge in the fight against breast cancer.

The Alamo Breast Cancer Foundation (ABCF) runs a grassroots advocacy program to eradicate the presence of breast cancer in our society. Every year, ABCF sponsors special mentoring sessions for patient advocates at SABCS. Leading experts in the field of breast cancer provide commentary on symposium presentations and respond to advocates' questions about the relevance of this scientific data. Last year, the ABCF sponsored 40 advocates who attended their 9th Annual Patient Advocate Program in conjunction with the symposium. Advocates came from many countries including Israel, Greece, Italy, Estonia, Canada, India, and Germany, with a majority from the US. I was one of this year's patient advocates who attended the symposium. When I got home, I tried to put my thoughts in order as to what participation in this important symposium offered for a cancer patient advocate.

These are some of my conclusions I came to after attending the symposium:

- Cancer is not "*something that happens within your body*". It's your body, it's you: the better you take care of your whole self, the better results your therapy will achieve.

- Try to get detailed information from your oncologist about the exact nature of your health problem and ask all the necessary questions you need to fully understand your diagnosis, therapy and prognosis. If possible, get a second opinion at an established breast cancer clinic.



*Diana Covone, Judy Gedalia, WBCC Board Member Galina Tash, Joy Moose, and Sandi Stanford (Chair of Alamo BCF)*

- The future lies with targeted therapies and the more you and your doctor know about the exact nature of your cancer, the better you both will be able to fight it.

- Do not consider the oncologist as "the magician of the village" who has all the answers; he does not, just as the top oncologists from around the world do not.

- A proposed therapy by a single oncologist may date back several years. If they do not regularly attend medical conferences in their specialty or if the hospital where they work is not equipped with modern diagnostic equipment, they probably do not have any research programs. Do not be afraid to ask questions.

- Networking with other breast cancer patient groups is vital for exchange of best practices, knowledge of what actually happens in hospitals in other parts of the world and of course, for making new friends.

- "Knowledge is Power" and the knowledge that I gained in San Antonio will help me be a better advocate.

I am grateful to the ABCF for giving me the opportunity to listen to the most eminent oncologists and researchers from around the world and to be able to discuss their research with them. Mentoring sessions were an excel-

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## President's Letter

We've been so busy lately, I can hardly believe that we're just getting into our "busy season" as breast cancer patient advocates.

First and foremost, I am excited to tell you we have updated our web site [www.standupandspeakout.org](http://www.standupandspeakout.org). With the help of one of our volunteers, Jeffrey Schrab, we developed a simple look and feel to incorporate the designs of our logo and other materials. Some of the highlights include the latest news about WBCC and upcoming events, updated accomplishments in the areas of education, collaboration, and legislation, PDF's of our newsletters, an online membership and donation capability, and of course new photos of our events and our advocates. Why not go and take a look?

We have just returned from our first WBCC Advocacy Day in Madison, where we visited many legislators' offices and talked about our organization, our recent activities, and most importantly our efforts toward effecting policy changes in our state.

In this newsletter, you'll read about our participation in the Spirit of Hope Dance Exhibition sponsored by Wisconsin Lutheran College, the Cedarburg Junior Women's Club Wearable Art Show, and an introduction to this year's Rare Chair Affair Honorary Chairperson, as planning for our annual fundraiser is already underway.

As you read this a group of about 15 of us are preparing to leave on our annual trip to Washington, DC and the National Breast Cancer Coalition's Annual Advocacy Training and Lobby Day, where we will bring the voices of the people of Wisconsin to our legislators there. In June, we will be holding an educational event in Milwaukee to share the things that we learned with you, and conduct an advocacy training that will provide participants with the tools to go home and make their voices heard in Madison and Washington DC on policy issues important to breast cancer advocates.

All of this, *and* we have projects underway in our communications, membership, and health-based initiatives committees ...whew!

So, busy we are, and I'm thrilled to be able to tell you about all of it. If you would like to be involved in any of our events and activities, please call our office. Opportunities exist for all levels of participation and expertise. We'd love to have you join our efforts.

