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About the pictures in this edition.
The beautiful women and their families shown in this edition are members of our Young Women’s Breast Cancer Program.

Have you heard? Celebrate Fitness is a 90-minute fitness workshop. This special event will be held on Saturday, March 6, 2010 and all proceeds will benefit our YWBCP. Form your own team or join the YWBCP team. Register today at www.celebrate-fitness.org

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New Genetic Tests Provide Answers for More Women

Jennifer Ivanovich, MS Genetic Counselor
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Many young survivors have had genetic testing. Information gained from this testing is used to plan a woman’s treatment and follow-up. Recent studies have identified a significant portion of mutations that were not identified with the testing that was available for most of the last decade. Additional tools used to perform genetic testing are now available and can detect a greater number of mutations. Young survivors who have had negative genetic testing (no mutation identified) may wish to consider having this updated genetic testing performed as this testing may identify a gene mutation which had previously gone undetected. If you are considering genetic testing you will also want to know this information to ensure complete testing is performed. Sequencing is commonly used to analyze genes for the presence of a mutation. A mutation is an abnormal alteration which disrupts the normal gene function. Sequencing detects many types of mutations but is not designed to identify all mutation types, in particular, large deletions and duplications. Consider this analogy… just as mammography cannot detect all breast cancers nor can sequencing detect all types of mutations. Multiplex ligation-dependent probe amplification (MLPA) is one technique that is used to analyze genes for the presence of large deletions and duplications. Additional approaches to screen for these types of mutations are necessary and these techniques have recently been added to routine genetic testing.

Why should a woman consider additional genetic testing?

Two independent research studies extensively evaluated the BRCA1 and BRCA2 genes among people with a personal and strong family history of breast cancer and who had negative clinical genetic testing (no mutation identified). For all of the people enrolled, gene sequencing was the primary technique used for their prior clinical genetic testing. These two studies found —10% of people studied had a mutation that was detected using techniques other than sequencing. That is, an additional —10% of people had a BRCA1 or BRCA2 gene mutation but were unaware of this information because their original genetic testing did not identify the mutation. These findings are not unique to the BRCA1 and BRCA2 genes. Similar studies of the e-cadherin, p53, and STK11 genes have shown a significant percentage of the mutations are deletions and duplications — mutations not detectable with sequencing.

These studies demonstrate that when clinical genetic testing is offered, multiple techniques must be utilized in order to provide as complete analysis as is possible. It does not matter how a mutation is identified. Individuals with a mutation in any of the genes listed in this article (BRCA1, BRCA2, e-cadherin, p53, STK11) have an increased chance to develop certain types of cancer and may benefit from earlier and more frequent cancer screening.

How do I determine what testing has been performed?

1. Contact your genetic counselor. This healthcare provider can review your testing and coordinate additional testing for you, if indicated.

2. Check your own test results. If you have had e-cadherin, p53, or STK11 gene testing, the reporting styles vary as a number of different laboratories may perform testing for these genes. Speak with your genetic counselor to determine what techniques were used to analyze these genes.

For BRCA1 and BRCA2 gene testing, if the results state one of the following, then analysis for deletion and duplication type mutations has been performed.

- BRCA1 sequencing
- Comprehensive rearrangement
- BRCA2 sequencing
- Comprehensive rearrangement

Or listed in a separate report as

- BRCA1 full gene arrangement
- BRCA2 full gene arrangement

If the report only states the following, then additional analysis for large deletions and duplications has NOT been performed.

- BRCA1 sequencing
- 5-site rearrangement panel
- BRCA2 sequencing

The majority of women who have had clinical genetic testing have not had testing for deletion and duplication mutation types referenced in this article. Evaluation for these types of mutation has only recently been incorporated into routine genetic testing. Some insurance plans do not yet cover this additional analysis, however, the charge for this additional testing is less than the charge for sequencing.

