



Lauren Doner Hirn was born in West Lafayette, Indiana, in the 1950s. She moved around a lot growing up. From Indiana to Rome, Chicago, Hamburg, Salzburg, and Boston, to name just a few of the places she lived. After studying painting at the Rhode Island School of Design she found herself in NYC, and has made a living as a scenic artist in United Scenic Artists Local 829 for the past 22 years.

She was diagnosed with breast cancer in 2008 when her son was six years old. She feels like the luckiest woman in the world now that Lou Gehrig is gone.

Stories Wanted By Lauren Doner

I keep glancing at the leaflet, thinking I have a few good stories. I come from a family of writers. I can tell a good joke. My face is rubbery and expressive and no emotion goes unnoticed. I am a terrible liar. I've been told you can read my face like a book.

As a child, at the dinner table my dad would begin to speak, getting more and more dramatic as the story went on. Mom would interrupt, "Oh Dean, that's not how it happened."

"Now, Lois," Grandma J. would say, "don't ruin a good story with the truth." Fast forward about six lives and 60 addresses, and here I am. A mom, a wife, a scenic artist, a daughter, a sister, a 52-year-old breast cancer survivor.

My dad died at 67. This seemed old to me at the time, but now it seems only half a life. My mom, now 89, lives in New Hampshire. Diagnosed with Alzheimer's, she is surrounded by wonderful, caring people, yet way too far away. I decided not to tell Mom about my cancer diagnosis.

I lost all my hair during the winter months. Who knew being bald was so cold? My lack of eyebrows and lashes made my whole face feel naked and raw. I decided to wait to visit Mom until a respectable fuzz was on my head — Mom's eyesight is not good, and my lashes and eyebrows were growing back. My husband kept telling me how good I looked. From people in town, I heard, "Nice hair cut!" a few times. When this happened, I would come home and ask my husband, "Do you think they are just saying that? Do they know? Do I really look good?"

I drove the five hours to see Mom.

I walked in. "What the hell did you do to your hair?" she asked. "You look like a boy!"

I went to the bathroom. Walking into the living room again, Mom sees me. "Oh, are you here?" she asks. "What the hell did you do to your hair?"

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If you would like an e-mail copy of *Bridges*, please sign up at www.mskcc.org/bridges to join the mailing list



Memorial Sloan-Kettering
Cancer Center



In honor of National Cancer Survivors Day, MSKCC hosted a Survivorship Celebration in June. Over 500 people attended the special evening, which featured a question and answer session with Joe Torre, former Yankees manager and prostate cancer survivor. Additionally, two inspiring MSKCC patient survivors, Jennifer Rogers and Anthony Corrao, gave heartfelt speeches about their experiences moving through the World of Cancer.

According to the National Cancer Institute, there are nearly 12 million cancer survivors in the United States; looking around the MSKCC auditorium that evening, you realize that cancer does not discrimi-

nate. It strikes rich and poor, all races, the young and old. The effects of surviving cancer can take a toll physically, emotionally and financially. After survivors endure pain and fear, they emerge as different people - perhaps tougher and wiser but definitely more resilient. It was a memorable evening to celebrate beating cancer, being alive, and giving an important voice to survivorship. A video presentation of the evening is available for viewing at www.mskcc.org/livingbeyondcancer.

If you are interested in submitting your story or have suggestions for newsletter content, please e-mail bridges@mskcc.org.



My MSKCC Hospital Card Is Almost 60 Years Old

By Dorothy Mortman

I still have the Memorial Hospital Clinic Card from my first visit to the hospital in 1952, when I was 26 years old. Fortunately that breast lump was benign.

In the subsequent years, I had other benign breast growths until 1995, when cancer struck my right breast. I had surgery one week after I returned from a trip to Morocco.

The nipple was loaded in all areas and the exact spot it broke through to the breast was uncertain. I had a mastectomy and reconstruction.

