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COVER STORY
Minnesota Oncology’s Survivorship Program
As part of a growing supplementary care program, Minnesota Oncology’s Survivorship Program helps patients and their families cope with life after a cancer diagnosis.

FEATURE
Fear Factor
This powerful story, first appearing in CURE magazine, illustrates how the fear of cancer recurrence can hinder survivors in their journey to get on with their lives.

Becoming Well
Within Conference Brings Cancer Survivors Together for a Day of Inspiration

Local Cancer Patients Benefit from Angel Foundation’s Record-Setting Year

DEPARTMENTS
9 President’s Letter
29 The Science of Caring
30 Minnesota Oncology News

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Defining Survivorship

This issue of Cancer Care Today focuses on cancer survivorship.

In the late 1980s, a courageous group of cancer survivors first gathered in Albuquerque, New Mexico, to form an organization called the National Coalition for Cancer Survivorship (NCCS). This group was led by Dr. Fitz Hugh Mullan, a testicular cancer survivor, who had published a landmark 1985 article in The New England Journal of Medicine entitled “The Seasons of Survival: Reflections of a Physician with Cancer.”

This was the first medical and public redefinition of the term “survivorship” to not only include patients who were free of disease at five years from their cancer diagnosis but also, in fact, define cancer survivorship as beginning at diagnosis and continuing through the balance of life.

This definition of survivorship has been widely accepted and sometimes extended to include family and loved ones as well — all of whom will forever thereafter see their world though a different perspective — that being the world of cancer survivorship.

I was personally privileged to spend five years as the president and chairman of the board of NCCS. This experience has forever made me a firm advocate for the needs of all cancer patients and their loved ones. This issue of Cancer Care Today will tell the story of your local cancer community and Minnesota Oncology’s work to support cancer survivors during active treatment and throughout their lives.

Dean Gesme, MD
President
Minnesota Oncology
When 47-year-old Connie Meyer was diagnosed with breast cancer in June 2012, she immediately became a survivor. As she underwent her treatment at Minnesota Oncology, she began to realize that a cancer diagnosis and treatment were affecting more than her physical health. Her entire world was changing. She wasn't able to continue working full-time as a hair stylist due to her treatment schedule and fatigue. Her family faced a degree of financial uncertainty with the unknown costs for Meyer's pending surgery, chemotherapy and radiation treatments. And a previous condition was exacerbated in her right arm, causing her pain and making it difficult for her to style hair. All of this forced her into a care-receiver role when she'd spent her entire life being a caregiver.
When she saw medical oncologist Dr. Mark Sborov at Minnesota Oncology’s Edina Clinic, he recognized the signs of distress. “I was telling him about my problems, and he said I should go see Michele O’Brien right away,” Meyer says. “And I thought, ‘Who is this Michele? And how is she going to fix my problems? Is she some kind of wizard?’”

But Meyer followed the doctor’s orders, scheduling the appointment and beginning her journey in Minnesota Oncology’s survivorship program. What Meyer learned in her first appointment is that Michele O’Brien is not a wizard, but she is a clinical nurse specialist, or advanced practice provider, with 22 years of experience in oncology. As part of the expanding supportive care program for Minnesota Oncology patients, O’Brien and Sborov began developing the integrated program in 2009.

**Who Is a Survivor?**
The National Coalition for Cancer Survivorship (NCCS) considers someone a cancer survivor from the day of diagnosis throughout the rest of life. Minnesota Oncology agrees with this definition. Currently, there are 13.7 million people in the United States living with a personal history of cancer. This number has increased dramatically from 3 million in 1971, according to the American Society of Clinical Oncology.

Despite this drastic increase, people living with cancer have a difficult time recognizing themselves as survivors, O’Brien says. “If a patient is at the start of their journey or had a change in their treatment, they may not feel like a cancer survivor,” she explains. “That’s OK. We still consider each of them a survivor.”

Even after an aggressive treatment protocol involving surgery, chemotherapy and radiation, Meyer struggled with the word “survivor.” As her treatment came to an end, she wanted to capture her journey through photographs of her without hair. When photographer Melissa Miroslavich gave Meyer a chalkboard and asked her to write “survivor” on it to use as a prop in one of the photos, Meyer was hesitant. “I wasn’t really ready yet. I said, ‘Why am I writing “survivor”? I’m still in treatment!’” But, when she did hold the sign, Miroslavich captured an image of Meyer with her bald head and her chemotherapy port showing, and Meyer says she felt empowered.

More than one in three people will be diagnosed with cancer in their lifetimes, according to a report by the National Cancer Policy Board of the Institutes of Medicine. While many cancer survivors experience a renewed sense of life and purpose, the impact of treatment can be profound, with late effects appearing years later.

“A cancer diagnosis causes physical, emotional and spiritual distress,” O’Brien says. Patients and their family may experience a broad range of emotions, including fear, anger, depression, fatigue and a sense of grief or loss. “From diagnosis throughout the cancer journey, survivorship care focuses on improving the person’s quality of life,” she explains. “This includes a patient’s physical, social, emotional, spiritual and functional well-being, as well as the impact it has on the patient’s immediate family.”

At Minnesota Oncology, the Survivorship and Supportive Care Program will be implemented in all 10 Twin Cities Metro clinic locations by the end of 2013, with the goal of making survivorship appointments a routine part of patient care. “The aim of our Survivorship Program is to identify and address the patient’s concerns at the time of diagnosis, when treatment is completed and beyond treatment,” O’Brien says. This includes patients living with advanced cancer. “No matter what their diagnosis or stage of disease, it is important to address their needs,” she says. “Cancer touches every aspect of our patients’ lives.”

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**What Being a Cancer Survivor Means to Me**

by **Connie Meyer**

Being a survivor to me means finding that inner force, drive and determination to fight for my life.

Cancer forever changes a person. And, in the process of mustering up all our strength and courage to survive, we gain an even greater appreciation for life — such a precious God-given gift!

We are our own warriors! Fight, survivors! Fight!
lives and impacts their relationships in some way.” Survivorship care at Minnesota Oncology begins shortly after a new patient's treatment plan is determined by his or her physician. “This is often a stressful time of uncertainty,” O’Brien says. “By introducing survivorship care early, we can improve their ability to cope with therapy while maintaining a satisfying level of everyday life.”

Patients have one-on-one visits with advanced practice providers who are trained survivorship professionals, at the time of diagnosis, when treatment is completed, three to 12 months following treatment, if cancer returns, anytime there is a change in their treatment plans or anytime they feel a need for further support. The focus of these visits, O’Brien says, is on quality of life and addressing any obstacle that inhibits the patient's ability to live a full and satisfying life.

In order to determine those obstacles, questions relate to the person's physical, functional, social and emotional/spiritual well-being. A graph reveals the results of their assessment in a visual format that allows patients to see where their distress is coming from and track their progress in future assessments. The report also provides access to local and national resources related to the person’s areas of concern. In addition to providing valuable insight to enhance patients' cancer treatment, the summary provides important information for their referring physicians as patients return to them for follow-up care.

