

# NMCCA

September 2006



## COMMUNITY NEWSLETTER

### Prostate Cancer Section

In each issue, NMCCA presents information about a different cancer. In previous issues, we discussed breast cancer and colorectal cancer. The focus for this summer issue is prostate cancer.

### Save the Date!

#### NMCCA's Annual HERO\* Recognition Breakfast

October 12, 2006

Watch for your invitation!

NMCCA's heroes are those people who took part in an NMCCA-opened cancer clinical research studies. This year's breakfast will recognize those HEROs who participated in the studies between January 1, 2005 and June 31, 2006.

### Advancing Cancer Clinical Research in New Mexico

New Mexico Cancer Care Alliance just completed its third fiscal year as a non-profit, charitable organization in Albuquerque. NMCCA is very proud of the advances it has made in our processes and staff to continue to provide access to clinical research for cancer patients in New Mexico. NMCCA currently has over 100 research studies available and 262 patients took part in NMCCA-opened cancer research studies from July 1, 2005 to June 30, 2006.

NMCCA's educational outreach program continued to expand as we co-sponsored a seminar with the Leukemia & Lymphoma Society called "Trials & Triumphs." Malcolm Purdy, MD, a physician with Hematology Oncology Associates and Ian Rabinowitz, MD, a physician at the UNM Cancer Research & Treatment Center, both NMCCA physician participants, talked to patients about cancer clinical research studies in general and how they relate to blood cancers in particular. Dr. Claire Verschraegen, NMCCA's medical director, and a UNM Cancer Research & Treatment Center physician, spoke at the annual People Living Through Cancer "Seeds for Survival" conference. Vincent Ortolano, MD, a urologist with Albuquerque Urology Associates, a Director on NMCCA board and a physician participant (as well as this issue's featured cancer conversation doctor) will join the Prostate Cancer Support Association at their September support

group meeting.

Regarding our clinical research study programs, one of NMCCA's goals over this past year was to open additional significant prostate cancer studies. Our medical oncologists and urologists are meeting to discuss the needs of the prostate cancer treatment community and set up an integrated, multi-disciplinary program for prostate cancer research studies. Additionally, we have a new community research coordinator, Melissa Valdez, who is working closely with the urologists at Albuquerque Urology Associates and just beginning to work with Dr Michael Davis at the VA Medical Center to advance the prostate cancer program.

NMCCA is very pleased to be reaching out to and supporting the community. Our close ties with the prostate cancer physicians prompted the theme of this month's issue. We hope you find that the information contained in the articles is informative. We also hope that we will encourage New Mexican men to have a prostate cancer screening.



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## A Brief Background on Prostate Cancer

Cancer can occur in any part of the body when cells grow out of control and form a mass of tissue called a growth or tumor. The prostate gland is part of the male reproductive system and is normally about the size of a walnut. It makes and stores the fluid that nourishes sperm. Located below the bladder and in front of the rectum, it encircles the urethra, the tube that empties the bladder. Prostate cancer occurs when cells grow abnormally in the prostate.

Although men of any age can develop prostate cancer, it is found most often in

men over age 50. In fact, more than 75 percent of men with prostate cancer are over the age of 65. Fortunately, the lifetime risk for an American man is low, only about 3.4 percent. Despite this low lifetime risk, prostate cancer is the second most common cancer in men in the United States. Skin cancer affects more people, and lung cancer, although it occurs less often than prostate cancer, causes more deaths.

In most men with prostate cancer, the disease grows very slowly. The majority of men with low-grade, early prostate cancer

(confined to the gland) live a long time after their diagnosis. Even without treatment, many of these men will not die of the prostate cancer, but rather will live with it until they eventually die of some other, unrelated cause.

However, prostate cancer also can be aggressive, grow quickly and spread to other parts of the body (metastasize). If a man is diagnosed with prostate cancer, he should see his doctor for additional tests to determine which form of cancer he has and the best treatment for him.

## CANCER CONVERSATIONS: Dr. Vincent Ortolano on Prostate Cancer

*New Mexico Cancer Care Alliance has many physicians who specialize in prostate cancer. Vincent Ortolano, M.D., the vice president of Albuquerque Urology Associates and a member of NMCCA's Board of Directors, agreed to discuss the issues surrounding risk, screening, diagnosis and treatment with NMCCA's Linda Green. Dr. Ortolano has completed a fellowship in urologic oncology, is a member of Society of Urologic Oncology and is a diplomate of the American Board of Urology.*

### **How common is prostate cancer?**

Prostate cancer is the most common cancer in American men. By some estimates, it may affect one in six males and is the second leading cause of cancer death in men, second only to lung cancer. Current estimates are that there will be 230,000 new cases this year and approximately 30,000 deaths.