*Ellen Vander Heyden*  
WBCC President

## Memorials and Honorariums January-February, 2007

### In Honor Of:

Jill Eder

Jan Eder

Jeane Carbon

Maxine

Papermaster

Rene Sadowsky

Betsy Trimble

Joyce Ownes

Rhonda Deneka

Nancy Schelble

Ellen Murphy

Roky Garcia

Sue Gorski

Mary Kaufman

Paul W.

Loewenstein, MD

Karen Case

Gloria Case

Cindy Robak

Sandra Orcholski

Barbara Bachman

Robin Gonring

Heather Wolden

Ed King

Terri Chelmowski

Gayle Effinger

Laura Goman

Beth Reidenbach

Luan S. Wells

Elizabeth

Wainright

### In Memory Of:

Marion Holzman

Maxine

Papermaster

Katherine Gorski

Sue Gorski

Elizabeth Wainright

Luan Well

Dorothy

Silver Prusback

Beatrice Harris

Janet Haydon

Nancy Danas

Betty Eder

Jan Eder

### In Kind Donations:

Milwaukee Catholic Home – meeting space and lunch for our Legislative Committee meetings throughout the year

Ed and Joyce Connolly – file cabinet for our office

Roy and Dawn Anderson – all-in-one printer/copier

Karen and Dan Maynard – printer

Connecture Inc. – conference calling service for Board of Director meetings

Brett Dangott – internet service for 1 year

Jeffrey Schrab - development, design, and hosting of our web sites ([www.standupandspeakout.org](http://www.standupandspeakout.org) and [www.rarechairaffair.org](http://www.rarechairaffair.org))

Meg Stoddard - graphic design

## “Spirit of Hope” raises \$1500 for WBCC

The temperature outside may have only been in the single digits on a chilly Friday night recently, but 15 dance squads really got things warmed up at WI Lutheran College at a benefit for the WBCC.

“Spirit of Hope” was a Pro and Collegiate Dance and Cheer Exposition hosted by the WI Lutheran College “Power Surge” dance team and organized by coach Heidi Zarder. Participating teams came from as far away as Madison’s Edgewood College and included the Milwaukee Bucks “Energee!” dance team and Wisconsin Professional Dance, Inc., who perform for the Milwaukee Brewers and Milwaukee Wave. There were many aspiring professionals in teams of young ladies under the age of 10, and a thrilling performance by the Germantown High School Competition Cheer Squad.



*Coach Heidi Zarder*

Coach Zarder’s inspiration for initiating the event was that too many friends had been diagnosed with breast cancer. “I wanted to do something about it,” she says simply. This is the 4th Spirit of Hope held to benefit a breast cancer organization. “The coaches and teams from other schools love participating and being able to give back to the community. Coaches love the non-competitive and sharing atmosphere,” she explains. Heidi’s most recently diagnosed friend, Patti Lenius has just finished chemotherapy and spoke to the crowd of about 300 people about the importance of staying fit, physically and mentally, during treatment. She encouraged everyone to be proactive in his or her health.

The WBCC would like to extend our appreciation and gratitude to Coach Zarder, Ms. Lenius, WI Lutheran College, and all of the teams who contributed their time and talents to the event.

## WBCC Advocates Meet In Madison

On Tuesday March 6, WBCC advocates met in Madison with nearly 20 key members of the Joint Finance Committee and Senate and Assembly Health and Public Health Committees. Although we have been involved in partnerships on some state legislation in the last few years, this was our first “lobby” day, where we actually sat down and introduced the WBCC to legislators involved in policy decisions that affect breast cancer specifically and cancer in general.

More information and photos may be found on our website, [www.standupandspeakout.org](http://www.standupandspeakout.org). If you are interested in participating in next year’s State Advocacy Day, please contact us!



*Dawn Anderson, Senator Carol Roessler, Karen Maynard, and Donna Johnson*



*Ellen Vander Heyden, Galina Tash, Senator Tim Carpenter, Linda Manwell, and Kathi Hansen*

## Pick ‘N Save WE CARE Program Benefits WBCC – #940586

Did you know that you can help the WBCC just by going grocery shopping at Pick ‘n Save?

