

Living Beyond Cancer Podcast

The Short and Long Term Effects of Breast Cancer

Guest: Dr. Hannah Hazard-Jenkins

Lauren Hixenbaugh: Welcome to Living Beyond Cancer, I am Lauren Hixenbaugh the Coalition Manager for Mountains of Hope. Living Beyond Cancer is a series of podcasts created for cancer patients, survivors, and their caregivers. This series is sponsored by the West Virginia Cancer Coalition, Mountains of Hope, and produced by the WVU Cancer Institute's Cancer Prevention and Control. Today's topic is "The Short and Long-term Effects of Breast Cancer" and our guest today is Dr. Hannah Hazard-Jenkins, the Interim Director for the WVU Cancer Institute and breast surgeon. We are so thrilled to have Hannah here today with us. And she has a pretty busy schedule, so we are glad that she could fit it in. But the first thing for our listeners is just, tell us a little bit about your job here at the Cancer Institute.

Dr. Hannah Hazard-Jenkins: Sure thanks very much for having me; I appreciate you actually asking me to talk a little bit about survivorship in the breast cancer population. What I do on a daily basis here is a combination of administrative things, which are relatively boring in the grand scheme of things, and then patient care which is always most surgeon's true love and certainly is my true love. So, I see both new breast cancer patients as well as my previous breast cancer patients that we see in follow-ups. So even though an operation may happen and we're finished operating, either myself or the team of providers around me including nurse practitioners and advanced practice providers like PA's, we see patients long after their surgical intervention. Usually every six months for the first couple of years and then once a year after that. Recognizing that they are graduating, so to speak, in their care from acute needs, or what would be perceived as acute needs, into more chronic, life-long adjustments associated with the diagnosis and treatment of breast cancer. And then some days I operate.

Lauren Hixenbaugh: Well we're really glad to have you with us today and we're really glad to have you as a part of our team here at the Cancer Institute and one of the things we like to talk about during this series has been, of course, survivorship but what does that, it seems like it means a little something different to everyone and it means a little something different depending on the cancer site that the patient had. So, what does that term survivorship mean to you?

Dr. Hannah Hazard-Jenkins: So, it's an excellent point, I think it is different for everybody. It is particularly different when you talk to a provider versus a patient and even every patient will have some version of survivorship. Part of the confusion, I think, is because there isn't a standardized definition of what survivorship is, when it starts. And that's okay, because not everybody is the same. Just as we are modifying how we treat people not because of one disease diagnosis but all of the different subsets within a disease, we too should treat patients in the survivorship period differently based on their needs and requirements. For me, survivorship is almost a graduation. I use that word a lot because I think when diagnosed with breast cancer it becomes somewhat all-consuming for not only the patient but the loved ones around them and the community around them. And when you get to a phase in your care where you are not acutely, constantly doing something for your care, for your cancer treatment, you transition into a more survivorship phase. There are pro's and con's to that. So if you think about patients who are weekly getting chemotherapy, daily getting radiation, getting surgical intervention and

they are constantly in the presence of providers and the health care system during this time and then they “graduate” into a less labor-intensive existence as far as your health care utilization. For some it's a graduation, for some it feels very uncomfortable because they are losing that constant contact and it becomes more of an unknown. So survivorship feels differently to everybody. You can define it by a book, the last day of whatever treatment. But I do think women come to the sensation of survivorship differently and at different times. I'll say that with a caveat that I am not a survivor of any cancer so, I don't want to suppose how somebody feels if they haven't been in that shoe, which I haven't. So, I say that based on my experience as a health care provider but not as a patient and as we all know, we all run around the world saying, "If I ever get this or if I ever do that, I'm going to do X". But when you get that, there's a 50% chance you're actually going to do X that you've been talking about for the last five years. So I cage my comments in the sense of, this is truly coming from somebody who treats and has not been treated for cancer.

Lauren Hixenbaugh: I really like the term graduation, as you said, sometimes people feel like they're graduating. Some people don't feel like that but that's okay. I like the kind of inspiration behind it though.

