

Lung Cancer Voice

Fall 2007

Staging of NSCLC: New guidelines to take effect by early 2009

The 12th World Conference on Lung Cancer was held from September 2-5 in Seoul, Korea. The biggest news coming from the conference, sponsored by the International Association for the Study of Lung Cancer (IASLC), was the announcement of an updated staging system for lung cancer.

What is staging and why is it so important?

Staging is a way of describing cancer tumors and whether or not they have spread to other parts of the body. There are several reasons why accurately staging someone's cancer is important. First, it provides a common language for doctors to use in describing a patient's cancer. Most lung cancer patients are examined and treated by at least two doctors, including medical and radiation oncologists, thoracic surgeons, or pulmonologists. When one doctor tells another doctor that the patient has a particular stage of disease, the second doctor has an immediate sense of what the tumor looks like and how far it has spread. Second, staging is crucial for evaluating new therapies; researchers must have a common "language" to compare treatment trials done on individuals in different locations with different levels of disease. Third, staging provides important information regarding prognosis. Finally, doctors use staging to help determine which types of treatments to use on which patients.

The current lung cancer staging system was developed over a decade ago, and is based on a very small number of patients – only about 5,000 – who were all treated in North America, mostly at a single location in the US. The updated staging system is remarkable for just how much data was collected to form the basis of the new guidelines. Over 100,000 patients' tissues and medical charts were examined from all around the globe. As a result, this new staging system should be a better guide for determining treatments and prognosis for lung cancer patients.

How is the updated staging system different?

Lung cancer staging is based on the size and location of a tumor (T), the number and location of lymph nodes (N) found to contain cancerous cells (if any), and whether the cancer is present elsewhere in the body. The process of cancer traveling to other areas of the body beyond the original tumor (such as the liver, brain, bone, or adrenal glands) is called metastasis (M).

The proposed update to the lung cancer staging system changes the definitions of "T" subsets, which describe the tumor's size and location, and re-defines "M", which describes metastasis. IASLC needs to collect more data before re-defining the "N" class, which describes lymph node involvement.

Why is all this re-classification so important?

With the refinements in the "T" and "M" classifications have come refinements in the overall staging of the individual. For example, in the current system, if a patient has tumors in a different lobe of the same lung where the primary tumor is found, the patient is considered to have metastatic, or stage IV disease. Stage IV patients are not usually offered surgery because surgery is not thought to be able to help since the tumor has already spread to other parts of their bodies. With the updated staging system, if the only sign of metastasis is in a different lobe of the same lung, IASLC recommends classifying people as having stage IIIA or IIIB disease, depending on the amount and location of lymph node involvement. Patients with stage IIIA or IIIB disease have a better prognosis than patients with stage IV disease, and some of these patients may be surgical candidates.

While the updated staging system will reclassify many patients into lower stages, there are some patients who will be classified at a more serious stage. For example, patients with pleural effusion (a fluid build-up between the lungs and the chest wall) are currently staged at IIIB; they will be staged at IV under the updated guidelines.

But, wait...

The updated staging system cannot be used until it is adopted internationally by the Union Internationale Contre le Cancer (UICC) and the American Joint Committee on Cancer (AJCC), which won't be completed until early 2009. It is absolutely imperative that doctors don't start actually staging patients based on the updated recommendations until they are adopted by the UICC and AJCC governing bodies, as it would affect the results of research studies the world over. As noted previously, staging across studies must be consistent in order for the studies to be able to be compared to one another.

Even though the updated *staging* system cannot be used until early 2009, doctors can and will

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Joan H. Schiller, MD

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begin *treating* patients based on the updated staging system before it is fully adopted. As a result, survival statistics for lung cancer treated from now until the updated guidelines are adopted will likely be somewhat different than from previous years.

The fact that the new staging guidelines won't be adopted until 2009 but that doctors will begin treating their patients according to the updated guidelines will be a complex situation, but one that ultimately should benefit patients greatly by ensuring the right treatments are chosen for the right individuals.



Joan Schiller with Hayley McDaid, winner of the 2005 Career Development Award, and Christoph Plass, winner of the 2005 Research Grant. Dr. McDaid and Dr. Plass presented their research findings at the Annual Meeting. For a summary of our Annual Meeting, please see page 3

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Letter from the President



Joan H. Schiller, MD

Once again we celebrate Lung Cancer Awareness Month, a time when lung cancer often gets more attention in the press and from the public. It is also a time to reflect upon the challenges to raising awareness of lung cancer. One of the greatest

challenges facing lung cancer patients and advocates is the stigma associated with the disease. Lung Cancer Awareness Month is an opportune time to talk about the disease and to begin to reverse the stigma.

