



President's Message

Last night I met a couple from Venezuela who were thrilled because they had just become U.S. citizens. "Why is this important to you?" I asked, fully expecting an answer having to do with their ability to work here, travel in and out of the country, or even carry a US passport. What I heard brought tears to my eyes; "We became US citizens so we could earn the privilege of voting in a free election," they answered.

In a few weeks, most of us will have the privilege and the responsibility of voting in our national and local elections. In case you need to be reminded of the importance of being an educated voter, let me give you a brief history lesson on the significant privilege.

"The women were innocent and defenseless. And by the end of the night, they were barely alive. Forty prison guards wielding clubs and their warden's blessing went on a rampage against the 33 women wrongly convicted of "obstructing sidewalk traffic."

Thus unfolded the "Night of Terror" on November 15, 1917, when the warden at the Occoquan Workhouse in Virginia ordered his guards to teach a lesson to the suffragists imprisoned there because they dared to picket Woodrow Wilson's White House for the right to vote. For weeks, the women's only water came from an open pail. Their food – all of it colorless slop – was infested with worms. When one of the leaders, Alice Paul, embarked on a hunger strike, they tied her to a chair, forced a tube down her throat and poured liquid into her until she vomited. She was tortured like this for weeks until word was smuggled out to the press."

"So, refresh my memory; some women won't vote this year because – why, exactly? We have carpool duties? We have to get to work? Our vote doesn't matter? It's raining?"¹

One of the most effective tools the Florida Breast Cancer Coalition Research Foundation has in the war against breast cancer is advocacy. Our mission is to effect public policy decisions that ensure funding for breast cancer research, equal access to quality health care for all without fear of discrimination, and an environment free of carcinogens. There are many elected officials on the national, state, and local levels who have consistently supported our mission and our legislative priorities. Unfortunately, there are others who have not chosen to help eradicate breast cancer.

When you exercise your privilege to vote this year, make sure you are an informed voter. Find out how your representatives in Congress voted on key legislation by going to NBCC's website, www.stopbreastcancer.org, Public Policy and click on "Voting Record." For those candidates who have not served in Congress, call their offices and ask for their commitment to support our efforts to end the breast cancer epidemic. And if they are elected, hold them to that commitment.

Your vote is your voice. Raise your voice to end breast cancer.

Thank you.
Jane A. Torres

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**Florida Breast Cancer Coalition Research
Foundation Board of Directors**

This year's Board of Directors election has brought a few changes. We are sorry to be losing five dedicated members who have given of their time, talents, and commitment over the past few years. As readers of this excellent newsletter, you will all know Sheila Freeman who served as co-editor of the newsletter for the past 5 years. The others, who have been a little more behind the scenes, have made equally important contributions to FBCCRF and our mission. Clara Felsher chaired the Education Committee and helped ensure that our education grants fund worthwhile projects empowering women to take control of their breast health. Lynda Esserman helped with our personnel policies and office space. Sue Myers made sure our newsletters and materials are distributed across the State. She also set up a web-based system for sharing information and organized our entire Lobby Day last year. And last, but certainly not least, Gina Fabelo created all the wonderful graphics you've seen on our brochures, emails, posters, and rack cards. We thank you all very much.

We are excited to welcome our new board members who bring their enthusiasm, expertise, and experience to FBCCRF.

- Wilma Siegel, MD(Fort Lauderdale) is a retired oncologist who has turned her artistic talents to a medium to educate the public on health issues.
- Alvin Horton (Miami), is a certified public accountant with many years of experience in banking, consulting, and the FBI.
- Terrie Glover (Tallahassee), an expert in public relations, coordinates the business development and marketing campaigns for clients of Moore Consulting Group.
- Julia Frey (Orlando) is an attorney specializing in estate planning; probate; guardianship and trust administration; federal tax, and family wealth preservation and succession planning.
- Francesca Polanco (Miami) is a member of the media practice of Burson-Marsteller public relations/public affairs Miami office. She is currently responsible for the corporate communications, community relations and media outreach strategies for clients in the technology, financial services and consulting industries.
- Eric Jacobs (Miami), a long time supporter of FBCCRF, is Director and Senior Vice President of Onstream Media, a public company specializing in webcasting and digital asset management.

Together with our professional staff and committee volunteers, our board is moving to the next level of organizational development with an increased ability to make a difference in the fight against breast cancer through education, research and advocacy. Please join with us.

Editor's Note

This newsletter is my last as co-editor. During the past five years, I have learned so much about breast cancer from my work on the newsletter, and have very much enjoyed producing it. I appreciate the assistance I received from so many dedicated volunteers, especially my co-editor, Lourdes Cambo. The support of you, the readers, has made this a very meaningful experience for me. I hope that you have found the newsletter informative and interesting.

Sheila Freeman

Information is Power! **EMPOWER YOURSELF**

Enhancing cancer survivorship is on the federal government's agenda. June 18-20, the Office of Cancer Survivorship, under the aegis of the National Cancer Institute (NCI), sponsored a summit for cancer survivor advocates from around the country. The specific group responsible for organizing the conference, the Director's Consumer Liaison Group (DCLG), is composed of individuals selected by the NCI Director who represent constituencies within the cancer survivor community. The DCLG exists to advise the Director on issues of concern to survivors, as well as to provide feedback on NCI's current and future priorities.

There were two primary purposes of the DCLG conference. The first was to offer cancer survivor advocates the chance to find out more about the activities of NCI and the Office of Cancer Survivorship (OCS). A second, and equally important, goal was for survivors and other advocates to network with each other in order to share knowledge and experiences in developing local cancer advocacy organizations.

FBCCRF supporters Nan Van Den Bergh and Ann Fonfa participated in this event. Below are some important informational points that we would like all FBCCRF members to know:

- 1) Cancer survivors are becoming a critical mass. There are currently 10 million of us within the US.
- 2) Increasingly, the federal government is including survivors within the planning and evaluation processes, in addition to seating them on grant review boards.
- 3) One is deemed a survivor from the moment he/she is diagnosed with cancer. Interestingly, his/her family, partner and others closely involved with treatment and recovery are also deemed to be surviving.
- 4) OCS offers workshops and training for localities in enhancing survivorship within communities. This is something that FBCCRF may wish to follow-up with, in terms of requesting that the OCS offer training for those of us interested in building a strong breast cancer survivor community in Florida.

An important aspect of the conference was in ensuring that participants be informed about the array of cancer survivorship information resources available through the federal government. Below are some important information resources that you should investigate:

- 1) **Medline Plus** (www.medlineplus.gov) is a free, authoritative, up-to-date health information web site managed by the National Library of Medicine (of the National Institutes of Health). Medline Plus will give you information on an array of health topics, in addition to drug information, interactive tutorials, current health news, a medical encyclopedia, and directories for doctors, dentists and hospitals.
- 2) **PubMed** (www.pubmed.gov) is an innovative web-based literature retrieval system, which is free to the public. Through PubMed, you can acquire access to articles published on all aspects of medicine and health care delivery. Its data base is more than 13 million citations and abstracts in the fields of medicine, nursing, dentistry, veterinary medicine, and health care systems.

