hadn’t slept all night. She was a day or two from being dismissed from the hospital. Physically, she was recovering. But emotionally, she was troubled, and spiritually, she felt confused and overwhelmed.

Until a few weeks ago, Ann had been consumed by her busy medical practice. She was the doctor in a small town in a rural area. Her days were filled with office appointments and house calls. She liked to visit the homes of her patients. She was a much loved, old-fashioned country doctor. But she had been experiencing what felt like vague stomach upset, was feeling bloated and having trouble in the bathroom. Then she noticed that she couldn’t button her slacks. Looking at herself sideways in the mirror she looked pregnant, but she wasn’t. Her belly was filling up with fluid. So she called a doctor colleague in a neighboring town, and after hearing her story and examining her, Ann’s friend referred her to a gynecologic surgeon.

I met Ann at her bedside in the hospital a few days after her surgery. She looked drawn and exhausted after a long, sleepless night. When I introduced myself to her, she began to quake, tears rolling down her cheeks. “I know I should feel strong because of my faith. But I don’t—I’m terrified,” she confided. She was experiencing spiritual distress.

Spiritual distress is that void that sets in when everything you’ve always believed in isn’t comforting you in your present situation. Some people experience spiritual distress as fear or confusion. Concentration is difficult. Spiritual distress feels unsettling. Others describe spiritual distress as a deeply troubling feeling that makes physical and emotional pain seem worse.
Together...

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Mayo Clinic Cancer Center
is part of Mayo Clinic. The
mission of the cancer center
is to provide compassionate
state-of-the-art care for the
patient with cancer today and
continued advancements in the
prevention, diagnosis, treatment
and cure of cancer in the future.
The programs and services of
the Cancer Center span the
three Mayo Clinic campuses in
Rochester, Minn., Jacksonville,
Fla., and Scottsdale, Ariz.

Together provides educational
information for cancer patients
treated at Mayo Clinic, their
family members, caregivers and
friends. Physicians, staff and
patients of the cancer center
write the articles.

You can access current and
archived issues of the
Together newsletter online at
http://www.mayoclinic.org/
cancer-education-rst/

Continued from page 1 The Spiritually Distressing Part of Cancer

Individuals experiencing spiritual
distress sometimes have questions
about the meaning of life – questions
that many of us do not spend much
time thinking about. Spiritual
distress can also result from having
to make difficult decisions about
complicated treatment options, such
as wondering what the “right”
decision is. Spiritual distress can
make sleeping difficult as nights
become filled with rumination,
the experience of
turning multiple
problems over and
over in one’s mind.

Spiritual distress may
result from feeling
conflicted about what
you believe, even if
you have been the
most religious and
religiously involved
person throughout
your entire life. Some
people look to their
spiritual beliefs for strength and
comfort, and it may be spiritually
distressing when they are unable to
find strength and comfort. Spiritual
distress may also result from having
concerns about your relationship
with your God. Praying may be
difficult. Attending religious
services may feel painful, sad or
lonely.

Often, when sudden, major change
occurs in life, such as a health crisis
or a life-threatening diagnosis, there
is a sense of loss of control.
Sometimes this experience of loss of
control feels terrifying because you
are being asked to make changes
you hadn’t anticipated and for
which you are unprepared. There is
also grief because you have lost, at
least temporarily, that “dream” you
had about your future. We all have
those dreams about our futures
and when something happens that
threatens those dreams we suffer
a loss.

When I met Ann she felt sad and
terrified by what was happening to
her. Not only was she experiencing
a major health crisis and the
possibility of death, she also was
distressed spiritually as she tried to
make some sense out of what was
happening to her. Ann was being
forced to make many unanticipated
changes for which she felt
unprepared. She was supposed to
be the caregiver, not the person
requiring care. She had
always been the healer,
not the person needing
healing. She tended to
the vulnerable, and was
not supposed to feel
vulnerable. Ann
expected to be the
person of faith feeling
peaceful, not the person
troubled by a lack of
peace in an effort to
cope with all of this.
She looked to her
spiritual beliefs, but
they did not provide the strength
and comfort she had come to expect
from them. She didn’t have access
to her life-lines – her spiritual beliefs
and practices upon which she had
always been able to rely on for
strength and comfort.

