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October 1988
Ladies' Home

Journal

The war against BREAST CANCER

EXCLUSIVE
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■ JOAN COLLINS
continued

reviews unless they're good. Because of my high profile, I know that critics, no matter how unbiased they try to be, will not judge the book on its merits but on their opinion of Joan Collins."

Joan is something of a hometown heroine in Britain, a chin-up survivor who is catnip to the tabloids and "our Joanie" to shopkeepers. Her popularity travels well between continents, across age groups and among women as well as men.

Part of Joan's appeal may come from her background of struggle. She retired a few times from a second-rate movie career to return to homemaking, odd jobs and even professional interior decorating. "I have an artistic flair for it," she says. In the seventies, strapped for cash and restless for a comeback, she appeared in *The Stud*, Ron Kass's steamy film of Jackie's novel. It made millions and jump-started her career again.

But in 1980, Joan's daughter Katy suffered severe brain damage in a car accident. She kept a forty-seven-day vigil by the child's bedside, living in a trailer behind the hospital. Katy recovered, and the experience inspired Joan's second book, *Katy, a Fight for Life*, published in 1981. Then *Dynasty* began the same year when the producers were looking to boost ratings and signed Joan for the newly created role of Alexis.

Joan still looks no more than forty, but she has no formula for her youthful appearance. "It's good genes, good luck, good bone structure and the way I was brought up. Even if I were not in the public eye, I wouldn't dream of going anywhere without being properly dressed and made up."

Her hand reaches for a cigarette, what she calls her real vice. "I have to say, I don't have any less energy since forty, and I live the same lifestyle I did at twenty-eight. I fly twice a month from L.A. to London without jet lag. I can drink. I can party. I consider myself an advance woman for the benefits of getting older—if not with grace, at least with *enthusiasm*!

"It sounds strange to say, but as far as looking young is concerned, I believe you are what you think," she goes on. "My father was eighty-five when he died recently. He was a difficult man, a rascal, but he did what he wanted, and until he fell ill, at eighty-three, he looked wonderful, because he was happy.

"Well, *I'm* happy with my life," she says with emphasis. "I like what I do. I like my children—they have turned out really well—not that there aren't minor problems sometimes. Sacha is living with me at the moment and so is Katy, of course, who's fifteen and has plans for college. But then I don't talk publicly about my children anymore. I need to keep back and keep myself more to myself, keep my life private. Privacy has become even more difficult since my last husband. For example, we agreed to get married in tremendous secrecy to avoid a fiasco. Well, Peter went out and sold our wedding pictures to one of the tabloids."

With a husband/manager out of her life, Joan controls the important decisions these days. She has a large staff, but the hard choices are hers. "It's time-consuming, but any mistakes are my own. I like being in charge again. I can do exactly what I like, and I'm not going to get sidetracked again."

Lunch is over, the Ritz is empty, and we exchange contented smiles. "This is the only life I'm going to have," she sums up, stuffing things in a purse. "I try to keep in mind those great words: 'Life is a banquet and most poor suckers are starving to death.' Well, I'll tell you — I'm just never going to starve." ■

In 1891 Mrs. Herbert Foster volunteered to take part in a stunt at Buffalo Bill's Wild West Show.

It was the only way to light up without upsetting her husband.

You've come a long way, baby.

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Ladies' Home Journal
October 1988

By Judy Foreman

THE WAR ON BREAST CANCER

More and more women are succumbing to this frightening and persistent disease. But what is being done to solve one of today's most urgent health crises? Here, the first of two LHJ special reports—essential reading for every woman

Photo, Alexander Tsiaras/Science Source/Photoresearchers.