Dr. Hannah Hazard-Jenkins: You know, when you graduate from something, it's a sense of accomplishment and I think a lot of times women going through this are somewhat slogging it out and it depends on the disease and subset and what the requirements are. But they're kind of slogging it out and, you know, it's one foot in front of the other. You're not really sure what the landscape is around you and now all of a sudden, if you cage this step in care as a success, as a victory of sorts, then that transition I think, can sometimes feel a little bit easier and a little bit less like the floor just dropped out from underneath you.

Lauren Hixenbaugh: Right, and what are some of the things that they're going through when they're experiencing this?

Dr. Hannah Hazard-Jenkins: You know, I sat in on and was part of a dissertation defense in the school of nursing half a decade ago and it was a discussion of, in essence, survivorship to some degree. But one of the concepts in that dissertation defense was the sense of loss or mourning in the breast cancer population. And I had never, until that moment, really thought about it. So if you are humming through life and you have no health care problems and you're young or you have the typical, expected health care problems of aging, hypertension, hypercholesterolemia, that is viewed as normal, so to speak. Not quite, but within the grand scheme and landscape of life, most of your friends have hypertension, most of your friends are on a cholesterol medicine. So, you have what is your normal health, what is your version of a healthy living. And then you get kind of smacked in the face, particularly for young patients. I don't mean to single out patients in the 50, 60, 70, which is where the majority of patients come from but at least when you're in that decades of life, there is that element of, it is a possibility. When you have a two year-old and you're worrying about whether or not the next door neighbors kid who got sick is going to make your kid sick and then somebody smacks you in the face with this, it is a really big rude awakening. And what happens, I think, but we don't acknowledge enough as provider, is you have to actually mourn your health prior to the diagnosis because life will never be the same, right? And from that mourning, if you think about losing a loved one you have to go through those stages of grief so that you can accept what is the next phase. And so we need to allow women, any patient, the ability to mourn it and to name it because they probably don't know what it feels like, they don't know what

they're feeling but if you say, "You are mourning this, here are the stages of grief, "you lost your dad, this is what it feels like". Then it's easier for them to wrap their head around kind of, the emotions that are circulating. So, I think that acutely there is that sense of mourning and that we have to be able to validate that. And then we have to empower them to embrace the new and be a stronger person beyond because they will have challenges within this phase of their life that they'd never wanted to face, never thought they could face and never thought they could come through on the other side with a sense of victory and you have to sort of tell them. You've been victorious, so to speak. And I don't mean to be cliché or anything but it is a lot and so you have to move beyond that. If, there are women that you have to kind of warn. It's that first mammogram, emotionally, nobody thinks about until they're sitting in the lobby and all of a sudden realizing the last time they were here, they got diagnosed with breast cancer. As a provider we need to warn them; this is a big step. Acknowledge it; it's okay. Last day of taking tamoxifen aromatase inhibitor, five, six year into treatment, right? Everyday they've done something to prevent it from coming back. The first day they don't, if they think about it.

Lauren Hixenbaugh: It's terrifying.

Dr. Hannah Hazard-Jenkins: It's scary!

Lauren Hixenbaugh: Yeah.

Dr. Hannah Hazard-Jenkins: Yeah, exactly. And the same thing for women who don't have that as a treatment option and their last day of chemo or the last day of radiation. So, it's a busy world, it's a busy practice and it's very easy for us to do what is within our construct as surgeon, medical oncologist, radiation oncologist and it takes a little bit more effort to step into that realm of here's what you might anticipate. And nobody's perfect, nobody does it all the time. Again, I try to teach students in residence, read the room. Figure out where their anxieties are, are they anxious, are they perfectly relaxed and comfortable? If they're not, figure out why. Because there's something brewing underneath there that you probably could take the extra two minutes to address. So those, I think, are some of those issues that people are very afraid to talk about. In the breast cancer population, I think for most of these women we block their estrogen and progesterone; we either make them post-menopausal when they weren't beforehand or we make them more estrogen-deprived if they were post-menopausal. We focus in on how this is saving your life, reducing your chance of recurrence. That is every three to six months when we see them but from a day-to-day perspective, how does that affect their own mental and physical wellbeing? How does that affect their interactions with others? How does that affect their relationship with a significant other? It can be on the superficial to the mood swings of perimenopausal status to something far more significant with very intimate personal relationships. And those are scary things for people to talk about and relatively taboo in our society; so again, it takes us being proactive to have these kinds of conversations with patients.