Decades ago, breast cancer wasn't talked about – it was considered “impolite” for conversation. But Betty Ford went public with her battle against the disease, and now everyone knows the pink ribbon is for breast cancer, and people proudly speak of being survivors. HIV/AIDS was also greatly stigmatized when the outbreak began, due to the group of people it appeared to be affecting in this country. With the realization that the disease was quickly reaching pandemic proportions, and that it is an “equal-opportunity” infection, came increased awareness and an impressive commitment of cross-governmental resources. Like HIV/AIDS, lung cancer is also an “equal-opportunity” disease. But because of the smoking link, many people view this disease as “self-inflicted”. Indeed, most cases of lung cancer are linked to smoking. However, 50% of the people in this country who get the disease have quit smoking, and an additional 10-15% (approximately 20-30,000 people each year) have never smoked at all.

This stigma can take its toll on individual patients themselves, who may practice self-blame, and with friends and family who may blame their loved one or be ashamed to ask for support due to a perception that others will not have sympathy. The stigma even affects some practicing physicians. This is particularly troubling, and so my colleagues and I decided to try to quantify how physicians' perception – whether conscious or not – of lung cancer as a self-induced disease affects the treatment patients receive.

We performed a survey of primary care physicians in the state of Wisconsin to gauge their likeliness to refer an individual for further treatment based on whether they had breast or lung cancer, and whether they had a smoking history or not. For hypothetical patients with early stage disease, primary care physicians were equally likely to refer patients with breast or lung cancer to an oncologist for possible further treatment after surgery. However, when cases were presented as having advanced (metastatic)

disease, physicians were somewhat less likely to refer lung cancer patients to oncologists than they were to refer breast cancer patients. Furthermore, when primary care physicians indicated that they would refer metastatic patients to an oncologist, they were more likely to refer breast cancer patients for treatment, while they were more likely to refer lung cancer patients for palliative care and symptom management only. These findings indicate that primary care physicians are aware of advanced breast cancer treatments, but less so for lung cancer. Clearly, primary care physicians need more education about lung cancer treatment options.

Another aspect of the survey looked at pain control. Most primary care physicians were interested in following their patients with cancer closely for control of their pain, but they were more likely to do so if the patient had breast cancer than if they had lung cancer. It was not clear why pain-management would be so affected by disease type, but it does indicate that lung cancer patients, especially, need to be proactive in requesting pain management.

When we talk about the stigma of lung cancer, we need to recognize that it not only can impact the psychosocial aspects of the patient's disease, but also their treatment options. Raising lung cancer awareness will help to dispel the stigma surrounding this disease, and as our study shows, should improve access to therapy for patients. So join us at one of our *Free to Breathe™* events, sign our petition calling on the federal government to increase funds for lung cancer research, or make a personal contribution. All of these activities help raise lung cancer awareness and much needed funds for research.

Sincerely,

Joan H. Schiller, M.D.
Chief, Division of Hematology and Oncology
Deputy Director, Simmons Comprehensive Cancer Center

Andrea L. Simmons Distinguished Chair in Cancer Research
University of Texas Southwestern Medical Center



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Advancing Lung Cancer Research

The National Lung Cancer Partnership Annual Meeting 2007

The Partnership's Annual Meeting, "Controversies in Lung Cancer Screening, Therapy and Advocacy", was held on June 1 in Chicago, just prior to the start of the Annual Society of Clinical Oncology (ASCO) Annual Meeting.



Heather Wakelee with Carolyn Dresler

Dr. Carolyn Dresler, a member of the Partnership's Board of Directors, Chair of the Partnership's new Mentoring Committee, and at the Faye Boozman School of Public Health at the University of Arkansas, discussed the changing use of tobacco throughout the world. With tobacco use decreasing in the US, Canada, and other countries that have adopted significant tobacco control initiatives, the tobacco industry is looking to Eastern Europe, Asia and Africa as their "emerging" markets. Sadly, these countries will also bear the brunt of the lung cancer epidemic as tobacco use increases. Dr. Dresler talked about the need for effective tobacco control measures to decrease lung cancer rates. She cited California as a particularly effective example.

In California, tobacco control measures began in earnest over twenty years ago. These measures included an increase in cigarette taxes and using that tax increase to fund aggressive advertising – primarily directed at youth – to prevent tobacco use. Tobacco cessation programs are also supported by California's cigarette taxes. The totality of this approach has yielded significant decreases in tobacco use, and consequently, lung cancer rates have decreased.

Screening: A lively discussion

Dr. Denise Aberle and Dr. Claudia Henschke presented their perspectives of two major lung cancer screening trials – the National Lung Screening Trial (NLST), and the International Early Lung Cancer Action Project (I-ELCAP).

Dr. Denise Aberle, of UCLA, described the National Lung Screening Trial (NLST), a randomized, controlled clinical trial (considered the "gold standard" in research) comparing the use of annual low-dose helical CT scans to the use of chest x-rays for the detection of lung cancer. The ultimate goal of the study is to understand whether CT screening or chest x-rays can decrease deaths (mortality) due to lung cancer.

The NLST has enrolled over 52,000 people, and is expected to begin generating data by 2009. The NLST is also designed to answer other important questions, such as: what

stage of disease people are diagnosed with during the course of the trial; how many and what medical resources are used by individuals who are found to have questionable lesions by one of the screening modalities; and the effects of screening on smoking behaviors. Also, a subset of participants has had blood, urine, and sputum specimens collected, and tumor tissue removed from participants during the trial is placed in a specimen bank. These specimens will enable future research on biological markers that might help detect early lung cancer.

