Lauren Hixenbaugh:

Welcome to Living Beyond Cancer. This is a series of podcasts created for cancer patients, survivors, and their caregivers. Hi, I'm Lauren Hixenbaugh, a program manager for mobile cancer screening at the WVU Cancer Institute's Cancer Prevention and Control. And I'm one of the hosts for today's episode and I'd like to introduce my co-host, Andi Hasley.

Andi Hasley:

Welcome everyone. I'm Andi. And in addition to being the Mountains of Hope coalition manager, I myself am a breast cancer survivor. Living Beyond Cancer is sponsored by the West Virginia Cancer Coalition Mountains of Hope and is produced by WVU Cancer Institute's Cancer Prevention and Control. We are thrilled to share today's episode with our listeners.

Lauren Hixenbaugh:

Thanks so much, Andi. I'd like to introduce our speakers today. I have nurse practitioner Samantha Hall with us and I have oncology pharmacist, Jordan Hill. Thank you both so much for being here today. Do you want to start off with telling our listeners a little bit about yourselves?

Samantha Hall:

Yeah, thanks for having us. So I'm Samantha Hall. I'm an oncology nurse practitioner here at the WVU Cancer Institute. I've been here for a little over eight years and I specialize in breast cancer, primarily in breast cancer survivorship.

Jordan Hill:

Yes, thanks for having us. My name is Jordan. I'm an oncology pharmacist that works with Sam here at the WVU Cancer Institute. I also specialize in breast cancer and I have been working here in Morgantown for a little over seven years now.

Lauren Hixenbaugh:

Well we're really glad to have both of you with us today and we're going to talk a little bit about the terms and the diagnosis of triple-negative breast cancer and we'll just kind of dive right into it. And if you all can give us a brief overview of triple-negative breast cancer and what the term means and kind of just give us some information about what we're going to be talking about today.

Samantha Hall:

So when a woman finds a breast lump or just has an abnormal mammogram, breast MRI, ultrasound, any kind of imaging, a biopsy is usually completed. If the radiologist feels that's necessary that is sent off to pathology, pathology will review it and once they determine it's breast cancer, there's actually three things that we test for on every invasive breast cancer, we call them the receptors. You might hear your provider say something like ER/PR Her2 or estrogen receptor. So they are estrogen, progesterone, Enhertu and they come back as a combination of positive or negative. So the term triple negative is just all three of them being negative.

Andi Hasley:

That's very interesting that I think sometimes when we think of breast cancer in general, we think it's this one diagnosis and I know through my own journey I learned that there are so many different kinds

and different treatment options and that can change even through the course of what your own diagnosis looks like. So when we were talking specifically about triple negative breast cancer, what does that treatment look like, and also how does that treatment differ from other kinds of cancer treatment, especially kinds of cancer that are maybe less invasive or even non-invasive? Maybe just an overview of what a patient experiences.

Samantha Hall:

Yeah, sure. So other types of cancer that are less invasive specifically in breast cancer is something we call DCIS or Ductal Carcinoma in Situ. So that is a stage zero non-invasive cancer. It is treated differently than say a triple-negative invasive cancer. We only check estrogen and progesterone on the actual cells. We don't do Her2 on that one and it's treated surgery plus or minus radiation plus or minus an anti-estrogen pill if it was fed by estrogen. But there is no chemotherapy discussion in a true DCIS. In general, the treatment for triple-negative breast cancer can be different from any other invasive cancer because typically there is a discussion involving chemotherapy. Like you said, there's so many different subtypes of breast cancer, they're not all treated the same. We have to take patients into accounts, we have to take the receptors into account. There's so many things that play into that, the decision that your provider is going to make. So in general, usually there is a treatment that involves cytotoxic chemotherapy, or traditionally, it that it would involve cytotoxic chemotherapy for triple-negative breast cancers.

Lauren Hixenbaugh:

And just generally you guys were talking about you find a lump, you go to see your provider. So how is the cancer determined? Kind of go back I guess a little bit in the previous question, but how do we determine that it's triple negative?