Lauren Hixenbaugh: So, one of the things that Living Beyond Cancer offers is an online Facebook support group and so as you're talking I was thinking that a lot of women might benefit for something like this where they can kind of rally together and talk about those feelings of loss and mourning, especially like you said younger patients mourning that loss and kind of talking about how we kind of rebuild this new life.

Dr. Hannah Hazard-Jenkins: Yeah, I think support groups are there for a reason and they're very helpful. And I think when you have active, engaged, positive, knowing people within that group who have been

there and done that not everybody's going to approach the same issue in the same fashion but a group like that will provide you tools.

Lauren Hixenbaugh: Yes

Dr. Hannah Hazard-Jenkins: Whether or not they are physical tools on how to manage the post-mastectomy period or emotional tools of how do I engage and be excited about an engagement with my significant other, you don't have to reinvent the wheel every day.

Lauren Hixenbaugh: Yeah

Dr. Hannah Hazard-Jenkins: You know, one in eight women get breast cancer. There are a lot of survivors out there. There are a lot of resources that are informal and sometimes more valuable depending on what the needs are.

Lauren Hixenbaugh: So, I want to kind of go back to the feelings and kind of touch on the short and long-term effects. So we, like I said, we touched on the feelings aspect, but what about the physical effects? What are patients experiencing?

Dr. Hannah Hazard-Jenkins: It's a great question, some of the short-term physical effects I think are completely related to what kind of treatment someone takes. So predominantly I would say on the local treatment side. So when we talk about treating breast cancer there are systemic treatment which would be chemo, the antiestrogen medication, and in some cases drugs like Herceptin or Perjeta that target HER2. But local treatment is really surgical and often times radiation therapy and that's where the physical component to a lot of this comes in. Now, you can have some pretty significant side-effects to chemotherapy and I'll talk about that in a second. For women who by and large have lumpectomy, which is removing the tumor but we're saving the breast. You know, short-term, you know, uncomfortable, need some time off work, probably not as much as you think. But within a couple of weeks, there's a pretty easy rebound. Depending on how much surgery's done in the axilla or the armpit, looking for those lymph nodes can impact range of motion. Sometimes sensation on the back of the arm, there are sensory nerves in the axilla that allow us to feel things on the back of our arm and in the armpit and if they are injured or cut in the process, it can alter. Those are some of the acute within that, for a mastectomy patient, totally depends on whether or not reconstruction is done and what kind of reconstruction. Implant-based reconstruction which is probably the most common type of reconstruction when done, puts a tissue expander or a spacer underneath the pectoralis major muscle, which is that one that, like, when you see people on, Venice Beach like pumpin' iron, that's the one they're trying to make big on their chest. But that muscles never been stretched. It may have been exercised and it may have been fatigued but it's never really been stretched. And so now you're putting an inanimate object underneath it and then stretching it and that can be pretty uncomfortable.

Lauren Hixenbaugh: It sounds uncomfortable

Dr. Hannah Hazard-Jenkins: Yeah right, sort of a vice-like feel to patients. In the acute setting, in the long-term that gets expanded over time. You know, every week, two weeks, just depends on tolerance of the patient and the muscle but each time gets a little uncomfortable until the muscle kind of adjusts. It's kind of like getting your braces tightened if you are a kid. I had braces for like a decade, not really, but a while and so every time you went and get them tightened you couldn't eat for days. Kind of that same sensation. So, short and long-term really kind of depends on that. Radiation can cause fatigue and