For example, as a breast cancer survivor, by searching in PubMed you would be able to acquire the most current information on all aspects of breast cancer prevention, screening, treatment, and survivorship, including research on complementary and alternative medicine. If you are currently deliberating whether or not to engage in an adjuvant drug treatment, you could find out the most recent research on side effects, treatment effectiveness, etc.

In addition to a one time search of a topic area, within PubMed, you may set up your own search profile under the option MY NCBI. This will establish a search profile which not only provides citations for all articles on the topic of interest, but when a new article on the topic is added to the data base, an automatic alert is sent.

Given advances in cancer treatment, most of us are likely to live long lives. Based upon the resources available within NCI and OCS, what would you like to know as a breast cancer survivor? What are your survivorship interests? What kinds of information would survivors like to acquire? Are there particular topics you would like to be trained on, or be given resources about, through the Office of Cancer Survivorship?

I encourage you to contact me about your interests. I will gather and organize them, and then with the approval of FBCCRF, forward them on to OCS for action: Nan Van Den Bergh at vandenan@fiu.edu, or 305-892-0928.

Nan Van Den Bergh, PhD

BE A POWERFUL SURVIVOR! GET INFORMED!

Florida's Senatorial Candidates Speak

FBCCRF invited Florida's senatorial candidates, Senator Bill Nelson and Representative Katherine Harris, to talk about what they have done in the past to help end the breast cancer epidemic. We specifically asked them to address their position on FBCCRF and NBCC's legislative priorities. We suggest that readers check the NBCC website for up- to-date information on what legislative priorities each has supported.

REPRESENTATIVE Katherine Harris

It was a call I never expected. My dear friend Peggy phoned to say she was diagnosed with breast cancer. An otherwise confident, healthy, and active woman, Peggy felt lost, frightened and insecure. Yet, she was determined to fight for her life.

The fear of cancer hit closer to home when I was diagnosed in July with a mass on my ovary that was surgically removed.

Each of us knows someone like Peggy. This year in the United States, an estimated 214,640 women and men will be diagnosed with breast cancer. About 41,430 will die from the disease. Annual statistics reflect the scope of this national epidemic; however, it is the individual battle of a mother, father, sister, brother, relative, or friend where we share their victory, or grieve their loss.

Spreading the word about breast cancer is among my highest priorities in Congress. I am the sponsor of a resolution designating October as Breast Cancer Awareness Month, a measure designed to educate women and their families of ways to become their own health advocates. I have co-sponsored the Breast Cancer and Environmental Research Act to find an explanation for the more than 70 percent of breast cancers not attributable to known risk factors.

We must use our laboratories to eradicate breast cancer. I continue the effort to secure \$150 million in level funding for the Department of Defense's Breast Cancer Research Program (BCRP). Projects under the BCRP have produced a new laser treatment to remove small breast cancer tumors rather than lumpectomy. BCRP has played a key role in the development of the cancer drug Herceptin, and has financed academic grants for historically black and minority colleges.

One of the best ways to fight breast cancer is to be proactive concerning your health. For women and men of all ages, eating well and exercising regularly are vitally important for prevention. Early detection is enhanced through annual physical exams, listening to your physician, and asking questions.

As for Peggy, and thousands of others like her, they are in remission today. Advances in medicine and personal awareness allow breast cancer survivors to live longer, healthier lives. Still, we must make progress toward improving the quality of patients' lives and the care they receive. This is a fight for people we know and love, and one we should never surrender.

The author is Florida's Congressional representative for the 13th District.

SENATOR Bill Nelson

Approximately 3 million Americans are currently living with breast cancer – the most frequently diagnosed cancer in women. But in so many cases, the pain extends far beyond those diagnosed, as families and friends watch their loved ones fight this difficult battle.

I understand what devastating diseases like breast cancer do to both patients and their families. My own mother suffered from Lou Gehrig's disease at a time when there was little known about the illness.

Today, we know more about breast cancer and other serious diseases than ever before. But too many families have to watch loved ones suffer. Despite progress in finding cures and new treatments, approximately 41,000 women will die from breast cancer this year.

While these statistics are daunting, I am optimistic that we will continue to find ways to fight this disease that too frequently takes the lives of our mothers, sisters, daughters and friends. The members of Florida Breast Cancer Coalition Research Foundation and other similar organizations are working tirelessly to save lives; and, I stand beside them in their efforts.

As you know, prevention and early treatment are key to saving lives, and improving access to health care is one of the best ways

to achieve this goal. Increasing access to health insurance has been one of my priorities in the Senate, and I've supported the Small Employers Health Benefit Program Act, legislation that is based on the successful federal employee health - insurance program. It would allow small businesses to pool their employees together to lower health care costs – while maintaining important consumer protections.

More than 50 million Americans receive their health care through Medicaid, including about 2 million people in Florida. Cuts to the Medicaid program would potentially affect tens of thousands of women fighting breast cancer.

In the Senate, I have been an advocate of the Medicaid program, and I do not support short-term federal savings through Medicaid cuts or caps that will only increase costs on other parts of the health-care system. When lives are threatened by breast cancer and other devastating diseases, these cuts are simply not worth their savings.

Breast cancer brings struggle – physical, emotional and financial – to the daily lives of too many American women. In the mid-1990s, when I was Florida's Insurance Commissioner, I proposed legislation to guarantee that insurance companies provide breast

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Senatorial Candidates

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cancer patients with adequate hospital stays so they have sufficient time to heal.

Also vital in our fight against breast cancer is continued research, which is why I signed a letter to Senate leaders, voicing my support of \$150 million in appropriations for the Department of Defense Breast Cancer Research Program this year. I've also supported increasing funding for the National Institute of Health, a leader in cancer research, and am a co-sponsor of the Breast Cancer and Environmental Research Act.

Breast cancer is the leading cause of cancer death for women in our country between the ages of 20 and 59. As you work hard to help advance research and increase access to care, the federal government must continue to work toward the same goals. We must find new treatments and cures and make sure patients receive the care they need. Together, we can make sure few people have to endure the pain and suffering of breast cancer.

The author is Florida's senior U.S. senator.

E-MAIL ACTION ALERT NETWORK

We invite you to join the E-Mail Action Alert Network to receive information on our legislative agenda, updates on specific issues, and alerts when immediate action is needed from our network. The alerts provide background information on each issue, a sample of the message to be sent to the Member of Congress, as well as telephone and fax numbers.

Sign up on our website (www.fbccrf.org) and become part of a grassroots network of men and women who care deeply about this cause and are willing to stand up and make their voices heard.