### **What puts a man at risk for prostate cancer?**

First, a man's risk increases as he ages. Physicians find that 75% of prostate cancer tumors occur in men over age 65. Racial background also is a factor in prostate cancer risk. African-American men are twice as likely as Caucasian men to

develop the disease, while Asians and Native Americans appear to have less risk than other races. Hispanic men have the same risk level as Caucasian men. A family history of prostate cancer only accounts for five to ten percent of all prostate cancers. However, if one brother has the disease, his male siblings' risk is twice the average. If a brother and father have prostate cancer, the male siblings' risk rises to five times the average.

Other possible risk factors may be smoking and a high-fat diet.

### **What tests are available to test for prostate cancer?**

Two basic tests are the digital rectal exam (DRE) and the prostate-specific antigen (PSA) blood test. With a DRE, your doctor may examine your prostate by putting a gloved, lubricated finger a few inches into your rectum to feel your prostate gland. A normal prostate feels firm. If there are hard spots on the prostate, your doctor may suspect cancer.

The other screening test for prostate cancer is the PSA. PSA is an enzyme produced by the prostate. When the prostate enlarges, it produces increased quantities. PSA levels in the blood are significantly elevated in cancer of the prostate and even higher in advanced

prostate cancer. The rate of fall of the PSA levels indicates the response to treatment.

When assessing a patient's risk, most physicians now accept an age-adjusted PSA. Men who have prostate cancer may have a higher level of PSA in their blood. However, the PSA level can also be high because of other, less serious causes.

### **What happens when those two screens don't agree? Are there other tests a physician can run to determine whether a man really has prostate cancer?**

If one or both of the PSA and DRE tests are abnormal, the patient will require a transrectal ultrasound (TRUS) and a biopsy to determine if cancer is present. Other blood tests that may be useful include percent free PSA and PSA velocity, which is the rate of change over time (definitions of these tests appear on page 2). An increase of .75 from the previous year's PSA may be significant. Additional tests that may be done include a bone scan, CT scan, MRI, or PET scan. Depending on the particular stage and progress of your disease, your physician can determine which of these tests will be appropriate.

*Continued to page 4*

# Prostate Specific Antigen

Prostate-specific antigen (PSA) is a protein produced by the cells of the prostate gland. It is normal for men to have low levels of PSA in their blood; however, prostate cancer or benign (not cancerous) conditions can increase PSA levels. As men age, both benign prostate conditions (non-cancerous) and prostate cancer become more frequent.

A PSA Test reports the level of PSA detected in the blood. The test results are usually reported as nanograms of PSA per milliliter (ng/ml) of blood. Many doctors now use the following ranges, with some variation:

Amount detected	Level
0 to 2.5 ng/ml	Low
2.6 to 10 ng/ml	Slightly to Moderately Elevated
10 to 19.9 ng/ml	Moderately Elevated
20 ng/ml or more	Significantly Elevated

Generally, the higher a man's PSA level, the more likely it is that cancer is present. But because various factors can cause PSA levels to fluctuate, one abnormal PSA test does not necessarily indicate a need for other diagnostic tests. When PSA levels continue to rise over time, other tests may be needed.

Other types of PSA tests exist to help doctors determine whether or not an elevated PSA in the basic test could indicate cancer. Some of these tests are:

## PSA velocity

PSA velocity is based on changes in PSA levels over time. A sharp rise in the PSA level raises the suspicion of cancer.

## Age-adjusted PSA

Age is an important factor in increasing PSA levels. For this reason, some doctors use age-adjusted PSA levels to determine when diagnostic tests are needed. With age-adjusted PSA levels, a different PSA level is defined as normal for each 10-year age group. Doctors who use this method generally suggest that men younger than age 50 should have a PSA level below 2.4 ng/ml, while a PSA level up to 6.5 ng/ml would be considered normal for men in their 70s.

## PSA density

PSA density considers the relationship of the PSA level to the size of the prostate. In other words, an elevated PSA might not arouse suspicion if a man has an enlarged prostate. The use of PSA density to interpret PSA results is controversial because cancer might be overlooked in a man with an enlarged prostate.

