



## President's Message

Dear Advocates,

Once again, I'm writing about the confusing world of research studies and the need to scientifically analyze the results rather than simply accept the headlines. When complicated research studies are translated into sound bites, the actual findings often get distorted.

Let's look at a few of the recent headlines:

- A low-fat diet doesn't prevent breast cancer, colorectal cancer or heart disease.
- Calcium and vitamin D don't prevent bone fractures or colorectal cancer.
- Breakthrough in Breast Cancer: Raloxifene cuts breast cancer risk in half.

In order to understand what the studies really show, we need to ask some important questions:

- Were the results statistically significant?
- Exactly whom did the research study?
- What were the benefits and for how long?
- What are the risks?
- What is the absolute risk reduction (rather than relative risk reduction)?

Looking at the above-mentioned studies, we can see what got lost in the headlines:

1. In the low-fat diet study, although few women cut as much fat as they were instructed to, the study did come extremely close to finding a significantly lower risk of breast cancer in the entire lower-fat group. Women in the lower-fat group who cut their fat the most had a significant 22 percent lower risk of breast cancer. Women on the lower-fat diet had fewer precancerous colon polyps.<sup>i</sup>
2. In the calcium research, although roughly 40% of the women stopped taking their supplements during the study, those who took at least 80 % of their pills had a 29% lower risk of hip fracture and had significantly higher hip bone density. Among women aged 60 or over, the risk of hip fractures was 21% lower. Many of the women taking 2,200 mg of calcium and 800 IU of vitamin D a day had a small but significant increased risk of kidney stones.<sup>ii</sup>
3. Although the tamoxifen – raloxifene study seems to show that raloxifene offers a better choice for women at high risk for breast cancer, because the side effects of uterine cancer and blood clots associated with tamoxifen were lower with raloxifene, the difference in risk was not significant. In addition, raloxifene, the supposed “winner,” did not cut the risk of early noninvasive tumors as well as tamoxifen. Cynthia Pearson of the National Women's Health Network analyzed the data and figures that only 30 of the 10,000 women who took raloxifene for up to 5 years actually benefited once the serious risks are taken into account. And we still don't know whether either tamoxifen or raloxifene actually prevent breast cancer or merely delay it.<sup>iii</sup>

As breast cancer advocates, it is our responsibility to understand the science of breast cancer and the details behind research studies.<sup>iv</sup> We must also learn to ask the right questions and demand informed answers from our doctors, scientists, drug manufacturers, and reporters. The Florida Breast Cancer Coalition Research Foundation promotes breast cancer education, research and advocacy. Please join with us. Together we WILL end breast cancer.

Thank you.

Jane A. Torres

i Nutrition Action Health Letter, Center for Science in the Public Interest, April 2006.

ii Nutrition Action Health Letter, Center for Science in the Public Interest, April 2006.

iii Ellen Goodman, “Aging Body- a complicated piece of equipment”, The Miami Herald, April 21, 2006.

iv For more information on the science of breast cancer and interpretation of results, check out Project LEAD on the NBCC website at [www.stopbreastcancer.org](http://www.stopbreastcancer.org).

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**Introducing...**

FBCCRF is pleased to announce that Shahla Masood, MD, has recently joined our Scientific Committee. Dr. Masood serves as Professor and Associate Chair for the University of Florida's Department of Pathology in Jacksonville, Florida. An internationally recognized expert in breast cancer diagnosis and prognosis, Dr Masood has fostered the concept of a multidisciplinary approach in breast cancer care, research, and education. Dr. Masood is the founder and Editor-in-Chief of The Breast Journal, the founder and Past President of the International Society of Breast Pathology, the Director of the Annual Multidisciplinary Symposium on Breast Disease, and the Director of The Breast Cancer Public Forum. A pioneer of using cytomorphology as a breast cancer predictor, Dr. Masood authored the textbook, *Cytopathology of the Breast*. She is heavily involved in the study of minimally invasive procedures such as fine needle aspiration biopsy and ductal lavage in providing diagnostic and prognostic information for women at high risk and breast cancer patients.

**Research Grants**

The following grants have been recommended by the Scientific Committee and approved by the boards of FBCCRF and FBCC. Proceeds from the sale of the End Breast Cancer license plate have allowed for funding of these grants.

**2006 Research Grant**

**Principal Investigator:** Dr Keith Webster

**Amount/type of Grant:** \$90,000, Research Grant

**Grant Period:** Calendar Year 2006

**Title of Project:** Targeting Pro-Apoptotic Bnip3 to Induce Death of Hypoxic Breast Tumors

**Grantee Institution:** University of Miami Miller School of Medicine

**2006-2009 Pre Doctoral Research Grants**

#1. **Principal Investigator:** Ping Luo

**Amount/type of Grant:** \$90,000 over three years (\$30,000 each year) Pre Doctoral Research Grant

**Grant Period:** July 1, 2006 through June 30, 2009

**Title of Project:** A Cognitively-based System of Perception and Interaction for CAD-Assisted Mammography Interpretation

**Grantee Institution:** H. Lee Moffitt Cancer Center and Research Institute

#2. **Principal Investigator:** Alyson K. Fay

**Amount/type of Grant:** \$90,000 over three years (\$30,000 each year) Pre Doctoral Research Grant

**Grant Period:** July 1, 2006 through June 30, 2009

**Title of Project:** The DNA Damage Response in Breast Cancer: Functional Analysis of the Interaction Between CHK2 and a Regulatory Subunit of Protein Phosphatase 2A

**Grantee Institution:** H. Lee Moffitt Cancer Center and Research Institute



**"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](http://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](http://www.fbccrf.org). To those of you who have already purchased your "End Breast Cancer" license plate, THANK YOU!

## Telling Your Child You Have Cancer

One of the hardest tasks cancer patients face is telling their children that they have cancer. Everyone wants to protect their children from sadness and fear. No one wants to tell their child that they have cancer. However, it's very important to tell your children what is happening. It is important to tell them the word "cancer" because they'll overhear it in conversations, and it is better that they hear it from you with an age-appropriate and hopeful explanation.

Find a calm time when you (and whomever you might want to assist you) can be alone with your child or children. It's important that all your children know the same information (age appropriately, of course) so they can feel free to talk with one another. Tell them who else in your family and friends network knows so they can have more support.