Samantha Hall:

So the specimen that gets sent off to pathology from the biopsy, there's like staining and different testing done on it to determine what those receptors are.

Jordan Hill:

I guess kind of going on to that first question as far as just a brief overview like Sam had discussed after we identify what the receptor types are, there are some additional information that we need to be able to determine what the overall treatment looks like for a triple-negative breast cancer patient. So for someone who potentially has been identified as having cancer in their lymph nodes, we would also want to do what we call systemic imaging and that would include a PET scan or potentially a CT scan to make sure that the cancer has not spread outside of the breast and lymph nodes because that would change what types of treatment they are going to be candidates for. So for someone who only has cancer in the breasts or lymph nodes, those people are going to be candidates for surgery and usually radiation. Whereas someone who has cancer outside of those areas, usually surgery is not discussed. Obviously, that can differ depending on the patient and the goals, and the discussions they have with their provider. But usually, the treatment focus for them is more medications as opposed to surgery, radiation, and medications.

Andi Hasley:

That's very interesting. You mentioned if cancer's found in other locations, with triple-negative as a diagnosis, is there any data, or what is the likelihood of that metastasizing have already happened when it has found?

Jordan Hill:

So in general because of the effective screenings that we have for breast cancer, less than 10% of all breast cancers are diagnosed metastatic. It's usually around the 7% mark. But like you mentioned, the cancers are all very different, and triple-negative breast cancer does tend to be more aggressive than some of the other types of breast cancer. And so sometimes because of that, it does grow quicker and therefore is more likely to have spread to an area outside of the breast in someone with triple-negative breast cancer.

Andi Hasley:

And so that's why one of the many reasons that it's really important that we make sure we're doing the screenings right because knowledge is power and when you can't fix something if you don't know it's broken. So I really appreciate that you mentioned that we have such a great screening tool and less than 10%, that's an amazing statistic. So I mean there are some kinds of cancer that it's only 10% that isn't. So I think that that's a testament for early detection and screening for sure.

Jordan Hill:

Yeah, absolutely.

Lauren Hixenbaugh:

So with it right now it's October and of course, that's breast cancer awareness month, which is one of the reasons that we're talking about this topic. But I was just thinking at this time of month we see lots of people raising money for research and awareness and that sort of thing as Andi just talked about promoting getting the screening that your body needs. So do you guys want to talk a little bit about research for newer or maybe more effective ways that we are treating triple-negative breast cancer?

Jordan Hill:

Sure. So I think it is important to continue to urge people to get screenings because we know that the earlier breast cancer is caught the more curative it is. And so with it being breast cancer awareness month, I think that is really important to make sure that people are getting their screenings and getting their screenings on time. As far as new research and data specifically for triple-negative breast cancer, since it doesn't have the ability to be able to be treated with an anti-endocrine therapy because it's not growing from hormones, I know a lot of times that can be very frightening for patients because they feel as though their treatment options are more limited. But one of the positive things about breast cancer being so common is we do have a lot of money from different organizations and foundations that go into breast cancer research.

And so there's constantly new medications and therapies being evaluated and approved by the FDA, which is super exciting. Specifically in triple-negative breast cancer, one of the more recent things that we have started using is immunotherapy. It's been around for almost 10 years now, but it took a little while to get into the breast cancer space. It mostly started with melanoma and lung cancer and we're starting to identify patients in that have breast cancer that do benefit from immunotherapy and those are the triple-negative breast cancer patients. So that's exciting to have a totally new mechanism of treating the cancer available for these patients. And that is in both people that have early-stage disease

but that require treatment prior to undergoing surgery can benefit from immunotherapy. And then there are some patients who have metastatic breasts cancer that is triple-negative that can also benefit from immunotherapy.

So immunotherapy in general is a totally different mechanism for killing cancers than what you traditionally think of with chemotherapy. So chemotherapy traditionally will go in and kill any cells that are growing rapidly, which tend to be cancer cells. Immunotherapy actually helps your body's own immune system recognize cancer cells as being foreign and bad and not supposed to be there and it actually helps your body's own immune system kill the cancer cells. So the way that it works against cancer is totally different and very exciting to have that new way of treating cancer specifically for these patients.