References

Bone physiology

The skeleton is a unique organ because it continually remodels throughout our lives. Every 7 to 8 years we have a brand new skeleton. This remodeling is achieved thanks to the constant and balanced activity of two groups of cells in the bone: the osteoclasts and the osteoblasts. Osteoclasts break down bone cells and osteoblasts direct bone formation by laying new bone matrix. In a premenopausal woman there are about 3 million resorption/formation units at work at any given time. With menopause and its associated rapid decline in estrogen, the bone resorption/formation units double. In the absence of estrogen, the osteoclasts become much more active and the osteoblasts cannot keep up with this increased resorptive activity. The imbalance between the osteoclasts and osteoblasts explains why menopause women start to experience a decline in bone mass. To treat and prevent postmenopausal bone loss, women with osteopenia and osteoporosis have been treated with oral bisphosphonate therapy (Fosamax, Risedronate,ibandronate) or with the intravenous form (Zoledronic Acid). Bisphosphonates work by blocking osteoclastic activity and therefore block bone resorption. However, these drugs cannot be given indefinitely. It is currently not known when a woman should stop taking these drugs so the bones may begin to remodel.

Bone, estrogen and antiestrogen therapy

Breast and bone health are closely linked because both tissues respond to estrogen, but in very different ways. Estrogen is an excellent bone agent that effectively prevents bone loss and reduces the risk of fractures, but can negatively impact breast health and increase the risk of breast cancer. The mainstay of therapy for estrogen-receptor positive breast cancer hinges on antagonizing the effects of estrogen in breast tissue. For decades Tamoxifen has been the gold standard anti-estrogen therapy. In recent years, a new class of drugs, called aromatase inhibitors (Arimidex, Letrozole and Exemestane), are increasingly being used to treat postmenopausal women. This class of drugs has been shown in numerous clinical studies to be superior to Tamoxifen in reducing the risk of breast cancer recurrence without an associated increased risk of uterine cancer and blood clots. Aromatase inhibitors (AIs) work by decreasing estrogen levels by as much as 99% and are associated with an increased risk of bone loss and fractures. A healthy postmenopausal woman is expected to lose 1% of bone mineral density annually, in contrast women treated with an AI have a 2% loss in bone mineral density per year. The effect of AIs on bone loss was established in the Arimidex, Tamoxifen, Alone or In Combination (ATAC) trial in which an incidence of fractures was noted to be higher in the Anastrozole arm compared with the Tamoxifen arm. Other studies using Exemestane and Letrozole have shown similar findings.

Chemotherapy induced ovarian failure and bone health

Managing the bone health in young women diagnosed with breast cancer is critical as many premenopausal women will develop chemotherapy-induced menopause. Cancer therapies can in fact cause ovarian failure leading to bone loss and an increased risk for osteoporosis at a younger age. Ablating agents, particularly cyclophosphamide, can cause changes in the ovaries. Women younger than 30 who receive cyclophosphamide may be at risk to lose their menstrual periods, but 40% of women younger than age 40 experience chemotheraphy-induced amenohreia and 70-90% of women 40 and older will experience ovarian failure. The rapid loss of estrogen production in premenopausal women with chemotherapy-induced menopause, can cause an average 4% decrease in bone mineral density in the lumbar spine within the first six months. For a woman who undergoes ablation in the ovaries, radiation, or chemical ovarian ablation, a loss as high as 13% in the bone mineral density may occur in the first year.

How can we prevent bone loss

A number of studies are now underway assessing the benefit and safety of zoledronic acid in preventing bone loss in women on AI therapy. Zoledronic acid has also been studied in premenopausal women receiving chemotherapy. In a recent study, 101 women were randomly assigned before starting chemotherapy to receive zoledronic acid or placebo (no drug) every 3 months for 1 year. Bone mineral density was measured at the beginning of the study and was repeated at 6 months and 1 year. Women who received zoledronic acid did not experience any bone loss whereas women assigned to placebo experienced an average 4% bone loss at the lumbar spine and 2% bone loss at the hip. Studies using oral bisphosphonates such as Risedronate are also currently on-going. Another medication called Denosumab, which is not yet FDA approved, may be available in the future to treat and prevent cancer therapy-induced bone loss.