Tell your children in the most direct and appropriate way you can. Ask them what they heard you say, and then listen. Ask: "What is it like for you to hear this?" Then, listen to what they have to say. Some children have lots of questions. Others have none. Some react with outbursts of emotions, while others appear not to care. Whatever your child's reactions are, accept them. Children generally don't tolerate upsetting feelings for long. They will often distract themselves. Adults think this means they don't care, but it's just your child's way of not becoming overwhelmed by the information. If you are worried about how your child is dealing with the cancer, treatments, and any effects on the family, please seek professional help.

Here are some guidelines for talking with your children:

**Tell** children as soon after diagnosis as you can. Children know when something is wrong, and if you don't tell them the facts, their imaginations will create ideas that may be more frightening than the facts.

**Practice** your explanation beforehand.

**Show** your feelings.

**Give** your children small amounts of information at a time, according to their ages and levels of maturity.

**Make** it clear that a cancer diagnosis does not necessarily mean death.

**Remember** that you may have to repeat what you say many times. It's difficult information for them to assimilate.

**Say**, "I don't know", if you don't know.

**Explain** what cancer is.

**Ask** them what they have heard about cancer so you can dispel any myths.

**Explain** and prepare them for your treatments. They will assume that the treatments are bad because they'll see the side effects. Tell them the treatments are making you better and the side effects mean that the treatments are working.

**Tell** them that you have doctors and other health caregivers who are helping you get better.

**Assure** them that they will be taken care of and that their needs will be met. If your caretaking of them has to be interrupted, tell them who will look after them. Be very specific about these plans. Children worry about what will happen to them.

**Tell** them that they did nothing to cause the cancer. It is not their fault. Neither the cancer nor the treatments are punishment.

**Tell** them that cancer is not contagious. Children are used to missing school or play so they won't "catch" an illness. Children often mistakenly assume cancer is contagious.



**Keep** routines around the house as much like before as possible, including their personal daily routines. Routine is comforting.

**Keep** discipline and house rules as much like before as possible. This is comforting for your whole family.

**Tell** them that your family and friends are here to support you and your children.

**Tell** them how they can help as part of your family team.

**Leave** them with feelings of hope and tell them that even though you and they are upset now, there will be better times ahead.

**If** you have to be away for a treatment, stay in touch the best you can to reassure them that your illness has nothing to do with how much you love them.

**Be** prepared to discuss death. From around age 7-10, children begin to understand the finality of death, although, like everything else, the age at which they understand is variable. Do not use terms such as "like sleeping" for any age child. Death and dying are not talked about much in our culture, so you might find it helpful to talk with someone about death and dying before you talk to your child. Children often know more than you think, and it always helps them to talk about their concerns.

Tell them you will always love them, wherever you are. Tell them that now.

Look at the situation as an opportunity to help your children learn how to handle difficult situations. Although I know you and your children wish this hadn't happened, it's a time to learn new life skills and to teach them to your children. If given the opportunity and guidance, children will learn and mature.

*This article was written by Stephanie R. Carter, Ph.D., a child and adolescent psychologist. Dr. Carter adapted this excerpt from her recently published book, Taking Charge of Fighting Cancer, an easy to use workbook with a soothing CD inside.*



## Sentinel Lymph Node Biopsy: Questions and Answers



### What is a sentinel lymph node (SLN)?

The sentinel lymph node is the first lymph node to which cancer is likely to spread from the primary tumor. Cancer cells may appear in the sentinel node before spreading to other lymph nodes. In some cases, there can be more than one sentinel lymph node.

### What is SLN biopsy?

SLN biopsy is a procedure in which the sentinel lymph node is removed and examined under a microscope to determine whether cancer cells are present. SLN biopsy is based on the idea that cancer cells spread (metastasize) in an orderly way from the primary tumor to the sentinel lymph node(s), then to other nearby lymph nodes.

A negative SLN biopsy result suggests that cancer has not spread to the lymph nodes. A positive result indicates that cancer is present in the SLN and may be present in other lymph nodes in the same area (regional lymph nodes). This information may help the doctor determine the stage of cancer (extent of the disease within the body) and develop an appropriate treatment plan.

## Resources

Y-ME National Breast Cancer Organization recently established a Y-ME satellite office in Miami in order to provide the greater Miami breast cancer community easier access to Y-ME's free-of-charge programs and services as well as to its 24-hour National Breast Cancer Hotline, which is completely staffed by breast cancer survivors.

Y-ME began 30 years ago when two cancer patients, Ann Marcou and Mimi Kaplan, sat around a kitchen table discussing how to provide support for fellow cancer patients. The organization has since grown into a premier resource center for breast cancer information with the important goal of ensuring that no one faces breast cancer alone. Its main service is a free-of-charge 24/7 hotline operated by trained peer counselors who are breast cancer survivors, and interpreters in 150 languages. The hotline offers personalized, one-on-one support to breast cancer patients and their loved ones.

Other Y-ME services and programs include Survivor and Partner Match Programs to provide support to patients and their partners, a Wig and Prosthesis Bank that provides products free of charge to women with limited resources, publications in various languages, public policy and research advocacy, and a ShareRing Network offering a monthly, one-hour teleconference featuring a breast cancer presentation by a professional in the field. Additionally, the organization offers all-day seminars in underserved communities called A Day for You; and Friends of Ann and Mimi, a group of trained volunteers who accompany patients to appointments when necessary.

Visit [www.y-me.org/miami](http://www.y-me.org/miami) to obtain a wealth of information online, including transcripts of many of the educational teleconferences. Y-ME is looking for peer counselors to volunteer from home in your area. If you're a breast cancer survivor and are interested in becoming a peer counselor for the Hotline, contact Y-ME about participating in the peer counselor training and certification program. For more information, visit the 24-Hour Hotline on their website or call 800-221-2141 in English or 800-986-9505 in Spanish.

### What happens during the SLN biopsy procedure?

In SLN biopsy, one or a few lymph nodes (the sentinel node or nodes) are removed. To identify the sentinel lymph node(s), the surgeon injects a radioactive substance, blue dye, or both near the tumor. The surgeon then uses a scanner to find the sentinel lymph nodes(s) containing the radioactive substance or looks for the lymph node(s) stained with dye. Once the SLN is located, the surgeon makes a small incision (about 1/2 inch) in the skin overlying the SLN and removes the lymph node(s).