Radiation Therapy Helps Prevent Recurrence of DCIS After Breast-Conserving Surgery

In a report published in the *Journal of Clinical Oncology* online June 26, 2006, the addition of radiation therapy to breast-conserving surgery for ductal carcinoma in situ reduced the risk of local recurrence by 47 percent. These results reinforce the benefit of radiation therapy after surgery for women with precancerous lesions.

Background

Ductal carcinoma in situ (DCIS) is a noninvasive, precancerous condition in which abnormal cells are found in the lining of a breast's milk duct. In some cases, DCIS may become invasive cancer and spread outside the duct to other tissues, although it is not known how to predict which lesions will become invasive.

The combination of breast-conserving surgery and radiation therapy has become a widely accepted treatment for early-stage breast cancer and precancerous masses. Several large studies, including the one described here, have been initiated to determine the long-term risks and benefits of the addition of radiation therapy to the treatment of DCIS.

The Study

This phase III, randomized clinical trial was designed to test whether radiation therapy after breast-conserving surgery for DCIS reduced the risk of cancer recurrence in the breast (local recurrence) compared to breast-conserving surgery alone. Between 1986 and 1996, investigators enrolled 1,010 women into the trial with DCIS who had had breast-conserving surgery. The women were randomly assigned to one of two groups: 503 received no further treatment and 507 received radiation therapy.

All women had a mammogram of both breasts before surgery, and annually during follow-up. Investigators compared the rates of local recurrence between the two groups, including both recurrence of DCIS and recurrence as invasive breast cancer. They also recorded incidences of contralateral breast cancer (cancer in the other breast), cancer spread (metastasis), and death. Participants were followed for a median of 10.5 years.

Results

Out of the 503 patients receiving no further treatment, 132 developed a local recurrence (26 percent). Out of the 507 patients receiving radiation therapy, 75 developed a local recurrence (15 percent).

Ten years after treatment, 93 percent of women in the radiation therapy group were free of local recurrence of DCIS compared to 86 percent of women who received no further treatment.

In addition, 92 percent of women in the radiation therapy group were free of local recurrence as invasive cancer, compared to 87 percent of women who received no further treatment. Overall, the risk of recurrence was reduced by 47 percent in the group that received radiation therapy after surgery.

The investigators did not observe any statistically significant differences in the development of contralateral breast cancer or metastasis, or in cancer-related death between the two groups. When included in an analysis with other variables including patients' age, treatment with surgery alone was significantly associated with an increased risk of local recurrence.

Limitations

"This study was done before [doctors regularly prescribed] tamoxifen," explains Jennifer Eng-Wong, M.D., a breast cancer specialist from the National Cancer Institute's Center for Cancer Research. "The standard of care now is excision [surgery], radiation therapy, and tamoxifen. So the local recurrence rates are now going to be even lower" than the ones seen in this study.

Comments

"With a median follow-up of 10.5 years, the results of this randomized trial...show that [radiation therapy] after local excision of DCIS of the breast reduces the risk of local recurrence as compared with local excision alone," state the authors.

"These results are in keeping with prior publications on this topic, showing again the benefit of radiation for local control," agreed Eng-Wong.

Journal of Clinical Oncology, published online June 26, 2006 (see the journal abstract) (J Clin Oncol. 2006 Jun 26; [Epub ahead of print]). This article reprinted from <http://www.cancer.gov/clinicaltrials/results/DCIS0706>.

Breast cancer survivors whose armpit lymph nodes are removed or irradiated are at risk of lymphedema, a painful swelling of the arm. Current guidelines urge them to avoid upper-body exercise that may worsen the condition. In this trial, however, such women who followed a six-month weight-training regimen were no more likely than those who didn't weight train to suffer from lymphedema.

Lymph is a clear fluid that travels throughout the body to help fight infections and other diseases. Lymph nodes in the arm, shoulder, neck, and torso may be compromised or removed during breast cancer surgery and radiation. If the lymph fluid traveling from the upper arm cannot be properly drained into the bloodstream, irreversible and painful swelling (lymphedema) may occur. About one in four breast cancer survivors suffer from lymphedema to some degree, which in the United States could mean more than a half million women.

Current clinical guidelines urge breast cancer survivors to avoid upper-body exercise, even to the point of not lifting children and groceries, despite small pilot studies suggesting such exercise does nothing to worsen lymphedema. Exercise, in fact, has been shown to have many benefits, including recovery from cancer treatment and protection against chronic disease.

The Study

The randomized, controlled intervention trial described here is a substudy of the Weight Training for Breast Cancer Survivors Study (WTBS), whose main results concerning body composition and insulin levels were published in 2005 (see the journal abstract).

Eighty-five breast cancer survivors in the Minneapolis area were enrolled in the WTBS between October 2001 and June 2002. All had completed primary treatment for breast cancer at least four months prior to joining the trial. Many participants were taking tamoxifen or an aromatase inhibitor to help prevent a recurrence. None were more than moderately active in terms of exercise, and none had ever tried weight training before. Their average age was 52, most were postmenopausal, and all except one were white.

Women in the trial were randomly assigned to one of two groups. The intervention group (42 women) followed a specific weight-training program for six months while the control group (43

Moderate Weight Training Won't Worsen Lymphedema after Breast Cancer

women) did not. Otherwise, both groups were asked not to change their regular diets or exercise patterns during the course of the trial.

For the lymphedema substudy, the researchers focused on just those women who'd had some or all of their axillary (armpit) nodes removed – 23 in the weight-training group and 23 in the control group. Lymphedema was assessed at the start of the trial and again at six months. Three sometimes overlapping measures were used: clinical diagnosis from a doctor; symptom reports from the participants themselves; and the circumference of the participants' arms.

In the weight-training group, seven women entered the study with a clinical diagnosis of lymphedema versus six in the control group; 10 self-reported symptoms versus seven in the control group; and four women in each group had arm swellings of greater than 2 centimeters.

The weight-training regimen included upper and lower body exercises with free weights and machines. At each session the women in this group increased their upper body workouts by the smallest amount possible, if no lymphedema symptoms had appeared. For lower body exercises, they used as much weight as they could manage each session. Fitness professionals oversaw the women's workouts.

The lead author of the lymphedema substudy is Kathryn H. Schmitz, Ph.D., M.P.H., now of the University of Pennsylvania's Center for Clinical Epidemiology and Biostatistics in Philadelphia.

The researchers defined a worsening of lymphedema as an increase of at least two centimeters (just under an inch) in arm circumference. After six months of weight training, only one patient exceeded this measure, and she was in the control group. Overall, there was no statistical difference in arm circumference changes or in self-reports of symptoms between those who lifted weights and those who did not.

Comments

The WTBS trial is "the largest and longest randomized controlled trial to date to examine the effects of upper body exercise on lymphedema," according to Schmitz and her co-authors. Their findings are consistent with prior studies and show that "twice-a-week progressive weight training does not increase the onset of, or exacerbate, lymphedema in recent survivors of breast cancer."