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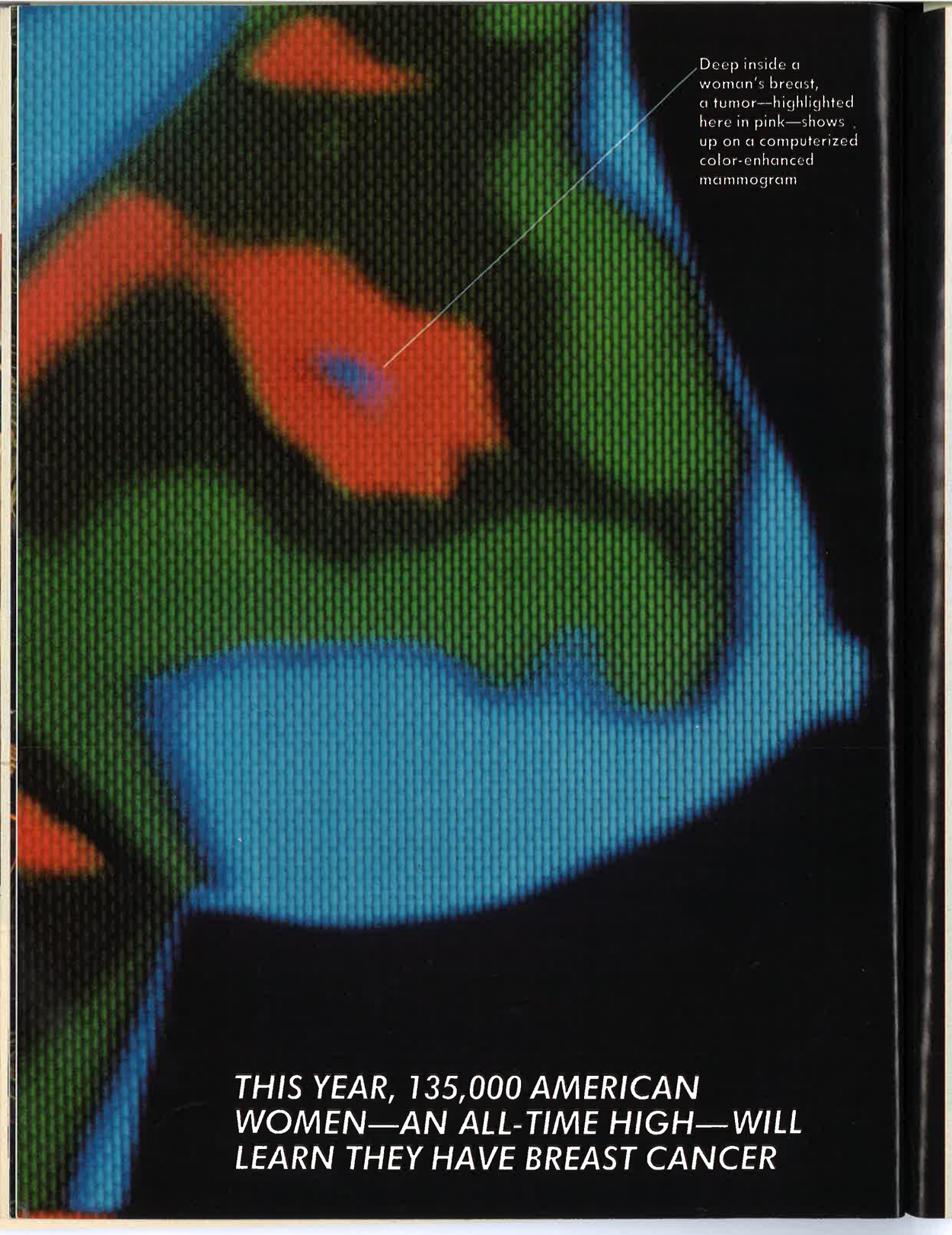
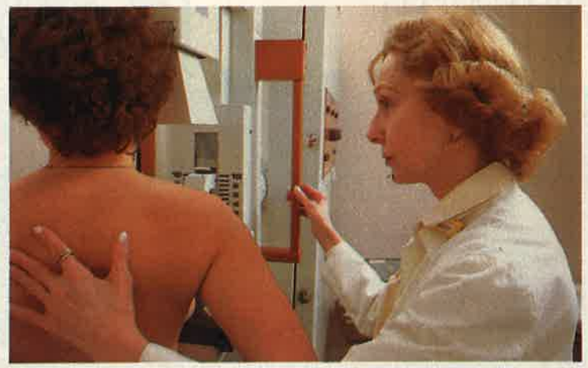


Deep inside a woman's breast, a tumor—highlighted here in pink—shows up on a computerized color-enhanced mammogram

THIS YEAR, 135,000 AMERICAN WOMEN—AN ALL-TIME HIGH—WILL LEARN THEY HAVE BREAST CANCER

Photos, clockwise from left: Howard Sochurek/Stockmarket, Jon Riley/Medichrome/courtesy Guttman Institute, Jon Riley/Medichrome, Alexander Tsiaras/Science Source/Photoresearchers.

THE WAR ON BREAST CANCER



Above: Many cancer experts recommend mammograms starting at mid-life. Below; After diagnosis, a woman needs to know her options. Her treatment should be geared to her condition

My friends are beginning to die of breast cancer.