Samantha Hall:

It also is a totally different side effect profile than your traditional chemos. When we think chemo, we think drop in blood counts, we think hair loss, we think nausea, vomiting, and kind of chemo kind of gets a bad rap. But immunotherapy, on the other hand, there's typically no hair loss. There is some fatigue, but there's just inflammation that could occur all over the body, so it could occur in the thyroid, rarely can occur in places like the liver, the kidneys, the colon. Most people, like nine out of 10 people do really well with immunotherapy. We really don't see much or any nausea and vomiting. There isn't the drop in blood counts, things like that. So it's a totally different ballgame completely than cytotoxic chemotherapy.

Jordan Hill:

So it's something that we can add to chemotherapy that works differently, helps it work better, and doesn't really add a lot of side effects.

Samantha Hall:

Absolutely.

Andi Hasley:

That's amazing. And I think that I don't know that there's a lot of awareness toward these kinds of cancers. I think it's really important because not a lot of people are aware of immunotherapy and the different side effects, long term, short term of its treatment. And I especially think it's interesting because I got an email from some CDC communications that I get weekly and it said, this is from a survey that was commissioned by Orlando Health, they found that 22% of women aged 35 to 44 years that were surveyed never planned to have a mammogram despite recently updated guidelines, of course. And I think that some of that comes from, you don't want to know because you don't want to go through the treatment and you don't want to take the time and it's easier to not have the information than to deal with the bad thing. And I don't know that people grasp that science is moving quicker that we can keep up with most of the time and there's these other treatments, therapies, options that exist.

But to our listeners, they might not exist if you wait too long. And then your treatment plan might look like the scary kind of treatment that we remember from our own childhood because I'm at the age where those screenings are beginning and so when we were a kid when you heard cancer, you thought that person's going to die, but that's not the case anymore. I'm living proof of that. So I think that we're still afraid that that information looks like it did when we were kids 30 years ago and it's not at all the case. So when I read that survey I thought, oh my gosh, it's such a simple screening to go through. It is

not painful, it is not scary. I've had so many of them that I'm here to tell you that you just... It's not a big deal.

And yet if you don't do that, these immunotherapy treatments, lumpectomies instead of double mastectomies, those surgeries may not be an option for you. So just to hammer home not only this treatment that is really exciting and with less scary side effects, you might not have that option if you don't do the screenings in the front end. So please, if you're listening and someone or you yourself are supposed to be having a mammogram or any cancer screenings and you haven't scheduled because it's really worth it and they're sharing with us treatments that say that early detection, you have these options. So I wanted to add that in because that was an astounding number to me.

Jordan Hill:

Yeah.

Samantha Hall:

Yeah, absolutely. Absolutely. Get your mammograms.

Jordan Hill:

And I think the other thing, as we talk about some of the newer things that have been approved for the treatment of breast cancer, I think it's important to point out that the supportive care that we give along with treatments has drastically changed in the last even just five to 10 years. And so you were saying things that used to be super scary when we were younger because the treatments were miserable to go through and we didn't have the right supportive medications to prevent those side effects we do now. And so even the medicines that we're able to give to prevent some of those side effects from happening are changing every day in addition to the actual treatments for the cancer. One of the other things that I wanted to mention along with treatments, I know people that have BRCA mutations, it's very scary for them knowing how high their risk for breast cancer is.

And so one of the other new medications that we have started using in the early stage breast cancer phase is a specific class of medications called PARP inhibitors that are really only used for patients that have BRCA mutations. And so in someone that has a BRCA mutation develops a breast cancer and they are able to go through their surgery, maybe radiation and then their chemotherapy, we are giving medications for a year after that to help prevent that breast cancer from coming back in these patients that we know are higher risk. And so for patients that have that added fear, because they have that genetic mutation, that's another newer type of medication that's available.