"We need more good studies like this one looking at symptom management," said Julia Rowland, Ph.D., director of the Office of Cancer Survivorship in the National Cancer Institute's Division of Cancer Control and Population Sciences. Despite the small number of patients, she explained, the study was rigorously designed to prove the principle that moderate weight training does not harm breast cancer survivors, even when they have lost or compromised axillary lymph nodes.

"This is important because more evidence is beginning to mount about the benefits of physical activity, and survivors are asking what they can do to enhance their recovery and their health," said Rowland. "And we are even beginning to think that physical exercise may have an important role in actually preventing breast cancer."

Limitations

Though this study shows no causal link between exercise and lymphedema, it is too early to recommend upper body weightlifting unequivocally, said Rowland. An acute injury from overexertion could cause some cases of lymphedema.

Though the study succeeded in demonstrating "no harm," there were several ways these results might have been more generalizable, she said. Measuring the arm's circumference is believed to be less reliable than measuring for volume. Symptoms might be better cataloged by actual clinical measures, rather than simply the patient's self-reporting used here. Evaluating symptoms and circumference more frequently might also pick up trends that were not seen here, as would a follow-up period longer than six months.

The Journal of Clinical Oncology, published online May 15, 2006; in print June 20, 2006, (see the journal abstract) (*J Clin Oncol*. 2006 Jun 20;24(18):2765-72. Epub 2006 May 15). This article reprinted from <http://www.cancer.gov/clinicaltrials/results/lymphedema0706>.

Research Report

The report below was written by one of the first researchers funded with money from the sale of the End Breast Cancer license plate, about the research project FBCCRF funded.

“N-TIMP-1 mutants as selective agents to inhibit angiogenesis and tumor cell metastasis via inhibition of activity of MMP-9”

The survival and growth of many types of tumors including breast cancer is dependent upon factors that help form new blood vessels which can supply the necessary nutrients to sustain the tumor cells. However, 90% of cancer deaths are not due to the presence of the primary tumor itself but due to metastases (growth of tumor cells in sites other than the site of origin). Therefore, controlling tumor growth by inhibition of the factors that sustain the tumor cells and the inhibition of metastases are the main goals of research in this field.

Growth of invasive breast cancer beyond 1-2 mm³ requires the induction of new blood supply, a process known as angiogenesis or neovascularization. Angiogenesis is induced by growth factors such as basic fibroblast growth factor (bFGF), vascular endothelial growth factor (VEGF) and insulin-like growth factor II (IGFII). Using these newly formed blood vessels, the tumor cells can migrate out and enter other tissues such as the lung or the bone marrow and grow at the secondary site. Matrix metalloproteinases (MMPs) are zinc dependent endopeptidases that are thought to play major roles in tumor progression. These metalloproteases can degrade extracellular matrix (ECM) components, allowing tumor cell migration. One crucial metalloproteinase, MMP-9, is produced at higher levels in tumors relative to untransformed tissues and has been implicated in cancer progression and metastasis in both human and animal models of cancer. MMP-9, also known as gelatinase B, is involved in angiogenesis, as degradation of the basement membrane is a necessary step for the formation of new capillaries from pre-existing blood vessels. Our laboratory has been studying angiogenesis and metastasis using a DA-3 mouse breast cancer model.

We have previously reported that the DA-3 mouse mammary tumor cells produce and secrete VEGF and the MMP-9 (2). Since angiogenesis is a key process in tumor progression, any factor that inhibits the action of MMP-9, thus limiting angiogenesis, would likely inhibit tumor growth and metastasis. Therefore, we focused our studies funded by the Florida Breast Cancer Coalition Research Foundation on the inhibition of MMP-9 activity.

The activity of MMPs can be inhibited by endogenous inhibitors, the tissue inhibitors of metalloproteinases (TIMPs). There are four members in the TIMP family (TIMPs 1-4) that have broad specificities for MMPs. TIMPs have two structural domains of which the N-terminal domain is responsible for the inhibition of the MMPs. Targeting MMPs in disease treatment is complicated by the fact that MMPs are also crucial for normal development and physiology. This complexity was revealed in clinical trials of drugs that inhibit MMP activity for the treatment of cancer. These trials were terminated because of undesirable side effects. A possible cause of these unsatisfactory results is the lack of selectivity of these molecules towards a particular MMP in vivo. The TIMPs offer

an alternative approach to regulating MMP activities in cancer. Since there is a lack of specificity in the binding of TIMPs to MMPs, we have developed variants of TIMP-1 (N-TIMP-1) which are based on the inhibitory N-terminal domain. These mutant TIMPs (T2R/AB2 and T2L/V4S/AB2) selectively inhibit MMP-9 and to a lesser extent MMP-2, but not other MMPs involved in normal matrix remodeling. Their selectivity as MMP inhibitors sets these mutant molecules apart from the wild type TIMPs. The object of this study was to determine whether angiogenesis and tumor cell migration, the two hallmarks of cancer, can be inhibited by these selective inhibitors of MMP-9.

Using these TIMP mutants, two types of assays were performed: 1) chicken chorioallantoic membrane assay to assess angiogenic activity and 2) modified Boyden chamber assays to determine the ability of tumor cells to invade through Matrigel (a gelatinous protein mixture that models the complex extracellular environment found in many tissues) coated membranes.

To determine effect of the TIMPs on angiogenesis, the DA-3 mouse breast cancer cells were treated with different concentrations of the mutant TIMPs that we have generated and placed on the chorioallantoic membranes of chicken embryos. If the TIMPs exerted their effects, we would expect to see decreased blood vessel growth. Both of the mutant N-TIMP-1 (T2R/AB2 and T2L/V4S/AB2) inhibited new blood vessel growth compared to the untreated tumor cells used as a control in this experiment. Since we observed decreased angiogenesis, we asked the question, does the inhibition of MMP-9 have an effect on VEGF secretion by the tumor cells? Our preliminary studies indicate that inhibition of MMP-9 does indeed result in decreased levels of VEGF secretion by the tumor cells. This could be one of the mechanisms by which inhibition of MMP-9 results in decreased angiogenesis.

The second goal of this study was to determine the effect of inhibition of MMP-9 on the ability of tumor cells to invade through Matrigel coated cell membranes. DA-3 tumor cells were treated with a fixed concentration of N-TIMP-1 mutants, placed on Matrigel coated transwell inserts and allowed to migrate towards a chemical attractant. There was 60% less migration by the N-TIMP-1 treated tumor cells compared to the untreated tumor cells, implicating N-TIMP-1 in decreased migration and thus metastatic potential of the tumor cells.