Each time you use their Advantage Plus® Savers Club card, you can help WBCC through their community dollar program called the Pick ‘n Save Advantage® WE CARE Program.

When you make a purchase and the cashier scans your card, your purchase amount will automatically be accumulated, earning WBCC a share of the total dollars Pick ‘n Save makes available to non-profit organizations. This is a great way for you to help support WBCC programs by just doing the things you already do every day.

Here’s what you need to do. If you already have a card you can call the corporate customer service line at 1 (866) 742-6728, and tell them you would like to change your WE CARE charity code. Give them your Pick ‘n Save Advantage card number and our charity code – WBCC # 940586 - and they will change it for you right over the phone. Or the next time you visit Pick ‘n Save, ask to fill out a “change” application and enter the WBCC # 940586. If you do not have a card, visit your local Pick ‘n Save store and ask to fill out an application form, and then write in WBCC # 940586 as your designated organization.

## Neoadjuvant Therapies and the Gepartrio Study

By Galina Tash

### What is Neoadjuvant Therapy?

Neoadjuvant (also called induction, preoperative or primary-systemic) therapy is a “treatment given first to help make the next treatment step go more smoothly.” It is a sharp contrast from its cousin, adjuvant therapy, which is a treatment given after a particular treatment has been completed. The key difference between neoadjuvant therapy and adjuvant therapy is whether it is administered before or after surgery.

Neoadjuvant chemotherapy refers to therapy administered prior to the surgical removal of a lesion and has been studied extensively in several types of cancers, including breast cancer. In neoadjuvant therapy, breast cancer patients with large tumors are given chemotherapy or hormone treatments to shrink a tumor before surgery so that surgical removal of the cancer may be completed without a mastectomy. With this therapy, the tumor would shrink and the remaining tumor can be removed more easily during surgery with less chance of the tumor being left in the patient.

In contrast, adjuvant therapy refers to the surgical removal of a cancer followed by a treatment of chemotherapy, radiation therapy, and/or other medications such as Tamoxifen, to treat the patient and lessen their chances of getting recurring tumors. Adjuvant therapy is often used to kill any cancer cells that may remain in the body following surgery.

Historically, neoadjuvant therapy was undertaken with the aim of shrinking tumors in patients who were not candidates for primary surgery with the hope of allowing greater conservation of the breast.

Today, the rationale is different. Neoadjuvant therapy is viewed as a means of testing the activity of a therapeutic approach or the potential importance of biological factors in determining disease outcome. Results are available quickly and valuable information can be gathered. Today’s treatments give patients results they were not able to achieve previously; local tumor regression, complete tumor eradication, and breast conserving surgery without risking patient survival. For these reasons, interest in the use of neoadjuvant therapy has been increasing.

### Current Applications of Neoadjuvant Therapy

According to a recent article published in the journal *Cancer*, the Proceedings of the Consensus Conference on Neoadjuvant Chemotherapy in Carcinoma of the Breast recommends that Neoadjuvant chemotherapy is “the appropriate treatment choice” for patients with stages III breast cancer, and is “worthy of consideration” for patients with stages IIA and IIB breast cancer. It is important for patients who have been diagnosed with these stages of breast cancer to speak with their physician about their individual risks and benefits of neoadjuvant chemotherapy.

Stage II breast cancers are primary cancers that either involve axillary (the arm pit) lymph nodes and are less than 5cm (2 inches) in size, or are greater than 2 centimeters (3/4 inch) in size and do not involve any axillary lymph nodes. Stage III breast cancers typically have one of three scenarios: 1) a primary cancer that measures less than 5 cm (2 inches) in size

and causes axillary lymph nodes to be attached to each other or other structures, 2) a primary cancer that is greater than 5 cm (2 inches) in size and involves axillary lymph nodes, or 3) a primary cancer that is attached to the chest wall or skin.

Traditionally, patients who had large localized, advanced lesions would need to have mastectomies followed by additional treatments of radiation, chemotherapy, and/or hormone therapy as prescribed by their oncologist.