Andi Hasley:

That's awesome.

Jordan Hill:

And then I think we see things that are either used in different stages of cancer or different types of cancer and then we start looking at them more to see can they be used in different places. And breast cancer is no exception. We're starting to see newer medications called antibody-drug conjugates, which are basically a targeted therapy with a chemotherapy attached to them. So it's a chemo that's less likely to cause side effects basically because it's going to be more specific to cancer cells. And those are coming out very often, especially in triple-negative breast cancer. There are two more recent ones, brand names Enhertu and Trodelvy that have really just been approved in the last little over a year. And

so I think that's really exciting for those people in the metastatic setting where having triple-negative breast cancer is even scarier. We are constantly having new medications approved in that setting as well.

Samantha Hall:

And like Jordan said, generally more well tolerated than just your traditional chemotherapies because they do come with a slightly different side effect profile, even though there is a chemo component to it's not nearly as bad as far as things like nausea and vomiting, which is usually the things that we see that people get the most scared of. Like, am I going to be really sick? Which is totally understandable because somebody knows somebody who had chemo and they did get sick. But like Jordan said, we have many, many ways to treat things like that now or even just prevent it from happening altogether.

Andi Hasley:

Well, and you said one of the medicines you said Enhertu, is that right?

Samantha Hall:

Yeah.

Andi Hasley:

So I have a friend who had breast cancer years ago and then had a recurrence and it was diagnosed as stage four metastatic and it was basically we're going to do the things that we can do to help you enjoy what's left of your life. And then she started taking that medicine and she posted, I don't know, it was maybe three or four months ago on Facebook that her most recent scan showed no evidence of disease. So if there is an example of a miracle out there, I can't imagine a better one. I mean I cried when I read her post because I knew her first journey was really rough and this was, oh gosh, it was probably 25 years ago. And then to have the reoccurrence and for them to say this is what it is, these are the things we can do. Oh wait, here's this new medicine.

And she may have been part of a trial even, I don't know the specific details, but to have that stage four diagnosis and then to see a scanned result of no evidence of disease, that's a miracle. So I just don't know that people that are at the screening age now understand that what treatment and options look like now are not what they look like when our mother's friends were going through these sorts of things. Not that that was a reason to not go because it wasn't. Not at all. But the options that we have were just really fortunate, and our daughters are going to be even more fortunate down the road. So yeah, when you said that, the name of that drug, I was like, oh my gosh, I think that's what she was taking and it was so wow.

Samantha Hall:

Yeah, that's the big buzzword lately is Enhertu because they presented the really impressive data at ASCO in June in Chicago and I was there for it and you literally just got chills all over. Everybody was standing up and applauding, people were standing on their chairs. It was incredible.

Andi Hasley:

Yeah, science for the win again.

Samantha Hall:

That's right. Yeah.

Lauren Hixenbaugh:

So as we're moving forward kind of talking about this conversation to the next level, we always like to talk about the overall being and then also the caregiver and their wellbeing. So kind of that. So psychosocial issues that people are going to deal with, follow up, fear, recurrence, maybe fertility for younger patients. You guys want to talk about that a little bit?

Samantha Hall:

Yeah, absolutely. So one of the common things we see with triple-negative cancer is because it is not fed by estrogen or progesterone, there isn't that pill that people go on for five to 10 years. So a lot of patients [inaudible 00:21:13] oh I had my chemo, I have my surgery, I had radiation, now what do we do? And we say we'll see you in three months. And they're like, you're, you're going to do what? You've been seeing me every week, you've been seeing me every three weeks for the last how long. And that's scary. That's scary that you no longer feel like you have that touch with your provider so often. So guidelines technically state, we follow up with you every about three to six months for the first couple of years and then every six months for year three to five, and then yearly after that.