Critics of the NLST contend that the study design is flawed, as only three years of screening will be funded in the trial, and many believe that will not be enough time to determine whether or not CT screening impacts mortality. Dr. Aberle stated that the study is large enough to determine if there is a 20% or greater drop in lung cancer deaths from CT screening compared to chest x-rays. She added that the benefit of screening for additional years has been considered—the added costs would be substantial and additional screening years would only minimally increase any potential mortality benefit.

Dr. Claudia Henschke, of Weill Medical College at Cornell University, heads the International Early Lung Cancer Action Project (I-ELCAP). She shared her data (published in the *New England Journal of Medicine* [NEJM] in October 2006) showing that CT screening increases survival from lung cancer, and addressed some of the criticisms of the I-ELCAP study.

Critics of I-ELCAP argue that, without a randomized control group that is not screened with CT, one cannot infer from the I-ELCAP data whether CT screening for lung cancer can actually save lives. Dr. Henschke asserted that a control group is necessary at the time of treatment, as opposed to at diagnosis. During the course of her study, eight individuals with stage I disease did not receive treatment; these individuals all died of lung cancer within five years of their diagnosis. Since the estimated 10-year survival rate for individuals treated for stage I lung cancer detected during I-ELCAP was 88%, and 92% if their cancer was surgically removed within one month of diagnosis, Dr. Henschke stated that these results show that screening with an associated treatment intervention for early-stage lung cancer can save lives. For a full discussion of the arguments surrounding the I-ELCAP data, see the letters to the editor in NEJM, Vol. 356, issue 7, pages 743-747.

Advocacy breakout: learning from the experienced

The advocacy breakout session centered on learning from two movements that have been successful in raising awareness and funding for research: HIV/AIDS and breast cancer.

B.J. Stiles, one of the founders of the National Leadership Coalition on AIDS, discussed the history of the disease. He also talked about the early and most effective advocates who were juggling the complex challenges of stigma and discrimination, as well as pain, suffering and fear. The advocates helped stimulate wider public awareness and increased demand for positive changes, both in public policy and private sector support. Some advocates utilized unconventional tactics to lend urgency to the

need for quicker action, especially from federal officials, to stymie the rapid increase in early deaths and undertake meaningful prevention efforts.

Mr. Stiles accentuated the effectiveness of having a unique blend of pioneering leaders from diverse sectors to spearhead efforts to jump-start scientific research, medical treatments, and community-based programs to decrease suffering and discrimination. The most critical factor was the inclusion of persons suffering with HIV/AIDS who played significant roles in shaping policy, stimulating support, and who served as spokespersons for the epidemic.

Carolina Hineostroza of the National Breast Cancer Coalition (NBCC) described how her organization, taking inspiration from the HIV/AIDS movement, went on to develop a highly successful grassroots movement of trained breast cancer advocates. NBCC has been instrumental in getting the Department of Defense to re-apportion dollars to breast cancer research since 1992, and they do this from a position of knowledge of how much is needed, while facilitating consumer involvement at all levels of decision-making to ensure transparency and accountability. Ms. Hineostroza stressed that this was not a short-term fight, and that everyone can be involved in advocacy on one level or another.



Denise Aberle with a group of advocates

Scientific breakout

The presentations that made up the scientific breakout session will be reviewed in detail in an article to be published in the *Journal of Thoracic Oncology*. We will announce the publication of the review article as soon as it is available.

In a conscious effort to save resources, we try to send only one newsletter to each household. If you receive more than one copy, if your address has changed, or if you wish to stop receiving *Lung Cancer Voice*, please email us at Info@NationalLungCancerPartnership.org or call us at 608-233-7905.

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Stories of Strength



Dan Waeger with Lance Armstrong

A Survivor's Story

Dan Waeger was diagnosed with cancer at age 22 while attending graduate

school. He had developed a persistent cough and was experiencing shortness of breath, even at rest. He was in the midst of taking final exams and training for a marathon when he was diagnosed. Now 24 years old, Dan is the Manager of Development at the National Coalition for Cancer Survivorship (NCCS), and in his "spare" time, runs the National Collegiate Cancer Foundation to provide services and support for college students diagnosed with cancer.

Q: What stage of lung cancer were you diagnosed with and how are you doing now?

A: When I was first admitted to the hospital in May of 2005, I had surgery to remove 1.5 liters of fluid that had accumulated around my heart. I was initially diagnosed with stage IV cancer of unknown primary. A year later, my diagnosis changed to stage IV NSCLC – adenocarcinoma. Now, I am doing great. After going through a lot of treatments, we've found one that works and I have been feeling unbelievable! My cancer has almost completely disappeared. One lung is completely cancer free and the other has tiny little nodules so small that it might not even be cancer.

Q: Do you talk about having lung cancer openly with others? What is the reaction you get when you talk about having lung cancer?