According to Dr. Von Minckwitz, today’s neoadjuvant therapy lets physicians first confirm, by observation, that the early response evaluation, after some cycles of chemotherapy, is a reliable predictor for overall chemotherapy effect and can be used as a decision aid for treatment planning. Only the neoadjuvant approach provides an opportunity for monitoring tumor response to treatment.

Neoadjuvant therapies have a substantial downside that has to be considered both by the patient and the physician. Many neoadjuvant therapies require a highly motivated patient. Unlike an immediate removal of the tumor, prolonged neoadjuvant therapy for respectable cancer can be physically, emotionally, and socially difficult for patients. In addition, ineffective neoadjuvant therapy means a delay of the definitive treatment and an increase in treatment-related toxicities.

### The Gepartrio Study

The purpose of the Gepartrio study was to develop a specific treatment strategy for patients with and without early responses to neoadjuvant treatment.

Patients with histologically confirmed invasive, unilateral or bilateral breast cancer were included in the Gepartrio study. Locally advanced tumors were eligible but were randomized to a different level. All patients needed to have a measurable tumor of at least 2 cm.

All patients in this study received 2 cycles of TAC (*TAC is named after the initials of the chemotherapy drugs involved, docetaxel, which is commonly known as Taxotere®, doxorubicin, which was originally called Adriamycin® and cyclophosphamide.*)

Their response to the treatments was assessed either sonographically or by physical examination. Patients that were in partial or complete remission were given another 4 or 6 more cycles of TAC. However, patients that did not show an early response to treatment were either given another 4 cycles of TAC or 4 cycles of NX in combination with vinorelbine and oral capecitabine.

Patients with a partial or complete response to 2 cycles of Docetaxel/Doxorubicin and cyclophosphamide – TAC – were considered to have highly chemosensitive tumors and therefore candidates for further treatment intensification, whereas for patients without an early response a switch to a non-cross-resistant combination of vinorelbine and capecitabine was planned.

Many factors were used to discriminate treatment effects. The main factor was if the patient responded after two cycles of

treatment. Responding patients that received TAC had greater response to treatment after 8 cycles of TAC as opposed to 6 cycles. Non-responding patients, however, achieved a significantly higher response rate with TAC as compared to NX. It was shown that receptor negative tumors had a similar response rates after 6 and 8 cycles of TAC, receptive positive tumors, on the other hand, showed different efficacy.

It was found that by including many factors such as: grade, age, histology type, receptor content, and response after 2 cycles - in a multivariate analysis were significant predictors of histological response. Similar to grade, negative estrogen and progesterone receptor content is a strong and highly significant predictor for pathologic complete response (path CR). Patients achieving a complete response already after 2 cycles of TAC have a 40% chance in obtaining a path CR at surgery, proving that early response assessment is a strong predictor of treatment effect. In non-responding patients, only age and receptor content remained significant predictors for path CR.

Patients with tumors involving the skin or muscle or with inflammatory breast cancer participated in the trial. Their path CR rate was slightly lower than in operable tumors, but there was no significant difference between inflammatory or locally advanced breast cancers.

Younger patients, especially those under the age of 40 had a higher chance for complete response. Also, it was determined that tumor stage is not a strong predictor for path CR.

Lobular type carcinomas were also observed in this study. It was found that lobular cancers had a path CR rate significantly lower than ductal or tumors of other types.

Patients with Her2 and hormonal receptor status, triple negative tumors had an impressive path CR rate of over 40% for a complete disappearance of all residual tumor tissue

The primary endpoints were different in the two populations. In responding patients they used path CR as a primary endpoint. For non-responding patients they used clinical responses measured by sonography directly before surgery as a primary endpoint.

In conclusion, with regard to the primary endpoints of the study, TAC times 8 are not superior to TAC times 6 in responding patients. However, in patients with a partial response after 2 cycles or both hormone receptors positive, the longer treatment achieved higher path CR rates. In non-responding patients, NX is not inferior to TAC, but as presented last year, less toxic. But again, patients with both hormone receptors positive had higher path CR rates with TACx6.