Vitamin D and Bone Health

Vitamin D is very important for bone health as it is fundamental for the intestinal absorption of calcium. When our vitamin D stores are low we cannot adequately absorb calcium. To maintain normal blood levels of calcium when vitamin D is low, the body obtains it from our biggest source, the skeleton. In order to mobilize calcium from the bones, osteoclasts degrade bone and release calcium and phosphorus in the blood stream. Chronically low levels of Vitamin D lead to continual degradation of bone, an additional risk factor for bone loss. Moreover, when our vitamin D levels are low the new bone matrix deposited by the osteoblasts cannot be adequately mineralized. Low mineralization of the bone matrix can lead to osteomalacia. Osteomalacia is usually a very painful condition characterized by diffuse bone/joint pains, muscle weakness particularly when climbing steps and profound fatigue.

A recent study showed 74% of premenopausal women diagnosed with breast cancer were found to be vitamin D deficient. Supplementation for these women for an entire year with 400 units of vitamin D and 1000 mg calcium was not sufficient to improve their vitamin D levels. It is important to note African-American women are at higher risk of vitamin D deficiency as the pigment melanin in the skin is a very effective sun screen. A vitamin D level between 40-60 ng/ml is advisable and these levels can be checked by your physician.

Have you heard? Our program website has been updated. Check out our new site and watch for future updates. ywbcp.wustl.edu.
Where do we find Vitamin D?
Our body has the capability of producing vitamin D when our skin is exposed to the sun. Sun screens are a very effective method of blocking vitamin D production by the skin. Of course we are not advocating stopping sun screen use, but reminding the reader of the importance of keeping adequate vitamin D stores.

The major source of dietary vitamin D is found in fatty fish such as salmon, mackerel and sardines, but in order to maintain adequate levels of vitamin D these types of fish would have to be consumed on a daily basis! Consuming this amount of fish is not a feasible way of obtaining vitamin D, especially considering our Midwestern diet. Vitamin D enriched milk cannot be considered a reliable source of this vitamin either as the less fat in milk the less vitamin D. There is a bit of vitamin D in egg yolk and mushrooms, but otherwise limited quantities are found in food. Given the limited amount of vitamin D in foods and the need to continue to use sunscreen, supplementation becomes the most reliable way of maintaining normal levels of vitamin D.

What can we do to maintain strong and healthy bones
When a woman is diagnosed with breast cancer, a baseline bone mineral density should be obtained along with a 25-OH vitamin D level prior to starting chemotherapy. If low mineral bone density is identified a work-up for secondary causes of bone loss may be needed. If Vitamin D levels are low at time of diagnosis then supplementation will be recommended. If the level is in the deficient-insufficient range (Vitamin D below 30 ng/ml) I usually recommend prescription strength vitamin D supplementation in the form of Ergocalciferol (vitamin D2), 50,000 units once a week for approximately 12 consecutive weeks followed by daily over the counter vitamin D, 1000 units daily. All women with breast cancer should have their total calcium intake of 1200-1500 mg daily either by dietary intake or by supplementation.

Addressing bone loss in young women diagnosed with breast cancer is an important aspect of a woman’s total cancer care and there are many positive steps young survivors can take to keep their bones healthy.

References

as compared to their sedentary counterparts. Any type of exercise is important to maintain muscle strength, improve balance, and prevent falls, and women are encouraged to exercise 30-60 minutes at least four-five times per week.

October 13, 2009 marked the first National Metastatic Breast Cancer Awareness Day. In the U.S., approximately 60% of newly diagnosed women will present with metastatic breast cancer or breast cancer that has spread to distant parts of the body at time of diagnosis, meaning that of the 192,000 diagnosed each year, 11,000 will have metastatic disease. Many other women will develop metastatic disease some time after their initial diagnosis. During a pink October, this day to recognize the unique needs of women with metastatic disease calls attention to the issues these women face. Susan Davies of the MBCN (Metastatic Breast Cancer Network) commented, “We are hoping that it (this day) will be a huge help in guiding recognition of what we need to do to live longer and live better” (www.bcmets.org).