## Free versus attached PSA

PSA circulates in the blood in two forms: "free" or "attached to a protein molecule." With benign prostate conditions, there is more free PSA, while cancer produces more of the attached form. Researchers are exploring different ways to measure PSA and to compare these measurements to determine if cancer is present.

For additional information concerning PSA testing, please visit the NCI website from which this article was taken, <http://www.cancer.gov/cancertopics/factsheet/Detection/PSA>

## Local Support Groups

**Support groups for men with prostate cancer are offered through: Prostate Cancer Support Association, e-mail [pcsanm@att.net](mailto:pcsanm@att.net) or call 505-254-7784**

**Other organizations also offer support groups. Some are: American Cancer Society, [www.cancer.org](http://www.cancer.org) or call 505-260-2105**

**People Living Through Cancer, [www.pltc.org](http://www.pltc.org) or call 505-242-3263**

Please visit the Albuquerque Cancer Coalition's Directory, which is offered hard copy at many physicians' offices or through their website, [www.nmcca.org/acc](http://www.nmcca.org/acc), for additional options.

## Possible Symptoms of Prostate Cancer

According to the American Cancer Society, the following symptoms could be a sign of prostate cancer:

- Difficulty starting to urinate
- Less force to the stream of urine
- Dribbling after you finish urinating
- Frequent urination
- Blood or pus in the urine
- Pain or burning feeling while urinating
- Pain with ejaculation
- Hip or back pain that does not go away over time

Although other diseases also may cause these symptoms, do not ignore them. Please make an appointment with your doctor to determine their cause.

Sources of information: Medline, a resource from the National Library of Medicine and the National Institutes of Health.

<http://www.nlm.nih.gov/medlineplus/prostatecancer.html>

# CANCER CONVERSATIONS:

## Dr. Vincent Ortolano on Prostate Cancer

*Continued from page 4*

**There are so many terms and abbreviations associated with prostate cancer. You've explained PSA and DRE, but physicians frequently use terms like Gleason Score and TNM. What do they mean?**

A Gleason Score is a number between two and ten assigned to the tumor by the pathologist who reviews the biopsy. This number describes how active the tumor may be. The higher the number, the more active and potentially dangerous the disease is.

All of the information from these tests is then used to assign a clinical stage through the TNM System. The T reflects the extent of the tumor itself, N represents whether the cancer has spread to nearby lymph nodes and M designates the presence or absence of metastasis in other organs. The overall stage takes all three categories into account.

See the box on page 6 for a further breakdown of the TNM System.

**What are the usual ways of treating prostate cancer?**

There are many treatment options for prostate cancer. The selected treatment will depend on the stage of the disease. Some options are surgery, external radiation, seed implant, cryotherapy (freezing) and watchful waiting.

If you are diagnosed with prostate cancer, your doctor will discuss these treatments

with you and help you decide. Meeting with a radiation therapist or medical oncologist may also help the patient in the decision process. Your physicians may talk about stratifying risks to help with the decision-making process. Stratifying risks means the treatments are listed in order of the risk of associated harmful side-effects, with the riskiest at the top and the least risky at the bottom.

Additionally, computer-based programs called nomograms help physicians and patients decide which treatment approaches will result in the greatest benefit. One such nomogram for prostate cancer can be found at the Memorial Sloan-Kettering website (see related article on page 5).

For patients with high-risk disease, a combination of treatment types (called multimodality treatment) may be appropriate. A high-risk disease could be one in which the lymph nodes are affected, the patient's Gleason grade is between 7 and 10 or if he has a pre-treatment PSA that is higher than 20. For other patients, a clinical research study, which offers a new drug, treatment or combination, may offer the best option.

**How do I know whether a clinical research study might work for me?**

Speak with your oncology physician. He or she will have the details of your cancer and the treatments you have already undergone, if

any. Your physician will compare your details with the eligibility requirements for prostate cancer studies that are open for enrollment in New Mexico. If there is a match, you can review the clinical research study forms and decide whether or not to take part. A research study is always voluntary (see "Is a Research Study Right for Me?" on page 7).

**You mentioned that age and race are risk factors, as is family history. A person can't change those risks. Is there anything men can do to lower their risk?**

The risk factors that you can adjust are diet and smoking. If you smoke, stop. If you eat a diet high in animal fats, consider increasing your intake of cruciferous vegetables, like broccoli, cauliflower, kale, cabbage, collard greens, Brussels sprouts, broccoli rabé, radishes, turnips, and watercress.