These studies have resulted in the generation of better selective inhibitors of TIMPs that can inhibit angiogenesis and tumor cell invasion. The use of engineered TIMPs that have selective action on individual or small groups of matrix degrading enzymes would greatly improve treatment of breast cancer. This would be a major step in the battle against cancer.

Vijaya Iragavaruapu-Charyulu, Ph.D., Assistant Professor, Department of Biomedical Sciences.



A New Assay to Define Who May or May Not Benefit from Adjuvant Chemotherapy

There is no doubt that the evolution of adjuvant chemotherapy and antihormonal therapy have clearly improved the prognosis for women with early stage breast cancer. Adjuvant antihormonal therapy is applicable, however, only to women who have hormone receptor positive tumors. Adjuvant chemotherapy can be used in many women whether they have nodal metastases or not. The problem is to identify which subset of patients truly need adjuvant chemotherapy and will benefit from treatment.

Traditionally, we have used the size of the tumor, whether the lymph nodes are involved or not, and other biological markers and pathological findings to recommend adjuvant chemotherapy. The problem, however, is that many women do not need adjuvant chemotherapy and/or will not benefit from it. Chemotherapy may represent a cost to society, for it is expensive; and of course, a physical and psychological cost for the patient. However, we do not want to deny a woman chemotherapy if she will benefit from it and reduce her potential for recurrence.

A new test called Oncotype DX has been developed by Genomic Health, a life science company founded in August 2000. The discovery of the human genome has expanded into a new field of genomics, which is a study of complex sets of genes, their expression, and their function. Identification of certain genes and their expression by certain tumors has been shown to identify certain patients that may be at risk for recurrence/metastases and which group of tumors may benefit from adjuvant chemotherapy.

The Oncotype DX test is a multigene assay that looks at 21 genes and predicts for risks for recurrence. Patients are divided into low, intermediate, and high risk groups for recurrence and, based upon weighting of these genes, a recurrence score is given. A retrospective analysis of a group of women who were hormone receptor positive and node negative, has identified subsets of women, based upon their recurrence score, who will benefit from adjuvant chemotherapy and who did not benefit in the past. This test can select women who solely need adjuvant antihormonal therapy rather than chemotherapy. These studies have been validated by several institutions. It also may identify groups of women who are more likely to develop a local recurrence.

A new partnership between the National Cancer Institute and the Breast Cancer Intergroup has recently been announced, called the TAILORx STUDY. This study will recruit ten thousand women who are hormone receptor positive and node negative. This trial will look at women from the midrange risk group to better understand which of these women will derive benefit from chemotherapy. Women in the low-risk group will receive hormone therapy alone, because we know that chemotherapy provides little or no benefit to them. Women in the high-risk group will be given chemotherapy plus hormonal therapy because we know that they receive great benefit from chemotherapy. The midrange group will be randomized with half of the group receiving hormonal therapy only, and the other half receiving hormonal therapy plus chemotherapy. It will determine, in a prospective fashion, which patients need antihormonal therapy and which patients need chemotherapy or a combination of both.

I wish to emphasize to you that, thus far, this study has been validated only for node negative and hormone receptor positive women. We do not have data yet in hormone receptor negative women. While still somewhat controversial, it is believed that genomics will offer the opportunity to identify which tumors behave in certain ways, which ones are high risks, and which ones need adjuvant chemotherapy; and even to be able to select out the form of chemotherapy for that individual patient. This is a new, exciting area of development and promises to further improve the cure rate in breast cancer. Additionally, as we start to learn more about the genes that may contribute to the aggressiveness or non-aggressiveness of breast cancer, we may be able eventually to change those genes and obliterate this disease.

Robert P. DerHagopian, M.D., oncological surgeon, co-chair of FBCCRF Scientific Committee, and member of FBCCRF Board.

NBCCF Collaborates with NCI on Study Aimed at Reducing Overtreatment

TAILORx trial analyzes chemotherapy use for early-stage breast cancer

Most women with early-stage breast cancer are advised to receive chemotherapy in addition to radiation and hormonal therapy; yet research has not demonstrated that chemotherapy benefits all of them equally. A key research question is: how do we determine which women can be spared toxic treatment without risk of recurrence of their breast cancer? There are now tools that may help us find the answer to this important question. NBCCF is partnering with the National Cancer Institute and the Breast Cancer Intergroup on a Phase III clinical trial seeking to determine whether women with early-stage breast cancer that is ER+ and Her2-, and who are at intermediate risk for breast cancer recurrence according to the OncotypeDx test, benefit from adding chemotherapy to standard treatment with hormonal therapy. The trial also seeks to confirm that patients with a low recurrence score do not gain additional benefit from chemotherapy that precedes treatment with hormonal therapy. OncotypeDx is a gene panel test that quantifies the likelihood of breast cancer recurrence in women with node negative and hormone receptor positive breast cancer on the basis of the expression of a set of genes in the patient's tumor. The results of the study will help patients and clinicians make more objective and informed decisions about adjuvant treatment, helping target these treatments to those who are more likely to benefit, and sparing those who are unlikely to benefit. The clinical trial, also known as TAILORx (Trial for Assigning Individualized Options for Treatment), will enroll more than 10,000 women from 900 sites in the United States and Canada.

For more information on the TAILORx trial, visit NCI's website at:
<http://www.cancer.gov/search/ViewClinicalTrials.aspx?cdrid=472066&version=patient>

To find a trial site closest to you, visit the ClinicalTrials.gov website at:
<http://www.clinicaltrials.gov/ct/show/NCT00310180?order=1>

Let's Brighton Your Day

Our goal is to brighten the day of thousands of men, women and family members who are and will be affected by breast cancer. How do we do this....we continue our fight to end breast cancer NOW by enlisting every one of our supporters and their friends to help us in our fundraising efforts.

SPECIAL EVENTS PLANNED

We start with our kick off event with BRIGHTON COLLECTIBLES in The Falls on October 1, 2006, the start of "October Breast Cancer Awareness Month" and Brighton's yearly "Power of Pink" fundraiser, benefiting FBCCRF.

We start with a breakfast at CAFÉ BICE for you and your friends with a speaker TBA and then we proceed to Brighton Collectibles' store in The Falls, where you will meet anchor woman Kelly Craig from South Florida Today and NBC 6. You can participate in our raffle with over 100 prizes and enter to be the winner of a specially created, hand painted jeans jacket designed with celebrity hearts, plus view and buy the newly designed collectable Breast Cancer Bracelet by Brighton. Last year's watch bracelet was exquisite; this year's will be even more unique in style.



Come and join us on Sunday, October 1, at Brighton Collectibles and breakfast at Café Bice in The Falls shopping center for all of our supporters, friends, family members, and neighbors. It is free, however, **reservations for breakfast are needed**, so let us know if you are coming by calling the FBCCRF office at (954) 454-4156 or toll-free at (877) 644-FBCC.