The sentinel node(s) is/are checked for the presence of cancer cells by a pathologist (a doctor who identifies diseases by studying cells and tissue under a microscope). If cancer is found, the surgeon will usually remove more lymph nodes during the biopsy procedure or during a follow-up surgical procedure. SLN biopsy may be done on an outpatient basis or require a short stay in the hospital.

### What are the possible benefits of SLN biopsy?

To understand the possible benefits of SLN biopsy, it helps to know about standard lymph node removal. Standard lymph node removal involves surgery to remove most of the lymph nodes in the area of the tumor (regional lymph nodes). For example, breast cancer surgery may include removing most of the axillary lymph nodes, the group of lymph nodes under the arm. This is called axillary lymph node dissection (ALND).

If SLN biopsy is done and the sentinel node does not contain cancer cells, the rest of the regional lymph nodes may not need to be removed. Because fewer lymph nodes are removed, there may be fewer side effects. When multiple regional lymph nodes are removed, the patient may experience side effects such as lymphedema (swelling caused by excess fluid build-up), numbness, a persistent burning sensation, infection, and difficulty moving the affected body area.

### What are the side effects and disadvantages of SLN biopsy?

Side effects of SLN biopsy can include pain or bruising at the biopsy site and the rare possibility of an allergic reaction to the blue dye used to find the sentinel node. Patients may find that their urine is discolored or that their skin has been stained the same color as the dye. These problems are temporary.

Although some surgeons consider SLN biopsy to be the standard of care for some cancers, its role and benefit are yet to be determined. We do not know whether SLN biopsy improves a patient's survival or reduces the chance that the cancer will recur (come back). That is why studies are being conducted to compare SLN biopsy with standard lymph node dissection.

### Where can I find more information about this trial?

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

This article was prepared by Martha Oliveros, Cancer Information Service.

# LEGISLATIVE

as part of FBCC 15th Anniversary

# UPDATE

In May, the National Breast Cancer Coalition (NBCC) launched its 15th Anniversary Year. According to NBCC President Fran Visco, "We have created an advocacy network that is unparalleled. We have put together unique training programs in science and advocacy that have benefited thousands of individuals and hundreds of organizations across the country. We have produced and distributed guides to quality care and voting records. We have made certain that advocates have a say in all areas of breast cancer, from public policy, to research, to quality care."

The Florida Breast Cancer Coalition Research Foundation (FBCCRF) and the NBCC are delighted to report that your advocacy made all the difference in getting 66 Senators to sign the Letter to the Defense Appropriations Subcommittee

## 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](http://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.

requesting \$150 million for the Department of Defense peer-reviewed Breast Cancer Research Program (DOD BCRP). And getting 231 House Members to sign the Letter to the Military Quality of Life Appropriations Subcommittee.

We would like to thank the Florida House Representatives and our two Senators for their support. I believe that this is the first time that our two Senators have ever signed onto the DOD BCRP.

If you would like to thank them, here is the list of signers (as of May 4, 2006):

Senator Mel Martinez (R)  
 Senator Bill Nelson (D)  
 Rep. Ginny Brown-Waite (R-5th)  
 Rep. Cliff Stearns (R-6th)  
 Rep. John Mica (R-7th)  
 Rep. Michael Bilirakis (R-9th)  
 Rep. Jim Davis (D-11th)  
 Rep. Mark Foley (R-16th)  
 Rep. Kendrick Meek (D-17th)  
 Rep. Ileana Ros-Lehtinen (R-18th)  
 Rep. Robert Wexler (D-19th)  
 Rep. Debbie Wasserman Schultz (D-20th)  
 Rep. Clay. E. Shaw (R-22nd)  
 Rep. Dave Weldon (R-15th)

*Susan Moreno, Legislative Chair*

## NBCC Annual Advocacy Conference

From April 29-May 2, I had the privilege of attending the National Breast Cancer Coalition's annual advocacy conference and lobby day. Our Florida group consisted of 12 women ranging in age from mid twenties to mid 60's and from various cities throughout Florida. We were joined by over 700 other women and men from across the United States and several countries overseas, united by a common thread – we had all been touched in some way by breast cancer.

The conference opening session featured an address by NBCC President Fran Visco, urging us to join her "revolution" to end breast cancer. She reminded us that this year alone, more than 269,000 women will be diagnosed with breast cancer and more than 40,000 women will die from this disease. Despite these statistics, we still do not know what causes breast cancer, how to prevent it, or how to treat it effectively.

During the conference, we attended many workshops which covered topics such as environmental factors that may affect breast cancer, how to ensure the media gets the story right, genetics and breast cancer, state advocacy, and so many more.

Throughout the conference, we were briefed thoroughly on NBCC's legislative priorities; and then on May 2, we went to

Capital Hill to speak to our Florida Congressional Delegation to work to ensure enactment of NBCC's legislative priorities for 2006:

- a. Guaranteed access to quality health care for all.
- b. \$150 million dollars for the Department of Defense Peer-Reviewed Breast Cancer Research Program.
- c. Enactment of legislation (S757/HR31) to study links between breast cancer and the environment.
- d. Preservation of the Medicaid Breast and Cervical Cancer Treatment Program.

Everyone in the Florida group went to Capital Hill. We broke up into teams in order to make sure we met with all 27 of our elected officials. In several cases, we were able to gain the representative's support for the first time. We were also able to spend some time thanking long- term supporters.

My experience at the conference is one I will never forget. I know that everyone in our group is planning on returning next year, and we encourage everyone to join us.

*Marjie Aloni, Executive Director*

### **Phase III Randomized Study of Triptorelin and Exemestane Versus Triptorelin and Tamoxifen in Premenopausal Women With Endocrine-Responsive Breast Cancer (IBCSG-25-02)**

The benefits of anti-estrogen therapy for breast cancer—in terms of reduced disease recurrence and improved survival – have been clearly established for postmenopausal women whose tumors can grow in response to the female sex hormone estrogen (endocrine-responsive breast cancer). Women who have not undergone menopause, however, may not benefit as much from anti-estrogen therapy because their ovaries are still producing large amounts of estrogen.