skin burns that usually can be just managed with local hydration and lotions and stuff like that. We are trying to be pretty proactive here at least. And I would encourage women to be proactive wherever they're treated, with women having large lymph node surgeries or big mastectomy operations and getting into a physical therapist early, even in the pre-op setting. One, we can assess what your arm circumference is. So the more lymph nodes you take out, the higher the risk of lymphedema and we should know what your pre-op arm circumference is. So that way when you're in the post-op period, if they aren't the same, well if they weren't the same before, then it's not lymphedema; it's just who you are. Because despite popular belief we are not symmetric side to side no matter what we try to think. But we also have them work with a physical therapist to improve their strength in the chest wall and in the arm and in the shoulder. So that way, in their recovery period, they've already kind of primed these muscles to be needed in the post-op periods so that their return to baseline function is faster than if we don't have them see physical therapy. So I think it's an excellent choice; it wasn't something that we used to do in the practice even five years ago. This is something that's evolved over time and I think women return to base-line functionality faster, which is important particularly in the population that's going to get radiation after mastectomy. Because that muscle is going to get a little radiation, it's going to tighten up in comparison to somebody's who doesn't. So if you get full range of motion before you go into radiation, your recovery on the back side of radiation is better too.

Lauren Hixenbaugh: So, a lot of these folks have needs that are special to their individual treatment, sounds like. But what are some common needs after these treatments, just in general, in their life.

Dr. Hannah Hazard-Jenkins: Some of the needs long-term physically may actually be dependent upon also chemotherapy. So some of the chemotherapies we give can cause neuropathies in the fingers and the toes. That can be pretty minimal or it could be permanent and significant. For some women, the ability to button your shirt.

Lauren Hixenbaugh: Right.

Dr. Hannah Hazard-Jenkins: For some patients, if the neuropathy in the feet is bad, can they sense where their feet land? Long-term are they having trouble with gait, are they falling, those kinds of things.

Lauren Hixenbaugh: So, that again, is some physical therapy.

Dr. Hannah Hazard-Jenkins: It's some physical therapy.

Lauren Hixenbaugh: Maybe some occupational therapy.

Dr. Hannah Hazard-Jenkins: Yes, all those kinds of things. On a big grand scheme of things I think what women struggle with the most in the long-term is a fear or recurrence.

Lauren Hixenbaugh: Absolutely.

Dr. Hannah Hazard-Jenkins: And it is, it can be managed. But, it never goes away and so as a surgeon, people come in and say, "Just cut it off" and I'll never have to worry about this again". Well, one, that's not true because you can't take somebody down to a zero risk of recurrence no matter what the operation is. At least a local recurrence. Two, the more significant recurrence is a systemic recurrence which has absolutely nothing to do with the surgical intervention to get rid of the primary tumor. And three, it is become part of your medical history, it is becoming part of who you are and by taking a

breast you don't erase that from your medical history or your problem list. And it gets back to what we were talking about earlier in mourning the loss of your health prior to diagnosis. So, no amount of surgical intervention or no amount of systemic therapy is going to pull the worry out of somebody's brain. It is our responsibility to help women, men, and other disease processes manage that worry, control that worry and though it's there, be able to function in life with it. Now, I'm not telling women not to get any care, let me be very clear. But it is something that is, it becomes part of who you are. It's no different than somebody, I don't mean to be trite, you know, by and large if you have a heart attack, you always will have coronary artery disease. Right? Unless you get a whole new heart. Our society doesn't put the same kind of pressure, psychologic pressure, on people because they have coronary artery disease than they do on breast cancer and such. So, it is different and yet the same. But it's the fear of recurrence.

Lauren Hixenbaugh: Certainly.

Dr. Hannah Hazard-Jenkins: And it's simple things right? I'm a gardener, the first spring day you're out and you do stuff in the garden, you can't walk for three days, right? Because you're using muscles you've never used, you're bending and planting and doing all that kind of stuff. For me, I know it's because I did something I haven't done in six months. For somebody diagnosed with a cancer, breast or any other, there is this thing in the back of their head that says, "Ooh, this may be a cancer, this may be my recurrence". And so it's, again, we have to know people are struggling with it to the point where it interferes with daily life.