Talking to someone about what you
believe and what troubles you can
reduce spiritual distress. It is helpful
to choose someone who can handle
your spiritual questions about the
meaning of life and death as well as
questions about your relationship
with your God. It is also helpful to
choose someone who doesn’t have
to solve your problems or give
advice, but someone who can simply
listen. Being able to trust another
person and to place yourself in his
or her spiritual care can be healing
and can help restore your own
serenity – that sense of inner peace,
tranquility and freedom that may
have been disrupted by the news
of cancer.

Talking to another person about what troubles you spiritually may seem simple. But this is difficult for some because we think our spiritual distress results from weak faith or a loss of faith. We might find it embarrassing or humiliating to reveal our spiritual struggles to someone else. Actually, spiritual distress, even though it can be painful, can be a sign of a vibrant faith that is alive and searching for new life or new understanding. It is this searching part that troubles most people. Most of us are not used to having to search for meaning in our lives until something deeply troubling happens.

Spiritual distress is a very personal and universal part of the human experience. It is a central part of the deep and simple human impulse to live, and to understand what is happening to us.

Mary E. Johnson
Chaplain

Cancer: Weaving a Tapestry of Care Through Education, Practice and Research

Saturday, April 1, 2006

Phillips Hall, Siebens Building • Mayo Clinic, Rochester, Minnesota

Sponsored by Mayo Clinic Cancer Education Program
The mission of the Mayo Clinic Cancer Education Program is to educate all audiences on cancer-related issues, including prevention, risks, treatment, end-of-life care and survivorship.

Purpose
Cancer touches the life of almost everyone today. Whether cancer has impacted your life or the life of a friend or family member, there is encouraging news on the horizon. This education event will focus on current topics in cancer care, including updates on nutrition, herbs and supplements, genomics, survivorship, caregiving, quality of life and the latest on cancer research and treatments.

The goals of this program are to:
• Provide up-to-date information on cancer treatment and research
• Highlight the importance of survivorship issues
• Provide a forum to talk with others about cancer issues and caregiving

Location
Phillips Hall, First Floor
Siebens Medical Education Building
200 Second Avenue Southwest
Mayo Clinic
Rochester, Minnesota

Call 507-288-5620 for more information about this program.
Colorectal cancer is the third most common cancer among men and women in the United States, with more than 145,000 new cases expected in 2005. It is also the second deadliest cancer in the United States, with more than 55,000 deaths expected in 2005. According to the American Cancer Society, the number of colorectal cancer deaths could be cut in half if Americans followed recommended colorectal cancer screening guidelines.

Colorectal cancer develops in the lower part of the digestive system, also referred to as the gastrointestinal or GI system. The digestive tract processes the food you eat and rids the body of solid waste. Colorectal cancer usually develops from precancerous changes or growths (polyps) in the lining of the colorectum.

Because colorectal cancer often does not cause any symptoms in its early stages, screening is very important. When rectal bleeding, blood in the stool, a change in bowel habits, or cramping in the lower abdomen occur, evaluation by a physician is critical to determine whether these symptoms might be associated with colorectal cancer.

**Risk factors**
The number one risk factor for colorectal cancer is age. Men and women 50 years old and over have an increased risk for colorectal cancer, even with no family history of the disease. Colorectal cancer is a leading cause of death in both men and women, but many Americans think of colorectal cancer as only a “man’s disease.” Women account for half of all new colorectal cancer cases and half of the deaths. In fact, colorectal cancer kills more women than ovarian, uterine and cervical cancer combined.

A personal or family history of colorectal cancer, polyps, or chronic inflammatory bowel disease increases the likelihood of developing colorectal cancer. Certain genetic factors also increase that likelihood. Other risk factors include smoking, alcohol consumption, obesity, physical inactivity, a diet high in fat and/or red meat, and a diet low in fruits and vegetables.