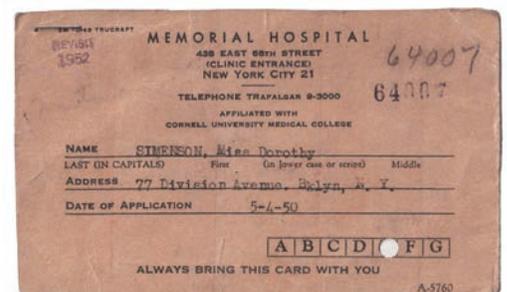
Two years later, in 1997, cancer appeared in my left breast. Fortunately, it was so small, at two millimeters, that I only had a lumpectomy — no need for radiation or chemotherapy.

Now at 86 years old, almost 14 years after my second breast cancer, I am still cancer-free. In the 60 years since my first visit to

MSKCC, I married, had two children, three grandchildren, obtained a bachelor's degree and a master's degree, and am still pursuing knowledge through the My Turn Program at Kingsborough Community College.

I pray that before I close my eyes forever the cure and prevention of breast cancer will be found. I pray that my daughter, my granddaughter, everyone's daughters and granddaughters, and, yes, in those rare cases, the sons and grandsons will be spared from this disease.

My first MSKCC hospital card is almost 60 years old. Would you like to see it?



Dorothy retired from her position as Sales Tax Auditor with New York State in 1990. Her husband, David, of 51 years, died two years ago. She has a son, daughter, and three grandchildren. In retirement, she takes courses at Kingsborough Community College and writes short stories. The last one was published in the anthology Murder New York Style.

Ask the Professional:

Palliative Care for Cancer Survivors

Paul Glare, MD

Dr. Glare is Chief of the MSKCC Pain and Palliative Care Service. He came to MSKCC in August 2008 from Sydney Australia, where he spent ten years as chief of a large academic palliative medicine program.



Q I have survived my cancer, but I experience ongoing pain as a result of my treatment. How is palliative care used in pain management for cancer survivors?

A Just as cancer survivorship is now a much broader concept than “disease-free five years post-treatment,” palliative care is much more than “comfort care at the end of life.” Modern palliative care is not hospice; it is patient-centered management of pain and other distressing symptoms that incorporates psychosocial and spiritual care according to patient and family needs, values, beliefs, and culture. It is provided alongside cancer treatment, or it can be the main focus of care affirming life by supporting the patient’s and family’s goals for the future, including their hopes for cure or life prolongation, as well as their hopes for peace and dignity throughout the course of illness. It aims to guide and assist the patient and family in making decisions that enable them to work toward their goals during whatever time they have remaining.

Pain management in survivors who are disease-free after completing treatment makes up about a quarter of my practice. Cancer survivors may face physical, emotional, social, spiritual, and financial challenges as a result of their cancer diagnosis and treatment — and effective management of pain is an important part of survivorship. In patients with progressive disease on active treatment, regularly scheduled doses of strong pain medicines like morphine are the mainstay of pain management. The aim is to titrate the dose of the pain medicine until comfort is achieved.

Pain can also affect survivors who have completed initial cancer management and have no apparent evidence of active disease. Pain may be a side effect of treatment or it may be unrelated. The prevalence of pain depends on the type of cancer treatment a person has had. For example, up to 50 percent of women have moderate-to-severe pain one year post-mastectomy.

Pain in disease-free survivors should be approached as chronic non-malignant pain, and pain medicines should play less of a role in the treatment. A careful history, physical exam, and data review (blood work, scans) are needed to a.) rule out recurrent cancer and b.) try to identify a cause, be it treatment related (e.g., postsurgical pain, chemotherapy-induced neuropathy), or unrelated (e.g., degenerative disk disease, migraine, fibromyalgia). A

comprehensive psychosocial assessment is also needed to rule out anxiety or depression and to determine the patient’s understanding of chronic pain and its optimal treatment. First-line therapies include physical treatments (rehabilitation, TENS, massage, acupuncture, aids), nerve blocks, and cognitive-behavioral approaches.