Women who have been told they have metastatic disease must decide what this news means to them as individuals. Thank about metastatic cancer as a chronic illness. There are many examples of chronic illness – diabetes, asthma, hypertension – the unifying characteristic is that they are not curable. These diseases can be deadly and require active management and medical oversight. Metastatic cancer fits the chronic disease model quite well. It will mean chronic medical treatment, regular medical follow-up, and vigilance on the part of the woman with the diagnosis.

Now What?

When chronic diseases become deadly, they rarely do so quickly. There is usually forewarning – scans indicating progression, changes in the treatment regimen, and conversations with the medical team about ineffectiveness of treatment. Although it may be hard to avoid thinking about death, it’s worth trying to do so as this kind of worry makes it hard to focus on living. If treatments start to fail, there will be time for women to focus on end of life concerns then, when it is relevant and more useful.

So, what does it mean to “live your life”?
The answer depends somewhat on what life was like before the diagnosis of metastatic cancer. Thank over what was going on before and choose which of these activities you want to continue. What is most important? Maybe a metastatic diagnosis will give the incentive to follow through on some of those delayed wishes.

It is very easy for cancer to take over your life, particularly in the face of metastatic disease and chronic treatment. It’s important to maintain a life beyond cancer. Be sure to continue to participate in pleasurable activities and make fun a priority. Quality of life is an important entity and is usually associated with a life that involves more than medical appointments and treatments. Continue those activities that bring joy or give your life meaning or purpose.

We at YWBCP have been fortunate that young women who have metastatic disease have willingly shared their experiences. Through our monthly newsletters, previous editions of YWBCP magazine (PDFs available on our website, ywbcp.wustl.edu), and the annual YWBCP conference survivor panel, these young survivors provide honest encouragement and hope. As Deb Bollman, a young survivor who recently participated on a YWBCP survivor presentation panel, states, “My doctor and another doctor at a metastatic conference I attended look at oncology as an art, due to the un-scripted path that cancer takes. We continue to dabble in different forms of treatment as the cancer takes its path. In the meantime, I feel well and continue to enjoy life, with some bumps along the way.”
In July 2009, Dr. Peter Fong and his colleagues reported the results of their phase 1 clinical trial to evaluate a promising new approach to treating cancers (New England Journal of Medicine;2009;361:123-134). They evaluated a new drug, olaparib, a potent PARP inhibitor in people with metastatic cancer, with a focus on individuals who had an inherited BRCA1 or BRCA2 gene mutation. The knowledge gained from this study brings us closer to tailored cancer treatment for people with an underlying mutation in specific genes or individuals whose tumors have acquired specific gene defects.

First, a little background information...

Our DNA, or genetic material, is subject to continuous disruption resulting in errors in the genetic code. These errors naturally occur as cells divide and may result from an outside stimulus, such as radiation. Fortunately, there are several highly effective repair mechanisms or systems which serve to correct DNA damage as it happens. Each of these mechanisms targets a specific type of error in the genetic code.

Poly(adenosine diphosphate (ADP)-ribose) polymerases, or PARPs, are a group of enzymes that function to correct single-strand DNA breaks. Single strand DNA breaks are only one of the several classes of errors in our genetic make-up that contribute to tumor development.

Double-strand DNA breaks represent a different type of abnormality and are corrected using a different DNA repair system. Although their names make reference to breast cancer, the BRCA1 and BRCA2 genes function to repair double-strand DNA breaks/damage.