Another important risk factor for colorectal cancer is race. African-Americans have the highest colorectal cancer risk and are more likely to die from the disease than most other racial or ethnic populations. One reason for this difference is that African-Americans are more likely to be diagnosed when the disease is at an advanced stage and more difficult to treat. However, for unknown reasons, colorectal cancer death rates remain higher among African-Americans even after matching for stage of disease.

Among African-American and Hispanic populations, colorectal cancer is the second leading cause of cancer death for men and women combined. Research also shows Hispanics are much less likely to get screened for colorectal cancer than Caucasians.

**Screening**
Unlike most types of cancer, colorectal cancer can actually be prevented by screening with appropriate follow-up, since polyps can be removed before they become cancerous.

There are several different colorectal cancer screening tests. The American Cancer Society guidelines for the early detection of colorectal cancer recommend that men and women 50 years old and older should discuss testing options with their physician or health care professional and choose one of the following options:

**Yearly fecal occult blood test (FOBT).** This test checks for microscopic amounts of blood in the stool, which can indicate the presence of polyps or other abnormalities in the colon.

**Flexible sigmoidoscopy every five years.** Sigmoidoscopy is an examination of the rectum and lower colon using a lighted instrument called a sigmoidoscope. Sigmoidoscopy can find precancerous or cancerous growths in the rectum and lower colon.

**Double-contrast barium enema (DCBE) every five years.** DCBE is an X-ray examination of the entire colon and rectum. The X-ray is taken after the patient is given an enema with a barium solution and air is introduced into the rectum and then into the colon. The barium and air help to outline any changes in the surface lining of the colon and rectum.
prostate exams. Colorectal cancer screening needs to become an accepted and routine part of everyone’s health care.

Making progress
According to the American Cancer Society’s Cancer Facts and Figures 2005, colorectal cancer incidence rates decreased by 2.9 percent per year between 1998 and 2001. This decrease may be a result of increased colorectal cancer screening and polyp removal, which prevents the polyps from becoming cancerous. In addition, colorectal cancer death rates have continued to decline in both men and women at an average of 1.8 percent annually for the past 15 years.

While fewer Americans are being diagnosed with and dying from colorectal cancer today, those numbers could be even lower if more men and women were getting screened for the disease. Colorectal cancer is one of very few cancers that can be prevented entirely with regular screening and appropriate follow-up.

Paul Limburg, M.D., is an Assistant Professor of Medicine at the Mayo Clinic College of Medicine, Rochester, Minn.

For more information on colon cancer and screening recommendations, visit:

Mayo Clinic
http://www.mayoclinic.com

American Cancer Society
http://www.cancer.org
800-ACS-2345

National Cancer Institute
http://cancer.gov
800-4-CANCER (800-422-6237)
Mary Lou Kurtz

Survivor

There is life after a cancer diagnosis

The call came at 10:30 p.m. and lasted almost an hour. Mary Lou Kurtz didn’t know the person at the other end of the line, but she recognized confusion and fear in the stranger’s voice — she had experienced those feelings herself.

Recently diagnosed with cancer, the caller found Mrs. Kurtz’s name on a list of cancer survivors to contact for understanding and support. When their conversation ended, each felt a sense of peace.

As Mrs. Kurtz explains: “I can’t offer medical advice, but I can offer hope. I encourage people to take control of their illnesses. You can find blessings in this experience.”

She speaks to groups as well as to individuals. Her positive outlook comes from her own battle with multiple myeloma. This form of cancer develops in the blood and attacks the plasma cells — an important part of the immune system. She was diagnosed with multiple myeloma in 1985.

To fight the disease, Mrs. Kurtz and her husband, Gene, find strength in their faith and family. They are close to their daughter, Lynn, and her husband, David; their son, Bobby, and his wife, Lisa; … and, as Mrs. Kurtz emphasizes, “our six beautiful grandchildren!”