For Meyer, her assessment revealed concerns she was aware of, along with some that were surprising. One unexpected stressor for Meyer was that she was uncomfortable receiving help from people. “I've always been such a caregiver, and I had to learn how to be a care-receiver,” she explains. "And that was a huge adjustment." But resources exist to make it easier for friends and family to help care for cancer patients, and Meyer's quality of life assessment report provided her with a list of those resources. She learned about Caring Bridge, a website where she could share her cancer journey, and the Lotsa Helping Hands, a website that allowed concerned friends and family to sign up to make meals for Meyer and her family. Rather than having to ask individuals for assistance, Meyer was able to post meal requests.

Concerns, such as financial stability, were more apparent to Meyer and her family. Her husband works as an independent contractor, and one week after her diagnosis, he learned that the contract he was working on at the time would be ending early. That news, along with Meyer's reduced work schedule and the pending costs for her treatment, left the family with a level of financial uncertainty. Through the Survivorship Program, Meyer learned about Angel Foundation, which provides non-medical financial assistance to cancer patients in need. Thankfully, they didn't need to apply for assistance in the end. "But
just knowing it was there gave me peace of mind,” she says. Resources such as acupuncture for fatigue and nausea and physical therapy for her arm also helped Meyer cope physically and emotionally.

**An Integrated Approach**
Minnesota Oncology’s integrated approach to cancer care also means that patients have a wealth of resources within each clinic. Nutritionists, genetic counselors, complementary care providers, financial counselors and social workers are all a part of the Supportive Care Program at Minnesota Oncology. The survivorship visit is a focal point to connect the patient to these resources, O’Brien says. “Some patients cannot identify what they need, and this is a way to help them self-navigate.”

While many survivorship programs are introduced to cancer patients at the completion of their treatment, Minnesota Oncology’s integrated care continuum provides patients with support and resources throughout their cancer journey. Having the information she didn’t even know she needed during treatment was invaluable to Meyer. “Without [the Survivorship Program], I don’t think I would have gone through the stages as quickly or smoothly,” she says. “I think Michele helped me understand them as they were occurring and gave me the information before the stages occurred, so I could identify them and be prepared.”

Meyer likened this approach with the grief counseling she received when she lost her brother to suicide in 1996. After learning the stages of grieving from the counselor, she could identify each phase and understand what she was experiencing. “It’s the same thing with cancer,” she says. “You’re grieving with cancer, and you need to know the stages you’re going through, just like losing a loved one.”

**Finding a “New Normal”**
The struggles survivors experience after treatment completion are different than the challenges of diagnosis and treatment, O’Brien says. “A lot of patients will say, ‘My biggest struggle is that everybody wants me back to my old self, and I’m not back to my old self.’” Even though their bodies may appear back to normal, they’re forever changed, she says. “They’re trying to find their new normal.”

For survivors, a part of their “new normal” usually involves facing the fear of recurrence. Preparation for those fears is critical to managing anxiety about follow-up visits and normal aches and pains, O’Brien says. “After treatment, cancer survivors are so aware of their bodies,” she explains. “With every little ache and pain that they have, the first thing they may think of is cancer.” By preparing survivors to expect these feelings and telling them to call the clinic if any physical concerns last more than a week, they are better able to cope with the fear of recurrence when it happens and not let it delay follow-up visits or cause unnecessary distress.

For patients living with cancer, Minnesota Oncology’s Survivorship Program practitioners work with them to understand their wishes and help them prepare and protect what is important to them through tools such as a health care directive. This patient-centered approach to shared decision-making allows patients with advanced cancer diagnoses to become aware of the resources available to them and focus on what matters most to them.

For Meyer, the Survivorship Program is providing the support she needs to cope throughout her journey. “I believe that there is no reason that a person should suffer through cancer alone when there are so many resources available to hold you up and to support you through it.”

“It’s about helping patients define their quality of life,” O’Brien says. “The Survivorship Program focus is on supportive care, and it’s about helping all survivors through this journey.”

---

**October 25, 2012 – Meyer celebrating with her son, Dylan Ellwanger, on his 18th birthday**
Ann Nelson graduated from nursing school at Northwestern Hospital School of Nursing in 1956. In 1985, she came to work for Dr. Burt Schwartz, Dr. John Brown and the late Dr. Ignatius Fortuny, when our practice was first formed under the name Oncologic Consultants. Prior to that, Nelson had been working as a chemotherapy nurse at Abbott Northwestern Hospital. Now, in 2013, Nelson has enjoyed a long career as a collaborative oncology nurse and has embarked upon her retirement years, full of plans to enjoy her leisure and find other ways to serve her community.

"Ann was my collaborative nurse for many years, and I treated her husband in his last years. She is a personal and family friend. I think she is the best nurse I have ever worked with," Dr. Brown remembers.

When she looks back on her nursing career, Nelson recalls in amazement the days when oncology was in its infancy and they mixed chemotherapy agents in a sink with no protective gear whatsoever — how times and safety measures have changed! Throughout the years she has seen many other developments in the world of cancer care.

"I've seen many positive changes," Nelson says. "There are many more treatment options, such as oral drugs, targeted chemotherapeutics and the ability to use pinpoint radiation treatment that spares surrounding healthy tissue. Treatment has fewer debilitating side effects now and has enhanced patient quality of life." The advent of the electronic medical record was another major change in health care during her career. Other positive changes that Nelson notes are the addition of nurse practitioners to the care team, more supportive services, such as the Survivorship Program and patient financial counselors, and the formation of Angel Foundation to assist families facing cancer.

People have sometimes wondered at Nelson's long career in oncology, thinking that this specialty must be discouraging. She has always assured them that cancer care is sobering but never depressing. "I have received more from our patients than I gave," Nelson declares. "Their remarkable tenacity, courage and humor are gifts they gave to me and lessons they taught." Patients often became her friends. She remembers them each year when looking over her collection of Christmas ornaments, many of which were homemade gifts from patients.

Their wisdom served her well when her husband John was diagnosed with lung cancer in 1983 and succumbed to his disease in 1984. A few years later, Nelson had her own brush with uterine cancer, which was successfully treated with surgery, and, in later years, her daughter also had a double mastectomy for breast cancer. Nelson's empathy and respect for cancer patients grew as she walked a mile in their shoes.

Nelson now stays busy with an outreach program at her church in St. Louis Park and traveling with some longtime friends on yearly trips to various locations.
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*August 2013 Minnesota Healthscores Report – Twin Cities Metro Area

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  - 3.5 months mean time to onset observed in responders
  - 12.5 months median duration of MCyR observed in responders (Kaplan-Meier estimate)

- 14% (5 of 35 patients) MaHR rate in accelerated phase patients (95% CI: 4.5%–30.3%)*
  - 2.3 months mean time to onset observed in responders
  - 4.7 months median duration of MaHR observed in responders (Kaplan-Meier estimate)

*MaHR: CHR (n=4), NEL (n=1). No accelerated phase patients achieved MCyR.

Abbreviations: MCyR is major cytogenetic response, MaHR is major hematologic response, CHR is complete hematologic response, NEL is no evidence of leukemia.