One was a teacher at the school up the street, a tall, strapping redhead with a love of songs and puppets and a passion for world peace. She died a year ago. She was forty-one.

Another friend, age forty-three, never gave cancer a second thought. A sophisticated medical consumer, she'd had her annual screening mammogram less than a year before her breast cancer was diagnosed, and it was negative.

Soon, she, too, became a statistic: one of the nearly 8 percent of women whose mammograms fail to reveal the presence of cancer. Her battle to live long enough to see her children grow up—a fight she never thought she'd have to wage—was just beginning.

Some women are able to smile in the face of the disease. Another friend, a blithe-spirited former pilot and world traveler, goes about her life as usual, a life of work, exotic trips and friends. At the age of fifty-three, five years after undergoing a mastectomy, she exudes nonchalance.

A discouraging battle

Not all women are as brave about breast cancer as my pilot friend. The disease scares women today as no other illness can. Almost everyone can name several friends or relatives who've had it, and *(continued)*

THE WAR ON BREAST CANCER

(continued) even reading about it can be frightening. But if you read carefully, you will find good news amid the bad. Although the statistics on breast cancer sound grim, it's important to remember that statistics apply to populations of women. As an *individual*, your chances of getting the disease may be quite low; if you already have it, your prognosis may be better than average.

That doesn't change the stark fact that this year, nearly 135,000 American women—an all-time high—will learn that they have breast cancer. A decade ago, it struck one in thirteen women. Today, for reasons unknown, it strikes one in ten, and of every three women diagnosed with breast cancer, one will die. This year, forty-two thousand women are expected to die of breast cancer, more than ever before in U.S. history. You may be surprised to learn that this number represents *more* deaths than the combined total from the first seven years of the AIDS epidemic.

There has, of course, been some progress. Instead of the modified radical mastectomy—surgical removal of the breast and underlying tissue—that virtually all patients faced fifteen years ago, many women now undergo lumpectomies—removal of just the tumor and a small amount of surrounding tissue, sometimes followed by radiation. If they wish, women today can also choose to have reconstructive surgery to replace a lost breast. And chemotherapy or hormonal treatment can add years to patients' lives following surgery, though this is hardly a cure.

No one ever said winning the war against breast cancer would be easy. But how effective a fight are we waging against this immensely complicated disease? Some of the battles are not going well. Consider the following:

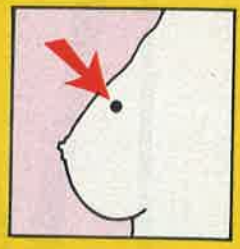
■ In January, the National Cancer Institute (NCI) canceled a $130 million experiment, the Women's Health Trial, designed to see if reducing dietary fat would cut breast cancer rates in high-risk women. Critics said that the trial was too expensive, that the hypothesis was shaky and that women might not report their fat intake accurately. Advocates of the program noted that the government had *already* paid $115 million for a study to help determine whether reducing dietary fat and cholesterol lowered *(continued)*

The stages of breast cancer

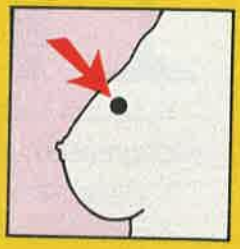
After surgery, a woman is assigned a stage that takes into account tumor size, presence of tumor cells in lymph nodes and whether cancer has spread (metastasized). Below, a system used by many doctors

Stage DCIS
(ductal carcinoma in situ)
A noninvasive tumor located within a milk duct. Almost 100 percent curable with mastectomy.

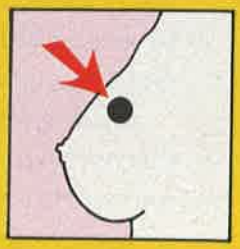
Stage I
Tumor is two centimeters or smaller. Patient is node negative—lymph nodes appear free of cancer. At diagnosis, about half of all patients are node negative.



Stage II
Two- to five-centimeter tumor, no lymph node involvement, or smaller tumor with positive nodes. No metastases. Many node-positive patients die despite treatment.

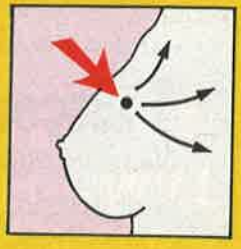


Stage III
Larger tumors with or without lymph node involvement. No metastases.



