Network

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Diet and disease: the supplement explosion

Editor's Note: *This article looks at the use of herbs, vitamins and minerals from the perspective of a pharmacist, a registered dietitian and an epidemiologist, all working to inform cancer patients at M. D. Anderson about the importance of paying attention to the supplements they take.*

Herb, vitamin and mineral supplements crowd the shelves these days, each claiming "to promote health" — heart health, women's health, bowel health, you name it.

Amidst this myriad of products, it is difficult for general consumers — let alone cancer patients — to know which ones are effective. In their zeal to battle cancer, some patients may be taking mega-doses of vitamin supplements that could result in side effects, according to Sally Scroggs, a registered dietitian in the Cancer Prevention Center.

This increased use of over-the-counter supplements concerns surgeons, oncologists, dietitians, pharmacists and other health care professionals because interactions between drugs and supplements can potentially affect the medical treatment of cancer patients. Appropriately used, they may benefit patients; inappropriately used, they may interfere with treatment.

"Taking too much can often have the opposite effect of decreasing immune system response," Scroggs cautions. "Nutrition and cancer is still a new science. But there's a lot of exciting research that will help us learn more about the relationship between diet and disease."

With more than nine million cancer survivors in the United States today, this scientific research takes on increased importance, especially since these supplements do not fall under the scrutiny of the Food and Drug Administration.

"One reason we've had this explosion of supplements over the last eight years or so is due to the Dietary Supplement Health and Education Act passed by Congress in 1994. This act defined a group of products that are dietary supplements, do not require prescriptions and are, therefore, exempt from the regulations governing drugs," says Laura Boehnke Michaud, a pharmacy clinical specialist at M. D. Anderson.

"The caveat with the act is that there are limits to the types of statements manufacturers of these supplements can put on their products. Regulations for labeling clearly state they may not claim that these supplements are for 'treating or preventing disease,' because that would make them a drug. But they can make statements such as 'it promotes health,'" Michaud says.

With no designated watchdog for these types of products, some manufacturers may be taking advantage of people who are very sick, have a terminal illness and are grasping at straws.

So how, patients ask, can they get more information about these supplements? And what harm can taking a natural product do? M. D. Anderson is attempting to help patients find answers to these and other questions on its Complementary and Integrative Medicine Education Resource Web site at www.mdanderson.org/CIMER.

Nancy Russell, an epidemiologist in the Department of Educational Programs, helps keep this Web site updated, reading through the volumes of research being done and posting the information. CIMER offers evidence-based reviews of supplements commonly used by cancer patients, including herbs such as garlic, green tea and aloe vera. It also links to additional evidence-based sources such as

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Diet and Disease

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M. D. Anderson's Department of Clinical Nutrition, the National Cancer Institute and the Natural Standard.

According to Russell, many of the herbs being sold have been around for thousands of years, so there is probably some rationale for their use. "However, patients need to check out the current scientific understanding of that herb," she emphasizes. "And it's important to confer with a physician or a pharmacist about it. Some pharmacies have even started putting information sheets into prescriptions that outline any herbal interactions to be aware of."

Researchers do know that many of these supplements can interfere with the processes of absorption, distribution, metabolism and excretion of drugs that cancer patients may be taking. "For example, laxatives can speed up the transit time of a drug through the gastrointestinal tract and decrease the absorption of some medications," Michaud says. "There are also issues with minerals like zinc that can bind some antibiotics and keep them from being absorbed. If you're treating cancer, you may get rid of the chemotherapy too quickly or, on the other hand, if you inhibit an enzyme, you could increase the toxicity."

For example, a study done in the Netherlands and recently published in the Journal of the National Cancer Institute found that St. John's wort interferes with the metabolism and potentially the effectiveness of the colorectal cancer chemotherapy drug irinotecan.

Russell points out that herbs also can counteract each other. "You may pick up passion flower tea because it tends to calm you down. However, if you mix that with black or any other kind of regular tea that wakes you up, the two counteract each other. For this reason, it is important to read labels! Many boxes of tea, for example, may display one ingredient in large print and a long list of other ingredients in small print."

Many supplements are antioxidants, such as vitamins A, C and E and the mineral selenium. An increasing number of cancer patients take antioxidant supplements because they are known to inhibit the action of free radicals, unstable oxygen molecules in the body that come from a variety of sources: diet, aging, ultraviolet rays from the sun and pollutants, to name a few.