Lauren Hixenbaugh: So, what advice do you have for those folks?

Dr. Hannah Hazard-Jenkins: So, you have to verbalize it. Right, you have to verbalize it. If nobody knows that you're struggling in your brain with this, you have to verbalize it. I think mental health is extraordinarily important when faced with any cancer diagnosis. And if you already have some underlying anxiety or depression and you're moving along in life and functioning and you add something like this on top of it, it exacerbates it tremendously. Women who are functioning fine and get this, will also have trouble with some mental illnesses. We as a society have stigmatized mental illness as a negative or as a weakness, so to speak. In my brain I think it takes a stronger person to admit it than a person who tries to battle on their own without help. So I think the most important thing is verbalizing the struggle and the magnitude of the struggle.

Lauren Hixenbaugh: Should they be verbalizing that, and maybe this is the answer, in all of these, but should they be verbalizing it to you as their surgeon? Should they verbalizing it to the PCP?

Dr. Hannah Hazard-Jenkins: I don't think it matters.

Lauren Hixenbaugh: Okay.

Dr. Hannah Hazard-Jenkins: You got to get it out there. Because if nobody knows it's an issue, nobody will take care of it. So it's who you're comfortable with I think, where is your safe environment? Who do you feel comfortable? And that's different for everybody. If you've had the same primary care provider (PCP) for 20 years and you have a very strong relationship, probably it's going to be that person. If you have worked with a surgeon or a medical oncologist that has been extraordinarily present and helpful and trustworthy, it may be that person. You have to remember that the person you verbalize it to, may not be the person who can fix it but they should be the person that helps you find somebody to fix it. So

for me, I can't sit and talk, I'm not a psychiatrist, I don't have a psychology degree. But, I know people who have all those things and I know the resources for that so, it's me spending time talking about something outside of my surgical wheelhouse to understand where the level of interference in daily living is and then what kind of resources we need to bring in.

Lauren Hixenbaugh: So, sometimes there's a lack of linkage.

Dr. Hannah Hazard-Jenkins: Total

Lauren Hixenbaugh: Between the primary care provider and the oncologist, how would you suggest that these patients kind of go about?

Dr. Hannah Hazard-Jenkins: Well, if you could fix communication between providers across the entire United States and world, peace prize. It's all communication right, I mean it's at the heart of the matter is communication. I think a lot of patients develop a very strong relationship with oncologists, particularly if you've gone through chemotherapy, you're seeing them every week, you've had complications, they've kind of pulled you through it. It's a comfort level and so they will tend to bring up most things, whether or not they're cancer related or not to those providers. One of the big pushes within the American College of Surgeons Commission on Cancer and other large organizations (I quote surgical because wheelhouse) is this notion that what is the next iteration in cancer care and standardization across the country. We now have more survivors than ever before. Our drugs are better and better. Our surgical therapy and radiation therapies are more and more sophisticated with almost every passing day. So 20-30 years ago, life expectancy for a stage three breast cancer is far different than it is today. And even just the advent of Herceptin targeting HER2 therapy has dramatically changed survival for that patient population. That continues to happen on a daily basis. So that's great news, except we're getting to the point where a medical oncologist alone can't take care of all of the survivors and so, when you look at national bodies like Commission on Cancer (CoC), their original intent was to help standardize cancer care so that if you were in Morgantown, Hinton or New York City, you should be getting pretty much the same care as based on national standards and that was really the mandate. But every year, when you look at new standards that are being rolled out. Whether it's the CoC or somebody else, there is more and more and more focus on the survivorship phase. What is the communication between PCP and oncologists? Whichever oncologist. What is the mandate for physical therapy? What is the mandate for supplemental services? What are the long-term needs? What are the financial resources, financial toxicity associated to this? And so those original requests and needs are still there - standardization of care, how many lymph nodes are taken out in a colon surgery, et cetera. They're there, but the survivorship components is becoming more and more prevalent. And that's because we have so many survivors and the care is so much better through the decades that we now have as a health care organization, need to focus in on what does that post-treatment survivorship phase look like and what resources patients need. I don't think we have a great understanding. I mean, certainly the WVU Cancer Institute's CPC Bridge Program has been a prime example of understanding the long-term needs in our lung cancer population. Again, a population where the systemic therapies have almost revolutionized how we take care of lung cancer patients and what it means for their survival. And we have to adjust appropriately.