Adverse reactions

- Serious adverse reactions (frequency ≥5%) in chronic phase patients: bone marrow failure, thrombocytopenia, febrile neutropenia, and infections
- Serious adverse reactions (frequency ≥5%) in accelerated phase patients: febrile neutropenia, thrombocytopenia, anemia, diarrhea, convulsions, and infections
- Most common adverse reactions (frequency ≥20%) in chronic and accelerated phase patients: thrombocytopenia, anemia, neutropenia, diarrhea, nausea, fatigue, asthenia, injection site reaction, pyrexia, infection, and lymphopenia

Indication

- SYNRIBO® (omacetaxine mepesuccinate) for Injection, for subcutaneous use, is indicated for the treatment of adult patients with chronic or accelerated phase chronic myeloid leukemia (CML) with resistance and/or intolerance to two or more tyrosine kinase inhibitors (TKIs). This indication is based upon response rate. There are no trials verifying an improvement in disease-related symptoms or increased survival with SYNRIBO

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– Bleeding: SYNRIBO causes severe thrombocytopenia which increases the risk of hemorrhage. Fatalities from cerebral hemorrhage have occurred. Severe, non-fatal gastrointestinal hemorrhages have also occurred. Monitor platelet counts as part of the complete blood count (CBC) monitoring as recommended. Avoid anticoagulants, aspirin, and nonsteroidal anti-inflammatory drugs (NSAIDs) when the platelet count is <50,000/μL as they may increase the risk of bleeding
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6 ADVERSE REACTIONS

The following serious adverse reactions have been associated with SYNRIBO in clinical trials and are discussed in greater detail in other sections of the label: Myelosuppression (see Warnings and Precautions (5.1)). Bleeding (see Warnings and Precautions (5.2)). Hypoglycemia (see Warnings and Precautions (5.3)). Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be compared directly to rates in the clinical trials of another drug and may not reflect the rates observed in practice. The safety data for SYNRIBO are from 3 clinical trials which enrolled a total of 63 adult patients with 70% resistant and/or intolerant chronic phase (N=101) and accelerated phase (N=55) CML. All patients were treated with initial induction therapy consisting of a dose of 1.25 mg/m² administered subcutaneously twice daily for 14 consecutive days every 28 days (induction cycle). Responder patients were then treated with the same dose and a twice daily schedule for 7 consecutive days every 28 days (maintenance cycle).

6.1 Clinical Trials Experience

Chronic Phase CML
The medium duration of exposure for the 108 patients with chronic phase CML was 7.4 months (range 0 to 13 months). The median total cycles of exposure was 6 (range 1 to 41), and the median total dose delivered during the trials was 131 mg/m² (range 1.2 to 67.8). Among the patients with chronic phase CML, 87% received 14 days of treatment during cycle 1. By cycles 2 and 3, the percentage of patients receiving 14 days of treatment decreased to 42% and 16% respectively. Of the 91 patients who received at least 2 cycles of treatment, 79 (87%) had at least 1 cycle delay during the trials. The median number of days of cycle delays was greatest for cycle 2 (7 days) and cycle 3 (25 days) when more patients were receiving induction cycles. Adverse reactions were reported for 99% of the patients with chronic phase CML. A total of 18% of patients had adverse reactions leading to withdrawal. The most frequently occurring adverse reactions leading to discontinuation were pancytopenia, thrombocytopenia, and increased alanine aminotransferase (each 2%). A total of 87% of patients reported at least 1 Grade 3 or Grade 4 treatment emergent adverse reactions (Table 1).

Table 1: Adverse Reactions Occurring in at Least 10% of Patients (Chronic Myeloid Leukemia – Chronic Phase)

<table>
<thead>
<tr>
<th>Adverse reaction</th>
<th>Number (%) of Patients (N=108)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All reactions</td>
<td>Grade 3 or 4 reactions</td>
</tr>
<tr>
<td>Patients with at least 1 commonly occurring adverse reaction</td>
<td>107 (99) 94 (87)</td>
</tr>
<tr>
<td>Blood and Lymphatic System Disorders</td>
<td></td>
</tr>
<tr>
<td>Thrombocytopenia</td>
<td>80 (74) 72 (69)</td>
</tr>
<tr>
<td>Neutropenia</td>
<td>66 (61) 39 (36)</td>
</tr>
<tr>
<td>Lymphopenia</td>
<td>34 (30) 48 (44)</td>
</tr>
<tr>
<td>Bone Marrow Failure</td>
<td>18 (17) 17 (16)</td>
</tr>
<tr>
<td>Febrile Neutropenia</td>
<td>11 (10) 11 (10)</td>
</tr>
<tr>
<td>Gastrointestinal Disorders</td>
<td></td>
</tr>
<tr>
<td>Diarrhea</td>
<td>50 (46) 12 (11)</td>
</tr>
<tr>
<td>Nausea</td>
<td>45 (42) 1 (1)</td>
</tr>
<tr>
<td>Vomiting</td>
<td>35 (32) 1 (1)</td>
</tr>
<tr>
<td>Constipation</td>
<td>16 (15) 0</td>
</tr>
<tr>
<td>Abdominal Pain</td>
<td>15 (14) 0</td>
</tr>
<tr>
<td>Vomiting</td>
<td>13 (12) 0</td>
</tr>
<tr>
<td>General Disorders and Administration Site Conditions</td>
<td></td>
</tr>
<tr>
<td>Fatigue</td>
<td>28 (26) 5 (5)</td>
</tr>
<tr>
<td>Periorbital Edema</td>
<td>26 (24) 1 (1)</td>
</tr>
<tr>
<td>Anemia</td>
<td>25 (23) 1 (1)</td>
</tr>
<tr>
<td>Edema Peripheral</td>
<td>14 (13) 0</td>
</tr>
<tr>
<td>Infusion and Injection Site Related Reactions</td>
<td>37 (34) 5 (5)</td>
</tr>
<tr>
<td>Infections and Infestations*</td>
<td>50 (46) 12 (11)</td>
</tr>
<tr>
<td>Musculoskeletal and Connective Tissue Disorders</td>
<td></td>
</tr>
<tr>
<td>Arthralgia</td>
<td>20 (19) 1 (1)</td>
</tr>
<tr>
<td>Pain in Extremity</td>
<td>14 (13) 1 (1)</td>
</tr>
<tr>
<td>Back Pain</td>
<td>12 (11) 2 (2)</td>
</tr>
<tr>
<td>Nervous System Disorders</td>
<td></td>
</tr>
<tr>
<td>Headache</td>
<td>20 (19) 1 (1)</td>
</tr>
<tr>
<td>Psychiatric Disorders</td>
<td></td>
</tr>
<tr>
<td>Insomnia</td>
<td>11 (10) 0</td>
</tr>
<tr>
<td>Respiratory, Thoracic and Mediastinal Disorders</td>
<td></td>
</tr>
<tr>
<td>Cough</td>
<td>17 (16) 1 (1)</td>
</tr>
<tr>
<td>Fatigue</td>
<td>16 (15) 1 (1)</td>
</tr>
<tr>
<td>Skin and Subcutaneous Tissue Disorders</td>
<td></td>
</tr>
<tr>
<td>Alopecia</td>
<td>16 (15) 0</td>
</tr>
<tr>
<td>Rash</td>
<td>11 (10) 0</td>
</tr>
</tbody>
</table>

*Occurred in the period between the first dose and 30 days after the last dose.

Data includes tumor, viral, fungal, and non-specific.