Every person has two copies of the BRCA1 gene and the BRCA2 gene, one inherited from her Mother and the other from her Father. For a person with an inherited BRCA1 or BRCA2 gene mutation, 1 of the 2 copies does not function properly in every cell. In order for a person with an inherited mutation to develop a cancer, it is believed the 2nd copy of the gene must acquire a mutation in a single cell, leaving the cell with no BRCA DNA repair activity. In essence, a person inherits a mutation in one copy of the gene but both copies of the gene must be rendered non-functioning in a given cell in order for a cancer to develop. Since normal cells have at least one functioning copy of the BRCA1 or 2 gene, it follows that drugs could be developed that would only target cancer cells in which both copies of the gene are nonfunctional.

Dr. Fong and his colleagues hypothesized if the mechanism responsible for single-strand DNA repair was inhibited in a tumor in which the double-strand DNA repair mechanism was already lost, then the cancer cells would die. This is in part because a drug to increase single strand breaks would lead to more double strand breaks that the tumors cells are unable to repair. Stated another way, if we give a drug that hinders PARPs from functioning properly in a tumor in which BRCA1 or BRCA2 has already stopped working, then the cancer cells would stop growing. Furthermore, if this hypothesis were to be correct, normal tissue would not be damaged by a drug used to inhibit PARP functioning as the drug is specifically targeting BRCA1 or BRCA2-derived cancer cells.

The drug olaparib, also known as AZD2281, had previously been shown in laboratory studies to inhibit or stop PARPs from functioning properly. Olaparib was shown to reduce PARPs from correcting specific types of DNA errors. With these data, a phase 1 clinical trial was initiated. The primary goal of a phase 1 is to identify if the drug can be safely administered with minimal side effects or toxicities.

The phase 1 trial...

60 people, all of whom had advanced cancer and who had previously undergone standardized therapies for their cancers, were enrolled in the study.

There were three important findings from this phase 1 trial.

1. There was minimal drug toxicity or side effects with the use of oral olaparib.
2. There was a significant decrease in PARP activity. That is, the drug performed its intended function, inhibiting PARP functioning. And,
3. The drug demonstrated antitumor properties only in people with an inherited BRCA1 or BRCA2 gene mutation. For the purpose of a clinical trial, antitumor refers to any agent that counteracts or prevents a cancer from developing or progressing.

The primary goal of a phase 1 trial is to examine drug safety, not to evaluate clinical response. However, critical preliminary data regarding the treatment response were found. 23 of the 60 people enrolled were known to have a gene mutation and among those 19 were followed throughout the study period. 12 of the 19 people (63%) showed a clinical benefit to the treatment. For example, one woman with a BRCA2 related breast cancer, who had previously been treated for pulmonary and lymph node metastases, showed a complete remission lasting for more than 60 weeks. Another woman showed regression of brain and skin metastases. One man with a BRCA2 advanced prostate cancer was found to have resolution of his bone metastases.

These results were so promising additional phase 2 and phase 3 clinical trials are now underway. This study provides exciting preliminary data regarding the use of drugs that inhibit PARP function in the treatment of people with cancer who have an inherited BRCA1 or BRCA2 gene mutation.

This study is an important step in developing therapies which target specific inherited gene mutations that lead to the development of cancer. Importantly, some cancers arise in people who do not carry a BRCA1 or BRCA2 mutation, but somehow these genes are completely shut off in the tumor. Like individuals with inherited BRCA mutations, people who have lost BRCA1 or BRCA2 function in their tumors could benefit from PARP inhibitor therapy.

Clinical trials with a much greater number of people are needed to demonstrate the treatment benefit of Olaparib therapy. Furthermore, scientists will continue to investigate the reasons why not every person with a gene mutation responded to the therapy.

To learn more about clinical trials and find specific clinical trials in your area, search the NIH sponsored website www.clinicaltrials.gov.

Reference


Have you heard? We sponsor an annual educational and networking symposium for young women with breast cancer and young survivors. Keep an eye on our website for new details. ywbcp.wustl.edu
Mentoring—Offering Meaningful Support

Jennifer Staed, MAT
Co-Director, YWBCP

The phone rings. It is your neighbor asking you to call a friend of hers who just learned that she has breast cancer. You have never met this woman, but you instantly feel a connection, remembering what that time was like for you. You tell your neighbor yes, write down this woman’s name and phone number, and hang up.