Pain medicines should be reserved for disease-free survivors who do not respond to non-drug therapies. If a decision is made to use narcotics long-term, issues like tolerance, dependence, addiction, and diversion need to be addressed. While pain medicines may be safe and effective in cancer survivors, many patients look forward to discontinuing them, as further proof that they have beaten the cancer and are returning to a normal life. Pain medicines can also be a problem for survivors returning to the workforce. This is especially the case if their occupation requires them to operate a vehicle or machinery, carry a firearm, count money, or perform other tasks that require acute attention.

Most cancer centers and hospitals now have a pain and palliative care service. Don’t be afraid to ask your oncologist, primary care physician, or survivorship practitioner if you think a referral would be of benefit to you.



Do We Know the Right Questions?

By David Ravin

David has been practicing law for 60 years. He specializes in corporate reorganization. In a sense, David explains, he does for corporations or creditors in financial trouble what the doctors at Memorial Sloan-Kettering do for their patients' physical issues — restructuring their debts or resolving their claims, as the case may be, to help give them a fresh start so they can get on with their lives.

By now, not only lawyers but hospital staff, patients, and their families know about Living Wills, Patient Directives, and Powers of Attorney. All of these documents anticipate that a patient will be in a mental condition in which he or she cannot make treatment-related choices.

Unfortunately, there is also a situation in which everyone, including the patient, believes the patient is rational and can make decisions – but it ain't necessarily so.

When I was diagnosed with cancer at the base of the tongue, my ENT doctor sent me to a surgeon who specialized in treating the disease. When I met with him and his radiological associate after further biopsies, I told him that in my legal specialty, Chapter 11 Reorganization, I have frequently found that the clients who need my services do not know the right questions to ask. “So,” I said, “tell me what questions I need to ask and what the answers are.”

The doctor told me I needed an operation on my tongue plus external-beam radiation. He thought the swelling of glands around my throat was a spin-off of the cancer. Only after I pressed did he concede I would most likely need

two operations and that I might need to use an electronic device to speak.

I told him that I could not practice law or live like that and I would rather die; so, I took my records and walked out.

I then went to another oncologist who ordered chemo to be followed by radiation. I got worse. I could not eat or swallow and lost 60 pounds and was in and out of the hospital and fading. My friend Mark visited me and said, “Why don't you go to Sloan-Kettering?” I was tired, disgusted, and depressed and only eating custard and Jell-O. I was shutting down physically, mentally, and emotionally.

I told Mark, “If you get me an appointment tomorrow, I'll go.” An hour later, he said he had an appointment at Memorial Sloan-Kettering for 2:00 PM the next day and to bring all of my reports and x-rays. Dr. P. saw us at 5:00 PM and answered every question we asked, and all the ones we hadn't thought of. He was puzzled by the swollen glands. We didn't leave his office until 7:30 PM.

Dr. P. called me the next morning at 7:30 AM and said he could not sleep thinking about my case. He asked me to come in the next day at 7:00 AM

for “grand rounds.” They put me up in a chair on a stage, and a lot of doctors probed my mouth, glands, throat, and nose.

Dr. P. then met with us and said that he was going to suggest a radical chemo treatment that he hoped would work on my cancerous tongue and reduce the swelling around my throat. He would order radiation, too, and thought this combination was my best shot for remission and a return to active law practice. I said, “Let's do it!” Three months later, I was, and have been, cancer-free for 13 years.

There are two important points here:

1. I was ready to give up and die because I was incapable of objectively assessing my condition.
2. Dr. P.'s concern and complete candor made me feel that he understood and knew what he was talking about. He answered my questions and presented my best chance for survival and having a productive life.

By sharing my story, I want to convey hope to others. The treatment was a success as I am writing this from my law office at the age of 85.

My Unplanned Journey

By Louis Onofrio

Louis Onofrio is 68 years old and lives in Branford, Connecticut. His birthday is September 11, 1942.