Serious adverse reactions were reported for 51% of patients. Serious adverse reactions reported for at least 5% of patients were bone marrow failure and thrombocytopenia (each 1%), and febrile neutropenia (6%). Serious adverse reactions of infections were reported for 8% of patients. Deaths occurred while on study in five (5%) patients with CML. Two patients died due to cerebral hemorrhage, one due to multi-organ failure, one due to progression of disease, and one from unknown causes.

Accelerated Phase CML
Median total cycles of exposure was 2 (range 1 to 29), and the median total dose delivered during the trials was 10 mg/m². The median duration of exposure for the 55 patients with accelerated phase CML was 14 months (range 0 to 30 months). Of the patients with accelerated phase CML, 85% received 14 days of treatment during cycle 1. By cycles 2 and 3, the percentage of patients receiving 14 days of treatment decreased to 51% and 44%, respectively. Of the 40 patients who received at least 2 cycles of treatment, 50% (20% of all 40 patients) had adverse reactions leading to withdrawal. The most frequently occurring adverse reactions leading to withdrawal were leukocytosis (6%) and thrombocytopenia (4%). A total of 84% of patients reported at least 1 Grade 3 or Grade 4 treatment emergent adverse reaction (Table 2).
Table 2: Adverse Reactions Occurring in at Least 10% of Patients
(Chronic Myeloid Leukemia – Accelerated Phase)

<table>
<thead>
<tr>
<th>Adverse reactions</th>
<th>Number (%) of Patients (N=108)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood and Lymphatic System Disorders</td>
<td></td>
</tr>
<tr>
<td>Anemia</td>
<td>42 (39)</td>
</tr>
<tr>
<td>Fever Neutropenia</td>
<td>11 (10)</td>
</tr>
<tr>
<td>Neutropenia</td>
<td>11 (10)</td>
</tr>
<tr>
<td>Thrombocytopenia</td>
<td>31 (29)</td>
</tr>
<tr>
<td>Gastrointestinal Disorders</td>
<td></td>
</tr>
<tr>
<td>Diarrhea</td>
<td>19 (18)</td>
</tr>
<tr>
<td>Nausea</td>
<td>15 (14)</td>
</tr>
<tr>
<td>Vomiting</td>
<td>8 (7)</td>
</tr>
<tr>
<td>Abdominal Pain</td>
<td>7 (7)</td>
</tr>
<tr>
<td>General Disorders and Administration Site Conditions</td>
<td></td>
</tr>
<tr>
<td>Fatigue</td>
<td>17 (16)</td>
</tr>
<tr>
<td>Pyrexia</td>
<td>16 (15)</td>
</tr>
<tr>
<td>Asthenia</td>
<td>13 (12)</td>
</tr>
<tr>
<td>Chills</td>
<td>7 (7)</td>
</tr>
<tr>
<td>Infection and Infection Site Related Reactions</td>
<td></td>
</tr>
<tr>
<td>Infections and infestations</td>
<td>31 (29)</td>
</tr>
<tr>
<td>Metabolism and Nutrition Disorders</td>
<td></td>
</tr>
<tr>
<td>Anemia</td>
<td>7 (7)</td>
</tr>
<tr>
<td>Gastrointestinal Disorders</td>
<td></td>
</tr>
<tr>
<td>Diarrhea</td>
<td>19 (18)</td>
</tr>
<tr>
<td>Nausea</td>
<td>15 (14)</td>
</tr>
<tr>
<td>Vomiting</td>
<td>8 (7)</td>
</tr>
<tr>
<td>Abdominal Pain</td>
<td>7 (7)</td>
</tr>
<tr>
<td>Respiratory, Thoracic and Mediastinal Disorders</td>
<td></td>
</tr>
<tr>
<td>Hematologic Parameters</td>
<td></td>
</tr>
<tr>
<td>Hemoglobin Decreased</td>
<td>62 (58)</td>
</tr>
<tr>
<td>Leukocytes Decreased</td>
<td>72 (67)</td>
</tr>
<tr>
<td>Neutrophils Decreased</td>
<td>81 (75)</td>
</tr>
<tr>
<td>Platelets Decreased</td>
<td>85 (79)</td>
</tr>
<tr>
<td>Biochemistry Parameters</td>
<td></td>
</tr>
<tr>
<td>Alanine aminotransferase (ALT)</td>
<td></td>
</tr>
<tr>
<td>Increased</td>
<td>6 (6)</td>
</tr>
<tr>
<td>Bilirubin Increased</td>
<td>8 (8)</td>
</tr>
<tr>
<td>Creatinine Increased</td>
<td>9 (9)</td>
</tr>
<tr>
<td>Glucose Increased</td>
<td>10 (9)</td>
</tr>
<tr>
<td>Uric Acid Increased</td>
<td>56 (52)</td>
</tr>
<tr>
<td>Glucose Decreased</td>
<td>8 (8)</td>
</tr>
</tbody>
</table>

6.2 Additional Data From Safety Population

The following adverse reactions were reported in patients in the SYNRIBO clinical studies of patients with chronic phase and accelerated phase CML at a frequency of 1% to less than 10%. Within each category, adverse reactions are ranked on the basis of frequency.

Cardiac Disorders: Tachycardia, palpitations, acute coronary syndrome, angina pectoris, arrhythmia, bradycardia, ventricular extrasystoles.

Ear and Labyrinth Disorders: Ear pain, ear hematoma, tinnitus.

Eye Disorders: Cataract, vision blurred, conjunctival hematoma, dry eye, lacrimation increased, conjunctivitis, diplopia, eye pain, eyelid edema.

Gastrointestinal Disorders: Stomatitis, mouth ulceration, abdominal distension, dyspepsia, gastrointestinal reflux disease, gingival bleeding, aphthous stomatitis, dry mouth, hemorrhoids, gastritis, gastrointestinal hemorrhage, metaplasia, mouth hemorrhage, oral pain, anal fissure, dysphagia, gingival pain, gingivitis.

General Disorders and Administration Site Conditions: Musculoskeletal inflammation, pain, chest pain, hyperthermia, influenza-like illness, catheter site pain, general edema, malaise.

Immunologic Disorders: Hypersensitivity.

Injury, Poisoning and Procedural Complications: Contusion, transfusion reaction.
FEAR FACTOR
Ruminating on possible cancer recurrence can adversely affect quality of life
by Kathy LaTour

A headache must mean a metastatic brain tumor. Insomnia sets in until a scan can be arranged. When sleep finally comes, the first thought in the morning is of cancer recurring. Fear of cancer returning consumes waking hours. The scan is clear.

Although it has been 17 years since Matthew Zachary’s initial diagnosis, he still fears his cancer will return. Photo by Rita Rosenblit.
This scenario was repeated multiple times after initial cancer treatment for Matthew Zachary, founder of Stupid Cancer, a nonprofit organization for young adult cancer patients launched in 2007.

In 1995, Zachary, then a 21-year-old concert pianist, was focusing on his final year in college at Binghamton University in upstate New York and making plans to move to Los Angeles to begin film school. When he began to have problems with his left hand, he was misdiagnosed for six months before learning that he had a medulloblastoma, a rare cancer that occurs in the part of the brain that controls movement and coordination, primarily in young children.