What happens next? Maybe you have been in this position, or maybe someone who you didn’t know reached out to you when you were first diagnosed. Reaching out to offer encouragement, support, or acknowledgement is a way that many survivors feel that we can “give back.” But how can we “give back” without reliving the trauma of our own experiences?

This topic is one that we discuss often at YWBCP. The Peer Network Program allows a young survivor to share her experience and knowledge to support another young woman. Through the Peer Network Program, survivors who are interested in being mentors gather to discuss methods for mentoring that keep everyone’s best interests in mind—whether the contact is one phone call to a neighbor’s friend or an ongoing mentorship that lasts a few months.

Here are a few additional questions to consider before reaching out and making that phone call. Remember your role.

- You are a woman who was diagnosed with breast cancer who is being asked to help someone else. You are NOT expected to know all of the answers. You are NOT expected to provide medical, legal, or religious counsel.
- Think about your cancer experience. Will talking about the maelstrom of emotions that a new diagnosis brings be unduly upsetting to you? What was your cancer experience like, and what about your experience will be helpful to the woman you will contact?
- What areas of your experience are you willing to talk about? How much of your personal story do you want to share? Realize that this woman may know you, your family, or your friends. Think about confidentiality.

Consider the shape you want this mentorship to take.

- Do you wish to limit this contact to a single phone call? Would you be interested in speaking every few weeks? Every week?
- What methods of communication are you comfortable with? What are your boundaries in terms of frequency, timing, and forms of communication? Being clear about these expectations will put you both at ease.

As survivors our phones will ring with members of the community seeking the wisdom that comes from a cancer experience—let’s be ready to give back.

If you are interested in learning more about mentoring or would like to be matched with a young survivor mentor, please contact Jennifer Staed or Jen Ivanovich at ywbcp.wustl.edu.

Consider how you want to handle confidentiality.

- Within a pairing that is facilitated by YWBCP’s Peer Mentoring Program, both parties will sign a reciprocal confidentiality agreement that promotes trust and allows for open sharing.
- For a pairing that is facilitated by a neighbor or mutual friend, you will want to discuss your confidentiality expectations. Discussing confidentiality will make it clear to her that you intend to keep her information to yourself unless you are overly concerned about her well-being. It will reinforce to her that you expect the same from her.

Thinking about this in advance will save you from tough moments, maybe when your neighbor calls you back and asks, “How is my friend doing?” You have your confidentiality words at the ready!“Giving back” by reaching out provides survivors the opportunity to use our experiences to help women who are newly diagnosed to cope with the effects of a cancer diagnosis. We know the power of talking to someone who understands the unique experiences of being young and having breast cancer.

Have you heard? Our Young Women’s Peer Network pairs a young woman who is newly diagnosed with a young survivor in a supportive one-on-one setting. Contact the program directors if you wish to be paired with a young survivor or if you wish to serve as a peer advisor.
And in the end, I have survived this amazing journey. My head is clearer, and my life has begun to become more focused on living in the moment. And I am stronger.

Diagnosed at age 38 with stage II B invasive ductal carcinoma, I was shocked. As the doctor spoke the words “you have cancer”, the only thing I could think was “Am I going to die?” I had only known one other young person who had ever had any type of cancer. I couldn’t have cancer…it didn’t happen to younger people. And it certainly didn’t happen to me.

But through two surgeries, chemo and radiation, I have come out on the other side of this process with a new sense of personal strength. It was not an easy journey but it was one filled with opportunity to re-evaluate life, love, friendships, and priorities. This life altering event offers many blessings if you chose to see them. Most significantly, I found that unlike many others who go through life without ever facing a life threatening illness, those who do are very intimately reminded of just how fragile life really is. And this awakening gives us an opportunity to begin cherishing this gift called life that so many people take for granted.

And in the end, I have survived this amazing journey. My head is clearer, and my life has begun to become more focused on living in the moment. And I am stronger.