Lauren Hixenbaugh: A lot of these patients, I guess. I want to go back to my favorite question, which is, it's a loaded one...

Dr. Hannah Hazard-Jenkins: Of course. Why wouldn't it be loaded if it's your favorite?

Lauren Hixenbaugh: But it really is, what are the questions that your patients ask, the common ones?

Dr. Hannah Hazard-Jenkins: In the survivorship phase? Some of the most common ones, you know, they don't ask. I mean there are some. I think, again, this is the soapbox of Hannah, but I think women are extraordinarily stout and extraordinarily strong and by nature (sorry men, gross generalization) but by nature caregivers. They are very uncomfortable with the role of being in need of something and so most women take this on, march through it, and then try to march out of it because their role as caregiver to their family at whatever phase, whether or not you're the family matriarch with 20 grandchildren and 16 great-grandchildren or you're the mom of a two year-old. You're still the person who really is the point person. Maybe it's a reflection of my style of practice in clinic? Or that there aren't a lot of questions? On self-reflection, maybe I need to modify? But there are times where I see women struggle, right?

Lauren Hixenbaugh: In talking with you I was almost thinking the opposite, that maybe you're covering a lot of the questions.

Dr. Hannah Hazard-Jenkins: I don't know, I mean I will confess, I don't ask about sexuality on a regular basis. There are things I could obviously do; we all can do something better. I think the bigger needs that I see, even though they may not ask, is the struggle of fear for recurrence. The other that I've heard vocalized a few times, addresses kind of what I just said in this sense that women are caregivers. So there have been a few times where women will be like, "You know, my husband, my family, my kids think, "Oh that wasn't too bad of a surgery, "you recovered quickly from that, you're fine, "go get the groceries, go do this, "here's your list of chores for the day" as if nothing ever happened. And I think while we take that on and we want that perception out there externally, internally, life is different. And so sometimes I hear a frustration that they don't want to be treated differently, they just want to have it acknowledged that it's different. I think sometimes there's a baseline that you'll have people come in and not take their drugs, like their antiestrogen drugs, and when you get down to the root of the matter it's either a sense of futility, why am I doing this, or just depression and fear. I tend to be a pretty blunt person, so sometimes my tough love works well, sometimes my tough love doesn't work so well? But I don't know, I think sometimes women are just afraid to ask for help and it goes back to mental health, it goes back to some of those things. Also, just don't forget the other people that are in the room with the patient. So we here have a patient who's husband actually kind of described it perfectly. She talked to us, I hope she publishes it, but she talked to us at about her husband's analogy, because she likes analogies. Her husband's analogy was that this was like a hurricane. She's at the center; she is the eye of the hurricane. And the eye of the hurricane is relatively calm but she, you know, you are kind of out of control on what was happening to you but you are sort of the calm center. And it's everybody else around you that feels the effects of the hurricane, right. So they're her kids, young kids, her husband, her parents.

Lauren Hixenbaugh: That's a powerful analogy.

Dr. Hannah Hazard-Jenkins: It's a wonderful analogy, isn't it? Because the focus becomes on the patient but everybody else around them is totally disrupted too. And it can be the simplest of things and it can be very complex things and so it's a phenomenal analogy. So ever since she said that, I remember that if you have a family member in the room with the patient who is uber quiet, there's something going on right?

Lauren Hixenbaugh: Talk to them.

Dr. Hannah Hazard-Jenkins: Talk to them. Figure out what it is because if they're struggling and the patient's struggling, then both of them are struggling and it's like any saying, if you're unhappy at work but happy at home, it's dealable, if you're happy at home and unhappy at work it's dealable, but if you're unhappy in both locations, it's hard to go on day-to-day. So if you have two people that are significant to each other in a room that are struggling and neither one of them can get their head above water for breath, it spirals or has the potential to spiral. So don't forget the person that's sitting in the room. They're in the hurricane.