After surgery to remove the tumor, Zachary took a leave of absence from college and moved home with his family on Staten Island while undergoing craniospinal radiation. Thanks to what he calls some gracious faculty members, he was able to finish college, after which he returned to Staten Island and crawled into bed. By November, he says his father told him to “Go get a job.”

“I resented having to work,” Zachary recalls, but he did, beginning what he now calls his second career in advertising, public relations and Web design, providing the platform in 2007 to create Stupid Cancer, a nonprofit for young adults with cancer, which hosts a nationwide Monday night radio show and an annual meeting, the OMG! Cancer Summit.

“There was no effective chemotherapy that I could use at that time, so it was only radiation. And they couldn’t give us specifics on recurrence,” Zachary says. “For younger children who were around 6, it was 50 percent survival for five years. I wanted 100 years.” (Today, survival rates have improved, ranging from 60 to 80 percent.)

More than 17 years after his initial diagnosis, Zachary still struggles with what the medical community has labeled fear of cancer recurrence (FCR), saying that he has learned to live a life in which every twitch could mean the cancer has recurred somewhere else in his body, and every headache might be a brain tumor.

Facing the Fear
FCR ranks as one of the most common unmet needs of cancer survivors, according to a review of 130 papers on the topic published in the Journal of Cancer Survivorship in March 2013. The review, while unable to determine numerous consistent findings due to variations in the study designs, did find associated factors around higher FCR and younger age, presence and severity of physical symptoms, psychological distress and lower quality of life. Other studies have shown that women may be at higher risk of FCR.

Who will suffer from FCR remains individualized and can ebb and flow depending on patients’ support systems, their level of education and their own psychological views.

The triggers for what could be called an episode of anxiety are a set of external and internal clues, says Laurel Northouse, professor of nursing at the University of Michigan School of Nursing in Ann Arbor, Michigan. She says that an upcoming medical appointment, news of a celebrity’s diagnosis or a friend’s recurrence can potentially bring on FCR, while experiencing a strange physical symptom can result in anxiety, insomnia and requests for scans.

“You encourage them to listen to their bodies, but on the other hand, you don’t want every symptom to be cancer.”
— Alejandra Perez, breast medical oncologist, Memorial Breast Cancer Center

What FCR can produce is a psychological response often referred to as intrusive thinking or “rumination,” she says, when negative outcomes are experienced in a continuous vision, and when future plans are canceled for fear of death, or the energy to begin new friendships seems pointless. Yet, how it manifests is unique among individuals, with her research showing caregivers experiencing FCR more intensely than patients in some instances (see sidebar on page 22).

Even the definition of FCR has yet to be formalized. The accepted understanding is that it is “fear that cancer could return or progress in the same place or in another part of the body,” a definition that survivors such as Zachary might think an understatement.

TALKING POINTS
• One of the best ways patients can handle fear of recurrence is to have a good relationship with their doctor.
• Patients should understand that scans and tests for every pain or ache could lead to unnecessary risk.
Applying the Brakes
Amy Jacobson, a nurse practitioner at the UCLA-LIVESTRONG Survivorship Center of Excellence in Los Angeles, says she hears many questions about cancer recurrence when developing a survivorship care plan with patients. In many instances, the fear may be tied to the unknowns of the cancer and its specific pathology, which she can usually quell through education or by sharing published guidelines.

“For example, for breast cancer, we have guidelines published by the American Society of Clinical Oncology (ASCO),” Jacobson says. “They outline specific symptoms that need follow-up,” such as new lumps in the breast, bone pain, chest pain, abdominal pain, shortness of breath, difficulty breathing and persistent headaches. Getting a scan with minimal symptoms that are not suggestive of a true recurrence will increase the proportion of “false positives” seen on scans relative to real recurrences, and could lead to unnecessary risks of biopsies or surgical procedures to follow these up.

Patients want to know why they aren’t getting routine full body scans or blood work all the time to check for recurrence, and I can use these guidelines to talk with them about how clinical trials have shown they aren’t necessarily beneficial for breast cancer survivors,” Jacobson says.

What is most important for patients in managing fear of recurrence is having a good therapeutic relationship with their doctor, she adds. Then, if they have a symptom that they think should be investigated, they may be more comfortable discussing it.

Jacobson also emphasizes participating in a good post-treatment support group, such as those available through the Cancer Support Community, or learning techniques, such as meditation, to keep the mind calm.

“Everyone’s mind can go from 0 to 60 in a second, and it’s best to put the brakes on before things get out of control,” she says.

Alejandra Perez, a breast medical oncologist at the Memorial Breast Cancer Center in Hollywood, Florida, concurs, but says offering the logical solution may not work when the fear is too great. “We spend a significant amount of time on four things when women come in for follow-up: weight gain, hot flashes, sexual dysfunction and fear of recurrence.”

Perez says if they come in with a headache, they want an MRI of the head, “always more imaging.” She tries to educate with the same

Caregivers Worry, Too
Patients with fear of recurrence (FCR) “ruminate” at times, says Laurel Northouse, a professor of nursing at the University of Michigan School of Nursing in Ann Arbor, Michigan. “That is, they worry about FCR to the extent that it interferes with the quality of their day-to-day lives.”

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For caregivers, this anxiety can be worse, she says, because they don’t get firsthand information. In a population-based study of the quality of life of cancer survivors and their family caregivers, Northouse and her colleagues reported “the strongest predictors for cancer survivors’ quality of life were family stressors, social support, meaning of the illness, and employment status, whereas the strongest predictors for family caregivers’ quality of life were fear of recurrence and social support.”

Northouse says caregivers might not be included in discussions that go on during clinical appointments. As a result, they can’t get their own questions answered and have more uncertainty, which often leads to higher fear of recurrence.

A powerful coping tool is acceptance, Northouse says. “FCR is a normal part of the cancer experience. It is important to accept that you will have some FCR. It’s not a sign of poor coping,” she adds. “But try not to let FCR consume you. Focus on the positive things in your life.”

Three-way communication can also be helpful. When caregivers are included in clinic visits, it facilitates communication between the patient, caregiver and health professional. When everyone is on the same page, it can reduce caregiver and patient uncertainty.

“It is helpful when families can find a new meaning in the illness,” Northouse says. “If people can reframe the cancer as something that can have positive effects for them, it brings the family closer and it increases the family’s ability to cope. And don’t ruminate about it. Try to break the cycle of thinking about it constantly. Try planning something fun for a few hours.”

On the Web
Get some practical tips and advice on how to cope with the fear of cancer recurrence.
curetoday.com/recurrence_checklist
Asco guidelines Jacobson uses but also knows that peace of mind only comes with time for some women. For these women, Perez will order a scan, if their insurance allows it.

“You encourage them to listen to their bodies, but on the other hand, you don't want every symptom to be cancer,” Perez says. “We all get headaches, and we all have aches. I tell them we are looking for things that don’t go away, things that wake you up at night. It’s not a headache where you feel better the next day.”

Buffering the Noise

For Zachary, the years provided what he calls “strategic distraction.” He had to relearn how to play music, which he did.

“And I got a girlfriend, whom I married,” he says. “All these things buffer out the noise.