In this trial, premenopausal women with endocrine-responsive breast cancer will receive the drug triptorelin to suppress the function of their ovaries (induction of menopause) and long-term anti-estrogen therapy with either exemestane (an aromatase inhibitor), to inhibit the production of estrogen outside the ovaries, or tamoxifen, to block the growth-promoting effects of any estrogen that might be produced. Researchers hope to determine which anti-estrogen treatment will help premenopausal women whose ovarian function is being suppressed survive longer without a recurrence of their cancer. “We hope to see the same degree of benefit in this younger population that we currently observe in older, postmenopausal women on aromatase inhibitors,” said Dr. Walley. “With this trial and others being conducted by breast cancer researchers, we hope also to determine the role of ovarian suppression in premenopausal women with early stage breast cancer.”

Researchers seek to enroll 1,845 premenopausal women diagnosed with breast cancer who have had their tumors surgically removed, have no clinically detectable residual loco-regional axillary disease, have had a total mastectomy with or without adjuvant radiotherapy, breast-conserving procedure (margins negative for invasive disease and ductal carcinoma in situ) with planned radiotherapy, had a tumor confined to the breast and axillary nodes with no distant metastases, and positive sentinel nodes must have either axillary dissection or radiation of axillary nodes.

Hormone receptor status: Estrogen and/or progesterone receptor positive (at least 10% of the tumor cells positive by immunohistochemistry)

Multiple study sites in the United States and Florida are recruiting patients for this trial, including the University of Miami Sylvester Comprehensive Cancer Center, 800-584-9976; the University of Florida Shands Cancer Center, 888-254-7581; and the Mayo Clinic Florida, 800-664-4542, [clinicaltrials@mayo.edu](mailto:clinicaltrials@mayo.edu)

Call the NCI’s Cancer Information Service at 1-800-4-CANCER (1-800-422-6237). The call is toll free and completely confidential.

### **New Website Facilitates Information About Phase III Gynecological Cancer Clinical Trials**

The Gynecologic Cancer Foundation, with grant support from Gynecologic Oncology Group, announces the launch of an addition to the Women’s Cancer Network’s ([www.wcn.org](http://www.wcn.org)) clinical trials section. Information about GOG Phase III clinical trials that are open for enrollment is displayed in an easy to understand format. Each trial is detailed in an in-depth manner to better assist women in determining their eligibility for the trial. The site also includes information about GOG and a Frequently Asked Questions (FAQ) section.

Women who believe that they are eligible for the trials are asked to call GOG Headquarters where a trained staff member will direct the caller to the most convenient clinical site. It is hoped that easily available information on the popular Women’s Cancer Network will encourage enrollment in the trials, thus shortening the time required to complete the trial.

For more information, visit the Women’s Cancer Network ([www.wcn.org](http://www.wcn.org)) and click on “clinical trials” on the home page. Remember, breast cancer and ovarian cancer often go hand in hand.

## Miami Breast Cancer Conference

More than 900 participants from around the world attended the 2006 Miami Breast Cancer Conference in February in Miami Beach. The conference once again provided health care providers, the majority surgical and medical oncologists, with seminars and workshops promoting a multidisciplinary approach to the practice of breast cancer management, bringing important information from the lab to the clinician who can apply the new knowledge in practice immediately in support of individual patients.

“This conference attracts participants from as far away as Turkey and Qatar because it has significant clinical relevance,” said Dr. Daniel A. Osman, a breast cancer surgeon and conference course director. “What you learn at the conference, you can apply in your practice by the time you return to your office, and it will help you individualize breast cancer management to your patient’s unique needs.”

According to Dr. Osman, one of the most important presentations at the conference discussed gene expression profiling as a way to identify sub-groups who may or may not need chemotherapy, and thus avoiding unnecessary treatments for those who will not gain significant benefits. The information was presented by Dr. Steve Shak, Chief Scientific Officer, Genomic Health, Inc. Other presentation topics included prevention, molecular biochemistry, breast imaging, risk prediction and management, and targeted therapies, and management of local disease and distant metastases.

At the 2006 meeting, presenters:

- Discussed strategies for risk reduction in breast cancer.
- Described advances in breast imaging.
- Reviewed the various techniques in local/regional management of breast cancer.
- Reviewed the rapidly developing role of micro array technology in assessing the need adjuvant therapy.
- Reviewed basic understanding of molecular biology of breast cancer.
- Described tailoring therapy to a tumor’s molecular portrait.
- Reviewed the integration of new therapies into your current strategies.
- Reviewed the molecular changes of the tumor after pre-operative adjuvant therapy.
- Described the factors associated with local recurrence and distal metastases.
- Reviewed current strategies for management of specific sites of breast metastases.

The conference was co-chaired by Dr. Robert DerHagopian, a breast cancer surgeon, and Dr. Neil Love, medical oncologist and editor of *Breast Cancer Update*. Next year’s conference is slated to take place Feb. 21-24, 2007 at Loews Miami Beach Hotel.

To obtain more information and order copies of the presentations on CD or DVD, visit <http://www.cancerconf.com/>. You can also call or fax 954-888-9472, or e-mail [info@cancerconf.com](mailto:info@cancerconf.com).

Inge Sengelmann

## Report Finds That Imaging Tests Cannot Reliably Be Used To Diagnose Breast Cancer After An Abnormal Mammogram

The Agency for Healthcare Research and Quality (AHRQ) recently released a report, *Effectiveness of Noninvasive Diagnostic Tests for Breast Abnormalities*, that found four commonly used imaging tests (positron emission tomography or PET scans, magnetic resonance imaging or MRI, scintimammography or nuclear medicine imaging, and ultrasound) cannot reliably be used to rule out the need for a surgical biopsy after an abnormal mammogram.<sup>1</sup>

AHRQ’s Effective Health Care Program aims to provide research on the comparative effectiveness of different health care treatments and clinical practices, thereby providing patients, health care providers, and policymakers with reliable and practical data to assist with informed health care decision making. One of the approaches the Effective Health Care Program uses to achieve its goal is to systematically review the published scientific evidence and synthesize knowledge on particular topics.