Entering the raffles will take place throughout the month of October, so you can come into the Brighton Collectibles store in The Falls and continue to enter our special raffles for prizes all month long. If you want more information, contact the FBCCRF office. We look forward to seeing you at this kick-off event and throughout the month of October.



THE SHOPPING BENEFIT

October 26, 2006, Bloomingdales has a special event state-wide – "THE SHOPPING BENEFIT" which will take place in five of their stores: The Falls, Aventura, Boca Raton, Palm Beach Gardens, and Orlando. Many charities are involved in this event, so be sure to get your tickets from FBCCRF. Tickets are \$10.00 each and entitle you to a 15% or 20% discount on purchases in the store on Thursday, October 26, 2006. Each ticket you buy allows FBCCRF to retain the entire \$10.00 cost of the ticket; and

when you hand in your ticket to any of the five Bloomingdales stores on that day, FBCCRF will receive an additional \$5.00. Each ticket benefits FBCCRF in the amount of \$15.00 and YOU the PURCHASER will receive not only a day of shopping, but the special events planned all day at all Bloomingdales stores, including food and fashion shows. Make a day of it, go Bloomingdales shopping and hopping, gather your friends and have lots of fun.

Gayle Jacobs

Study Finds Young African American Women More Likely to Develop Basal-Like Type of Breast Cancer

An analysis of the Carolina Breast Cancer Study, published in the June 7, 2006, issue of the *Journal of the American Medical Association*, found that young African American women with breast cancer are more likely to have an aggressive form of the disease compared with older African American women and also pre- and post-menopausal non-African American women. The authors suggest that this higher frequency of basal-like tumors, as well as lack of access to proper care and treatment, are the main reasons for the poor survival rate observed among young African American women with breast cancer.

How was the study done?

Previous studies have established that while African American women are less likely to be diagnosed with breast cancer than white women, they are more likely to die from the disease.¹ Other research points in the direction that breast cancer can be divided into several biological subtypes, each varying considerably in their therapeutic targets and prognoses. The Carolina Breast Cancer Study is the first population-based study to systematically examine the prevalence of these subtypes of breast cancer and their relationships with demographic variables, particularly race and menopausal status.

The study analyzed data from 496 breast cancer patients. In order to properly examine race and age-related variability among two traditionally underrepresented breast cancer populations – pre-menopausal women and African American women – women under 50 years of age and African American women accounted for approximately 50% of the patients studied. Race was self-reported by study participants and categorized as either African American or non-African American. While the majority of non-African Americans were white, the study also included 14 women who reported their race as Native American, Hispanic, Asian American, or multiracial.

The authors identified different subtypes of breast cancer using immunohistochemical (IHC) profiles.² A pathologist reviewed each of the study's tumors and divided the subjects' breast cancer into one of five subtypes: basal-like, HER2+/ER-, luminal A, luminal B, or unclassified.³ Basal-like and HER2+/ER- are considered to be more aggressive types of breast cancer, while luminal A and B tumors are not as aggressive and have a more favorable survival outcome than basal-like or HER2+/ER-.

What were the results?

The Carolina Breast Cancer Study found that a significantly greater percentage of pre-menopausal African American women with breast cancer developed aggressive basal-like tumors (39%) when compared to post-menopausal African American women (14%) and also pre- and post-menopausal non-African American women (16% each). Basal-like tumors were also twice as likely to occur in African American women than non-African American women, and were more frequent in pre-menopausal women (24%) than post-menopausal women (15%). In contrast, the less aggressive luminal A subtype appeared less in pre-menopausal African American women (36%) compared to post-menopausal African American women (59%) and non-African American women (54%). There was no significant difference in breast cancer subtypes between pre-menopausal and post-menopausal non-African American women.

During the 8 to 11 year follow-up period, 20% of the study participants died of breast cancer, resulting in an 80% overall disease-specific survival rate. African American women had a

significantly worse survival rate than non-African American women (74% versus 84%, respectively).

Among breast cancer subtypes, survival was found to be significantly worse among patients with basal-like (75%) and HER2+/ER- tumors (52%) than luminal A (84%) and luminal B (87%).⁴ Survival outcomes in pre-menopausal African American patients were also significantly worse (64%) compared to post-menopausal African American women (81%), pre-menopausal non-African American women (81%) and post-menopausal non-African American women (91%), even after basal-like cases were excluded from the analysis.

What does this study mean for women?

This study suggests a biological explanation to the discrepancy in mortality rates between African American and non-African American breast cancer patients. The basal-like subtype has been associated with poor clinical outcomes in previous studies, and likely reflects the lack of targeted treatments available for this type of breast cancer.

Recognizing that younger African American women are more likely to develop a certain, more aggressive, form of breast cancer is an important first step toward developing appropriate targeted treatments. However, more clinical research is needed in order to identify the biomarkers⁵ which define the basal-like subtype and to subsequently develop treatments that will target these biomarkers.

Lastly, by showing that young African American women with breast cancer are more likely to die from the disease than non-African American women even after the basal-like subtype is omitted from analysis, the study suggests that subtype might not be the only factor affecting prognosis and survival. Poorer survival rates may also be a result of a variety of interacting factors – including access to care and treatment, unidentified biological factors, or other factors.

What are the limitations of this study?

Despite this new data, the findings should be interpreted with caution due to several inherent limitations:

- This study offers possible explanations for the low survival rates for African American breast cancer patients, however, the findings represent a good starting point for future research and cannot be regarded as definitive. Further research is necessary to determine the extent to which access to care, treatment received, medical history, socioeconomic, genetic, health, exposure and other factors may contribute to prognosis.
- The study does not address why pre-menopausal African American breast cancer patients are more prone to have basal-like tumors than other breast cancer patients. Additional

continued on next page



Tamoxifen: Questions and Answers



What is Tamoxifen?

Tamoxifen (Nolvadex(r)) is a medication in pill form that interferes with the activity of estrogen (a hormone). Tamoxifen has been used for more than 20 years to treat patients with advanced breast cancer. It is used as adjuvant, or additional, therapy following primary treatment for early stage breast cancer. In women at high risk of developing breast cancer, tamoxifen reduces the chance of developing the disease. Tamoxifen continues to be studied for the prevention of breast cancer. It is also being studied in the treatment of several other types of cancer. It is important to note that tamoxifen is also used to treat men with breast cancer.

Can tamoxifen prevent breast cancer?

Research has shown that when tamoxifen is used as adjuvant therapy for early stage breast cancer, it reduces the risk of recurrence of the original cancer and also reduces the risk of developing new cancers in the other breast. Based on these

African American Women *continued from previous page*

research is needed to identify the risk factors that contribute to this prevalence.

- The study was carried out within a specific geographical area of the United States (eastern and central North Carolina). This limits the study's generalizability to other parts of the country or other parts of the world.

Source Carey LA, Perou CM, Livasy CA, Dressler LG, et al. Race, Breast Cancer Subtypes, and Survival in the Carolina Breast Cancer Study. *JAMA* 295 (21); 7Jun 2006.