"The problem here is that many chemotherapies work by producing free radicals to kill cancer cells," Michaud says. "Therefore, antioxidants could interfere with the efficacy of the chemotherapy. Our concern is that, if patients are going to go through the toxicity of chemotherapy, we don't want them taking something that's going to counteract the activity of the drug."

M. D. Anderson offers two Web sites for investigating supplements and nutrition: Complementary and Integrative Medicine Education Resources at www.mdanderson.org/CIMER and the Department of Clinical Nutrition at www.mdanderson.org/departments/nutrition. In addition, the American Institute for Cancer Research, the nation's third largest cancer charity focusing exclusively on the link between diet and cancer, offers a Web site with science-based information called the Cancer Survivor's Guide at www.aicr.org/survivor.

Russell suggests three important steps for patients in evaluating these herbs, vitamins and minerals. "Learn about the traditional use of the supplement. Obtain the current science. And consult with a physician."

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Community outreach group provides support 'For Men Only'

Community outreach groups, known as COGs, have been part of the Anderson Network's programming since 1991. While many are in outlying areas around Texas, one of the most active groups is in Houston, "For Men Only Cancer Support Group."

"For Men Only" meets the first Monday of each month, 7-9 p.m., at St. Martin's Episcopal Church, 717 Sage Rd.

"We discuss our ailments, our diagnoses, how we live with the side effects and other items of interest to the attendees," said Bill Cutshall, a member of the group. The group was formed in 1992 and it is moderated by Steve Thorney, a former chaplain at M. D. Anderson.

Participation in the group is open to all men who have been diagnosed with cancer, are recovering from cancer treatment or who know someone who has cancer. For more information about "For Men Only," contact Bill Cutshall at (713) 781-1997 (home) or (713) 644-9500 (work).

There are other Texas COGs in Harlingen, McAllen and Midland/Odessa. In the past year Harlingen has sponsored a series of mind/body workshops to explore the role of complementary therapies in healing, while the McAllen group hosted Sister Alice Potts, a chaplain at M. D. Anderson, who spoke on "How to Use Spirituality to Cope with Cancer." If you are interested in starting a community outreach group in your area, call (713) 792-2553 or (800) 345-6324 for more information.

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Cancer patient makes connection after 16 years

Until recently, Jennifer Ball had never talked to another patient with her type of cancer, but that hasn't kept her from being an inspiration to her doctor and nurses and people whose lives she touches. Since her diagnosis with medullary thyroid carcinoma in 1986, she has lived with an enormous burden, suffering daily pain, but has done so with great courage and grace, according to her primary M. D. Anderson physician, Robert Gagel, M.D.

Jennifer was an undergraduate at the University of Texas, majoring in art history, at the time her problems began. When the undiscovered tumor was small, her face would flush and she would have an upset stomach for 10-15 minutes after eating. She went to an allergist, a gastoenterologist and other specialists, but the tests always came back negative.

"I didn't seem to be especially harmed by the process," she says, "so I would just go home and live with it for a while longer. Then I went in to have my birth control pills renewed and a nurse assistant did something none of the doctors had done — she felt my throat. And she said, 'Sweetie, your thyroid is really big on this one side.'"

A doctor and friend of the family suggested she see an endocrinologist who did a needle aspiration and that's when they discovered the cancer in December 1986.

"The amazing thing," Jennifer says, "is that they took out the thyroid and some of the lymph nodes around it. Then, they did some radiation. But they didn't explore the rest of my body."

What the doctors in Austin did not realize is that the cancer had already metastasized. In May 1987, they discovered a large tumor in her upper right arm that had eaten away so much of the inside of the bone that they had to place a pin and give her radiation therapy.

In subsequent years, Jennifer has dealt with a chain of ailments related to her cancer. She has had tumors up and down her spine and hip, some in her skull, and the cancer has metastasized to her lungs, liver and bones. In the early 1990s, she actually broke her neck on a roller coaster at Disneyland.

"Dr. Gagel has always encouraged me to do what I'm comfortable doing and at the time, it seemed OK!" she laughs.

In 1992, Jennifer and her companion, Shawn McKinney, now an assistant professor in the School of Journalism at the University of Texas, took off for California where he pursued a graduate degree in computer graphic design. Then in 1995, with Gagel's blessing, she and Shawn spent two years in New Zealand. It was there that Jennifer discovered a love of gardening. She remembers a field of magnificent calla lilies and how one day a farmer mowed them down like weeds.