Both Mr. and Mrs. Kurtz describe philanthropy as an important way to make a difference. Active with their church and many other organizations, they support multiple myeloma research at Mayo Clinic. They also provide financial support for Mayo’s programs and facilities in patient care, research and education.
Six statements to live by

Mrs. Kurtz’s diagnosis came during the busy years when she and Mr. Kurtz were rearing their children and growing their business. Describing their close relationship, Mr. Kurtz says: “We meet every problem head-on, together.”

The turning point came when her local doctors said Mrs. Kurtz’s case was untreatable. “The finality of the diagnosis made me determined to explore all options, which opened the door to a long and successful relationship with Mayo Clinic.” She went to Rochester in February 1991 and met Robert Kyle, M.D., an internationally recognized hematologist. “He gave me six statements, which I’ve always cherished,” she recalls:

- Cancer is not your fault.
- We’ll try everything — if one approach doesn’t work, we’ll go on to the next.
- There’s no guarantee, but we’ll fight this together.
- We’ll help you have the best quality of life for as long as possible.
- Go home and be active.
- Come back every six months.

Those statements became a creed for Mrs. Kurtz. She takes control of multiple myeloma by following a healthy lifestyle, enjoying family and friends, and relaxing with her husband at their vacation home outside San Antonio. Riding horses and tending Longhorn cattle are among her favorite pursuits. As Mrs. Kurtz says: “There is life after a cancer diagnosis.”

Having seen Mayo Clinic through his wife’s experience, Mr. Kurtz became a Mayo patient in 1996. Their friendships with Dr. Kyle, Angela Dispenzieri, M.D., and many others inspire Mr. and Mrs. Kurtz to support Mayo.

Years later, the Kurtzs still tell their friends about their Mayo experience. “It’s a huge, efficient operation, but they always respect your dignity,” says Gene.

Calendar of Events 2006

January
Cervical Health Awareness Month
National Cervical Cancer Coalition
800-685-5531 — www.nccc-online.org

March
20-26 Daffodil Days
American Cancer Society
800-ACS-2345 — www.cancer.org

National Colorectal Cancer Awareness Month
Cancer Research and Prevention Foundation
800-227-273 — www.preventcancer.org/colorectal

April
1 “Cancer: Weaving a Tapestry of Care through Education, Practice and Research”
Mayo Clinic Cancer Center
Rochester, Minn.
507-288-5620
7-8 Hilltop Retreat
Rochester, Minn.
507-288-8354 — e-mail: thehilltopretreat@yahoo.com
17-23 National Oral, Head and Neck Cancer Awareness Week
Yul Brynner Head and Neck Cancer Foundation, Inc.
843-792-6624 — www.yulbrynnerfoundation.org
16-22 National Minority Cancer Awareness Week
American Cancer Society
404-329-5788 — www.cancer.org

May
Melanoma/Skin Cancer Detection and Prevention Month
1 Melanoma Monday
American Academy of Dermatology
888-462-DERM — www.aad.org

7-13 Brain Tumor Action Week
North American Brain Tumor Coalition
630-325-261 — www.nabraintumor.org

Oncology Nurses Month
Oncology Nursing Society
866-257-4667 — www.ons.org

June
4 National Cancer Survivors Day
National Cancer Survivors Day Foundation
615-794-3006 — www.ncsdf.org
Cancer Terms

3-Dimensional (3-D) conformal radiation therapy: A procedure that uses a computer to create a 3-dimensional picture of the tumor. This allows doctors to give the highest possible dose of radiation to the tumor, while sparing the normal tissue as much as possible.

Cervix: The lower, narrow end of the uterus that forms a canal between the uterus and vagina.

Colorectal: Having to do with the colon or the rectum.

Depression: A mental condition marked by ongoing feelings of sadness, despair, loss of energy, and difficulty dealing with normal daily life. Other symptoms of depression include feelings of worthlessness and hopelessness, loss of pleasure in activities, changes in eating or sleeping habits, and thoughts of death or suicide.