So you do still absolutely touch base with your provider, but the things to know are the things that we get concerned about these signs and symptoms of recurrence, which is the things that hopefully your provider goes over with you once they do release you out to these three-month follow-ups. The things we get concerned about are if you find a new lump or bump, we want to know about it. If you suddenly have a bone pain, and I'm not talking joint pain, we all have joint pain, we all have joint stiffness. This is a bone pain that's like deep in the bone. You can usually point to it and say it hurts right here. And it's usually in hips or spine or the long bones in your legs, things like that. Usually, like a dull aching that doesn't go away. We get concerned about unexplained weight loss.

If you're trying to lose weight, perfect. If you have lost 20 pounds in the last month and you're eating more than you ever did and you're just suddenly losing a bunch of weight, we get concerned about that kind of thing. Headaches that are all over and usually accompanied with nausea and vomiting, things that are happening every day, we get concerned about those. So we want you to report symptoms and I tell people, your body, your body better than anybody. So if there's something that is not right, I would rather you reach out to me. Don't worry about ever bothering a provider. We are never ever bothered by you. I hear that a lot. Oh, I didn't want to bother you with this. We're never bothered. We want you to contact us when you feel something is off when you think something is wrong, if you have new symptoms that way instantly I can see you. You'll be in clinic next day, you'll be in clinic that day.

Lauren Hixenbaugh:

So I have a little bit of a follow-up question with that. So Andi always introduces herself as a breast cancer survivor. I was a caregiver for a family member that has gone through some cancer treatments. So I kind of ask questions from that side often. And one of the things... We said the same thing, we didn't want to bother the provider with X, Y, Z. So for patients, what is the best way for them to get in touch with you? A lot of times we're cold calling the office and trying to talk to maybe a receptionist... What is the best way for them to get in touch and ask those questions?

Samantha Hall:

So certainly here I can speak for here, you can call in. There is usually a nurse triage. Most places have some sort of nursing line that you can call in a lot of places now you have access to your own medical

record through some sort of app through something that you can actually get on and send an email to your provider and they can email you back. Calling patients does get a little more tricky sometimes because you don't know how long you're going to be on the phone, you've got other patients in clinic, that sort of thing. But emailing your provider that says, hey, I found a new lump, they can instantly email you back and say, cool, I'd like to see you at 10:00 AM tomorrow. Something like that. But a phone call or an email is perfectly sufficient.

Andi Hasley:

Are there any concerns for young patients that maybe are still interested in bearing children? What does that look like and how do you manage that both and long-term for the patient?

Lauren Hixenbaugh:

I want to also refer listeners to, we did a genetic podcast, you guys can talk a little bit about if triple negative is considered a genetic cancer or not. I don't know about that, but if people do have questions in addition to what we're going to discuss here, we also did a podcast with Dr. [inaudible 00:25:13] from WVU specifically about genetic cancers and genetic counseling.

Samantha Hall:

So I'll let Jordan address the fertility one first and then I'll do the genetics.

Jordan Hill:

So with fertility, a lot of the treatments that we use for cancer definitely can impact females reproductive potential and can impact their future fertility. And so anyone that's of childbearing age, we try to have that conversation with. And we always would encourage people listening to the podcast to ask your provider about fertility preservation if they don't bring it up to you because a lot of the treatments that we use are going to affect fertility, especially chemo, but even some other targeted therapies can as well. And so the best way to preserve fertility is to take care of it upfront. And so there are lots of different ways that you can do that.

For some people that might be cryo-preservation, so that might be being able to freeze your eggs. For some people we also have the option, it's a little bit of a quicker and cheaper option because some fertility preservation options can be cost-prohibitive of using a medication that kind of puts the ovaries to sleep. And so if you can put the ovaries to sleep prior to receiving chemotherapy, then they're less likely to be damaged. And then once chemotherapy is complete, they're more likely to regain their function. And so that's probably the most common thing that we utilize here because it's quick and it's inexpensive. But there are lots of options that are available, some of which are potentially more effective than the medication to suppress the ovaries and put them to sleep. But that do have their own logistical concerns.