Jennifer Ball and Shawn McKinney pose by their Austin Healy in New Zealand. They lived in Wanganui, a town of 35,000 on the North Island.

In gardening classes, she learned to make her own garden containers out of cement and sand, studied ikebana and the wild array of plants that grow so easily in that climate.

Since their return to Austin, Jennifer has been an advocate and periodic volunteer for Reading Is Fundamental, a program that distributes free books to schools where 50 percent or more of the children are on a free-lunch program. She regrets that her health in the last year has prohibited her involvement with RIF.

One of the distressing aspects of Jennifer's condition has been the constant diarrhea and her inability to maintain her weight. For a while she was hooked up to two bags of nutrients that she would wear during the night. But in 1999, when her doctor discovered that her body wasn't making enough cortisone, they put her on high doses of cortisone, alleviating her of the bags of nutrients.

To date a successful mix of chemotherapy drugs has not been found for Jennifer's cancer. However, she has been on two clinical trials in recent years. One was a Phase I trial with a farnesyl transferase inhibitor BMS-214662. Then she was switched to PKI-166.

"They haven't seen tangible evidence of its helping as far as CT scans go," Jennifer says of the latter one. "But I'm sure this drug has helped me. I have almost no diarrhea and for someone who has had diarrhea since 1987, this is a big deal!"

Jennifer's interests today are mostly sedentary. She loves Scrabble, reading and things that don't take a lot of energy, especially in this last year of ill health. "That's one of the things that Dr. Gagel's so wonderful about. He pushes me to claim back my life. If I could, right now I'd go back to work with RIF and I'd like to help my sister with a Girl Scout troop."

After 16 years of being alone in her diagnosis, Jennifer recently talked to someone with her same disease, thanks to Dr. Gagel. "She was only diagnosed two years ago and is a young mother," Jennifer says. "It was so amazing to talk to someone who has a similar situation to mine. You just can't imagine. It was really good for both of us."

Editor's Note: *If you would like to talk to someone about your cancer experience, either as a newly diagnosed patient or a cancer survivor, call the Anderson Network Patient and Caregiver Support Line at (800) 345-6324.*

Issam Raad, M.D.

Doctor, doctor

Medical devices: Essential tools for the advancement of medicine

Medical devices have become essential tools for the advancement of medicine in the 21st century. Catheters, stents and pacemakers, pins and prostheses are crucial to the care of cancer patients and those critically ill. However, the most frequent complication of cancer treatment comes from infections often caused by these very devices.

Issam Raad, M.D., chair *(ad interim)* of the Department of Infectious Diseases, has spent the last decade developing novel technologies to prevent catheter-related infections. Recently, these developments were incorporated into the "Guidelines for the Prevention of Intravascular Catheter-Related Infections" published by the Centers for Disease Control and Prevention. They are supported by professional organizations representing the disciplines of critical care medicine, infectious disease, health care infection control, surgery, anesthesiology, interventional radiology, pulmonary medicine, pediatric medicine and nursing.

Why are devices so prone to infection?

Every medical device has an outstanding vice: infection. Because they are made of polymer, they do not have cells to fight organisms and keep them from entering the body. Therefore, organisms attach themselves to the device and migrate through a contaminated area like the skin or the mouth.

The leading cause of bloodstream infections is the vascular catheter which goes through the skin. Basically, it opens a wound and connects two environments that are not supposed to be connected. One is the skin, which is a barrier. The other is the blood, which is sterile.

What are vascular catheters? Why and how long are they used?

For cancer patients, vascular catheters become the lifeline. They are inserted under the skin into the vascular system and are used to give patients blood products, fluids and many times nutrition. Nurses also draw blood from them. They keep the blood vessels from being constantly poked and prodded which can eventually cause them to collapse.

Long-term catheters stay in for an average of six months though some can stay in place for years. Short-term catheters stay for less than 30 days.

What sort of infections do medical devices cause?

Vascular catheters contribute to at least 200,000 episodes of bloodstream infections occurring in the United States each year. Mortality can be high in such situations, up to 25 percent. The same is true of endotracheal tubes. They go through the mouth into the lungs. The mouth is contaminated with bugs and these bugs migrate along the tube into the sterile lungs and cause pneumonia. This is our challenge. We need medical devices. We can't live without them, but at the same time, they can cause serious problems.