This current study by AHRQ’s Effective Health Care Program was a comprehensive review of the literature to determine whether four specific non-invasive imaging tests are sufficiently accurate to be appropriately used in the evaluation of women with abnormal screening mammograms.<sup>2</sup> Surgical biopsy is the gold standard for diagnosing breast cancer; however, one-in-five women who undergo this invasive procedure will be found to be disease-free. This review addressed the accuracy of four imaging tests in the diagnosis of breast cancer, and whether the accuracy was affected by other factors such as patient demographic or clinical risk factors.

The four non-invasive imaging tests evaluated in this review were

PET scans, MRI, scintimammography, and ultrasound. Eighty-one studies from the scientific literature were used to assess the performance of these four imaging tests in diagnosing breast cancer after an abnormal mammogram or clinical breast examination. The rationale for using these non-invasive tests after an abnormal mammogram is to reliably identify women who do not have breast cancer, and rule out the need for them to undergo the invasive procedure of a surgical biopsy. This comprehensive review found that while each of the imaging tests could reduce the need for surgical biopsy, each also missed an unacceptably high percentage of cancers. AHRQ concluded that none of the imaging tests were sufficiently accurate to replace surgical biopsy as the diagnostic method for women with abnormal mammograms.<sup>3</sup>

The work of AHRQ and its Effective Health Care Program is extremely important. Studies such as this one are essential for the practice of evidence-based health care because they help address gaps between scientific research and clinical practice. While it may be disappointing to find that none of these four imaging tests are accurate enough to rule out cancer, it is important for clinicians and patients to make health care decisions based on evidence of clinical utility. The study indicates that the use of these diagnostic tests in breast cancer is not warranted, and instead add layers of procedures and cost to the diagnostic process.

The study’s authors indicate that one of the limitations they faced was a lack of data to estimate the accuracy of diagnostic imaging in the situation when a screening mammogram indicates a likely benign lesion. Since this is an important group of women for

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whom we would want to rule out the need for a surgical biopsy, this is a huge data gap. Another limitation recognized in the review was that the 81 studies had an unusually high prevalence of breast cancer among the patients, which makes it difficult to assess whether the report results can be generalized to the overall population of women with abnormal mammograms.

## NBCCF Analysis

### Quality of data

NBCCF is very concerned about the revelation of poor quality data for this study. The authors report that much of the evidence was insufficient to calculate an estimate of test accuracy, and the estimates that were calculated were at best only moderately stable.<sup>4</sup> The study's authors report that the lack of strong confidence in the conclusions was due to "flaws in the evidence base." Such flaws include the "incomplete reporting of study design and patient characteristics,...[and]...insufficient numbers of studies reporting data for particular subgroups of patients."<sup>5</sup> This points to the urgent need to develop and enforce standards for the design of quality research studies, and for the publication and full disclosure of research methods and results. Without good quality data, there can be no confidence in a study's conclusions.

### Health care costs

Evidence-based health care requires that the adoption of new technology be accompanied by a clear understanding of its clinical utility. In practice, technologies such as MRI and PET scans are being adopted to diagnose breast cancer before their clinical utility is known. This adds an extra layer of procedures of questionable clinical utility, exacerbating the existing issues of breast cancer medical treatment overuse and rising health care costs.

### Remaining gaps

Concerns remain about the limitations of mammography, and what a woman should do after an abnormal mammogram. Low- and high-tech approaches have so far not been adequate to bridge this gap. We need to examine better alternatives, and ensure that research studies are well-designed and reported to be able to trust the answers.

Recent data presented at the San Antonio Breast Cancer Symposium may help fill this gap. Researchers found that needle biopsy as an initial diagnostic lessened the need for repeated surgery, decreased the total number of surgeries, and shortened the time to complete surgery for patients when compared to initial diagnosis with surgical biopsy.<sup>6</sup> We await publication of this study in a peer-reviewed journal to assess the quality of the data and the reliability of the results.

### Footnotes

<sup>1</sup> Agency for Healthcare Research and Quality. Effectiveness of noninvasive diagnostic tests for breast abnormalities. Effective Health Care Final Report. February 9, 2006

<sup>2</sup> It is assumed that prior to such use of these non-invasive imaging tests women would have undergone a diagnostic mammogram.

<sup>3</sup> The AHRQ report mentioned an "acceptability standard of less than a 2% risk of breast cancer with a negative diagnostic test." (The probability that a woman has breast cancer after a negative diagnostic test.) AHRQ used this 2% as a reference point, and not as an agreed upon nor enforced standard. The issue of defining an acceptable probability of disease with a negative diagnostic test result is still ongoing, and requires further research. AHRQ cited the Ontario Ministry of Health and Long-Term Care (Government of Ontario, Canada) as the source of the report's reference point to an acceptable level for any diagnostic test to reliably preclude breast biopsy. Ontario Ministry of Health and Long-Term Care. Scintimammography: health technology scientific literature review. February 2003.

<sup>4</sup> A highly stable estimate indicates that if new data were added to the estimate calculation, the new estimate would likely be the same or very similar. Stability is the confidence one has that a particular estimate is very close to the truth.

<sup>5</sup> Agency for Healthcare Research and Quality. Effectiveness of noninvasive diagnostic tests for breast abnormalities. Effective Health Care Final Report. February 9, 2006.

<sup>6</sup> Edge SB, Ottesen RA, Lepisto EM, Niland, JC, Theriault RL, Bookman MA, Weeks JC. Surgical biopsy to diagnose breast cancer adversely affects outcomes of breast cancer care: finding from the National Comprehensive Cancer Network. San Antonio Breast Cancer Symposium, December 8-11, 2005.

*Reprinted from Breaking News on the NBCC website.*

## **Study Finds That Short Course of Herceptin Might Be Effective Against Breast Cancer Recurrence and Also Limit Heart Damage Among HER2-Positive Patients with Early Breast Cancer**

A 3-year interim analysis<sup>1</sup> of the FinHer (Finland Herceptin) study, published in the February 23, 2006 issue of the New England Journal of Medicine, found that adjuvant treatment with docetaxel (Taxotere<sup>®</sup>) prior to chemotherapy significantly decreases recurrence in women with node-positive or high-risk node-negative early stage breast cancer compared to vinorelbine (Navelbine<sup>®</sup>). A planned subgroup analysis of HER2-positive patients found that adding a nine-week course of trastuzumab (Herceptin<sup>®</sup>) to Taxotere or Navelbine prior to chemotherapy also significantly improved recurrence-free survival.