“Everyone’s mind can go from 0 to 60 in a second, and it’s best to put the brakes on before things get out of control.”
— Amy Jacobson, nurse practitioner, UCLA-LIVESTRONG Survivorship Center of Excellence

“Standing in my office, I know I am living the best I can,” he says. It’s not denial, he adds, it’s acceptance. Zachary is now the father of 3-year-old twins, though FCR returned after their birth.

“Being a parent changes it all,” he says. “It got a little worse after the kids were born. ‘What were we thinking bringing children into this world?’ But we did it. You can’t let it control you.”

Zachary says he is far enough away from his cancer treatment that now he worries about getting cancer as a result of the radiation, and he has already had one late effect of the treatment, a radiation-induced stroke, in January 2011.

“The radiologist misdiagnosed it as a recurrence,” he says. “My kids weren’t even [a year old] yet.”

But, he adds, you have to grow a protective skin. “You have to feel the fear, know the fear and know you can control only part of it and do it anyway,” he says.

“That doesn’t mean you don’t cry every so often,” he adds. “It’s a constant reminder. I have chosen this. It’s how you choose to live.”

Originally published in CURE magazine’s Fall 2013 issue. CURE is the nation’s largest magazine for cancer patients, survivors and caregivers. To read more stories like this, or to sign up for your free home subscription, visit curetoday.com or call (800) 210-CURE.

Checklist: Coping with Fear of Recurrence

by Kathy LaTour

Fear of recurrence ranks as one of the most common unmet needs of cancer survivors, according to a systemic review of 130 papers published in the Journal of Cancer Survivorship in March 2013. The first step is to recognize when and why you experience these emotions, then learn ways to minimize and cope with that fear.

Understand your triggers. The American Cancer Society has listed several common events that may trigger fear and anxiety in survivors, including:

- Follow-up medical appointments
- Anniversary events, such as the date you were diagnosed, had surgery or transplantation, or ended treatment
- Birthdays
- Illness of a family member
- Symptoms similar to the ones you had when you received the initial diagnosis
- A friend or family member receiving a diagnosis or dying of cancer
- Personal reminders, such as a certain food you enjoyed while in cancer treatment or article of clothing you wore to surgery
- News of a celebrity receiving a similar diagnosis

Find ways to cope. For some, talking their fears out with others can help reduce anxiety, while others find distractions in their everyday lives more beneficial.

- Acknowledge your fear, anger or sadness. Accept that sometimes you may worry about cancer returning and talk about it in a support group, with friends or with a counselor. Talk to friends who will listen and not judge.
- Live your life. Pursue activities that distract you. Plan for a trip or other distraction around the time of your checkups to give yourself something to focus on.
- Exercise. Find an exercise you enjoy that will take your mind off fear. Exercise also helps with stress.
- Pet therapy. Consider adopting a dog, cat or other animal, and focus on the animal’s needs. Walking a dog daily takes your focus off yourself and increases fitness.
- Be informed. Learn the actual signs of a recurrence. Ask your doctor and your health care team about potential warning signs of a recurrence and the potential risk, which may be quite low. This knowledge may help ease your concerns.
- Go in for a checkup. If you find your fear overwhelming, talk to your doctor about blood work or other tests that will alleviate your fear.
- Get help with emotional stresses not related to cancer. The fear of recurrence may be linked with other problems, such as anxiety or depression.
- Learn techniques to quiet the mind. Use meditation or wakeful visualization to relax your mind and body. Massage may help.
- Work toward having a positive attitude. Self-talk in the mirror about the positives in your life.
Becoming Well Within Conference Brings Cancer Survivors Together for a Day of Inspiration

The good news is that cancer patients in general are surviving longer periods of time after their initial diagnosis. The challenge for those in health care is to facilitate access to all of the supportive care and education needed for our patients to live fully and meaningfully with cancer.

On September 14, 2013, Minnesota Oncology and Well Within, a local holistic wellness resource center, collaborated on the Becoming Well Within survivorship conference at the Prom Center in Oakdale, Minnesota. The goal of this conference was to provide a day of inspiration, hope and humor, as well as connections to a variety of Twin Cities resources for survivors, caregivers and those who love them. Participant feedback was enthusiastically positive, and plans are in the works to make this an annual survivorship event.

Featured speakers included:
- Henry Emmons, MD, PhD – author of *The Chemistry of Joy* and *The Chemistry of Calm*
- Brenda Elsager – cancer survivor, humorist and author of *If the Battle Is Over, Why Am I Still in Uniform?*
- Ruth Bachman – survivor and author of *Growing Through the Narrow Spots*
- Cami Smalley, MA – wellness coach and facilitator of Well Within’s Holistic Survivorship Program

Conference master of ceremonies Mary Treacy O’Keefe, MA, founder and president of Well Within, welcomes guests to a day of hope and healing.

Michele O’Brien, RN, CNS, MA, talks to the audience about Minnesota Oncology’s Survivorship and Supportive Care Program.

Cancer survivor, amputee and author of *Growing Through the Narrow Spots* Ruth Bachman uses humor and her own experiences to share ways for cancer survivors and their loved ones to discover and enhance their capacity to embrace the inevitability of change and move forward.
THANK YOU

Thank you to all of the sponsors who helped Minnesota Oncology and Well Within make this conference possible.

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Bronze Sponsors

Promotional Sponsors

Scholarship Fund Donors

Conference guests enjoy the opportunity to connect and share stories.

Brenda Elsagher, colorectal cancer survivor, comedienne and author, turns her bleak situation into humorous stories that have educated and entertained thousands across the country.

A group of survivors ends the day with smiles.

Cami Smalley, MA, wellness coach and facilitator of Well Within’s Holistic Survivorship Program, shares 10 Tips for Holistic Wellbeing and several strategies that will help survivors focus on increasing their vitality and rebuilding their health.

Blending new neuroscience with ancient wisdom traditions, Henry Emmons, MD, PhD, resiliency expert and author of The Chemistry of Joy and The Chemistry of Calm, explores what it takes to cultivate inner calm and joy, and to protect our brains throughout our lives.

Photos courtesy of LK Fotography

Cancer Care Today
Minnesota-based Angel Foundation continues its record-setting fundraising year, with events such as its 11th annual Angels & Eagles Golf Classic generating $170,000 to benefit adults with cancer and their families. Seventy-five percent of all funds raised at Angel Foundation go directly into programs to benefit cancer patients.

The golf classic is the latest in a series of record-setting fundraisers for the organization, which provides emergency financial assistance, education and support to local families. In January, the Angel Gala reached new heights, generating $437,000 (compared to $280,000 last year). In June, the organization’s fundraising luncheon for its Kids Kamp brought in $42,000, far surpassing goals to send kids who have a parent with cancer to Angel Foundation’s Kids Kamp in August.

The successes are welcome, because the need is great.

Since 2001, Angel Foundation has provided nearly $4 million in emergency financial assistance and has helped more than 18,000 people through its programs. As a result of this year’s fundraising successes, Angel Foundation recently increased the size of grants awarded to cancer patients in active treatment who ask the organization for financial help for essential nonmedical needs, such as house payments, groceries, utilities and gas for their cars.

“It is so gratifying that so many people are stepping forward to give of their time, talent and money to help meet the needs of people in our own community facing cancer,” says Margie Sborov, founder of Angel Foundation. “This has been an amazing year, and it is wonderful to see people embrace our mission.”