### My Conclusions

In conclusion, I think the use of neoadjuvant therapy is very beneficial for the treatment of stage II and III local breast cancers and should be used whenever possible. There are several reasons for this opinion. First, neoadjuvant therapy gives patients hope of sparing their breasts and other organs by having a lumpectomy performed instead of a mastectomy. Secondly, if a mastectomy is performed instead of a lumpectomy many women may choose to have reconstructive surgery. This is the best hope for these women to feel like women again.

Neoadjuvant therapy has the potential of saving women from the physical, emotional, and economic turmoil that usually comes from the diagnosis, and treatment of breast cancer. Finally, patients diagnosed with breast cancer go through emotional and psychological issues including severe depression. This depression may be caused by many factors of this disease including: partial or complete loss of insurance coverage, losing jobs and/or livelihood, marital and family problems, and most importantly, losing the very essence that makes them women. This treatment can lessen the burden of depression that these patients face on a daily basis.

Even though this therapy has many positive aspects it does have at least one huge disadvantage and that is the prolonged time and toxicity of the treatment: chemotherapy, surgery and chemotherapy.

Every cancer patient is personally familiar with the motto "No Pain, No Gain". For most, during their recovery and remission they realize that "Life Is Beautiful" that is what we are fighting for... The chance to show all cancer patients that life truly is beautiful no matter what their obstacle.

Neoadjuvant therapies have become an essential component of modern multidisciplinary cancer therapy. As stated above, it is important for patients who have been diagnosed with any form of breast cancer to speak with their surgeon, oncologist, or other healthcare providers about their individual risks and benefits of neoadjuvant chemotherapy and other treatments. Remember that neoadjuvant therapy helps determine if the tumor responds to a specific chemotherapy regimen. If the tumor is removed first, there is no way of knowing that information. Neoadjuvant therapy also allows us to determine the benefits of new chemotherapy regimens in certain types of breast cancer. For example, carboplatinum is being tested in triple negative tumors in the neoadjuvant setting. If this shows a high response rate, then we wouldn't have to do such a large study to prove it has benefit.

### References

Abstract [42] Individualized treatment strategies according to in vivo-chemosensitivity assessed by response after 2 cycles of neoadjuvant chemotherapy. Final results of the Gepartrio study of German breast group. From the San Antonio Breast Cancer Symposium 2006. v Minckwitz G, Kuemmel S, du Bois A, Hanusch C, Eidtmann H, Hilfrich J, Gerber B, Huober J, Costa S, Jackisch C, Smeljanski N, Kaufmann M.. GBG, Neu-Isenburg, Germany; Univer. Essen, Essen, Germany; HSK, Wiesbaden, Germany; Rot-Kreuz Hosp, Munich, Germany; Univ Kiel, Kiel, Germany; Henrietten Stiftung, Hannover, Germany; Univ Rostock, Rostock, Germany; Univ Tuebingen, Tuebingen, Germany; Univ Magdeburg, Magdeburg, Germany; Hosp Offenbach, Offenbach, Germany; SKM, Wiesbaden, Germany; Univ Frankfurt, Frankfurt, Germany

*This article was written as a requirement of the scholarship Ms. Tash received from the Alamo Breast Cancer Foundation to attend the San Antonio Breast Cancer Symposium. Articles are then submitted to an oncologist for review and comment on the writer's understanding of the topic. Opinions expressed are the writer's.*

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lent opportunity to review and digest all the information that was presented during the day. Mentors presented the essence of each day's sessions, as they had seen it. In addition, these sessions allowed advocates to ask questions, as well as exchange information and opinions among ourselves. It is worth mentioning that this year's mentoring faculty included a very distinguished oncologist, who very patiently and scientifically answered all of our - sometimes not well articulated - questions.

I was particularly impressed by the SABCS presentation of Dr. Ravdin on the decrease of breast cancer incidence in the USA. My interest was also focused on the posters on

Advocacy and Education, Familial Breast Cancer, and Genetic Testing and Epidemiology. The exhibitors' stands also offered hands-on opportunities to learn about the latest developments in diagnostic and therapeutic equipment and medicines and to network and learn from other breast cancer patient groups in attendance.