This study randomly assigned 1,010 women with node-positive or high-risk node-negative early stage breast cancer to either 3 cycles of Taxotere or Navelbine, followed by (in both groups) three cycles of fluorouracil, epirubicin, and cyclophosphamide (FEC). Women who were estrogen-receptor positive and/or progesterone-receptor positive were also put on Tamoxifen for 5 years following chemotherapy (approximately 72.5% of patients). All women who had a lumpectomy received adjuvant radiation therapy after chemotherapy (approximately 97% of patients).

There were 232 women with HER2-positive breast cancer (23% of the study population) who were further randomized to receive either nine weekly infusions of Herceptin or no Herceptin. HER2 expression was scored by immunohistochemistry (IHC) and HER2/neu gene amplification was confirmed by chromogenic in situ hybridization (CISH) when IHC findings were scored as 2+ or 3+ (on a scale of 0, 1+, 2+, or 3+).

This is one of several studies looking at Herceptin in addition to chemotherapy in the adjuvant setting. While all reports from interim analyses of these studies favor the use of Herceptin, the optimal length of treatment with Herceptin has not been established. This is the first study to report on the effect of a short course of treatment (less than one year) with Herceptin on patient outcomes.<sup>2</sup> Women randomized to Herceptin started their treatment at the same time as Taxotere or Navelbine. By administering Herceptin before FEC, the authors sought to determine whether this schedule would "limit cardiotoxicity and maintain efficacy."<sup>3</sup> The primary endpoint of this study was recurrence-free survival.<sup>4</sup> The authors of this study plan to release a final analysis of their findings in two years (after five years of follow-up).

The study had a factorial design<sup>5</sup> that included the prospective comparison of all HER2-positive patients who were randomly assigned to receive one of the two chemotherapy regimens

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described above with or without Herceptin. Factorial designs can be appropriate and efficient methodologies to answer multiple research questions in prospective clinical trials. Subgroup analyses in this setting differ from the data mining that occurs when studies 'slice' the population of participants to analyze the effects of interventions among groups with specific characteristics.<sup>6</sup>

The preliminary results of this study show that women taking Taxotere experienced a 42% reduction in risk of recurrence or death<sup>4</sup> compared to women taking Navelbine (8.4% versus 14% recurrence rate, or a 5.6% absolute difference), and a 44% reduction in risk of metastasis (6.6% versus 11.4%, or a 4.8% absolute difference). At this time, there is no observed significant difference in overall survival between the two groups. Women on Taxotere experienced more adverse effects<sup>7</sup> than those on Navelbine, and as a result the originally scheduled dose of Taxotere had to be lowered during the course of the study.

Among HER2-positive patients, women who took Herceptin in addition to either Taxotere or Navelbine and chemotherapy experienced a 58% reduction in risk of recurrence or death compared to those not on Herceptin (10.4% versus 23.3%, or a 12.9% absolute difference), and a 71% reduction in metastasis (7.0% versus 22.4%, or a 15.4% absolute difference). There was no observed difference in overall survival between these two groups. Women taking Herceptin did not experience significantly more cardiac events than those not on Herceptin.

### What are the implications of this study?

#### • Taxotere in the Adjuvant Setting

The preliminary findings of this study suggest that Taxotere significantly improves recurrence-free survival compared to Navelbine among women with node-positive or high-risk node-negative early stage breast cancer. However, Taxotere was associated with more toxic effects than Navelbine. A significant number of women in the Taxotere group (almost 40%) were diagnosed with neutropenic fever soon after the trial began, leading the study-monitoring committee to recommend a 20% dose reduction.

#### • Herceptin in the Adjuvant Setting

##### – Length of Herceptin Therapy

This is the first time it has been shown that a short (9 week) course of Herceptin can significantly reduce recurrence among women with HER2-positive breast cancer. These results add to the increasing body of evidence confirming Herceptin's efficacy in the adjuvant setting. However, the number of HER2-positive patients randomized within the four separate arms of this study was small<sup>5</sup>. It is important that larger studies be conducted in order to determine the optimal length of therapy with Herceptin. If it can be demonstrated that a shorter course of therapy preserves efficacy, the implications for patients would be positive in terms of quality of life (by reducing the number of patient visits to the doctor) and in terms of cost.

##### – Sequencing of Herceptin Therapy

Prior studies have shown that Herceptin can have a harmful effect on the heart, particularly when combined with certain chemotherapy regimens<sup>8</sup>. This study's findings are very interesting because they suggest that administering Herceptin prior to other therapies with known heart-damaging effects (such as anthracyclines) reduces the risk of adverse cardiac events<sup>3</sup>. Further follow-up is necessary in order to assess whether the improved safety of this mode of administration is preserved over time. Future studies of Herceptin in the adjuvant setting should explore this mode of administration.

The preliminary data from this study on timing of, administration of, and length of treatment with Herceptin are provocative when considered in the context of other recent findings. Four other studies have shown a substantial decrease in relapse among women with HER2-positive early breast cancer who received adjuvant Herceptin in addition to chemotherapy, but the duration of Herceptin use in these trials was much longer (52 weeks on average). Those studies also showed a substantive increase in the risk of cardiac toxicity in women who took Herceptin with or after anthracycline-containing chemotherapy regimens.

Because this is an interim analysis and the follow-up period is limited, there should be caution when interpreting these results. Since the study's factorial design took into account a prospective analysis of HER2-positive patients who were randomized to treatment with or without Herceptin, the limitations usually associated with a subgroup analysis are not a major concern. However, the number of HER2-positive patients (232) between the 4 arms of the Herceptin study makes it imperative that these findings be confirmed prospectively with a larger study population.

Further follow-up of patients in this study is necessary in order to confirm whether (1) the survival benefits observed for Taxotere over Navelbine hold up over the long term, (2) the safety benefits observed for short-term adjuvant Herceptin therapy hold up over the long term, and (3) whether the Taxotere- and Herceptin-containing regimens will have a significant effect on overall survival in the future.