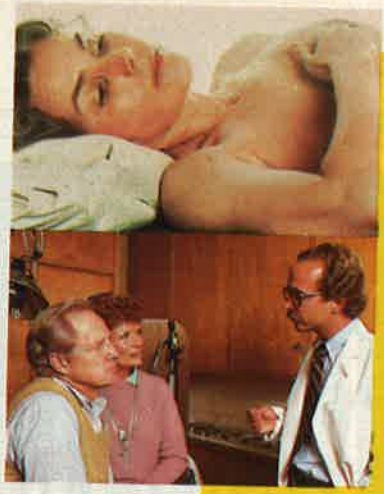
Stage IV
Any size tumor, any nodal status, with metastases to distant organs.

About half of all breast cancers are diagnosed at Stage II, III or IV. Few stage IV women survive more than ten years.



Photo, Alexander Tsiaras/Medichrome; illustrations, Linda Eisenberg

THE WAR ON BREAST CANCER



(continued) the risk of heart disease in men.

■ The American Cancer Society and the NCI recommend a mammogram either annually or every two years starting at mid-life. But one American Cancer Society survey showed only 10 percent of doctors recommend the exams to patients.

■ A survey by the National Women's Health Network showed that nearly 20 percent of seventy mammography clinics polled throw away baseline mammograms after five to seven years, although keeping the X-rays for comparison is the main reason they are done in the first place.

■ Only a handful of states now require insurers to pay for screening mammograms for women under 65.

■ New tests, developed by scientists in California and Texas, can identify which women with breast cancer are at greatest risk of relapse and death. But historically, advances like this move slowly from research labs to clinics. Will this unfortunate state of affairs continue?

The verdict: We are not yet winning the war against breast cancer. One giant in the field, Maurice Fox, Ph.D., chairman of the biology department of the Massachusetts Institute of Technology, confesses, "We have not gotten very far."

Others agree. "We know less about breast cancer and about the specific cancer-causing genes that may be involved than we know about many other cancers," says Philip Leder, M.D., professor and chairman of the department of genetics at Harvard Medical School.

"With early detection, we have done a good job, and early detection saves lives. But we have done a lousy job on prevention," says Jay Harris, M.D., clinical and educational director of Harvard's Joint Center for Radiation Therapy.

Experts give various reasons for the relative lack of progress in some areas of breast cancer research. Susan Love, M.D., head of the Faulkner Breast Center, in Boston, fears that there is "no sense of urgency" in breast cancer research, partly because it is almost solely a woman's disease.

Marc E. Lippman, M.D., former head of NCI's medical breast cancer section, blames a lack of funding for much of the problem. "The entire federal budget for research and development in all of biology is exceeded by the cost overrun of the Sherman tank," he maintains.

Breast Cancer Awareness Week

Ladies' Home Journal **has joined with leading cancer research and information organizations across the country to bring you the latest news about breast cancer. To focus attention on this major health concern, October 17–23 has been designated Breast Cancer Awareness Week. *LHJ* is taking part in the effort to help educate millions of American women—an effort that will include special reports in this issue and next month on new findings, public and media appearances, as well as public service announcements on radio and television to give women the latest information on breast cancer. Participating organizations include:**

■ ***The American Cancer Society,*** the nation's leading voluntary organization, with affiliates in major communities.

■ ***NABCO (National Alliance of Breast Cancer Organizations),*** which provides up-to-date information on all aspects of breast cancer.

■ ***The National Cancer Care Foundation,*** a voluntary agency that helps patients and their families deal with the psychological, social and financial problems caused by cancer.

■ ***The American Academy of Family Physicians,*** a professional association representing sixty thousand family doctors.

■ ***ICI Pharmaceuticals Group,*** a research-intensive company that is involved in the discovery and development of new therapeutic drugs.

■ *LHJ* will also contribute by offering part of the proceeds of its holiday card sales to the American Cancer Society, NABCO and the National Cancer Care Foundation. (To order cards, see page 128.)

Still other experts say the problem is lack of both money and coordination. As Helene Smith, Ph.D., associate director of the Peralta Cancer Research Institute, in Oakland, California, puts it, "If the government made a long-term commitment to labs, you'd find scientists more willing to try new directions." But as things now stand, scientists and the public are discouraged by the lack of progress. Says Smith: "It's like my father keeps saying to me: 'Helene, you've been working on breast cancer for fifteen years. Why does Aunt Sadie still get it?' "

How breast cancer begins

Although we don't yet know exactly why Aunt Sadie—or any specific woman—gets breast cancer, we are learning some things about why and how it develops. An *(continued on page 197)*

Photo, courtesy of the American Cancer Society.