Sborov, the wife of Minnesota Oncology Medical Director Dr. Mark Sborov, founded Angel Foundation after working as a patient advocate at Minnesota Oncology, seeing firsthand many of the issues cancer patients face and the heartbreaking decisions many have to make: “Do I buy my medication or do I pay my rent?” “Should I cut my medication in half and hope it works so that I can afford groceries to feed my family?” In 2001, with funds from the doctors of Minnesota Oncology, Angel Foundation was born.

From a passionate team of one, Angel Foundation has grown to a staff of 12 professional employees, a volunteer board of 17 and an impressive overall volunteer force of 400. In 2013 alone, Angel Foundation is poised to provide $1 million in emergency financial assistance.

About Angel Foundation
Angel Foundation provides emergency financial assistance to adults in active treatment for cancer in the seven-county metro area of the Twin Cities to meet critical nonmedical needs, such as mortgage or rent payments, food, utilities and transportation costs. Angel Foundation also offers education and support to families who have a parent with a cancer diagnosis through its Facing Cancer Together program. For more information about Angel Foundation, go to www.mnangel.org or call (612) 627-9000.

SAVE THE DATE
Angel Foundation
Upcoming Event
January 25: Angel Gala at Hilton Minneapolis

From left to right: Tim Toonen, MD, Amy Schorn, CNP, Craig Howe, MD, and Karin Armstrong, MD

From left to right: Matt Graczyk, MD, Ted Bjork, our caddy, P.J. Flynn, MD, and Bryan Flynn
Only XGEVA®

is proven to be better to the bone than zoledronic acid in preventing serious bone problems caused by bone metastases.

Ask your doctor if XGEVA® is right for you to prevent these serious bone problems caused by bone metastases: fractures, spinal cord compression, the need for radiation, or surgery to the bone.

Bone metastases from breast cancer put you at risk for devastating bone problems like painful fractures—and only XGEVA® is proven better than zoledronic acid at helping to prevent these serious bone problems caused by bone metastases. XGEVA® has been researched in 3 large clinical studies.

- In a study of patients with breast cancer, XGEVA® lowered the chance of serious bone problems by 18% more than zoledronic acid.
- In a study of patients with prostate cancer, XGEVA® lowered the chance of serious bone problems by 18% more than zoledronic acid.
- In a study of patients with other solid tumors or multiple myeloma, XGEVA® was no worse than zoledronic acid in lowering the chance of serious bone problems.

ASK YOUR DOCTOR IF XGEVA® IS RIGHT FOR YOU.

XGEVA® is a prescription medicine used to prevent fracture, spinal cord compression, the need for radiation, or surgery to the bone in patients with bone metastases from solid tumors. XGEVA® is not used to prevent these bone complications in patients with multiple myeloma.

IMPORTANT SAFETY INFORMATION

What is the most important information you should know about XGEVA®?

Low calcium levels in your blood (hypocalcemia)

- XGEVA® can significantly lower the calcium levels in your blood. You may experience severe low calcium levels, including symptoms. Your low blood calcium must be treated before you receive XGEVA®. Your doctor may prescribe calcium and vitamin D to help prevent low calcium levels in your blood while you take XGEVA®. Take calcium and vitamin D as your doctor tells you to.

Severe jaw bone problems (osteonecrosis)

- Severe jaw bone problems may happen when you take XGEVA®. Your doctor should examine your mouth before you start and while you are taking XGEVA®. Tell your dentist that you are taking XGEVA®. It is important for you to practice good mouth care during treatment with XGEVA®.

Possible harm to your unborn baby

- You should not become pregnant while taking XGEVA®. Tell your doctor right away if you are pregnant or plan to become pregnant. XGEVA® can harm your unborn baby.

Before taking XGEVA®, tell your doctor if you:

- Have low blood calcium
- Cannot take daily calcium and vitamin D
- Have kidney problems or are on kidney dialysis
- Plan to have dental surgery or teeth removed
- Are pregnant or plan to become pregnant
- Are breastfeeding or plan to breastfeed
- Are taking a medicine called Prolia® (denosumab)

What are the possible side effects of XGEVA®?

- The most common side effects of XGEVA® are tiredness/weakness, low phosphate levels in your blood, and nausea. The most common serious side effect of XGEVA® is shortness of breath.
- Cases of severe low calcium levels, including some deaths, have occurred. These are not all the possible side effects of XGEVA®. For more information, ask your doctor or pharmacist. Call your doctor for medical advice about side effects.

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit www.fda.gov/medwatch, or call 1-800-FDA-1088.

Visit myXGEVA.com for more information.

Please see brief summary of Prescribing Information on the adjacent page.
MINNESOTA ONCOLOGY

XGEVA® (X-gee-va) (denosumab) Injection

This brief summary of the package insert provides information for people who will be receiving Xgeva or their caregivers. This brief summary does not tell you everything about Xgeva. You should discuss any questions you have about treatment with Xgeva with your doctor.

What is the most important information I should know about Xgeva?

Xgeva can cause serious side effects including:

1. Low calcium levels in your blood (hypocalcemia). Xgeva can significantly lower the calcium levels in your blood. You may experience severe low calcium levels, including symptoms. Your low blood calcium must be treated before you receive Xgeva. Call your doctor right away if you have symptoms of low blood calcium such as:
   - Spasms, twitching, cramps, or stiffness in your muscles
   - Numbness or tingling in your fingers, toes, or around your mouth
Your doctor may prescribe calcium and vitamin D to help prevent low calcium levels in your blood while you take Xgeva. Take calcium and vitamin D as your doctor tells you to.

2. Severe jaw bone problems (osteonecrosis).
   - Severe jaw bone problems may happen when you take Xgeva. Your doctor should examine your mouth before you start Xgeva. Your doctor may tell you to see your dentist before you start Xgeva. It is important for you to practice good mouth/dental care during treatment with Xgeva.

3. Possible harm to your unborn baby
   - If you are pregnant, Xgeva can cause harm to your unborn baby. You should not become pregnant while taking Xgeva. Tell your doctor right away if you are pregnant or plan to become pregnant.

Call your doctor right away if you have any of these side effects.

What is Xgeva?

Xgeva is a prescription medicine used to prevent fracture, spinal cord compression, the need for radiation, or surgery to the bone in patients with bone metastases from solid tumors. Xgeva is not used to prevent bone complications in patients with multiple myeloma. It is not known if Xgeva is safe and effective in children.

What should I tell my doctor before taking Xgeva?

Before taking Xgeva, tell your doctor if you:
   - Are taking a medicine called Prolia (denosumab). Prolia contains the same medicine as Xgeva.
   - Have low blood calcium.
   - Cannot take daily calcium and vitamin D.
   - Have kidney problems or are on kidney dialysis.
   - Plan to have dental surgery or teeth removed.
   - Are pregnant or plan to become pregnant. Xgeva may harm your unborn baby. Tell your doctor right away if you become pregnant while taking Xgeva. Pregnancy Surveillance Program: You should not become pregnant while taking Xgeva. If you become pregnant, talk to your doctor about enrolling in Amgen's Pregnancy Surveillance Program or call 1-800-772-6436 (1-800-77-AMGEN). The purpose of this program is to collect information about women who have become pregnant while taking Xgeva.
   - Are breastfeeding or plan to breastfeed. It is not known if Xgeva passes into your breast milk. You and your doctor should decide if you will take Xgeva or breastfeed. You should not do both.