Dosimetrist: A person who determines the proper radiation dose for treatment.

Hematologist: A doctor who specializes in treating blood disorders.

Intensity Modulated Radiation Therapy (IMRT): A type of 3-dimensional radiation therapy that uses computer-generated images to show the size and shape of the tumor. Thin beams of radiation of different intensities are aimed at the tumor from many angles. This type of radiation therapy reduces the damage to healthy tissue near the tumor.

Pap test: A procedure in which cells are scraped from the cervix for examination under a microscope. It is used to detect cancer and changes that may lead to cancer. A Pap test can also show noncancerous conditions, such as infection or inflammation. Also called a Pap smear.

Polyp: A growth that protrudes from a mucous membrane such as the lining of the intestines.

Medical oncologist: A doctor who specializes in diagnosing and treating cancer using chemotherapy, hormonal therapy, and biological therapy. A medical oncologist often is the main health care provider for someone who has cancer. A medical oncologist also gives supportive care and may coordinate treatment given by other specialists.

Radiation oncologist: A doctor who specializes in using radiation to treat cancer.

Simulation: In cancer treatment, a process used to plan radiation therapy so that the target area is precisely located and marked.

Stereotactic radiation therapy: A radiation therapy procedure that uses special equipment to position the patient and precisely deliver a large radiation dose to a tumor and not to normal tissue. This procedure does not use surgery. It is used to treat brain tumors and other brain disorders. It is also being studied in the treatment of other types of cancer, such as lung cancer. Also called radiation surgery, radiosurgery, stereotactic external-beam radiation, stereotactic radiosurgery, and stereotaxic radiosurgery.

Therapeutic: Having to do with treating disease and helping healing take place.

Patients and caregivers often turn to the Internet for cancer information. Many sites offer high quality information: news reports, reprints from medical journals, clinical trials information and patient education materials. Using web technology empowers patients with knowledge and enables them to take a more active role in their own care.

However, it is important to be a good detective to be able to sort through the many options available online. Anyone with the right software can publish on the Internet, regardless of the accuracy of the information. To a large extent, Internet information is unregulated, so users should be aware that inaccurate information can be presented on a professional-looking Web site.

It is important for health information seekers to always check the source of information. The Health On The Net Foundation (HON) (http://www.hon.ch) and Quackwatch (http://www.quackwatch.org) are reputable sites that monitor health information materials and work to combat misinformation.

Another way to check the accuracy of Internet information is to research the topic through multiple sources. When sources report similar information on a topic, it is more likely to be accurate. Be suspicious of those that seek to discredit other sources or promise a cure-all.

Here are some questions to ask in order to evaluate Web site credibility:

- Who wrote the information? What are the author’s qualifications? The author should be clearly identified.
- How reliable is the evidence that the findings are based on? Credible Web sites will provide links or references to their source of information.
- Is the information current? Check the dates on the references; there may be more current research on the subject. Check the date the Web site was last updated.
- Is there a conflict of interest? Some for-profit companies provide reliable health information, but others may bias their content toward the product or procedure they sell.

In addition to medical information, many patients and caregivers look to the Internet for support and a connection to others with a similar cancer story. Shared personal experiences are helpful to others, but patients should remember that opinions are not facts, and one person’s experience may not be an accurate predictor of someone else’s.

There is a wealth of helpful information on the Internet, but it is important to make good choices on which sites to visit. Talk to your physician before following advice you find on the Internet.

For general cancer information, visit:

- The American Cancer Society at http://www.cancer.org
- National Cancer Institute at http://www.cancer.gov
- People Living With Cancer at http://www.plwc.org
- Mayo Clinic at http://www.mayoclinic.com
Clinical Depression and Cancer

By Teresa Rummans, M.D., PhD

Clinical depression is very common in cancer patients. Approximately 58 percent of cancer patients exhibit at least some symptoms of depression and fifteen percent experience significant depression.* Individuals who have experienced depression in the past, who have certain types of cancer, and who have fewer social supports or feel isolated are at greater risk for developing a depressive illness. Left untreated, depression can contribute to higher complication and death rates in patients with cancer.