How has your research approached these problems?

My colleagues and I have tried to approach these problems of medical devices and infectious diseases in an interesting way. This has been my work for the last few years. The catheter cannot protect itself, because it is polymer; it has no cells to fight organisms. It doesn't have the antimicrobial agents that cells produce. So we decided to impregnate these catheters with antimicrobial agents. It makes them like a minefield for organisms. Bugs attach themselves to the catheter and they are destroyed. Using antimicrobial central venous catheters has decreased the risk of bloodstream infection by more than 15 fold.

What are these antimicrobial agents?

We coat the catheter with antibiotics, for example, minocycline and rifampin. As a result, we have decreased the risk of hospital-acquired bloodstream infection in the intensive care units and saved the institution more than $1.2 million a year. And we have decreased the risk of resistant, bacteria-causing bloodstream infections. It has had a tremendous impact on morbidity, as well as to some degree, on mortality.

What about other medical devices besides vascular catheters?

We are going in many directions. We are pioneering with urinary catheters and endotracheal tubes. Our dream for the future is to impregnate every device used as an implant, based on our antimicrobial technology. In the very near future, we would also like to impregnate certain devices with antiseptics. For this, my colleagues have developed a combination of gentian violet and chlorhexidine which we call "gendine." It is very good for urinary catheters and we might use them in long-term catheters. The combination is an excellent one.

In addition, patients with fractures have various implants: metal rods, pins, nails, joint and knee prostheses. These can get infected, especially the metallic devices that go through the skin. They're foreign bodies, so we're trying to impregnate them with gendine.

Our mission is to do no harm and to alleviate suffering. Every intervention has the risk of doing harm, just by the fact that it is an intervention. If you take out this harmful aspect and just provide the benefits without the risk, that's a major advancement in medicine.

We're really at the shore. But there's an ocean of tremendous discoveries and novel technologies that would improve patient care and redefine the new boundaries for infection control.

Taking a different perspective on a baffling disease

Myelodysplastic syndromes have long baffled scientists who, despite concerted efforts, have been unable to find an effective treatment for this group of disorders. Characterized by a condition in which bone marrow does not produce enough blood cells and platelets, MDS usually affects older adults. To date, the only treatment has been supportive care through blood transfusions, sometimes two and three times a week, and antibiotics to reduce infection.

According to Jeffrey Molldrem, M.D., associate professor of medicine and chief of transplantation immunology at M. D. Anderson, since the cause of these disorders is not well understood, they have been particularly troublesome to treat. More than half the patients die from having low blood counts or end up having strokes or bleeding to death.

This led him and his colleagues at M. D. Anderson and the National Institutes of Health to look at MDS from a different perspective. Rather than treating it as a cancerous condition, they decided to treat it as if it were an autoimmune disease, using antithymocyte globulin, a medicine typically used in organ transplant patients.

"We chose ATG because it suppresses the immune system and is used to successfully treat patients with aplastic anemia, a related bone marrow failure disorder. There was good evidence that aplastic anemia is probably an immune-mediated effect, so we reasoned that MDS may be similar," Molldrem says.

Between January 1994 and June 1998, 61 patients were entered into a Phase II trial of ATG treatment for myelodysplastic syndromes. The protocol was restricted to those who were dependent on red blood cell transfusions. In addition, one month before entering the study, patients were required to discontinue all other treatments capable of stimulating bone marrow.

In the August 6, 2002, issue of the Annals of Internal Medicine, Molldrem and his group reported that with the immune-suppressing ATG one-third of the patients improved their ability to make enough blood cells to stop blood transfusions.

"We are able to impact a lot of people's quality of life," Molldrem says. "We restored blood counts to normal and they remained normal over a period of five, and now, up to almost seven years. With this study, we are the first to demonstrate that MDS has an autoimmune component. Now, we can think of this as having an autoimmune component in *some* patients and tailor treatment accordingly."

The advantage of the ATG treatment, Molldrem says, is that it is administered once a day for four days during a hospital stay, and if it works, the effect is long lasting. In fact, among the patients who responded to ATG, 90 percent were making enough blood cells to be transfusion-free after five years. Perhaps as significant, none had progressed to leukemia.