Footnotes

¹According to the American Cancer Society, black women have a higher breast cancer mortality rate at every age, and a lower survival rate than white women. The five-year survival rate for white women diagnosed with invasive breast cancer is 90% while the five-year survival rate for black women diagnosed with invasive breast cancer is only 76%.

²Immunohistochemistry is a technique used to identify whether specific proteins are present in a cancer tissue in order to identify cancer subtype and appropriate treatment (e.g. estrogen receptor-positive or negative, progesterone receptor-positive or negative).

³Breast cancer subtype is classified according to the tumor's genetic expression:

basal-like: Estrogen Receptor (ER)-negative, Progesterone Receptor (PR)-negative, HER2-negative, cytokeratin 5/6-positive and/or HER1-positive.

HER2+/ER-: ER-, PR-, HER2+.

luminal A: ER+ and/or PR+, HER2-.

luminal B: ER+ and/or PR+, HER2+.

unclassified: negative for all 5 markers.

⁴The observation period for survival ranged from about 8 years to about 11 years.

⁵A biomarker is any measurable cellular, subcellular, or humoral factor that demonstrates the presence of malignancy or malignant potential, or predicts tumor behavior, prognosis, or response to treatment.

Reprinted from NBCC's website; posted June 2006.

findings, the National Cancer Institute (NCI) funded a large research study to determine the usefulness of tamoxifen in preventing breast cancer in women who have an increased risk of developing the disease. This study, known as the Breast Cancer Prevention Trial (BCPT), was conducted by the National Surgical Adjuvant Breast and Bowel Project (NSABP), a component of the NCI's Clinical Trials Cooperative Group Program. This study found a 49 percent reduction in diagnoses of invasive breast cancer among women who took tamoxifen. Women who took tamoxifen also had 50 percent fewer diagnoses of noninvasive breast tumors, such as ductal or lobular carcinoma in situ. However, there are risks associated with tamoxifen. Some are even life threatening. The decision to take tamoxifen is an individual one: The woman and her doctor must carefully consider the benefits and risks of therapy.

Does tamoxifen cause cancers of the uterus?

Tamoxifen increases the risk of two types of cancer that can develop in the uterus: endometrial cancer, which arises in the lining of the uterus, and uterine sarcoma, which arises in the muscular wall of the uterus. Like all cancers, endometrial cancer and uterine sarcoma are potentially life-threatening. Women who have had a hysterectomy (surgery to remove the uterus) and are taking tamoxifen are not at increased risk for these cancers.

Do the benefits of tamoxifen in treating breast cancer outweigh its risks?

The benefits of tamoxifen as a treatment for breast cancer are firmly established and far outweigh the potential risks. Patients who are concerned about the risks and benefits of tamoxifen or any other medications are encouraged to discuss these concerns with their doctor.

How long should a patient take tamoxifen for the treatment of breast cancer?

Patients with advanced breast cancer may take tamoxifen for varying lengths of time, depending on their response to this treatment and other factors. When used as adjuvant therapy for early stage breast cancer, tamoxifen is generally prescribed for 5 years. However, the ideal length of treatment with tamoxifen is not known.

Two studies have confirmed the benefit of taking adjuvant tamoxifen daily for 5 years. These studies compared 5 years of treatment with tamoxifen with 10 years of treatment. When taken for 5 years, the drug reduces the risk of recurrence of the original breast cancer and also reduces the risk of developing a second primary cancer in the other breast. Taking tamoxifen for longer than 5 years is not more effective than 5 years of therapy.

Where can I find more information about tamoxifen?

Additional information about tamoxifen is available at <http://www.cancer.gov/cancertopics/factsheet/Therapy/tamoxifen> or by calling the NCI's Cancer Information Service at 1-800-4-CANCER (1-800-422-6237).

Prepared by Martha Oliveros, Cancer Information Service.

The Florida Breast Cancer Coalition Research Foundation

Salutes Our Donors

July 1, 2005 - June 30, 2006

Through your generous support the FBCCRF is able to work toward its mission
to eradicate breast cancer through research, education, and advocacy.

A Heartfelt Thank You for Your Support. Together we will end breast cancer.

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continued on next page

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We apologize if we inadvertently omitted your name from this list.

Resources

Habla usted español?

Breast Cancer Action's (BCA's) Spanish-language newsletter, Saber Es Poder (Knowledge Is Power), is published two times a year. Past issues are archived online at www.bcaaction.org.

BCA mails single and multiple copies of Saber Es Poder to individuals and institutions around the world. If you would like to add yourself, or an organization, to their mailing list, please contact Brenda Salgado at bsalgado@bcaaction.org, 415/243-9301, ext. 14, or (toll-free) 877/278-6722.

Evaluating Medical Information on the Internet

The internet is a great place to get information fast. But you have to be careful, not all information is correct. The National Cancer Institute recommends asking the following questions:

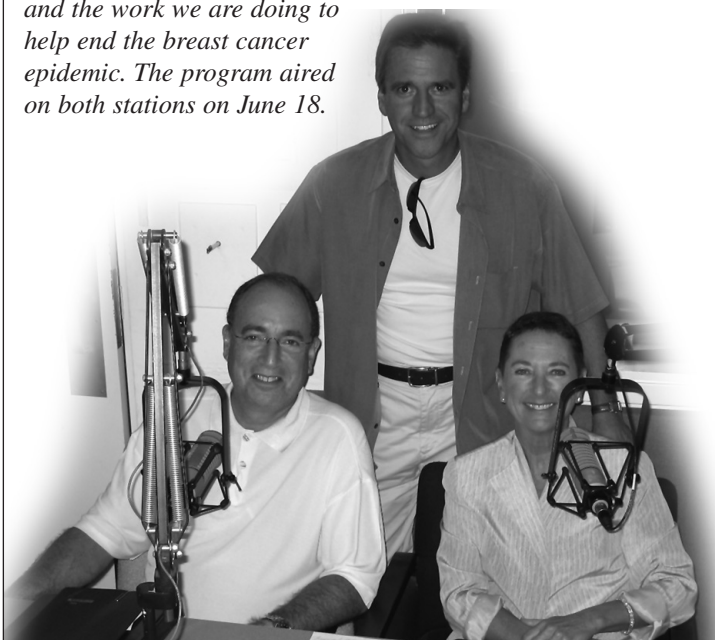
1. **Who runs this site?** Any good health-related website should make it easy for you to learn who controls the site.
2. **What is the goal of the site?** This is related to who runs the site and who pays for the site (see #8 below). The goal of the site should be clearly stated. Look under "About this Site" or "Mission Statement." These are common titles for this kind of information.