A: I am very open with others about my situation, about lung cancer, and about cancer in general. People's first reaction is shock, disbelief, followed by the usual phrase – "I'm so sorry." I talk about cancer to educate others, to educate my friends, to create awareness of an issue that has such a bad stigma, and to create awareness about cancer in general.

Q: What keeps you hopeful about lung cancer research and/or treatment?

A: Many things keep me hopeful: hearing a survivor's success story on a clinical trial or a particular drug therapy; having the Lance Armstrong Foundation put cancer on the political map with a presidential forum just on cancer; hearing how progress is being made with new therapies; and working with NCCS and seeing how advocates can change the way our nation looks at cancer care. (Editors' note: Please see page 6 for more information on the presidential forum.)

Q: What is the biggest issue associated with lung cancer diagnosis, treatment, and/or research you wish you could change?

A: I've never smoked. My family has never smoked. But I don't care that I am associated with a group of smokers because there's no such thing as "non-smoker's" lung cancer. Lung cancer is still lung cancer. I want to change the stigma so our Congressmen, government, and those who can put money into research, detection, and new therapies can understand that the dismal survival statistics are the same for any lung cancer case – regardless of smoking history. New therapies and promising research provide lung cancer patients with a sense of hope. Hope is all we have. The lack of research funding doesn't just cut our chances for survival but crushes our spirit as well.

Q: What advice would you give to others recently diagnosed with lung cancer?

A: It's not a death sentence, and to remember there is somebody like you with the same symptoms, same markings, same diagnosis, and they are beating it somewhere, somehow, and you can too.

Q: What advice would you give to physicians and health care providers in dealing with patients with lung cancer?

A: I would advise physicians to not write off a lung cancer diagnosis any more than another cancer diagnosis. The mean is not the message and even though the average life expectancy might be dismal, your attitude will be reflected towards your patients.

Q: What is the most important thing you believe the general public needs to know about lung cancer and how it affects you?

A: Lung cancer kills more people than breast, colon, and prostate cancers combined. We need more funding!! Lung cancer patients deserve to not just have equal funding as the other major cancer killers, but deserve an equal amount of hope from day one as well. A hope that encompasses the feeling that we will be around for our family and friends, to see our kids or grandkids grow up, or to even start a family and have kids in the first place.

Do you have a Story of Strength you would like to share? Do you want to read more Stories of Strength? To read more stories about lung cancer survivors and submit your own, visit the Patients & Friends section of our website, www.NationalLungCancerPartnership.org.



Kelly Young, RN, MSN, ANP-C, AOCN

An Oncology Nurse's Perspective

Kelly Young is an oncology nurse at Duke University Medical Center. When she is not working with her patients, she is often busy fulfilling her roles on the Partnership's Board of Directors and the Development and Outreach Committee.

Q: What inspired you to enter lung cancer treatment?

A: I had a great role model in Dr. Jennifer Garst. By chance, I began working in the hospital with Dr. Garst. Her enthusiasm, passion for clinical work and desire to support lung cancer patients through diagnosis and treatment inspired me. I transferred to her clinic where I quickly fell in love with this patient population.

Q: What advances in lung cancer research have made you hopeful as an oncology nurse?

A: Advances in targeted therapy have made me hopeful. It has been wonderful to offer patients new options for care. With targeted therapy, some patients are surviving much longer than they would have otherwise, with an excellent quality of life. I hope that other targeted

therapies will soon show effectiveness against lung cancer so we can help more patients live with this disease.

Q: What would you like young professionals entering into lung cancer research/treatment to know about this field?

A: Lung cancer can be treated and, in some cases, even cured. While it isn't a field that currently has a high survival rate, it is a field where there is much to discover and learn. With each new piece of research and treatment, we are constantly getting closer to helping patients live longer and better.

Q: What do you see as the greatest strength of the Partnership?

A: The greatest strength of the Partnership is its focus on research and the determination to find a cure for lung cancer. By offering research grants and having plans to keep growing the research grant program, the Partnership is at the forefront of organizations funding lung cancer research.

Q: What role do you see the Partnership playing in the future of oncology and oncology nursing?

A: I hope that the Partnership will fund the researcher who will unlock the secrets to lung cancer and a cure. Also, the Partnership has great respect for the contributions of oncology nurses, and I am honored to be a representative of this group to the Board of Directors. I hope to see collaboration with organizations

and individuals in research, advocacy and fundraising endeavors.

Q: What is your greatest challenge as an oncology nurse and Partnership Board Member?

A: The biggest challenge I see as an oncology nurse is trying to end the stigma of lung cancer and encourage young people to become interested in the field. The membership on the board is a humbling experience. I am challenged by the experience to contribute the best I have to offer.

Q: What would you like patients to know about lung cancer treatment – now and for the future?

A: Remember that treatments have changed through the years. Treatments can now not only provide quantity of life, but also a quality of life. In the future, I anticipate more oral therapy. The ease of treatment and the time commitment required by the patient will improve, which will continue improving patients' quality of life while living with lung cancer.

Q: What is the most important thing(s) you have learned from your patients?

A: My patients teach me to celebrate every day. I also learn from them – as they, too, are often learning – that there is no absolute right or wrong when making decisions. The "right" decision is what is best for each individual at a given time.