### Source

*Joensuu H, Kellokumpu-Lehtinen PL, Bono P, et al. Adjuvant Docetaxel or Vinorelbine with or without Trastuzumab for Breast Cancer. N Engl J Med 354(8) 809-20; Feb 23, 2006.*

### Footnotes

<sup>1</sup>An analysis that compares intervention groups at any time before the trial is formally completed. This type of analysis should be considered preliminary.

<sup>2</sup>Previous trials have looked at Herceptin therapy in the adjuvant setting for either one or two years.

<sup>3</sup>According to the authors, the principal adverse effects attributable to 12 months of Herceptin therapy given with or after chemotherapy in the adjuvant setting include heart failure, which occurred in 1.7% to 4.1% of women treated with the antibody, and a substantial decrease in the left ventricular ejection fraction (LVEF), which occurred in 10% of Herceptin-treated patients. The risk of cardiac dysfunction with Herceptin treatment increases with the use of anthracyclines. (Slamon, et al., *NEJM* 2001; 344:783-92 and Perez, et al., *JCO* 2004; 22:322-9.)

<sup>4</sup>Recurrence-free survival was defined as the time from the date of randomization to the date of detection of local, distant, or contralateral invasive breast cancer or death, whichever occurred first.

<sup>5</sup>In a trial using a factorial design, participants are allocated to one of a certain number of combinations. In the case of the FinHer study, HER2-positive participants were allocated to (a) Taxotere followed by chemotherapy [n=58], (b) Navelbine followed by chemotherapy [n=58], (c) Taxotere plus Herceptin followed by chemotherapy [n=54], or (d) Navelbine plus Herceptin followed by chemotherapy [n=62].

<sup>6</sup>Since the effect of an intervention is evaluated within a defined subset of trial participants (e.g. hormone receptor status), sample sizes within subgroup analyses are often small. Even if the results are statistically significant, these are considered to be hypothesis-generating and therefore require confirmation in randomized, prospective studies.

<sup>7</sup>Taxotere was more commonly associated with neutropenic fever (fever due to infections that develop after an individual's white blood cells have decreased), stomatitis, alopecia, toxic effects on the skin, nail problems, allergic reactions, neuropathy, and edema than was Navelbine, which more frequently caused peripheral-vein phlebitis, and elevation in the serum aspartate aminotransferase level.

<sup>8</sup>These studies include the NSABP B-31, NCCTG N-9831, and BCIRG 006 trials.

*Reprinted from Breaking News on the NBCC website, March 2006.*

## National Breast Cancer Coalition Responds to STAR Trial's Initial Results

*NBCC urges caution in interpreting the preliminary findings of the Study of Tamoxifen and Raloxifene (STAR) Trial, which report that raloxifene is as effective as tamoxifen in reducing the risk of invasive breast cancer among postmenopausal women who are at increased risk of developing the disease.<sup>1</sup>*

### How was the STAR study done?

The STAR trial enrolled almost 20,000 postmenopausal women at increased risk of developing invasive breast cancer.<sup>2</sup> Participants were randomly assigned to receive either raloxifene or tamoxifen daily for five years to assess the number of breast cancer cases and serious side effects (such as uterine cancer cases and strokes) in the two groups.

The STAR trial builds upon the results of two previous studies, the Breast Cancer Prevention Trial (BCPT) and Multiple Outcomes of Raloxifene Evaluation (MORE) Trial, each of which looked at tamoxifen and raloxifene's effect in reducing breast cancer risk, respectively.

### What were the results?

The initial findings of the STAR Trial (after four years of follow-up) report that breast cancer incidence is similar in the two groups. These results were interpreted as a 50% reduction in incidence based on the findings of the NSABP P-1 Trial, which compared tamoxifen with placebo. Less than 2% of women in both groups developed invasive breast cancer (about 17 cases per 1,000 women). Tamoxifen was also shown to reduce the number of lobular carcinoma in situ (LCIS) and ductal carcinoma in situ (DCIS) cases by half compared to raloxifene.

More than half of the study population (52%) had had a hysterectomy and were not at risk of uterine cancer. For those women with a uterus, the risk of developing uterine (mainly endometrial) cancer was 0.76% for those on tamoxifen and 0.48% for those on raloxifene. This finding was of borderline significance, indicating that there might not be a difference in uterine cancer risk between tamoxifen and raloxifene. The risk of stroke was the same in both groups (0.5%).

### What are the limitations of this study?

It is important to keep in mind that neither tamoxifen nor raloxifene have been proven to prevent breast cancer in any group of women – they have only been shown to reduce the risk of developing breast cancer over a specific amount of time on a specific group (women at increased risk according to the GAIL model).<sup>2</sup> There are still a number of questions that need to be answered for women considering taking tamoxifen or raloxifene for risk reduction. For example, we don't yet know whether these drugs will reduce a woman's overall risk of developing or dying from breast cancer, or extend a woman's life. We also don't know how many of these women will ultimately develop adverse effects from taking these drugs over the long-term, or the mortality rates associated with these adverse effects. The STAR trial was not designed to answer

these questions and only plans to follow the study's participants for 5 years. A participant's willingness to continue follow-up past the 5-year mark is strictly voluntary. In order to answer these questions, it would be necessary to follow these women for a much longer period of time (such as 20 years).

If women are to start taking these drugs, we would also need to know the best age to start taking them, as well as the optimal amount of time to stay on them. Lastly, because there was no placebo arm in this study it is impossible to know tamoxifen and raloxifene's true magnitude of benefit or risk on long-term incidence and mortality. A trial needs to be carried out that can answer these questions.

### What does this study mean for women?

Most women will not develop breast cancer in their lifetime. Therefore, taking tamoxifen or raloxifene as a preventive measure will be unnecessary for most. Unfortunately, we do not yet have the precise risk assessment methods with which to figure out which women will benefit the most from these drugs. Until we do, we won't be able to properly target these interventions.

All drugs have side effects and it is important to avoid exposing women to unnecessary treatment. The Coalition urges women to make an informed decision in weighing the risks and benefits, and physicians to prescribe tamoxifen and raloxifene responsibly. Raloxifene should not yet be prescribed to any woman for breast cancer risk reduction as it has not been FDA approved for this use. Physicians should fully understand the potential risks and benefits of tamoxifen and raloxifene before prescribing them, and should make sure that women understand the risks and benefits as well.