I have to say this conference was the best I have ever attended; it was useful and enjoyable. Hot topic articles I wrote as part of my requirements for ABCF from this year's symposium will be published in future issues of this WBCC newsletter.

## 8th Annual Rare Chair Affair – Friday, September 28, 2007

### *Did you know?*

- X Most men believe only women get breast cancer
- X Men often ignore the early signs of breast cancer
- X 2030 men will get breast cancer in the year 2007
- X 450 of those men will die

**The Rare Chair Affair**, the signature fundraiser for the WBCC, has always profiled women who are surviving breast cancer. We are excited to introduce you to our 2007 honorary Rare Chair Affair chairpersons Robert and Kären Cohen. Robert is a 6-year breast cancer survivor and will share his story of survival. Each year for the Rare Chair Affair, our Survivor Artists paint chairs for our famous voice auction. Robert will be our first male breast cancer survivor to paint a chair. Please plan on joining us as we celebrate the survivorship, courage, and creativity of all our Survivor Artists!

**THE RARE CHAIR AFFAIR  
BRYNWOOD COUNTY CLUB  
MILWAUKEE, WI  
FRIDAY, SEPTEMBER 28, 2007  
6:00 P.M.**

Call our office for further information 414-963-2103 or to make sure you are on the invitation list.

## WBCC plans new Advocacy Training Event

Each year before we travel to Washington DC for the Annual Advocacy Training Conference and Lobby Day, organized by the National Breast Cancer Coalition, the WBCC hosts a small pre-conference training session for participants traveling with us. Because we realize not everyone can take the time to join us for 4 days in DC, we wanted to expand that educational opportunity to more people. In June, in Milwaukee, we will host a half-day advocacy training session called "Beyond the Pink Ribbon™" - What ELSE you can do in the fight against breast cancer". Our successes have proven the power of advocacy, but we cannot do it alone. We are not professional lobbyists – so we need your voices as grassroots participants in the political process of enacting good breast cancer policy. You will get a refresher course in how a bill becomes a law and learn what hurdles a policy idea has to overcome before it becomes reality. We will provide training and materials on how to contact your elected officials at the state and federal level, and how to talk to them so they will listen. We'll provide examples of how grassroots advocacy works when ordinary citizens get behind a good piece of policy – and what happens when our elected representatives DON'T hear from their constituents. Details are still being finalized as of press time for this issue, but please call our office for more information or to get on the invitation list. 414-963-2103 or email at [wbcc@standupandspeakout.org](mailto:wbcc@standupandspeakout.org)

## TAILORx – Breast Cancer Clinical Trial Overview

According to ECOG (Eastern Cooperative Oncology Group), the cancer cooperative that is coordinating this clinical trial, great progress has been made in the treatment of breast cancer. Many treatments have been developed that can often slow or stop breast cancer's steady progression. But some of those same treatments, such as chemotherapy, have serious side effects. Patients often experience severe nausea, hair loss, fatigue, and other short- and long-term side effects.

When women are diagnosed with early-stage breast cancer they, along with their doctors, have to decide on treatment(s) and they need the answers to questions like: Which treatment will work best? Should there be hormonal therapy and/or chemotherapy? Why is additional treatment after surgery needed? The purpose of the TAILORx (Trial Individualized Options for Treatment - Rx) trial, is to determine whether adjuvant (treatment given after surgery) hormonal therapy alone is as effective as adjuvant hormonal therapy in combination with chemotherapy for certain women with breast cancer. The results of the TAILORx clinical trials will help determine which patients with early-stage breast cancer would be more likely to benefit from chemotherapy, and reduce the use of chemotherapy in those who are unlikely to benefit from it.