Lauren Hixenbaugh: And they're typically the caregiver that's in the room.

Dr. Hannah Hazard-Jenkins: They're the caregiver, yep.

Lauren Hixenbaugh: And they need to be on board

Dr. Hannah Hazard-Jenkins: That's exactly correct. That's correct and and they need to be resourced and if it's bad enough, they need a group.

Lauren Hixenbaugh: Right, sometimes they need to be the rock for that person.

Dr. Hannah Hazard-Jenkins: Maybe we need a different group.

Lauren Hixenbaugh: You're right.

Dr. Hannah Hazard-Jenkins: That is the caregivers, that is the significant others. I mean how do they deal with changes in hormonal things in these breast cancer populations that trickles down to their relationship? How do they deal with that, without being resentful? I mean, there's so many layers to this.

Lauren Hixenbaugh: Certainly, yeah. I feel like we've covered so much today and I feel like I've learned a lot.

Dr. Hannah Hazard-Jenkins: Well, you've hit the soapbox of Hannah a few times but, I just think, I am lucky. Anybody who takes care of patients with cancer should feel honored and privileged, right? And I tell that to the students. I mean, you have to trust me with a whole lot of information in the first five minutes of knowing me. And that's an honor so it's our obligation to continue to build that trust and to be a responsible person, not just for what is acutely at hand but everything else that comes with it.

Lauren Hixenbaugh: So if people were to look back at our talk today and they were to pull one thing, what's the one thing that you would have wanted them to learn today?

Dr. Hannah Hazard-Jenkins: For a patient, it's important to verbalize what's going on. For a family member it's also important to verbalize. So, it's kind of fun when I'm in clinic and like the spouse rats out the patient and then there's this sort of like daggers, and I'm like, "Well I'm not going to get in the middle of this but thanks for doing that". So I think it's important. For those that are listening that aren't patients or are providers. I think it's really important to listen and to read non-verbals. You can tell a ton from a non-verbal.

Lauren Hixenbaugh: Yes.

Dr. Hannah Hazard-Jenkins: And I think it's very easy to be busy and to miss them. Sometimes they're so obvious they're smacking you in the face and you just have to address it. But sometimes they're subtle and you have to read those.

Lauren Hixenbaugh: So for our listeners today we have some resources available. I talked a little bit earlier about Living Beyond Cancer, which is an online Facebook support group for patients, caregivers and survivors. We also have Mountains of Hope, the West Virginia Cancer Coalition, which you can find at moh.wv.gov and lastly, we have the WVU Cancer Institute which you just visit wvucancer.org but then, are there any additional resources that in particular breast patients should know about? I mean, the American Cancer Society has resources that aren't necessarily specific to breast cancer patients. There are certainly informational sites that are well-known like cancer.org. I think one of the things I would tell women or anybody who's diagnosed with a cancer is that Dr Google is bad and scary. Anybody can write anything unedited, unsubstantiated. Dr Google is a disaster. It's a disaster for our medical students who think that they know something, it is a disaster for patients because they get themselves down a rabbit hole that's hard to come back out of with bad data. So if you're looking at websites, anything that has .org or .gov or .edu associated with it has validation checkpoints and has valuable, worthwhile, accurate information. I don't dislike the internet, I just think you have to be very careful where you go for that.

Lauren Hixenbaugh: Certainly. Well, are there any other additional items that you would like to talk about today?

Dr. Hannah Hazard-Jenkins: No, I think that's good.

Lauren Hixenbaugh: Well.

Dr. Hannah Hazard-Jenkins: Thanks for tolerating me.

Lauren Hixenbaugh: I'm so glad you we're here, Living Beyond Cancer world certainly like to thank Dr. Hannah Hazard-Jenkins, for joining us today as well as our listeners, we hope they all continue to join us.

Dr. Hannah Hazard-Jenkins: Absolutely. Thank you very much.