■ BREAST CANCER

continued from page 146

individual's genetic heritage is considered one of the significant factors. The process that ends in a cancerous tumor begins the same way all human life does: with a fertilized egg that holds all the genetic material—perhaps 100,000 genes—that a person will ever need. There are genes for making us tall, or thin, or even musical; genes for telling some cells in a growing fetus to become a heart or a brain. And there are also genes to stop this growth, so that, for example, the heart doesn't become too big for a person's chest.

But genes can also change twenty, forty or even eighty years after a person is born, mutating in ways that kick off the process that results in the disease we call cancer.

Indeed, scientists now believe that proto-oncogenes—the genes that may someday kill through cancer—are actually just disturbed versions of genes that are essential for normal growth.

Genes become disturbed for various reasons: They may break apart by pure accident, be hit by radiation or chemicals, make too many copies of themselves, or simply become lost during cell division for reasons doctors don't yet understand. But whatever it is that causes the disturbance, once a normal-growth gene goes bad, the cell in which it lives escapes from the normal cycle of rest and growth, entering an irreversible phase of uncontrolled growth.

But merely locking a cell into an "on" mode for continuous division is not enough to cause cancer.

"If a cell just continued to divide, the result wouldn't be cancer," explains Smith. "Instead, it would be a benign tumor." To become a cancer, Smith says, a tumor must not only grow uncontrollably but must also invade neighboring tissues and mutate again. The cells that are the most vulnerable to cancerous growth are the ones that divide most often. That's because most genetic accidents happen during cell division. And the breasts are particularly susceptible, since their milk ducts are filled with just such frequently dividing cells, called epithelial cells. But what tells cells to start dividing in the first place?

The answer, at least in part, is found in so-called growth factors, substances that are made by the cancerous cell itself or by another cell. These growth factors—among them the female hormone estrogen—nestle in receptors on the surface of cells. Their presence triggers the chemical changes that ultimately tell DNA in the cell nucleus to make copies of itself.

Of all the growth factors that lead to breast cancer, hormones—especially estrogen, progesterone and prolactin—are among the most important. Overall, say researchers, about one third of premenopausal breast cancer patients and 80 percent of postmenopausal patients have tumors that are rich in receptors that retain estrogen. Every month of a woman's reproductive life, some three hundred to five hundred times in all, her breast cells are bombarded with hormones.

But some researchers believe this monthly hormonal barrage seems most likely to trigger the process during a critical "window of vulnerability"—the time between a woman's first menstrual period and her first pregnancy. The longer this window is, the greater a woman's chances of developing breast cancer later in life. Breast tissue does not fully mature until a woman finishes her first full-term pregnancy, according to Susan Love. And since cancer is most likely to strike immature cells, delaying or avoiding pregnancy may put a woman at increased risk for breast cancer.

Cells most vulnerable to cancerous growth are the ones that divide most often—like those found in milk ducts.

The growing evidence that breast cancer is linked to estrogen bombardment of immature cells has wide lifestyle implications. For example, some research suggests excessive estrogen production may be related to a high-fat diet. Therefore, adolescent girls who consume such a diet may be at increased risk for breast cancer later in life. The evidence also suggests that an active lifestyle may be beneficial. That is because regular exercise can delay the onset of menstruation.

Third, while researchers aren't yet sure whether breast tumors actually grow faster during the high-estrogen phase of a woman's monthly cycle, preliminary studies on animals suggest that timing breast-cancer surgery to coincide with ovulation—when estrogen levels are lower—may improve the odds against relapse.

But there are ways to avoid estrogen's ill effects. Some physicians believe that women at high risk of breast cancer might in fact be protected from their own hormones by taking drugs such as tamoxifen that appear to block estrogen. But such drugs can never protect *all* women against breast cancer, in part because many tumors that initially need estrogen to grow *stop* needing it after a while.

Finally, there is still debate over possible links between birth control pills and estrogen therapy for menopausal women. There have been many studies attempting to link the Pill to breast cancer; so far, the results have been mixed. Doctors also disagree about the effect of estrogen replacement therapy. Overall, postmenopausal estrogen therapy appears to be more of a risk for uterine cancer than for breast cancer, says I. Craig Henderson, M.D., of the Dana-Farber Cancer Institute, in Boston. Henderson adds that this risk is probably small for women who use moderate estrogen doses for a short period of time.

"The risk-benefit equation is quite complicated," adds Ronald K. Ross, M.D., professor of preventive medicine at the University of Southern California School of Medicine, in Los Angeles. "On average, we predict that women will live longer if they take estrogen than if they don't, because it reduces the risk of cardiovascular disease and osteoporosis."