### Footnotes

<sup>1</sup> All STAR participants had to have an increased risk of breast cancer equivalent to or greater than that of an average 60 to 64 year old woman (1.66% of women would be expected to develop breast cancer within 5 years). The average risk of breast cancer in the women who chose to participate in STAR was about twice as high as the minimum risk.

<sup>2</sup> Increased risk was calculated using the GAIL model, which is a computer program that uses personal and family history to estimate a woman's chance of developing breast cancer. The factors that most affect a woman's risk of breast cancer include age, the number of first-degree relatives (mothers, daughters, or sisters) diagnosed with breast cancer, whether a woman has had any children and her age at her first delivery, a woman's age at her first period, and a woman's age at menopause. The average risk of the women who took part in the STAR trial was 3% to 4%, about double the average risk.

*Reprinted from Breaking News on the NBCC website (www.stopbreastcancer.org), posted April 2006. Source: National Cancer Institute press release. Initial Results of the Study of Tamoxifen and Raloxifene (STAR) Released: Osteoporosis Drug Raloxifene Shown to be as Effective as Tamoxifen in Preventing Invasive Breast Cancer. April 17, 2006. (<http://www.cancer.gov/newscenter/pressreleases/STARresultsApr172006>).*

## 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 January 28 and April 26, 2006.

### *Donations made by Supporters*

<u>In Honor of</u>	<u>Donor</u>
Ruth and Morris Allen	Jane Torres
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### *Welcome New Supporters!*

<p>Amparo Alvarez – “in lieu of my participation in this year’s Race for Life event.” Gardens America, Inc. Laura Dalmau Bloomingdale’s</p>	<p>Amy Buchman, M.D. Minthra Moodley Keepsake Floral, Inc. Delta Kappa Sorority Rhonda Renea Hendricks Richard Lippert</p>
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### **Another Way of Giving**

During all of our lifetimes, we will inevitably find ourselves in need of assistance. Sometimes this help is in the form of emotional support from our family or friends, other times it may be support from our physicians and hospitals. At one time or another we will all be touched and compelled to give thanks and give back to our community.


And while over 80 percent of us will choose to support a charity, less than 10 percent of us will arrange to provide on-going support through a charitable bequest.

Some of us believe that this charitable giving is only for the wealthy. However, this is not the case. Even the smallest of gifts can make a difference in the lives of others.

Others believe that we should be leaving our entire estate to our children and grandchildren. However, did you know that a charitable bequest may benefit your family and your estate after you are gone?

According to an Associated Press news story, only 42 percent of adults have wills, a five percent drop since 2000. If only 20 percent of Americans left a charitable bequest, the current number of charitable bequests would more than double. Imagine what the impact would be if the 80 percent of Americans who give during their lifetimes also made a charitable gift through their estate plans!

Just as the Florida Breast Cancer Coalition Research Foundation continues to advocate for more government funds to support research for a cure, we also need to look to you, those we help and those who support our endeavors of research, education and advocacy – to help us plan for the future. Contact your lawyer or financial planner today to find out how leaving a legacy can benefit you and all those that we serve.



Earn money for FBCCRF while you shop. Go to [www.igive.com](http://www.igive.com) and while you shop at more than 1000 stores (including Amazon, Barnes and Noble, Eddie Bauer, and Toys R Us), up to 20% of your purchases will go to FBCCRF. All you have to do is designate FBCCRF as your charity.

### **A Special Thank You to:**

- The following volunteers who helped to plan the Palmetto Bay Race for Life: John Moore, Armand and Lori Tesserot, Eileen Goodman, Loly Costo, Joe Greene, and Bridget Williams. Special thanks go to the church staff: Reverend Sammy Flores and Worship Assistant Christian Keaton. The race raised \$6000 for FBCCRF.
- Volunteers Janice Gates and Carolyn Kerr of The Camp and Associates Real Estate Company, Dawn Donaldson, Virginia Speaker, Janet Nielson, Ann Rothman, Inge Sengelmann, Annette Fromm, and Susan Silberman for their work in support of FBCCRF.
- Floyd Amos, manager, Comfort Inn Fort Lauderdale Airport, for providing complimentary lodging for out-of-town Board members.
- Ileana Ros-Lehtinen, for donating her honorarium from an appearance on the Bill Maher show to FBCCRF.

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



*Gayle Jacobs presented a Flower of Hope stained glass window to Robin Strickland, manager of Brighton Collectibles at The Falls, in appreciation of her and Brighton Collectibles fundraising events involving the Think Pink Breast Cancer Bracelet and the month-long Octoberr breast cancer awareness events of 2005.*

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## Calendar

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### August 2-6

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**Quality Care Project LEAD** will be held in San Jose, California. For further information or to download an application, go to NBCC's website at [www.natbcc.org](http://www.natbcc.org).

### October 1

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Breast Cancer Awareness month Kick off Event. Brighton Collectibles will sponsor a breakfast at Bice Grand Café in the Falls with a local celebrity speaker. The event continues at the Brighton Store with raffles, give aways, and the presentation of the new Think Pink Bracelet designed by Brighton for the purpose of raising money for breast cancer. Bracelets can be purchased that day and all throughout the month. A portion of the funds raised by the sale of bracelets bought and ordered through The Falls' Brighton Collectibles store goes to FBCCRF. There will be activities at Brighton throughout the month for Breast Cancer Awareness.

### October 26

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Bloomingdale's big fundraising event, "The Shopping Benefit." All Bloomingdale's stores will honor specially purchased tickets sold by non-profit organizations throughout Dade, Broward, and Palm Beach counties and in Central Florida. FBCCRF would appreciate your support. Tickets will be available starting in August. For further information or to order your tickets, please call the FBCCRF office. Each ticket costs \$10 with the total going to the charity you buy from...so buy from FBCCRF. In addition to a 15-20% discount on purchases, there will be entertainment, fashion shows, children's activities, product demonstrations, and more at all Bloomingdale's stores.

### November 1-5

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Project LEAD will be held in Washington, D.C. Registration deadline is September 1. For further information or to download an application, go to NBCC's website at [www.natbcc.org](http://www.natbcc.org).

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

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**Check out FBCCRF's website: [fbccrf.org](http://fbccrf.org) • Call us at 954-454-4156**

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