Patient Points of Interest

Update from ASCO

The Annual Meeting of the American Society of Clinical Oncology (ASCO) directly followed our own conference, a summary of which is presented on page 3. We've briefly summarized the major lung cancer news from ASCO here.

Prophylactic Cranial Irradiation (PCI) for extensive stage SCLC

Small cell lung cancer (SCLC) occurs in about 15% of people with lung cancer, while the other 85% of patients have non-small cell lung cancer (NSCLC). Unfortunately, less research is done on SCLC due to the fact that significantly fewer individuals develop SCLC (about 30,000 people each year!) compared to NSCLC. However, the biggest news for lung cancer at ASCO was in SCLC.

Limited stage SCLC, where the cancer is confined to one side of the chest, accounts for about 1/3 of SCLC cases. For limited stage disease, prophylactic cranial irradiation (PCI) is helpful in preventing the spread of the cancer (metastasis) to the brain in those who have responded to chemotherapy and radiation, and actually improves survival. It was not yet known, however, if PCI was beneficial to those with extensive stage SCLC, where the cancer has spread beyond one region of the chest.

A randomized, controlled clinical trial (considered the "gold standard" in research) was conducted to determine if using PCI for individuals with extensive stage SCLC would decrease the chances of symptomatic brain metastases developing at a later time. Patients with extensive stage SCLC who responded to chemotherapy but had no known brain metastases were randomized to either receive PCI or not. Astoundingly, not only did the PCI prevent a significant number of symptomatic brain metastases from occurring in these patients, it actually improved one-year survival of these patients by about 14%. So, it is now known that anyone with SCLC who responds to chemotherapy may benefit from PCI, whether their disease is originally found at the limited or extensive stage.

Avastin really does work

Bevacizumab (Avastin) was approved for first line therapy for late-stage lung cancer in combination with chemotherapy in 2006. However, trials were still ongoing to better assess its effectiveness, particularly in non-North American populations. Results from one such trial, AVAIL (Avastin in Lung Cancer), were presented at this year's ASCO Meeting.

The AVAIL clinical trial directly compared the cisplatin & gemcitabine combination, a standard chemotherapy regimen, to the same drugs used in combination with bevacizumab (Avastin). The study went further, however, as it also compared two doses of bevacizumab: the standard dose vs. half of the standard dose. This was done to try to understand whether the lower dose was also effective.

The results of the AVAIL trial showed that progression-free survival was significantly better in people who received chemotherapy plus either the standard dose of bevacizumab or half the dose, compared to those who received chemotherapy alone. These results re-affirmed the data that led to the approval of bevacizumab for first-line therapy in conjunction with chemotherapy for late-stage lung cancer patients. Whether bevacizumab dosing will ultimately change as a result of this trial remains to be seen.

Advanced lung cancer: how much chemotherapy is enough?

For stage IIIB lung cancer with pleural effusion and stage IV lung cancer, patients have relatively limited options for treatment. An open question is if the patient responds to the first chemotherapy regimen chosen, should they then receive a second chemotherapy immediately, or should the doctor wait and only give the second chemotherapy if the patient progresses? Results of a large, randomized trial studying this question were presented at ASCO.

This study showed that the disease took longer to progress in patients if a second chemotherapy regimen (docetaxel) is given immediately after the first one (gemcitabine

plus carboplatin). However, the overall survival of patients given docetaxel immediately after the first chemotherapy regimen was not significantly improved compared to patients receiving docetaxel after their disease progressed. Future trials will have to be conducted to definitively know whether additional chemotherapy given immediately versus waiting until progression is best for advanced-stage lung cancer patients.

OneTalk

New Patient Resource Tool: Ask the Expert at OncTalk

National Lung Cancer Partnership is pleased to announce a new partnership with Dr. Jack West, medical oncologist, and his colleagues at OncTalk. OncTalk's expert-mediated blog on issues important to lung cancer patients and their families can now be accessed through our website by clicking on "lung cancer info" and "ask the expert".

As treatments change and new studies are published and widely debated, OncTalk provides a forum not for specific answers to individual cases, but for a trusted source of information that patients can integrate with recommendations from their own oncologists and physicians so as to ensure the best possible treatment options. This online tool has functions for Dr. West to post and comment on current information about lung cancer research and treatments as well as a Q&A and discussion forum. These tools, combined with an extensive list of other online resources, provide patients with the most current and best information available.

New Clinical Trials in Lung Cancer Available Now

Stage IIIB/IV NSCLC

No prior therapy:

This study is investigating the use of a genomic prediction test to determine who will benefit from cisplatin-containing chemotherapy. This study is designed for advanced stage patients who have received no prior chemotherapy, radiation therapy, or biologic/targeted therapy. The study will assign patients to either pemetrexed (Alimta) plus gemcitabine (Gemzar) or cisplatin plus gemcitabine (Gemzar) chemotherapy, depending on results of a genomic test that is designed to identify which patients are likely to respond to cisplatin-containing chemotherapy, and which ones aren't.