**What about screening? Does that help with risk?**

Screening helps to catch a cancer earlier, when it may be easier to treat. By the time symptoms appear, the cancer may have begun to spread. If a man is not at a high risk for prostate cancer, he should begin screening at age 50. Men at higher risk, such as African-Americans and those with a family history, should begin screening at age 40. A PSA blood test or a DRE during your annual physical are both good options.

## Could you be a HERO?

Helping to Enhance Research in Oncology<sup>SM</sup>

NMCCA's HERO Program events range from educational, awareness and recognition events (such as our annual Recognition Breakfast in February) for the public to educational programs for medical professionals. All these programs are designed to

provide knowledge as to what a cancer clinical trial is and is not and how participating in a clinical trials may benefit a cancer patient. As a 501(c)(3) non-profit organization, NMCCA relies on, and greatly appreciates, grants and donations to support

the HERO Program.

Please consider making a tax-deductible donation to New Mexico Cancer Care Alliance. You may clip this portion and send it with your donation in the enclosed envelope.

**I am pleased to donate to NMCCA's HERO Program. Enclosed is my donation of** (Circle One)

\$10      \$15      \$25      \$50      Other \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

I give permission for NMCCA to acknowledge me by name in the next newsletter

## Phases of Clinical Research Studies

Each new treatment must pass three phases of clinical research study before the Food and Drug Administration (FDA) approves it.

If we knew which arm was better, there would not be a need for a clinical trial. Sometimes the clinical trial shows, in fact, that the standard arm is better. Sometimes the reverse is the case. Sometimes doctors discover that the results of the two arms are the same, but people tolerate one of the treatments better. Unless patients enroll in clinical trials, doctors can only guess which treatment will be safer and more effective.

### Phase I

In Phase I trials, the treatments are new and the side effects may be unknown. Phase I trials determine the highest dose possible of the new treatment and the best method of giving the treatment without serious side effects. The main concern of these trials is safety. The doctor carefully observes each patient for both good and bad reactions while also watching for effects on their tumors. The

dose is usually very low at the beginning and increased only if there are no or minor side effects. Very few people take part in Phase I trials. Patients are usually people for whom existing treatments are not working. If a Phase I trial finds the treatment is reasonably safe, it can then begin Phase II.

### Phase II

In Phase II trials, doctors look for evidence that the treatment is working. The evidence may be that the tumor is shrinking or has disappeared, or it may be that the remission time is longer than with other treatments. Doctors still watch closely for side effects in case new ones appear. More patients take part in Phase II trials than in Phase I trials.

### Phase III

Phase III research begins only after a treatment shows promise in Phase II trials that it is equal to or better than the standard treatment. At this level, trials take place in many cities across the country at the same time. Several hundred to several thousand patients

participate. Doctors compare the safety and effectiveness of the new treatment against the current standard treatment. To compare the treatments correctly, the study randomly divides the patients equally into two treatment arms. No matter which arm a patient is in, his or her doctor watches carefully and provide the best possible care. In a Phase III trial, some people simply may feel uncomfortable about not being able to choose their treatment arm.

### Approval

If a treatment offers obvious improvements for the patient after its Phase III research study, the FDA approves it for the use studied. Sometimes, though, a treatment that appeared to be a big breakthrough in a Phase II trial turns out to be only slightly better than, or has no real improvement over, the standard treatment when tested on thousands of patients in a Phase III trial. However, if the new treatment is much easier for the patient to take than the standard treatment, a new FDA-approved therapy is born.

## Pioneering Treatment Calculator from Memorial Sloan-Kettering

Researchers at Memorial Sloan-Kettering have pioneered the use of computerized tools called nomograms to help patients and their physicians decide among the major treatment choices for prostate cancer. To use a nomogram, a patient and/or his physician enters into the program a combination of disease factors such as stage of the cancer, prostate specific antigen (PSA) level, biopsy pathology, use of hormone therapy, and radiation dosage. The system then determines which available treatment might work best for that patient's disease.

To use this nomogram, connect to <http://www.mskcc.org/mskcc/html/10088.cfm> on the Internet. You should have the following information on hand:

### *If you have not yet received treatment for prostate cancer*

- your most recent PSA (prostate specific antigen) value
- your doctor's assessment of your clinical stage (using the 1992 TNM system)

- your primary and secondary Gleason grade
- if you've already seen a radiation oncologist, the radiation therapy dose that he or she would deliver.