Jeffrey Molldrem, M.D., continues his research into myelodysplastic syndromes at M. D. Anderson.

"They got off of transfusions and could then lead a normal life," he says. "In fact, they live longer than the patients who didn't respond to ATG."

The researchers are not sure why the other two-thirds of patients did not respond to the treatment. Dr. Molldrem suggests that one reason for these findings is that there are five subtypes of the syndrome and that those with the refractory anemia subtype respond best.

The five subtypes are refractory anemia, refractory anemia with ringed sideroblasts, refractory anemia with excess blasts, refractory anemia with excess blasts in transformation and chronic myelomonocytic leukemia. However, not all were included in the study. Patients with chronic myelomonocytic leukemia and those with 20 percent or more blasts in the bone marrow were excluded.

Approximately 20,000 new cases of MDS are documented annually in the United States, according to Molldrem, with numbers steadily on the rise. Early symptoms of the disorders, such as weight decrease, fever and loss of appetite, are vague and could be attributed to many other causes, making it difficult to diagnose in its early stages.

M. D. Anderson researchers are currently following up the results of this clinical trial with studies using other immune-suppressing drugs such as cyclosporine and combinations of drugs, including ATG.

This study was supported by a grant from the National Institutes of Health. The manufacturer of ATG is Pharmacia Corp.

Technology and the personal side of cancer

While surgeons have developed innovative techniques to fight breast cancer, patients continue to find the issue of breast reconstruction highly personal and sometimes overwhelming. To help them learn about reconstruction options at their own pace in a comfortable setting, plastic surgeons at M. D. Anderson have developed an interactive CD-ROM.

Conceptualized and designed by Michael Miller, M.D., associate professor of plastic surgery, the CD-ROM "Breast Reconstruction: What You Need to Know" communicates the latest reconstruction techniques available and illustrates the procedures using highly detailed, step-by-step, three-dimensional animation.

"My colleagues and I were struck by the shortage of good information available to women about breast reconstruction," Miller says. "Most of the lay educational material available is about diagnosis and treatment, not breast reconstruction. Yet, a very important part of the breast cancer recovery process is empowering women with information so they can select an option that best helps them to achieve their goals."

The CD-ROM, produced by UT Television, features Miller and his colleagues explaining reconstruction techniques via streaming video. In addition, they present the information in text and chart form so women can print the data to review with their doctors.

Miller emphasizes that it is vital for women facing breast cancer to learn about the reconstruction experience from women who have been there. On the CD-ROM, 15 breast cancer survivors, all current or former M. D. Anderson patients, relate their personal journeys and discuss the reconstruction techniques they chose.

"We want women who are considering one of the different types of reconstruction to learn from women who opted to have the same procedure," Miller says. "From our experience in the clinic, we know that patients appreciate other women talking about their own experience."

The 15 survivors — of diverse ages, races and breast reconstruction techniques — are shown living their lives, running, swimming, working and caring for their families. Among them are women from the Pink Ribbon Project, a program of the Department of Volunteer Services, which brings volunteer survivors face-to-face with newly diagnosed and current patients undergoing treatment in the Breast Center.

"It's important that we let patients know that you can get through cancer, and these women are proof," Miller says. "We felt strongly that our message regarding the state-of-the-art breast reconstruction available here be delivered using the latest technology, yet in a very personal and user-friendly way."

According to Miller, breast reconstruction demographics vary widely across the country. Each year at M. D. Anderson, about 350 mastectomies are performed with about 80 percent of those patients undergoing reconstruction at the same time. In the United States, Miller says, reconstruction rates range from 8 percent to 40 percent, with most procedures being performed later during the course of treatment. Older women are significantly less likely to want reconstruction, while younger patients often are more willing to undergo the extensive procedure for aesthetic purposes.

Every new patient who comes to M. D. Anderson's Nellie B. Connally Breast Center for a consultation during the next year (more than 2,000 women receive consultations annually, according to Miller) will receive a complimentary copy of "Breast Reconstruction: What You Need to Know."

The CD-ROM is available for $10 plus $3 shipping by calling (713) 794-1247. It also can be ordered on the Internet at www.mdanderson.org/diseases/breastcancer/breastsurgery/. Funds from its sale will further the reach of the CD-ROM, including production of Spanish and Arabic versions. ❑

Michael Miller, M.D., wants women to have the most information possible before making decisions about breast reconstruction options.