Judge carefully what you are reading. The site's goal may not be to give fair, correct health information. The goal may be to sell you something.
3. **Where does the information come from?** Many health/medical sites post information collected from other websites or from offline sources. The source should be clearly labeled if the information came from somewhere else.
4. **What is the information based on?** The site should give the evidence that the material is based on. Medical facts and figures should have references. A reference can be an article in a medical journal or the agreement of a meeting of experts. Opinions or advice should be clearly set apart from information based on research results.
5. **How is the information selected?** Is there an editorial board? Do people with very good medical backgrounds review the information before it is posted?
6. **How current is the information?** Websites should be reviewed and updated regularly. Each major page should show this information (example: "this page last updated on 7/9/02"). It is very important that medical information be current. Even if the information has not changed, the site owners should review it often. That is the only way they can be sure the information is still valid.
7. **How does the site choose links to other sites?** Websites usually have a policy about how they choose links to other sites. But they don't always tell what that policy is. Many medical sites don't link to any other sites. Some link to any site that asks, or pays, for a link.
8. **Who pays for the site?** It costs money to run a website. Some websites are labors of love, but most have an outside source of funds. Again, this should be clearly shown on the site. For example, web addresses ending in ".gov" mean a

government pays for them. You should know how the site pays for itself. Does it sell ads? Is it paid for by a drug company? The source of funding can affect what is there, how it is presented, and what the site owners want from the site.

9. **What information about you does the site collect and why?** Websites routinely track the paths visitors take through their sites. They want to find out what pages are being used. But many health websites ask for you to "subscribe" or "become a member." Sometimes this is so that they can collect a user fee (see #8) or choose information that relates to you. In all cases, this will give the site personal information about you. Any health site should tell you exactly what they will and will not do with your information. Many sites sell data about their users to other companies. In some cases, they may collect and reuse information that could identify you, such as your zip code, gender, and birth date. Be sure that you read and understand any "privacy policy" or words like that on the site. And don't sign up for anything that you do not understand.
10. **How does the site interact with visitors?** There should always be a way for you to contact the site owners with problems, feedback, and questions. Does the site host chat rooms or other online discussion areas? If so, the site should tell visitors what the terms of using this service are. Is it moderated? If so, by whom and why? It is always a good idea to spend time reading the discussion before joining in. That way, you can be sure you feel comfortable being part of it.

FBCCRF President Janes Torres and Board member Lee Edelstein (seated) were interviewed by Jeff Martin, Director of Public Affairs Broadcasting for Beasley Broadcasting WKIS/WQAM for their weekly radio program highlighting community organizations. Jane and Lee spoke about FBCCRF and the work we are doing to help end the breast cancer epidemic. The program aired on both stations on June 18.



Thank You to our Supporters

FBCCRF gratefully acknowledges the generosity of all our supporters. Listed below are the names of new supporters and those who made gifts between April 26 and July 6, 2006.

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Jan Woods	Jill and Robert Adler

A Special Thank You to:

- **Virginia Speaker** and friends, **Ann Fonfa**, and **Carolyn Kerr** for staffing FBCCRF *booths* at various community events;
 - **Inge Sengelmann** for helping us find public relations student interns to assist with our marketing and PR efforts;
 - **Teresa Menendez** for translating our new brochure and rack card into Spanish;
 - **David Aloni** for delivering and assembling office furniture for us;
 - **Lisa England** for helping us design a new volunteer recruitment flyer and helping develop a system for volunteer management;
 - **James Bailey** of **Comfort Inn Airport Suites** for donating a room for one of our out-of-town Board members;
 - **El Heraldo** and **Elaine Vasquez** for providing us with a free booth at 8 Fiesta Fort Lauderdale community events;
 - **Florida Frenzy**, Florida's indoor football league, for allowing us to be the charity to have a booth at their home game, which drew 4000 people;
 - **Annette Fromm** for proofreading the newsletter;
 - **Ann Rothman** for distributing materials and phoning to thank donors for contributions;
 - **Dawn Donaldson** for contacting support groups statewide regarding new brochures and asking them to display and distribute the brochures on our behalf;
 - **Ann Fonfa** for distributing license plate materials;
 - **Nan Van den Bergh**, **Ann Fonfa**, and **Jen Levinson** for their legwork and follow-up related to the NBCC Advocacy Conference and for serving as team leaders at the conference; Rhonda Renea Hendricks for distributing brochures;
 - **Lawrence Bath** and **Kitchen Showplace** for donating computer repairs for the FBCCRF office;
 - **Cristina Davenport** and the Okaloosa Tax Collector's Offices for distribution of license plate flyers in October renewals and promoting the plate in their offices;
 - **Clair Jargiello** for assistance with marketing and **Arthur Donovan** with public relations;
 - **Mary Anne Nestor**, development consultant;
 - **Jim Hughes**, consultant on board development; and
 - **Bob Zona** for consulting and organizing the Board Assessment.
- We apologize if we inadvertently omitted your name from this list.

Welcome New Supporters!

Carol Beer	Elizabeth Melick
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Keepsake Floral, Inc. proudly presents the "Breast Cancer Awareness" keepsake designed to help support the mission of the Florida Breast Cancer Coalition Research Foundation. The cubes are available throughout 2006 for \$10 with \$7 of the proceeds going directly to the FBCCRF.

For more information, please contact Keepsake Floral, Inc at 1.800.616.5337 or visit their website at www.keepsakefloral.com.

"End Breast Cancer" license plate is now available online.



Show your support and order your "End Breast Cancer" plate now. Buying the license plate is a simple and powerful way to help fund the research that will eradicate breast cancer. Go to any tag agency to purchase in person, call 1-888-END IT NOW to order by telephone, or click on the license plate at www.fbccrf.org, to order online. For more information on becoming involved in the fight to end breast cancer, contact us directly at 954-454-4156 or visit our redesigned website at www.fbccrf.org. To those of you who have already purchased your "End Breast Cancer" license plate, THANK YOU!



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Calendar

OCTOBER IS BREAST CANCER AWARENESS MONTH

October 1

Breast Cancer Awareness Month Kick off Event. Brighton Collectibles will sponsor a breakfast at Bice Grand Café in The Falls. For more information about this and about activities at Brighton throughout the month, see the article on page 4.

October 26

Bloomington's big fundraising event "The Shopping Benefit." All Bloomington stores will honor specially purchased tickets on this day. Charities throughout Dade, Broward, Palm Beach Counties and Central Florida will be selling these tickets. FBCCRF would appreciate our supporters, their family, and friends buying these specialty tickets from FBCCRF. Tickets are available. Please call the FBCCRF office to order your tickets and find out more information. Please see article on page 4.

November 1-5

Project LEAD, Washington, D.C. For further information, look on the NBCC website at <http://www.stopbreastcancer.org/bin/>.

**When making a donation to FBCC please ask your employer if they offer matching funds.
We'll be happy to file the paperwork.**

Check out FBCCRF's website: fbccrf.org • Call us at 954-454-4156

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