### *If you have been treated for prostate cancer with surgery*

- your PSA (prostate specific antigen) value prior to surgery (and prior to hormone therapy, if you received it)
- your prostatectomy Gleason Sum
- whether or not your surgical margins were positive
- the level of prostatic capsular invasion
- whether or not your seminal vesicles have cancer
- whether or not your lymph nodes have cancer (if any were removed)

If you choose to use this nomogram on your own, please be sure to discuss the results with your oncology physician.



## Stages of Prostate Cancer

- Stage I:** The cancer is still within the prostate and has not spread to lymph nodes or elsewhere in the body. The cancer was found during a transurethral resection, it had a low Gleason score (2 to 4), and less than 5% of the tissue was cancerous.
- Stage II:** The cancer is still within the prostate and has not spread to the lymph nodes or elsewhere in the body, and one of the following applies:
- It was found during a transurethral resection and has an intermediate or high Gleason score (5 or higher), or more than 5% of the tissue contained cancer.
  - Or, it was discovered because of a high PSA level, cannot be felt on digital rectal exam or seen on transrectal ultrasound, and was diagnosed by needle biopsy.
  - Or, it can be felt on digital rectal exam or seen on transrectal ultrasound
- Stage III:**
- The cancer has begun to spread outside the prostate and may have spread to the seminal vesicles, but it has not spread to the lymph nodes or elsewhere in the body.
- Stage IV:** **One or more of the following apply**
- The cancer has spread to tissues next to the prostate (other than the seminal vesicles), such as the bladder's external sphincter (muscle that helps control urination), rectum, and/or the wall of the pelvis, and/or;
  - It has spread to the lymph nodes, and/or;
  - It has spread to other, more distant sites in the body.

## Prostate Cancer Research

**Prostate Cancer Research Studies Offered by NMCCA Physicians (Please view the NMCCA website [nmcca.org](http://nmcca.org) for a complete and up-to-date list of trials)**

**CALGB 90401:** A Randomized Double-Blinded Placebo Controlled Phase III Trial Comparing Docetaxel And Prednisone With and Without Bevacizumab (IND #7921, NSC #704865) in Men with Hormone Refractory Prostate Cancer

**RTOG-P-0126:** Phase III Randomized Study of High Dose 3D-CRT/IMRT versus Standard Dose 3D-CRT/IMRT in Patients Treated for Localized Prostate Cancer

**RTOG 0232:** A Phase III study comparing combined external beam radiation and transperineal interstitial permanent brachytherapy with brachytherapy alone for selected patients with intermediate risk prostatic carcinoma

**RTOG 0521:** A Phase III protocol of androgen suppression (AS) an 3DCRT/IMRT vs. AS and 3DCRT/IMRT followed by chemotherapy with docetaxel and prednisone for localized, high risk prostate cancer

**SWOG-9205:** Central Prostate Cancer Serum Repository Protocol

**SWOG-9346:** Intermittent Androgen Deprivation in Patients with Stage D2 Prostate Cancer, Phase III

**SWOG-S9917:** L-Selenium-Based Chemoprevention of Prostate Cancer Among Men with High Grade Prostate Intraepithelial Neoplasia

**SWOG-S9921:** Adjuvant Androgen Deprivation Versus Mitoxantrone Plus Prednisone Plus Androgen Deprivation in Selected High Risk Prostate Cancer Patients Following Radical Prostatectomy, Phase III

## The TNM System

The following numbers are intended only as a general description. Each level may have additional sub-levels. Please discuss your personal details with your physician.

### T Categories

**T1:** Your doctor can't feel the tumor or see it with imaging such as transrectal ultrasound.

**T2:** Your doctor can feel the cancer when a digital rectal exam (DRE) is done, but it still appears to be confined to the prostate gland.

**T3:** The cancer has begun to spread outside your prostate and may involve the seminal vesicles.

**T4:** The cancer has spread to tissues next to your prostate (other than the seminal vesicles), such as the bladder sphincter (muscle that helps control urination), the rectum, and/or the wall of the pelvis.

### N categories:

**N0:** The cancer has not spread to any lymph nodes.

**N1:** The cancer has spread to one or more regional (nearby) lymph nodes in the pelvis.

### M categories:

**M0:** The cancer has not spread beyond the regional lymph nodes.

**M1:** The cancer has spread beyond the regional nodes.

Source: American Cancer Society, Cancer Information, Detailed Guide: Prostate Cancer, Updated April 2006.