Samantha Hall:

The injection is something you get once a month. We like to start it about a week before you actually get chemotherapy so that it goes ahead and does put them to sleep ahead of time and then it continues monthly until you are off of chemo or until you're ready to have kids after that. But there's also reproductive specialists that you absolutely could be referred to. The problem is they're not always covered by insurances and they can get very costly and it can take time as well to do things like that. So sometimes if you're pressed for time and your insurance doesn't want to cover it, the injection is an alternative as well.

Jordan Hill:

And our reproductive specialists for people that are coming to WVU work very closely with our oncologists and our cancer teams, they usually will get our cancer patients in very quickly. I have had patients that are seen same day and next day whenever I reach out to them. So they have been excellent to work with and I would highly encourage all women of childbearing potential to have that conversation with your doctor.

Andi Hasley:

Are those Zoladex injections? Is that what you're talking about?

Jordan Hill:

Yeah.

Andi Hasley:

You're kidding me. Wow. See I'm like the fascinated by all of this. That's wild. I'm so impressed that... Yeah. Again, another resource that... Is any of this fun? No, nobody wants it to happen, but you have options and that's an amazing one.

Lauren Hixenbaugh:

So ladies, kind of thinking about our larger audience and not just those in West Virginia, what should folks be looking for in the provider in what should they be asking that provider in their appointments?

Samantha Hall:

So as far as what to look for in a provider, I would say somebody who specializes in breast cancer. Some places your provider will subspecialize in a different cancer type as opposed to just a general oncologist who treats all of the cancers. As you can see of everything we've talked about, breast cancer research moves quickly and there's all kinds of things out there. And so I would recommend somebody who actually does specialize in breast cancer. I'm also a huge advocate for clinical trials. So if you find institutions that have things like clinical trials, it's also something to ask your provider to sort of segue into that, am I a candidate for a clinical trial? Do you have any of those here that I could possibly take part in?

Jordan Hill:

Yeah, I think other things that are good to talk to the provider about if they don't already bring it up on their own is we talked a lot about medications and side effects and how to manage those. Sometimes there are non-pharmacologic things, there are ways that you can help keep your breast cancer from potentially coming back. There are ways to manage side effects that aren't medicines. And so asking what those options are can be a good question to ask as well. Sometimes providers will give you their best recommendation on what treatment you should receive, but it's never a bad thing to ask what your other options are. Like what other treatment options do I have, and why do you think this one is the best, and what are the differences in side effects between these two options? And then I think depending on where you are, what kind of cancer you have, your prognosis and your goals can vary greatly.

And so it's always good to have that conversation with your provider so that way you can really be your own advocate and be a strong member of your healthcare team and help make those shared decisions

and feel like you're really taking an active part in your treatment. And then don't be afraid to ask questions that you think might be embarrassing. Especially when we're talking about cancers in females. Some of the treatments that we use may affect sexual health and that might be something that is important to you and nothing is embarrassing. You shouldn't ever be afraid to ask any of those types of questions to your providers either.

Samantha Hall:

Absolutely. Another thing is I'm going to ask if you qualify for genetic counseling and testing. All triple negative cancers regardless of the age of diagnosis, now qualify per guidelines.

Andi Hasley:

That's awesome. Yeah, I know sometimes getting insurance to cover the difference of the genetic testing can be a challenge. So I'm very glad to hear that that's part of those guidelines now.

Jordan Hill:

With the genetic counseling and the genetic testing that's available, there are a lot more... You would know better Sam than me, but there are a lot more people that do the genetic test then in the past. And so the cost of that has drastically changed. And I know that is something that is important to everyone is how expensive is this going... Is this test going to be? And so that's something that's good to ask too.

Samantha Hall:

Yeah, there's all kinds of companies out there and everybody uses different companies depending on who's doing the testing and where it's at. But most of them are extremely affordable now and companies are working with people to set up payment plans if they even charge you. And that's something I know personally, I do genetic counseling and I look for in different companies are people who are going to make things affordable, people who are going to work with us as opposed to just charging patients astronomical expenses out of pocket. Because that's not feasible for anyone.

Andi Hasley:

Especially after a cancer diagnosis.

Samantha Hall:

Exactly.