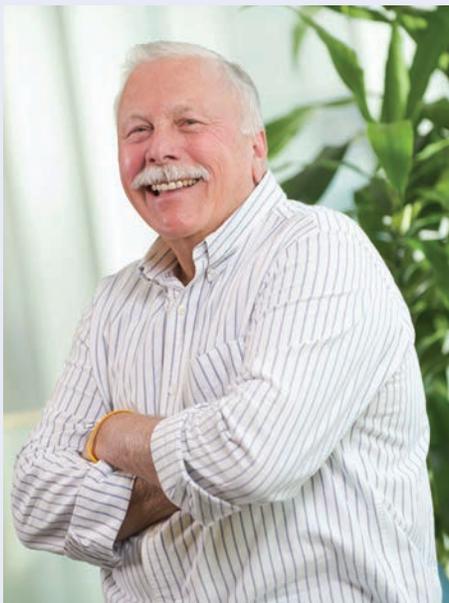
When I started urinating blood last September, I went to my GP. He said it sounded like a urinary tract infection, took a urine sample, and sent it to the lab. The day after Labor Day, he called me and said that since there was no bacteria growth I should see a urologist.

When I went to see Dr. C., I was bleeding too much to be scoped. When he was finally able to perform the procedure, all I thought about was what I was going to do if it was bad news, so I formulated a game plan to help me cope.

When I got the report late on Friday, October 2, my wife had left for Vermont with a couple of her friends for the weekend; so I didn't tell her until she got back. She was mad at me for not telling her before (she does not take the news of illness well), but ultimately, she and our fourteen-year-old daughter and my two married daughters adjusted to our new reality. The news was not good.

I learned that the blood came from a broken papillary tumor and that there was another one in my bladder that had to come out. I also learned that all papillary tumors in the bladder are either invasive or noninvasive.

I called my brother, Dominick, a twenty-year lung cancer survivor and asked him to ask his doctor, Dr. K. from MSKCC, for a referral. I learned that the cancer was invasive and that my bladder had to come out. Also it was small cell cancer, and I had to get treated within six weeks.



When I saw Dr. D. at MSKCC, he explained the treatment would be first chemotherapy, then surgery. He also informed me that I was a candidate for a neo-bladder. Dr. D. then called Dr. B., a research oncologist who would set up my treatments. On November 10, 2009,

I had my first chemo treatment. I was given six rounds of chemo, with the last one on February 24, 2010. The treatments were three days a week, every three weeks.

On April 29, 2010, Dr. D. removed my bladder and prostate and constructed a neo-bladder from my small intestine. The entire process had to be scheduled, coordinated, and performed by the best doctors, nurses, and staff in their fields at MSKCC. On my first follow-up visit on May 11, 2010, Dr. D. told me that my pathology report from the surgery was clean. I was now cancer-free and thankfully, the cancer had not extended outside my bladder.

It has been a long journey since last September and I have learned much. Prayer helped. I'm Catholic, and the church I attend would put my name in the bulletin every week I was sick and ask the parishioners to pray for me. I strongly believe that it helped. The prayers of my fellow parishioners combined with early detection, treatment, and the experienced and knowledgeable doctors, nurses, and staff at MSKCC completed the bargain and helped me on my unplanned journey.

■ *Continued from page 1*

I ran out to the car to get the bags. Coming back in Mom sees me and says, "Oh, when did you get here? What the hell did you do to your hair?"

Dinner at Mom's is a nice affair. They have white tablecloths, and polite young college kids serve the residents. We sat down and Mom introduced me: "This

is my daughter Laurie, the one who used to have the long, beautiful locks. What the hell did she do to her hair?" After dinner we grab some coffee and chocolate. I set up the card table. Scrabble is a must when two or more of our clan ever happen to be together for more than 45 minutes at a stretch.

Mom crushes me, her mind as sharp and fluid as ever. She can't see the

letters, but the words form almost magically. Triple word scores seem to line up for her. If she grabs a Q, a U always follows.

"Nice game, Mom," I say.

She looks up: "Laurie? Are you here? What the hell did you do to your hair?"



TO TELL OR NOT TO TELL

By Simona Nadelson

Simona was born in Vinnytsa, Ukraine, was educated in Leningrad, and lived in Minsk before immigrating to the United States in 1981. Now retired, she has worked in both countries as a physicist, a chemist, and most recently as a criminalist with the NYC Police Department. Simona and her husband of 53 years live in Brooklyn.