If you are interested in learning more about this study contact: The office of Jennifer L. Garst, MD, Duke Comprehensive Cancer Center, Durham, NC. 919-668-6498. Protocol ID: 9474.

Prior therapy:

This study is testing the use of two drugs, vinflunine and cetuximab (Erbix), together for the treatment of lung cancer in advanced-stage patients who have seen their disease progress after previous anti-cancer treatment (second-line therapy). Drugs used in chemotherapy, such as vinflunine, work to stop the growth of tumor cells, either by killing the cells or by stopping them from dividing. Monoclonal antibodies, such as cetuximab (Erbix), can block tumor growth in different ways. Some find tumor cells and help kill them or carry tumor-killing substances to them. Others interfere with the ability of tumor cells to grow and spread. Giving vinflunine together with cetuximab may kill more tumor cells.

If you are interested in learning more about this study contact: The office of Thomas E. Stinchcombe, MD, Lineberger Comprehensive Cancer Center, University of North Carolina, Chapel Hill. 919-966-4432. Protocol ID: UNC-LCCC-0503.

Relapsed or refractory SCLC

This study is testing the side effects and best dose of obatoclax mesylate when given

together with topotecan (Hycamtin) and seeing how well they work in treating patients with relapsed or refractory small cell lung cancer. Obatoclax mesylate may stop the growth of tumor cells by blocking some of the enzymes needed for cell growth. Drugs used in chemotherapy, such as topotecan (Hycamtin), work to stop the growth of tumor cells, either by killing the cells or by stopping them from dividing. Giving obatoclax mesylate together with topotecan may help kill more tumor cells.

If you are interested in learning more about this study contact: The office of Lee Krug, MD and Naiyer Rizvi, MD, Memorial Sloan Kettering Cancer Center, New York. 800-525-2225. This study is also being conducted at the Sidney Kimmel Comprehensive Cancer Center at Johns Hopkins, Baltimore, MD. 410-955-8804. Protocol ID: MSKCC-07082.

Source: TrialCheck® searchable database for cancer clinical trials, provided by the Coalition of Cancer Cooperative Groups, and available at www.CancerTrialsHelp.org. For telephone support, contact the Coalition Call Center via the American Cancer Society: 1-877-227-8451.

Upcoming Events



Three *Free to Breathe™* Run/Walk events will take place in November to help raise awareness of the deadly impact of lung cancer and to increase funding for National Lung Cancer Partnership's lung cancer research, education, and awareness programs. For more information, to register, or to donate, please visit www.FreetoBreathe.org.

Raleigh, NC – Saturday, November 3

This 5K and 1 mile run/walk is organized by the North Carolinians Against Lung Cancer and is sure to be a great family affair! With a rally and other family fun activities like a short kids dash, a clown for entertainment, and pizza for a snack, you shouldn't miss this fun event that will raise money for National Lung Cancer Partnership's research grant programs. Registration begins at 7:30 AM and the walk begins at 9:00 AM at Ravenscroft School, located at 7409 Falls of Neuse Road; Raleigh, NC.

Past Events

Inaugural Roseann's Gift Charity Event

On September 18, 200 people joined **Kellie Safar Lerner** at the Manhattan Penthouse in New York City to honor the life of her mother, Roseann Safar. This inaugural event was the first in a series of events to raise money for the Roseann Safar Lung Cancer Grant. Christy Turlington, author, model and entrepreneur was the special guest and speaker, and Stacey London of TLC's *What Not to Wear* and *Shut Up! It's Stacey London*, was the guest auctioneer. This event raised over \$30,000!! Watch for more Roseann's Gift charity events in the future.



Co-Founder of Roseann's Gift, Kellie Lerner, along with special guests Stacy London, Dr. Joshua Sonett, and Christy Turlington Burns

Free to Breathe™ 5K

In Memory of Beth Kenny Foretic

The *Free to Breathe™* 5K walk in Glastonbury, CT was a held on September 23 in memory of Beth Kenny Foretic, a young mother who was diagnosed with and passed away from lung cancer soon after her daughter was born. The

Philadelphia, PA – Sunday, November 4

The second annual *Free to Breathe™* 5K run/walk and 1 mile walk will be a fun community event with a rally and patient support and education fair after the race. Registration begins at 6:30 AM and the race begins at 8:30 AM from Lloyd Hall in Fairmount Park at 1 Boathouse Row; Philadelphia, PA.

Los Angeles, CA – Sunday, November 11

This 8K run, 5K run/walk and 1.4 mile walk will be an enjoyable way to celebrate Lung Cancer Awareness Month. A rally and expo will follow the run/walk. Registration begins at 6:30 AM and the race begins at 8:30 AM in Lake Balboa Park at 6300 Balboa Blvd.; Encino, CA.

If you are interested in volunteering, please contact Kenda Schwarz, Director of Development & Outreach, at 608-233-7905 or Kenda@NationalLungCancerPartnership.org.