Children's Art Project + M. D. Anderson = a new Texas license plate

M. D. Anderson now has its own license plate. Using the floral motif from a popular Children's Art Project card and scarf, designed by pediatric patient Sayna Rahbari, 15, the plate highlights both the institution and the art project.

The license plate is the 49th in the collegiate series approved by the Texas Department of Transportation. (As a component of The University of Texas System, M. D. Anderson qualifies for collegiate plates.) The plates cost $30 annually, in addition to regular vehicle registration fees. Of that amount, $25 is deposited in the state's general revenue fund for college scholarships.

To obtain a plate, access TxDOT's Web site at http://www.dot.state.tx.us/vtr/spplates/specialplate.htm?nbr=112; the Harris County Tax Office Web site at www.tax.co.harris.tx.us/; call the TxDOT Help Desk at (512) 465-7611; or check out the Children's Art Project Web site, www.childrensart.org.

Molecular tag pinpoints which breast tumors may spread

A new molecular tag discovered by scientists at M. D. Anderson may help doctors decide which breast cancer patients need more aggressive treatment and which can forego the potentially toxic course of chemotherapy.

Khandan Keyomarsi, Ph.D., associate professor in experimental radiation oncology, and her colleagues reported in the Nov. 14 issue of The New England Journal of Medicine that high levels of a protein called cyclin E are closely associated with aggressive, invasive breast cancer.

The study, conducted with tissue samples of current or former breast cancer patients, appears to show that cyclin E is a much better predictor of patient outcome than any current predictive marker. However, says Keyomarsi, the study must be repeated with newly diagnosed patients to determine its true predictive value.

The ability to predict which breast cancer tumors will recur or spread throughout the body is an important aspect of breast cancer treatment.

Currently, the prognosis for women diagnosed with breast cancer is determined by whether tumor cells have spread to lymph nodes. But some women who have cancer cells in the lymph nodes never have a recurrence, while others whose cancer has not spread do have a recurrence.

Many women, after discussions with their doctors, opt to undergo grueling chemotherapy in hopes of ensuring that any rogue cancer cells that may be present are killed. If an accurate predictive marker were available, many women could be spared chemotherapy, Keyomarsi says.

For the study, scientists examined tumor tissue from 395 patients with breast cancer. Of those patients with stage one breast cancer, in which a single tumor is found and the cancer has not yet spread, about 10 percent had high levels of cyclin E in their cancer cells. All of these patients had died from a recurrence of breast cancer within five years of diagnosis, while none of the patients who had low levels of cyclin E had died. The proportion of tumors that had high levels of cyclin E increased with increasing extent of disease.

"However, we have to validate the study using newly diagnosed patients in which we are blinded to the diagnosis," Keyomarsi says. "We are in the midst of that study now. If it bears out our initial results, we will try to get it into the clinic as soon as possible, though it may be at least one year. My hope is that this technique may help ease the burden of chemotherapy among breast cancer patients. Women who don't overexpress cyclin E may not need chemotherapy which kills all dividing cells and can do significant damage to other tissues and organs."

Keyomarsi's research was supported by grants from the U.S. Army Medical Research and Material Command and the National Cancer Institute. She holds U.S. patents on the use of cyclin E to detect and treat cancer.

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… please use the appropriate telephone number below to receive the information you need.

M. D. Anderson's main phone number — (713) 792-2121
for help in contacting various offices and individuals

New Patient Referral — (800) 392-1611 (option 1)
for when you or your physician wish to make your first appointment

The M. D. Anderson Information Line — (800) 392-1611 (option 3)
for questions about treatment options, resources and programs at M. D. Anderson

The Welcome Center — (800) 889-2094
for patient information

Patient Business Services — (800) 527-2318
for questions about any phase of the billing process or your patient statement

Rotary House International — (800) 847-5783
for hotel reservations

Cancer Information Service — (800) 4-CANCER
for learning more about a particular type of cancer, treatment options and community resources

Cancer Prevention Center — (800) 438-6434
for cancer screening to detect any existing cancer at its earliest and most treatable stage

Sharing hope, support and understanding with anyone diagnosed with cancer regardless of where treatment is or was received, the Anderson Network is a program of the Department of Volunteer Services at M. D. Anderson. Visit the Anderson Network Web site at http://www.mdanderson.org/andersonnetwork.