But just as my own cancer came as a shock, my family was again faced with yet an even bigger challenge to our faith and to our strength. Benjamin, my precious youngest son (age 11), was diagnosed with Ewing’s Sarcoma, a bone and soft tissue cancer. And here we were, just two years and 4 days from when I first began my battle against cancer, with my baby beginning his.

As things began to unfold with my son – the all too familiar biopsies, scans, tests and multiple doctor’s visits – I knew that we were headed toward a diagnosis of cancer. But no mother is ever really prepared to hear those words. Suddenly, my own diagnoses seemed so minimal, a scraped knee in comparison to the battle my son was about to face. As one would expect, it took weeks to wrap my head around what was happening to my son and why. I spent endless nights in bed crying after he was asleep. I felt an overwhelming amount of pain and sadness, knowing first hand the journey he was about to embark on.

But, perhaps because of my own diagnosis, my own survival of this horrible thing we call cancer, I was also able to see that those words are not void of hope, without promise of a future. They are a challenge, a mountain we must climb, a detour in life. And because of my own experience, I felt that in some ways I was better prepared to take this journey with my son…an honest and intimate understanding of what he was facing – the sickness, the fatigue, the hair loss, the anger, and the ability to find humor and strength in the most darkest of moments.

I am a survivor, and Ben is too. He is now cancer free. The struggles we have faced have brought many blessings, an unbreakable bond, and a renewed faith in God. Both Ben and I have used our sense of humor, strength and faith to show others that they too can survive. You have a choice when you are in the face of adversity…to succumb to life’s challenges or to triumph over them. There is a survivor in all of us, whether it be to beat cancer or any other challenge life brings to us. The gift is the inner strength we find to overcome.

And here we were, just two years and 4 days from when I first began my battle against cancer, with my baby beginning his.”
Our survivor story continues...

My Story
Ben Walters
12 years of age

What did you think when your mom told you she had cancer?
I felt like “oh great…” I was sad. I worried that she would not survive and stuff.

What did you think while she was going through treatment?
I was thinking that it must have been really hard.

What made you feel that way?
I just had a weird feeling.

How has it been going through treatment?
It has its ups and downs.

Did it help that your mom had went through treatment/cancer too?
Nope.

What kinds of things are the hardest for you with treatment?
The stomach issues and constipation.

Are there any good things?
Getting to meet all the baseball and hockey players and stuff.

What have you been doing about school this year?
I have had to stay home but after hours I go up to school and work with the librarian.

Are you different now that you have had cancer?
I was not going to die. I knew I was going to survive.

The stomach aches.

In what ways?
In just knowing to stick with it.

Do you think that having had cancer will make a difference in what you do in your life?
I got stronger.

What would you tell other people who have just found out they have cancer?
They have cancer.

Are there anything they can do to make it easier?
By taking stuff to entertain them (during treatment) like the ipod touch or a computer.

Are you different now that you have had cancer?
I got stronger.

What would you tell other people who have just found out they have cancer?
I got stronger.

Are there any good things?
Getting to meet all the baseball and hockey players and stuff.

What have you been doing about school this year?
I have had to stay home but after hours I go up to school and work with the librarian.

Do you like doing that?
It is okay.

Do you miss your friends?
Heck ya!

How do you stay in touch with them?
I got a cell phone and I text them a lot.

What made you feel that way?
I felt like “oh great…” I was sad. I worried that she would not survive and stuff.

What did you think when you found out you had cancer?
I was thinking that it must have been really hard.

What did you think when your mom told you she had cancer?
I felt like “oh great…” I was sad. I worried that she would not survive and stuff.

What did you think when your mom told you she had cancer?
I felt like “oh great…” I was sad. I worried that she would not survive and stuff.

What would you tell other people who have just found out they have cancer?
I got stronger.

Are there any good things?
Getting to meet all the baseball and hockey players and stuff.

What have you been doing about school this year?
I have had to stay home but after hours I go up to school and work with the librarian.

Do you like doing that?
It is okay.