The Great 108 – Friday, December 21

Please join the National Lung Cancer Partnership for the third annual Great 108 Yogathon at the Yoga Spot, 501 Washington St. Suite K, Durham, NC, to benefit our Lung Cancer Research Grant program. Yogis often celebrate the change of seasons by doing 108 sun salutations on the solstices and equinoxes. You can celebrate the Winter Solstice by sponsoring The Great 108 or join your friends in doing 108 sun salutations to bring hope to lung cancer survivors everywhere. For more information please call 919-667-YOGA or email webmaster@yogaspot.com

Glastonbury community showed their love of Beth and support for the Kenny and Foretic families with over 500 walkers on the day of the event and by raising more than \$75,000 for lung cancer research. A very special thanks to **Marilyn Shirley, Joan Schwartz, the Kenny family and their team of planners** for making this first annual event a huge success!



Abigail, Beth's daughter, and the crowd of walkers

Hike for Lung Health

The weather was perfect for a hike along Lake Michigan in Chicago and in Palatine, IL on Sunday, September 23. National Lung Cancer Partnership teamed up with Respiratory Health Association of Metropolitan Chicago for a multi-charity walk to help raise awareness of lung disease and help support lung disease education & research. A special thanks to **Laura Syracuse, Michelle DesLauriers, and Meg Skelton** for their phenomenal fundraising efforts!

You CAN Help!

How can you help raise awareness of lung cancer while helping the National Lung Cancer Partnership? We have many creative individuals who strive to find unique ways of fundraising for the Partnership.

Students at **St. John's High School** raised money in honor of their mothers for Mother's Day and donated it to National Lung Cancer Partnership in hopes of finding a cure!

Daniel Bellman, a 7th grader from Glastonbury, CT, sold lemonade during the *Free to Breathe™* walk in memory of Beth Kenny Foretic and donated the proceeds to the walk.

The **Jennifer L. Bartlett-Perini Women's Lung Cancer Education Foundation** hosted their third annual Jennifer L. Bartlett-Perini Golf Outing at The Jackal Golf Course in Brighton, MI and chose National Lung Cancer Partnership as a beneficiary.

Other ideas to help raise funds to support National Lung Cancer Partnership include:

- Ask family and friends to celebrate a birthday, wedding anniversary, or survivorship anniversary by donating to National Lung Cancer Partnership.
- Organize a *Free to Breathe™* run/walk, a bike ride, golf outing, luncheon or other community event.
- Donate a portion of your proceeds from the crafts, art, food, or other goods you sell.
- Visit our online marketplace to purchase lung cancer awareness pins and bracelets and other goods that benefit National Lung Cancer Partnership.
- Consider using charity-friendly websites to do your searching and shopping. A few notable sites include www.GoodSearch.com, www.GoodShop.com, www.GiveLine.com, and www.IDoFoundation.com. Be sure to select National Lung Cancer Partnership as your charity of choice when searching or checking out!

National Lung Cancer Partnership Executive Director, Regina Vidaver, PhD and Lung Cancer Ambassador, Lori Monroe, RN attended the **LIVESTRONG Presidential Cancer Forum** in August. All Democratic and Republican 2008 Presidential candidates were invited to the forum for a unique opportunity to discuss how they, as President, would combat cancer. Candidates answered questions posed by cancer patients, survivors, and advocates. Lance Armstrong and Chris Matthews of MSNBC moderated the forum.



Lori Monroe, National Lung Cancer Partnership Lung Cancer Ambassador, with Chris Matthews of MSNBC

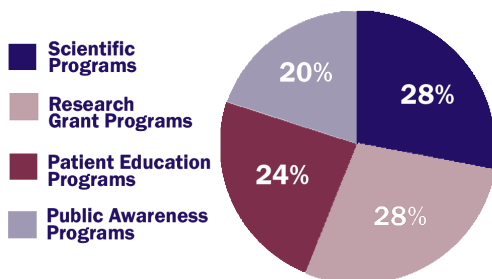
Support Research, Awareness, and Change

National Lung Cancer Partnership Program Spending

Leading up to and during Lung Cancer Awareness Month, our office fields a lot of calls and emails from people in communities across the country asking how they can help in the fight against lung cancer. There are many different ways to help – one of those is by making a donation to a lung cancer organization. Donations given to lung cancer organizations that fund research, like National Lung Cancer Partnership, are critically important because of the lack of federal research funding allocated for lung cancer and the limited interest in this disease among the general public.

We know it's important for donors to understand how their donations are used and to know that we are stretching your dollars as far as possible. The National Lung Cancer Partnership is proud of our record as a non-profit organization. We have been growing our programs significantly for the past three years, yet have kept our administrative overhead under 18% of our organizational budget. This means that for every dollar donated to the Partnership, 82 cents go directly into program funding.

How do we spend the 82 cents of every dollar given? Here's a breakdown of our programming expenditures:



Scientific Programs – 28%

The Partnership began its science programming by launching our Annual Meeting in 2005. The Annual Meeting is the premiere scientific event for discussing how lung cancer affects women and men differently, and is held in conjunction with the American Society of Clinical Oncology (ASCO) Annual Meeting. In the past, we've had the Director of the NCI speak, moderated discussions on screening and heard reports on the research we are funding. Other science programming includes hosting ancillary meetings at other large conferences, and piloting an education

program for primary care physicians, as well as a tumor board program for community oncologists in conjunction with the Respiratory Health Association of Metropolitan Chicago.