It was autumn, 2004. As soon as I knew that my best option was an open surgical biopsy on my enlarged salivary gland, my reaction was to have it.

“No complications, everything is fine,” the doctor said when he came to visit me at night after surgery.

A week later I was in his office to have the more than 20 stitches behind my left ear removed. He looks worried, was my first thought when I saw the doctor enter. I managed to catch his eye.

“You need radiation immediately,” he said.

His words sent a chill down my spine. The stillness around me screamed that things were not working the way I wanted them to. For emotional support, I looked at my husband. His whole head had turned a purplish red.

“Do you have a good specialist?” he asked the doctor. My husband’s simple

question changed the atmosphere in the room. I could breathe again.

Returning to our car, neither my husband nor I said a word. I opened my purse and took out the pathology report the doctor had given me. As I sat reading it, I was astonished to learn that my particular disease was called mantle cell lymphoma. My eyes opened wide. How could I have been so mistaken? When the doctor had told me its name minutes earlier, I thought he said mental cell lymphoma. The word “mental” had shocked me even more than the word “radiation.”

I was on the verge of reading the report to my husband when he spoke.

“You must not tell anyone,” he said in a strong voice. His words took me back to the Soviet Union, where we lived before we came to America. We used to say that sentence to protect ourselves when one of us shared certain information with the other, both of us aware that it was almost as dangerous just to

know it as it was to tell it. Revealing a secret could destroy our lives. Did the past still have an influence on my husband’s thoughts?

“Why do you say that, Allen? Why must I not tell anyone?”

“It’s simple, he said. “You will be upset to discover that people avoid listening to such news because then when they go to bed they want to be able to fall asleep.”

But I had no intention of keeping my diagnosis a secret. I would need advice, information, and support. Anyway, I always feel better when I tell people what is on my mind.

That same evening I called my friend Olga in Florida. I told her my story, including the name of my cancer. Two days later she called me back.

“Simona,” she said, “everything you told me, it was too much of a distraction. I couldn’t sleep all night.”

Resource Review: Now in iTunes: Our Survivorship Video Podcast



Memorial Sloan-Kettering Cancer Center now offers a free and convenient way to download our latest videos. Go to iTunes, subscribe to our podcast, and watch recent Memorial Sloan-Kettering events focusing on a range of physical, social, practical, and personal concerns that cancer survivors face.

Furthermore, web casts of over 20 selected meetings, lectures, and discussions designed to assist in adjustment to life after cancer treatment are available on the Living Beyond Cancer section of the Memorial Sloan-Kettering Cancer Center website www.mskcc.org/livingbeyondcancer. Each program is tailored to a specific aspect of living well after cancer. These programs are sponsored by our Post-Treatment Resource Program.

Ask the Survivor: Nutrition

Q It's not news that nutrition is a huge factor in the body's ability to find the strength to withstand trauma, but while undergoing cancer treatment/recovery, nutrition is often the last thing considered in any kind of practical sense. Surgery, chemotherapy, radiation – all of these stress body and mind (for patient and caregiver alike) and meals are often haphazard, if not skipped entirely. Given all this, how can a patient's diet contribute to his or her recovery?

A Cancer treatment is likely to affect both the taste buds and the salivary glands so that not only does food not taste normal, it may actually taste bad and the diminished saliva may make only liquid foods palatable. Even very small particles may make foods feel gritty in the mouth, and dry foods in liquid may still be too dry to tolerate. Since taste may be disrupted during the patient's



By Ellen J. Greenfield

When her husband, Mark, went through the rigors of treatment and recovery for head and neck cancer, Ellen created tasty, calorie-packed, nutritionally complete meals to support his return to health.

treatment and recovery, texture becomes a much more significant factor. For example, while dark chicken meat in a soup may be fine, white chicken meat might not be.

Even after treatment has ended, cancer patients may be left with eating constraints. The body is looking for nutritional backup in order to heal, but the person may be hard-pressed to take in sufficient calories to satisfy the need.

Practical advice: If you can only eat small portions, you want to make every mouthful count. Calorie density is the key. Every spoonful should contain a humming little factory of vitamins, minerals, protein, carbs, and fats to fuel the body.