Tell your doctor about all the medicines you take, including prescription and nonprescription drugs, vitamins, and herbal supplements:

Know the medicines you take. Keep a list of medicines with you to show to your doctor or pharmacist when you get a new medicine.

How will I receive Xgeva?

- Xgeva is injected under your skin (subcutaneous).
- You will receive Xgeva 1 time every 4 weeks.
- You should take calcium and vitamin D as your doctor tells you to while you receive Xgeva.
- Take good care of your teeth and gums while you receive Xgeva.
- Brush and floss your teeth regularly.
- Tell your dentist that you are receiving Xgeva before you have dental work.

What are the possible side effects of Xgeva?

Xgeva may cause serious side effects.
   - See "What is the most important information I should know about Xgeva?"

The most common side effects of Xgeva are:
   - Tiredness/weakness
   - Low phosphate levels in your blood
   - Nausea

The most common serious side effect of Xgeva is shortness of breath. Cases of severe low calcium levels, including some deaths, have occurred.

Tell your doctor if you have any side effect that bothers you or that does not go away.

These are not all the possible side effects of Xgeva. For more information, ask your doctor or pharmacist.

Call your doctor for medical advice about side effects. You may report side effects to FDA at 1-800-FDA-1088.

General information about Xgeva

The prescribing information summarizes the most important information about Xgeva. If you would like more information, talk with your doctor.

For more information, go to www.myxgeva.com or call Amgen at 1-800-772-6436.

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AMGEN Oncology
New GYN Oncology Team at St. Paul Cancer Center

Dr. Amy (Jonson) McNally comes to Minnesota Oncology from the University of Minnesota’s Department of Gynecologic Oncology, where she held a variety of academic administrative positions and academic appointments. She received her medical degree from Creighton University School of Medicine, Omaha, Nebraska, and completed a fellowship in gynecologic oncology at the University of Minnesota.

Hieu Cabak, PA-C, assists Dr. McNally with patient care and surgery. She holds a Master of Science degree in physician assistant studies from the University of Nebraska and a Bachelor of Science degree in physician assistant studies from the University of Wisconsin.

Carmen Jacobson, PA-C, Joins Coon Rapids Team
Carmen is a valuable addition to the provider team at Coon Rapids clinic. She holds a Master of Medical Science degree and physician assistant certification from St. Louis University, St. Louis, Missouri.

Meet Colleen Schwab, Our New Director of Marketing
Colleen brings 15 years of marketing and communication experience to her new position. She holds a Bachelor of Arts degree in journalism from the University of Minnesota and a Master of Arts degree in human development from Saint Mary’s University, Minneapolis.

Dr. Michaela Tsai Shares at Breast Cancer Awareness Conference
Dr. Michaela Tsai from our Minneapolis Clinic was a plenary session speaker at this year’s Breast Cancer Awareness Association Conference at the Minneapolis Convention Center on October 12, sharing on the topic “Oncology Updates.” This conference brings together top local and national leaders in breast cancer care and prevention. Highlights of this year’s convention included experts on breast health, interventional nutrition and new technologies in breast cancer.

Dr. Nisha Jacobs Talks About Breast Health on WCCO Radio
Dr. Jacobs was interviewed by WCCO Radio’s Roshini Rajkumar in October for Breast Cancer Awareness Month. Dr. Jacobs, who treats patients at our Coon Rapids clinic, offered expertise on the importance of mammograms, genetic testing, myths about soy intake and more.

Dr. Thomas Flynn Named Chair of Angel Foundation Board
Minnesota Oncology’s Dr. Thomas Flynn was recently appointed as chair of the board for Angel Foundation. Dr. Flynn was one of the physicians who helped found Angel Foundation in 2001, and he has been an active board member and supporter for many years. Most recently, he was vice chair of the board. “We are very excited to have Dr. Flynn as our new board chair,” said Angel Foundation President Mark Wilkening. “His understanding of our mission, vision and values, along with his skills and experience in cancer care, will help propel Angel Foundation into the future.”

Minnesota Oncology Clinics Earn Top State Health Scores
Minnesota Oncology is proud of the care and service that we provide for our patients, and now we have confirmation and external validation of our high quality of care in the form of the recently published Minnesota HealthScores. Out of more than 1,500 medical clinics in the state of Minnesota, five of Minnesota Oncology’s clinics rate in the top 40 in satisfaction with patient experience. In fact, Minnesota Oncology’s Fridley clinic was the highest rated clinic in the Twin Cities overall in patient experience!

Get Social with Minnesota Oncology!
Keep up with the latest news from Minnesota Oncology by connecting with us on social media.

Minnesota Oncology now has a Facebook page, Twitter account and LinkedIn company page to provide links to the latest cancer and hematology-related news and information, notifications about events and classes, and news about our staff, programs and locations. Watch for our YouTube channel as well in the coming months!

Facebook: facebook.com/mnoncology
Twitter: @mnoncology
LinkedIn: linkedin.com/company/3301095
New Plymouth Clinic Opens
Minnesota Oncology opened its 10th clinic location at the new WestHealth medical building (2805 Campus Drive, Suite 105) in Plymouth on November 4. Providers currently seeing patients at this location are Dr. Nicole Hartung, Dr. Dean Gesme, Dr. Uzma Ali, Dr. Burt Schwartz, and certified nurse practitioner Sarah Jax. The Plymouth clinic is managed by Ginna Pearson. Appointments can be made by calling (763) 519-7440.

Minnesota Oncology Partners with National Leaders on Lynch Syndrome Conference
Minnesota Oncology was pleased to partner with several national groups to sponsor the Fifth Annual Living with Lynch Syndrome conference on September 14 at the Marriott Minneapolis Hotel.

With a record-smashing attendance of nearly 200 from around the county and the world, this family-focused event provided ongoing information and support for patients and families with Lynch syndrome — the most common form of hereditary colorectal cancer. Local and international experts presented medical updates, while breakout sessions provided in-depth information on specific topics, including nutrition, coping with uncertainty and family communication. The conference was followed by a reception and dinner organized by leaders of the online communities of Lynchville and Colon Town, and the evening's festivities were wrapped up on a high note by the hilarious local comedian and cancer survivor Brenda Elsagher.

Our thanks to Mayo Clinic, Myriad Genetics, Lynch Syndrome International, Get Your Rear in Gear and the Minnesota Genetic Counselors Association for making this event possible.

Reaching the Community
Community cancer awareness fundraisers have continued throughout the summer and into early fall. Minnesota Oncology was a proud participant and sponsor of several major events: A Breath of Hope Lung Run, MOCA Silent No More, Miles for Melanoma, Dash for Dads (prostate cancer), Purple Ride for Pancreatic Cancer and the Breast Cancer Awareness Association convention.

Clinic staff members were also out in full force representing us at the American Cancer Society Relays For Life in Blaine, White Bear Lake, Burnsville and Stillwater, as well as two community wellness events.

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Our Board-Certified expert physicians are specially trained to treat cancer of the head and neck. We are committed to staying current on ever-evolving advances in technology and treatments.

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