What is clinical depression? The actual cause of clinical depression remains unclear, however, much progress has been made over the last couple of decades in identifying underlying factors contributing to its development. These include specific biological and/or genetic variables, psychological stresses, and environmental and/or social elements.

How can you recognize clinical depression in someone with cancer? Some symptoms that seem like depression can be experienced by cancer patients. However, most of the symptoms of clinical depression are not generally experienced by someone with cancer. Several depression-like symptoms can be a result of cancer or the side effects of cancer treatment. These include loss of appetite, weight loss, and sleep disturbances. The hallmark of clinical depression is the development of a sad or irritable mood with loss of interest or pleasure in daily activities that lasts more than two weeks. Additional symptoms that accompany this change in mood may include agitation or withdrawal, fatigue or sluggishness, difficulty concentrating and remembering, feelings of guilt, helplessness or hopelessness. Severe depressive episodes left untreated can lead to thoughts of death and even suicide.

Once clinical depression has been recognized, what can be done to treat it? Various methods have been shown to be successful in treating depression. These fall primarily into two categories—psychotherapy or counseling, and biological interventions including antidepressant drug therapy, light therapy, or electroconvulsive therapy. Recent studies have found that these therapies work differently and that a combination of psychotherapy and biological therapy often is more successful than either one alone.

Psychotherapeutic interventions involve listening, talking, dealing with negative or unproductive thoughts and feelings, identifying destructive behaviors, and then changing these thoughts and behaviors to benefit the individual. Biological interventions include antidepressants, stimulants, and mood-stabilizing medications. These agents often take several weeks to work, and individuals may experience side-effects before they experience the effectiveness of medications. Many medications are chosen on the basis of their specific side-effects. For example, some medications can produce drowsiness. Therefore, individuals with higher levels of anxiety and insomnia may benefit from more sedating antidepressants. On the other hand, those who are withdrawn, lethargic (sluggish/tired), or fatigued will benefit from more stimulating antidepressants.

Many options are available to treat depression if cancer patients develop it. Patients should work with their health care providers to recognize clinical depression and determine which treatments may be best for them. Early intervention may decrease the risk of unnecessary suffering associated with depression, thereby increasing the patient’s quality of life. Treatment of depression can be coordinated with other therapies to ensure the highest possible quality of life for patients with cancer.

Supportive Resources for Cancer Patients

American Cancer Society
http://www.cancer.org
Cancer Care
http://www.cancercare.org
Cancer Hope Network
http://www.cancerhopenetwork.org
People Living With Cancer
http://www.plwc.org
National Coalition for Cancer Survivorship
http://www.canceradvocacy.org
National Institute of Mental Health
http://www.nimh.nih.gov
National Cancer Institute - Coping with Cancer
http://www.cancer.gov/cancer_information/coping

External Radiation Therapy — What is it and What Does it Involve?

By Julie Earle, RN

**External Radiation Therapy**

External radiation therapy is most commonly delivered using a machine called a linear accelerator. This machine produces high energy X-rays that can be used to treat cancers and occasionally benign or non-cancerous conditions. When cancer cells are exposed to therapeutic doses of radiation, they lose their ability to divide and grow. Radiation can be used as the primary form of treatment, or in combination with other treatments such as surgery and/or chemotherapy to reduce the risk of a cancer returning, or to alleviate pain or other symptoms. Radiation therapy is often part of a standard treatment course but may also be a component of a clinical trial.

**Evaluation**

When evaluating whether radiation would be beneficial, the radiation oncologist (a physician specialized in the treatment of cancer using radiation) works closely with other physicians such as surgeons, medical oncologists and general internists to determine the best options for the patient. Diagnostic tests such as blood work, CT or MRI scans and pathology reports are reviewed prior to any decisions being made. The patient and family members are included throughout the process to determine the best treatment options.