Andi Hasley:

You're probably looking at a lifelong financial situation potentially. So you feel like, well that's something that maybe I shouldn't do, but again, I feel like [inaudible 00:33:05] advocate on this podcast, but knowledge is power and you're not just helping yourself, but you're helping your medical team. The more information you have about yourself, the more information they have about you and what your treatment is going to look like.

Samantha Hall:

Absolutely. And that helps family as well because genetic testing is a family ordeal. If you have it, there's a chance you've passed it along to kids. There's a chance siblings have it. Cousins, aunts, uncles, everybody.

Andi Hasley:

Yeah. So before we wrap up, are there any online resources for breast cancer patients that you have found to be credible, reliable?

Jordan Hill:

Yes. I think that there are lots of good resources out there. There are lots of not-great resources out there too, but there are plenty of really helpful and credible resources out there depending on what you're looking for. American Cancer Society has a lot of information just on breast cancer in and of itself and what potential treatments there are. Breastcancer.org also has similar information that is very reputable. There are specific guidelines for patients on provider sites like NCCN where we use them for treatment guidelines. There are guidelines for patients. The NIH website has really up-to-date information on treatments that are available and then there are more support resources available. So the cancer support community we talked about earlier. Patient Advocate Foundation is really good for people who need financial assistance. They not only can help with copays but bills and all sorts of financial aid. And then we had briefly mentioned caregivers needs earlier, which are also really important and there's a National Alliance for Caregiving and their website is very helpful and provides a lot of resources for caregivers that also need support.

Lauren Hixenbaugh:

So one of the things I like to ask at the end of every podcast as we begin to wrap up today if listeners were to remember one thing from today's podcast, what would you hope it would be?

Samantha Hall:

I think that the most important thing is to ask questions. Right? When you're at your appointments, don't be afraid to ask things. Don't be afraid to bring things up if you aren't sure. If you're a candidate for immunotherapy, ask them. If you aren't sure what the side effects are, ask. If you want to know what your stage is, ask. Don't ever be afraid to talk to your provider and ask questions about what's going on with your own health.

Jordan Hill:

I totally agree. Be your own advocate and don't be afraid to ask questions. That's why we're here. We get a lot of people that say, well I didn't want to bother you. Like Sam was mentioning with concerns after their treatment is over. But we get that a lot with initial diagnosis too. People are afraid that by asking questions that that is a bother. That's our job. That's why we're here. That's what we want to be able to help you with. And then we've mentioned this a few times, but I'm just going to keep reiterating it. Early detection is super important, so please get your screenings.

Samantha Hall:

That's exactly right. Make sure you get your screening.

Andi Hasley:

Thank you both so much for being here today. My takeaway from all of this is I hope our listeners realize that the options that exist out there with cancer diagnosis and treatment, and that if you're at screening age, you need to go be screened and then not be afraid of what the test results might be. Because there's a lot of hope in this conversation, a lot of hope in the options. So just embrace that and take care

of yourself. Thank you both so much for helping us share that message of hope with our listeners and we'd love to have you back again because I feel like this just scratched the surface of the resources that the two of you have, so hopefully, we can make that happen.

Samantha Hall:

Yeah, we thank you so much. We've had a really great time and we'd be happy to come back anytime.

Lauren Hixenbaugh:

Truly you guys, I totally agree with Andi. This is just scratching the surface. I feel like there's so much more here to cover, different angles to look at, different stories to tell. So if listeners want to find out more or have additional questions for any of us, Sam, Jordan, Andi, or I, feel free to reach out. You can always go to Living Beyond Cancer or the Mountains of Hope website, which is the West Virginia State Cancer Coalition. That can be found at moh.wv.gov. Or you can go to wvucancer.org and we also have a Facebook support group called Living Beyond Cancer. Just go to Facebook, type in Living Beyond Cancer in the search bar, and you'll find us there. We have a really supportive community that shares experiences and stories. Funny memes, you name it, we shared on there. But really thank you both for being here today and joining us as well as our listeners. We hope that they'll continue to join-