Breast cancer research has previously delved into the area of treatment in efforts to find less toxic chemotherapy drugs or other approaches to treatment such as hormonal therapy. Now, many breast cancer patients can be treated with hormonal therapy alone to reduce or eliminate cancer. The TAILORx trial continues this type of research by using the Oncotype DX Assay to identify women who would most likely require chemotherapy and those whose cancer will most likely respond to hormonal therapy.

The Oncotype DX Assay is a clinical cancer test that can tell the doctor the likelihood that cancer will recur. The results of the Oncotype DX Assay test are reported as a Recurrence Score (RS) that ranges from 0 to 100. Patients with a low RS have been found to have fewer recurrences and often receive only hormonal therapy. Patients with a high RS have more recurrences and usually have hormonal plus chemotherapy treatment. At this time, researchers do not know which treatment(s) work best for patients with a mid-range RS. TAILORx has been developed to help determine which patients in the mid-range group would do well with only hormonal therapy and which need both therapies.

To be eligible for this clinical trial, women must have estrogen receptor-and/or progesterone receptor-positive, no positive axillary lymph nodes, HER2/neu-negative breast cancer. The tumor size must be 1.1 to 5.0 centimeters (or 5.0 millimeters to 1.0 centimeters, with unfavorable histological features). Participants must meet standard clinical criteria and be medically suitable candidates for adjuvant chemotherapy.

The TAILORx clinical trial is being conducted by all of the major National Cancer Institute-funded cooperative groups in the United States. ECOG is coordinating this trial. ECOG is one of the largest cancer research organizations in the United States. It has networks of researchers, physicians, and healthcare professionals at public and private institutions across the country.

One of the healthcare systems participating in the TAILORx clinical trial is Wheaton Franciscan Healthcare – All Saints Cancer Center, in Racine, Wisconsin. The chief researcher on the TAILORx trial at All Saints Cancer Center is Dr. Richard N. Odders. Dr. Odders indicated that the importance of the TAILORx trial is that individual “gene signatures” will be used to predict the recurrence risk level in women with early-stage breast cancer. According to Dr. Odders, this recurrence risk prediction can be made in “real time,” and then used to help determine appropriate, individualized treatment. Dr. Odders suggested that more far-reaching, future benefits of the TAILORx trial might be “geneship” protocols for other cancer diagnoses, resulting in more individualized treatment options for those other cancers.

Several locations in Wisconsin are currently recruiting for this trial. You can go to [www.clinicaltrials.gov](http://www.clinicaltrials.gov) for more information on eligibility and to find one near you.

For more information about cancer and clinical trials, visit: The Coalition of Cancer Cooperative Groups: [www.CancerTrialsHelp.org](http://www.CancerTrialsHelp.org)  
The National Cancer Institute (NCI) Cancer Information Service: 1-800-4-CANCER, [http://cancer.gov/clinical\\_trials](http://cancer.gov/clinical_trials) for clinical trial information and [http://cancer.gov/cancer\\_information](http://cancer.gov/cancer_information) for more information about cancer.

For more information about the OncotypeDX Assay, visit: [www.oncotypedx.com](http://www.oncotypedx.com)



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**WBCC MISSION**

The Wisconsin Breast Cancer Coalition brings Wisconsin voices together to Stand Up and Speak Out about breast cancer with:

- Education** – spotlighting critical breast cancer issues
- Collaboration** – empowering through strategic alliances
- Legislation** – influencing policy making.

**TO CONTACT WBCC**

414.963.2103  
888.295.2622  
wbcc@standupandspeakout.org

**STAND UP**

**and  
speak  
out**

- I'd like to become a member of WBCC.
- I'd like to donate\* to WBCC.
- I'd like to become a WBCC volunteer.
- I'd like to join the WBCC Alert Network. (Please be sure to enter your email.)

Annual Membership: **\$30**\_\_\_\_\_

Please enter the amount you would like to donate\*: \_\_\_\_\_

Total Amount: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

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Please find my enclosed check made payable to the **Wisconsin Breast Cancer Coalition**.

Please charge my credit card:  VISA  MasterCard

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Expiration Date: \_\_\_\_\_ Signature: \_\_\_\_\_

*\*All donations are tax-deductible to the extent provided by law.*