**Simulation**

Once it is determined that radiation therapy will be part of the patient’s treatment course, a coordinated timeline is determined. A simulation (planning session) is scheduled prior to beginning radiation. During simulation, several things may occur. A special device may be made such as a face mask or shoulder rest to help the patient maintain the exact position daily. A contrast dye may be used to help identify the area to be treated. A CT scan or X-ray films are taken and special marks are placed on the skin as reference points for daily treatment. These marks are often permanent like a tattoo and are about the size of a freckle. Once all the information is gathered during the simulation process, the radiation treatment plan can be developed.

**Radiation Treatment Plan**

Following simulation, the radiation oncologist determines the area(s) to be treated and the area(s) to be protected. With the help of a dosimetrist and physicist (health care team members specially trained in the properties of radiation), the physician completes a treatment plan. This planning process may take from several hours to a week or more, depending on the complexity of the plan. IMRT (Intensity Modulated Radiation Therapy), stereotactic, and 3-D conformal are examples of more complex treatment plans. This takes place behind the scenes and the patient does not need to be present for this portion of the planning process. Once completed, the radiation treatments can start.

**Radiation Treatments**

Radiation treatments can be arranged as a one time appointment or as long as daily appointments for eight weeks. The treatments are generally once a day, Monday through Friday. Some patients may have variations in their treatment schedule such as twice daily or twice weekly treatments based on their cancer type and other considerations. Treatments generally last several minutes, but depending on the complexity of delivery of the treatment, a 15-45 minute appointment slot is made. Patients will meet with their radiation oncologist, or another member of their treatment team, weekly to monitor how they are tolerating the treatments. As with other treatment courses, such as surgery or chemotherapy, each individual may tolerate the treatment differently.

After completion of a course of radiation therapy, follow-up care may include diagnostic tests, blood work, visits with the radiation oncologist and other members of the care team such as the surgeon, medical oncologist or hematologist. Follow-up visits may vary for each individual, but are important components of ongoing care.

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By Julie Earle, RN

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Julie Earle, RN
Look Good … Feel Better

**What** – Free program that teaches cosmetic techniques to women to help them manage the appearance-related side effects of cancer treatment

**Who** – Any female patient with cancer currently in treatment

**Where** – Mayo Clinic Hospital – 1st floor, 5777 E. Mayo Blvd, Phoenix, Ariz.

**When** – Second Tuesday of each month, 5:30-7:00 p.m.

Cancer can rob a woman of her energy, appetite and strength, but it doesn’t have to take away her self-confidence. Look Good … Feel Better trained, volunteer cosmetologists teach women how to cope with skin changes and hair loss using cosmetics and skin care products donated by the cosmetic industry. Free cosmetic kits provided at these groups are available to enhance all complexion types. Women also learn ways to disguise hair loss with wigs, scarves and other accessories. Call to register.

Shayna Diamond, ACS Patient Navigator, 480-301-5990.

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Cancer Education Group

**What** – Free program offering education and support

**Who** – Cancer patients, their families and care-givers

**Where** – Mayo Clinic – Classroom inside the Patient Library, Concourse level, Scottsdale, Ariz.

**When** – Tuesdays, 9:30-11:00 a.m.

Each meeting will focus on a different topic for education, but there will also be time for general discussions and group support. Topics include nutrition and exercise, managing side-effects of treatment, community resources, financial issues, coping with changes and emotions. Space is limited. Call to register.

Shayna Diamond, ACS Patient Navigator, 480-301-5990.

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Support Items

**What** – Items include wigs, head coverings, liquid nutrition, and breast forms

**Who** – Cancer patients

**Where** – Onsite in the ACS Patient Navigator’s office, inside the Patient Library, Concourse level, Scottsdale, Ariz.

**When** – Tuesdays, Thursdays and Fridays

Call to make an appointment with Shayna Diamond, ACS Patient Navigator 480-301-5990.