[http://www.cancer.org/docroot/CRI/content/CRI\\_2\\_4\\_3X\\_How\\_is\\_prostate\\_cancer\\_staged\\_36.asp?sitearea=](http://www.cancer.org/docroot/CRI/content/CRI_2_4_3X_How_is_prostate_cancer_staged_36.asp?sitearea=)

## Save The Date

### Help Support Prostate Cancer Research

October 14, 2006

9 am - 5 pm

Del Norte Sports & Wellness  
Indoor & Outdoor Cycling Programs

Call for more information

**(505) 857-0123**

NMCCA is the designated beneficiary of this fundraising event

## Is a Cancer Research Study Right for Me?

**Possibly, yes.** Although cancer affects every person in the patient's life in some way, cancer is still a very personal disease and its treatment options vary for each individual. For some people, their cancer is at a stage where the standard treatment is the best option. For others, the disease might respond better with a clinical research study.

The goal of cancer clinical research studies is to find out whether the disease or the patient responds better to a new treatment instead of the standard treatment.

Because of that uncertainty, some patients might be nervous about taking part in a clinical research study. It sometimes helps to know a little background of the study process. For example, every over-the-counter or prescription drug you have ever taken has gone through a research study to determine if it is both safe and effective before it becomes available for sale.

Even before a new treatment or drug can involve people, researchers test it in a laboratory. If the laboratory test results show the treatment might slow the growth of or destroy cancer cells, a clinical research study is set up. Out of 1000 potential drugs tested in the laboratory, only one will reach this stage. Before the Food and Drug Administration approves a new drug, or a new use for an old drug, it must go through three phases of research with people (see "Phases of Clinical Research Studies" box on page 5).

These three phases of research are the "clinical research" studies, also known as clinical trials. Cancer research studies test new drugs, combinations of treatments, new approaches to surgery or radiation and other methods for treating cancer.

Every clinical research study has guidelines, known as the protocol, that describe what will be done in the study and why. Each protocol has very specific requirements regarding the patient and the stage of his or her disease and treatment. With NMCCA, a group of about 18 cancer physicians called the medical scientific review committee reviews all protocols for scientific worth. In all organizations, an institutional review board reviews the protocol to ensure that patients receive ethical treatment (for example, all patients must receive at least the standard treatment). The institutional review board also reviews an "informed consent" form, which outlines the treatment and any known possible reactions. All patients receive a copy of the informed consent, read it, and are encouraged to ask questions before signing it and joining the research study.

An appropriate clinical research study may or may not be available for your particular disease. However, if one is available, there are many advantages to taking part one. For instance, you may have access to therapies that would not be available otherwise, the number of your treatment options may increase and the trial may provide more careful monitoring of your condition and the possible side effects of the treatment. It also will give you the chance to help find better treatments for the next generation of cancer patients.

Participating in a cancer clinical research study is voluntary. New Mexico Cancer Care Alliance encourages cancer patients to discuss your options with your physician, family and trusted friends before making a final decision.

## Volunteer Opportunities



Volunteer Jody Donadio and NMCCA staff member Linda Green at People Living Through Cancer's annual conference, "Seeds for Survival" held on June 10, 2006.

### *New Mexico Cancer Care Alliance has many upcoming events and a limited staff!*

#### **NMCCA HERO Recognition Breakfast, October 12, 2006**

- Mail Invitations prior to event
- Registration or room set-up at event

#### **Pink Shawl Pow Wow**

Spring 2007

#### **Exhibit with NMCCA**

Join NMCCA personnel as we discuss the possible benefits of a cancer clinical research study as part of a patient's treatment (training provided)

- People Living Through Cancer Spring Conference
- Cancer Services of NM Spring and Fall Conferences

To learn more about NMCCA, please visit our website, [www.nmcca.org](http://www.nmcca.org). To inquire about these or other possible opportunities, please contact Linda Green, Communications and Development Specialist, at 505-272-7819 or [lgreen@nmcca.org](mailto:lgreen@nmcca.org).

## New Mexico Cancer Care Alliance **STAFF**

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## Sharing Thoughts

Have you participated in a clinical trial? Would you like to share a few words about your experience? If so, we'd love to include your thoughts in our newsletters. Please write to Linda Green at [lgreen@nmcca.org](mailto:lgreen@nmcca.org) or at NMCCA, 801 University Blvd. SE, Suite 304, Albuquerque, NM 87106.

## Advancing Oncology Clinical Trials IN NEW MEXICO

For more information about NMCCA, clinical trials or to request additional copies of this newsletter, please contact 272-7813 or by email at [info@nmcca.org](mailto:info@nmcca.org).

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**We're on the Web!**  
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