Research Grant Programs – 28%

We are the only organization to offer research grants specific to understanding how lung cancer affects women and men differently. By exploring this topic, we are helping find better treatments for everyone with the disease. We also provide a Career Development Award for young investigators. This award is critical to the future of lung cancer research. We are partnering with organizations like LUNGevity, IASLC, and Genentech to increase the amount of resources available for our research programs.

Patient Education Programs – 24%

Earlier this year we debuted our booklet for lung cancer patients and their families: *Living with a Diagnosis of Lung Cancer*, and our DVD for individuals considering clinical trials: *Stories of Strength: Making the Decision to Enter a Lung Cancer Clinical Trial*. These resources are being used all around the country by patients, nurses and physicians, bringing hope to the recently diagnosed. We also provide this print newsletter on a tri-annual basis, sending it to hospitals, clinics and individuals across the nation to give them timely, useful information. In between printings, we send electronic newsletters to our constituents. (If you aren't on our e-newsletter list and would like to be, please send us your email address!) Our website is also updated on an ongoing basis, providing access to pertinent lung cancer information with the click of a mouse.

Public Awareness Programs – 20%

We initiated the *Free to Breathe™* Lung Cancer 5K series to increase community awareness of lung cancer. We began the series in 2006 with a single site in Philadelphia, PA and have expanded to four sites in 2007 (see page 6). We hope to bring the event to an additional 2-4 cities in 2008. If you are interested in organizing a *Free to Breathe™* event in your area, please send us an email or give us a call.

As part of our public awareness efforts, we also travel to various health fairs and events throughout the country, and ask volunteers to work for us in the locations we aren't able to travel to ourselves. If there are events in your area where you think our information would be appropriate to display and if

you are interested in working a table on our behalf, just let us know – we'll provide the materials and talking points. The more we can increase awareness of lung cancer, the better we can advocate for increases in research funding from public and private sources.

Together, We Can Make a Difference.

Like many non-profits do at this time of year, we were going to send a letter asking you to support us with an end of the year gift. However, in the spirit of keeping our administrative expenses as low as possible, we decided to ask you to make that end of year gift now, using the pledge envelope inserted in this newsletter.

We hope you will take this opportunity to celebrate the lives of those living with lung cancer and remember those who lost their valiant battles by making a contribution to the National Lung Cancer Partnership.

Please use the pledge envelope included in this newsletter to make your tax-deductible contribution. It doesn't matter if you give \$10 or \$1,000. Your donation will help us make a difference in the lives of lung cancer patients today and for the future!

In the Press:

National Lung Cancer Partnership has received many press mentions in the past several months. The availability of our free booklet, *Living With a Diagnosis of Lung Cancer*, was picked up by *Healthday* and run in many local and regional papers across the nation. *Parade* magazine ran a short clip called the "Sunday Freebie" about our free booklet on Sunday, September 30.

Dr. Regina Vidaver, Executive Director, National Lung Cancer Partnership, was quoted in an article run by the *New Scientist* that describes a simple blood test that identifies early lung cancer before it has had a chance to spread.

The National Lung Cancer Partnership was featured as a "health quickie" in the October issue of *Glamour* magazine (page 168).

The National Lung Cancer Partnership and several of the Partnership's members were featured in the *Wisconsin Counties* magazine.

The *Free to Breathe™* 5K in memory of Beth Kenny Foretic was highlighted in the *Hartford Courant* and Marilyn Shirley, event organizer, was interviewed on the *Dan Lavallo Show*.

Memorial Giving:

Donations have been made to National Lung Cancer Partnership in memory of the following people (May 2007 to September 2007):

Michiko Awanohara
Renate Baldwin
Lorraine Blackwell
Linda Bonsaint
Tonja Bourassa
Daniel Breen
Charles H. Brooks
Fran Cornell
Jill Cotoia
Bud Crow
Mary Pat Darling

Marnie Graf Davidow
Doris Adele Dillon
Tammy Dudley
Estelle Flanagan
Beth Kenny Foretic
Dave Grant
Vicki Heilmann
Dianna Marie Holcomb
Elaine Isaac
Madeline MacDonald
Helene Marks

Emma Jean McGinty
Lauren Feinswog Millin
Kathleen Lemon's Nanah
Helen O'Donnell-Dewey
Marjorie Pacitti
Corinne Perkins
Dr. Ilene F. Rockman
Charlotte L. Simpson
Stan Slosarczyk
Sheree Swetin

**November is Lung Cancer Awareness Month.
See inside for information about promising research advances
and ways you can help in the fight against lung cancer.**

**If you're waiting for someone else to do something about lung cancer...Don't hold your breath.
Look inside for what you can do.**

**National Lung Cancer Partnership is dedicated to decreasing deaths due to lung cancer, and helping
patients live longer and better, through research, awareness, and advocacy.**



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