Soups – made with lots of fresh vegetables, potatoes, simple proteins like beans, chicken or tofu, and beneficial fats like olive or walnut oil – offer an

excellent solution, since they are easily tolerated, palatable, nutrient rich, and filling. Smooth, pureed soups may be called for toward the end of treatment and in the first few weeks afterward, when a sore mouth/throat may be an issue. If necessary, soups can be made even silkier by pressing them through a sieve. As you are able to tolerate more texture, foods can be left chunkier to offer more textural interest – and skinless, boneless chicken thighs or tofu (bean curd) might be cubed and mixed in for protein, flavor, and texture.

Other foods to consider are eggs, particularly soft boiled, sunny side up, or very softly scrambled (the cheese in omelets may be too dry), and various types of shakes, especially those used by professional bodybuilders. To shakes, I suggest adding premium-quality ice cream or yogurt, smooth peanut or almond butter, bananas, or other soft fruits and even a bit of flax seed oil. With these additions, you may be able to squeeze some 600+ calories into each shake!

Two important words: Things Change. If a particular food doesn't work for you at one point, don't reject it completely. Try it again in another couple of weeks. As recovery continues, your tolerance and enjoyment of texture and flavor will change and grow. Texture, in particular, can become even more important than taste if taste buds are affected by treatment. A texture that seems intolerable at one point may become palatable a few weeks later. Let yourself experiment. And if you're the caregiver, don't expect a lot of compliments on your culinary expertise and don't take it personally when something doesn't work. Freeze it, move on, and try it again in a few weeks.



Eyeing the Unsayable

By Ted Stein

The last transformation / is the one /you'll never see

— Christine Pugh

Except in the face of another.
It's time. I feel the cold moon-loneliness
of a sailor peering through spray far out from shore.
The doctor now must speak the unspeakable words
and give me a clear sustaining call
over the rocking heart of things.

He stands en face. How odd that he looks
a bit like me. But he's afraid of my face.
His blank eyes skitter beneath my chin, caught
in a thought-nystagmus looping on itself,
so that I cannot parse or get any help
from the stuttering argot he uses to console
and at the same time flee me while he can.

I turn to my left. In the shadow behind,
a second doctor I didn't know was there,
in a long white coat hanging open enough
to show her modest cleavage. Her eyes are fixed
on my face, their brown depth asking wordlessly,
“And how is it with you?”

At my back a western wind is freshening fast,
ahead a little squall. I'm ready now.

Ted retired from teaching college English in 1998. Since retirement, when he began to make serious daily efforts, he has found that the exploratory work of writing provides clarification of feelings and a sense of consolation through connecting one with the sufferings and joys of others. During his treatment for cancer at Memorial Sloan-Kettering, he was involuntarily looking for a reciprocal recognition in a physician, and by confronting his internal search was able to create a vision of how this might happen and how it might help heal the spirit.

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Bridges is available to read online at www.mskcc.org/bridges.

If you would like to connect with other survivors through the Post-Treatment Resource Program, please see the online calendar at www.mskcc.org/livingbeyondcancer.

PATIENT – TO – PATIENT

We are grateful for the support of our patients and family members. If you are a former patient or family member who has completed treatment please consider becoming a Patient-to-Patient Volunteer.

For more information contact Marina Lenderman at 212-639-5329 or e-mail patient2patient@mskcc.org.

DEDICATION

Bridges is dedicated to all of the MSKCC patients who have endured many hours of arduous treatment and difficult challenges and, as a result, have become cancer survivors. The purpose of this newsletter is to offer a forum where patients and their families can share experiences.

Bridges is also dedicated to all of the MSKCC professionals who have worked in the world of cancer. These people have devoted their lives to making it possible for cancer patients to become survivors.

We hope that you and your family will share your stories with us.



Memorial Sloan-Kettering
Cancer Center

Bridges is a publication of the Memorial Sloan-Kettering Cancer Center Survivorship Initiative.

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For more information or to arrange a writing session, please contact Judith Kelman at 212-535-3985 or kelmanj@mskcc.org.