But Ross acknowledges that no one really knows how great the risks of estrogen therapy may be. For, as with so much else in the breast-cancer field, much desperately needed research simply hasn't been done.

Changes in treatment

The studies that *have* been done highlight the complexity of the disease. Indeed, scientists' understanding of breast cancer has changed radically in the past twenty years. It is no longer seen as a fast-growing, local disease; rather, it is now thought of as a slower-growing illness that ultimately involves the patient's whole body, not just the breast.

This understanding reduces the importance of local treatment such as breast surgery. At the same time, it means that many women need systemic, whole-body therapy. And until researchers develop drugs to combat the basic genetic mutations that underlie cancer, that means chemotherapy or hormone treatment.

The NCI recently announced that virtually all breast- *(continued)*

■ BREAST CANCER
continued

cancer patients should strongly consider postsurgical chemotherapy or hormonal treatment, even those women who might be advised against it—those whose cancer has not appeared to spread to the lymph nodes. Without such postsurgical treatment, the agency says, three to four of every ten node-negative women will die within ten years after diagnosis.

Some researchers feel the NCI blanket pronouncement on chemotherapy was premature. Henderson, of Dana-Farber, is among those who are still not convinced that the chemotherapy regimens currently available for early-stage breast-cancer patients will ultimately cure them. And chemotherapy has a price, Henderson points out; some drugs or dosages can be toxic or cause leukemia.

But Vincent T. De Vita, Jr., M.D., director of the National Cancer Institute in Bethesda, Maryland, is convinced of the value of chemotherapy and hormonal treatment. In fact, he says, "the only women I would *not* treat with chemotherapy or hormonal therapy are those with in situ carcinoma"—a noninvasive cancer in the milk duct that is virtually always curable

with mastectomy. De Vita also urges physicians to abandon the common practice of "shaving" chemotherapy dosages to reduce side effects and to shift instead to higher, potentially curative doses. He is concerned that some doctors shave doses to compete for patients who are leery of more toxic therapy. But paternalism may also play a role. Jerome Block, M.D., head of medical oncology at the Harbor-UCLA Medical Center, in Torrance, California, says doctors may give higher doses of chemotherapy to men "because they feel men can take it. But they don't want to make women sick."

Improved medication

There may soon be better ways than dose shaving to reduce chemotherapy's negative side effects. A new drug, GM-CSF, might make higher doses of chemotherapy easier on the body, in particular the delicate bone marrow. Last spring, a Duke University team showed that GM-CSF boosts the bone marrow cells responsible for fighting infection in breast-cancer patients who undergo high-dose chemotherapy and bone-marrow transplant. (Some researchers, however, question whether high doses of this powerful drug are truly beneficial.)

And in Canada and Italy, physicians are trying another tack, giving chemotherapy *before* surgery.

Another development—flow cytometry—may also help improve treatment, especially for node-negative women. Until recently, it has been impossible to tell which node-negative patients are in the 70 percent that will live at least ten years after surgery without treatment. But flow cytometry, a test developed by William L. McGuire, M.D., chief of medical oncology at the University of Texas Health Science Center at San Antonio, picks out the women most likely to die from undetectably spreading cancer. Flow cytometry spots the tumors that have too much DNA and those in which a lot of cells are getting ready for cell division—both bad signs.

Beating the odds

What should you do if you already have a diagnosis of breast cancer? You and your doctor might want to discuss the developments outlined above, such as the availability of flow cytometry in your area or the possibility of getting chemotherapy treatments before, not after, surgery.

You might also want to ask your physician about getting into a clinical trial, a study that compares different treatments. Being part of such a trial won't guarantee more effective treatment, but at worst you will be in the control group of the study, which means you'd receive standard treatment; if you're in the experimental group, you could get a newer treatment that may be more effective. And clinical trials help provide knowledge that might benefit other women.

"The main crisis we face now," adds De Vita, "is getting patients into clinical trials. Very few are presently enrolled. If we had fifteen percent of patients participating, we could drive mortality rates down."

Ultimately, say breast-cancer activists and researchers alike, it is only a larger commitment to research, including more clinical trials, that may provide the answers we need to win the war on breast cancer—answers that are so obviously lacking today.

Judy Foreman is a staff medical writer for The Boston Globe. ■

Next month: What you can do to prevent breast cancer; getting the best available exams and treatments; and coping with the emotional consequences of the illness. Don't forget to send for the Coors and AMC Cancer Research Center Shower Card to tell you how to do a monthly breast exam. See page 140.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