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Oncology Buddies
Your guide to cancer care

PUBLISHER: Karen Joseph
karen@buddiesforlife.co.za
EDITOR: Laurelle Williams
editor@buddiesforlife.co.za
DESIGN & PRODUCTION:
Sandra De Oliveira
sandra@buddiesforlife.co.za
MEDIA SALES: Nomonde Maroga
nomonde.maroga@buddiesforlife.co.za
DISTRIBUTION & SUBSCRIPTION:
subscribe@buddiesforlife.co.za

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Mission
Oncology Buddies informs and inspires all those who have, or are affected by cancer. Oncology Buddies is committed to working with all stakeholders to find solutions aimed at improving the quality, lifestyle, satisfaction, enjoyment and activities of people affected by cancers.

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CONTENT

Issue 60 | October-November 2025

Cover by:
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WELCOME

by Laurelle Williams

What this issue has taught me is that there are many aspects of oncology treatment that many people (myself included) aren't aware of. The story of Maryke du Toit, who has Stage 4 pancreatic cancer (NETS), is a prime example with peptide receptor radionuclide therapy (nuclear medicine) coming into the spotlight. Despite experiencing an adverse reaction due to a quality defect, Maryke sees this treatment as hope and anticipates receiving it again; read *Whipple Warrior*. Dr Lizette Louw explains exactly how this treatment works in *Lutetium-177 DOTATATE therapy*.

October is Mental Health Month and Caroline Rich shares pointers on how to *Start the mental health conversation* while Dr Michelle King explores *The effect of invalidation*. *The power of a mother's intuition*, by Bonni Suckling, touches on this, when she was repeatedly told by doctors that she is being paranoid yet deep down she knew something was wrong with her son, Jed.

With the theme *My happy and peaceful era*, may all of you experience this era.

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Start the mental health conversation

Caroline Rich shares tips on how to talk to your doctor about your mental health.

Each person is different as to how they deal with emotional issues in life. Being diagnosed with cancer is overwhelming and brings about fear of the unknown and feelings you may not even realise you have. There is no wrong or right way to feel. Whatever you're experiencing is your truth and part of your journey.

It's sometimes difficult to talk about emotions but in this setting, you must share them with your doctor. This can help you cope better which can make a difference to your quality of life during treatment.

SHARING YOUR FEELINGS

Some people have a better understanding than others of what cancer is and what is going to happen going forward. You may go onto the internet to read more about the cancer you have. However, sometimes having too much information (which may not always be scientifically accurate) can add to your fear and anxiety. That doesn't mean you should never look online; use it as an opportunity to prepare questions for the doctor when you see them.

If you already have underlying mental conditions (depression and anxiety), it's important to let your doctor know what treatment you are receiving for this. Make a list of the medications you are taking to give to the doctor at your first appointment.

In many instances, the doctors will share information with each other so that they can monitor your mental health through the treatment.

Besides the initial appointment, you will find that you don't get to spend much time with the doctor. There is much to discuss during the appointments regarding your physical condition, but it's vital that time is used to express how you're feeling emotionally. Even if you are the one to instigate the discussion.

Note, when you are with your doctor in their rooms, this is your sacred space, and you need to be honest and open with how you are coping mentally.

PREPARE FOR YOUR APPOINTMENT

Prepare by jotting down your feelings and be specific. Examples could be:

- Mood changes (sadness, irritability, numbness, hopelessness).
- Anxiety about treatments, test results, or the future.
- Sleep or appetite problems.
- Trouble concentrating or lack of motivation.
- Fear of being a burden to loved ones.

In addition, always make a list of questions that you want to ask regarding your mental health. Some examples:

- Is it normal to be anxious, depressed, and overwhelmed during treatment?
- Will the medication cause side effects that will affect my mood?
- What can I do to make sure that I can cope better emotionally?
- Are there medications that can help?
- What other coping strategies are there to help me feel less anxious?

SHOVE THE SHAME

Don't be embarrassed to share or ask about anything that is troubling you, even if you think it seems small. Your doctor is used to talking about the emotional aspect of your diagnosis, so use the time you have with them optimally.

Ask the doctor for resources that are available with regards to helping you cope better. Many practices have in-house counsellors. If they suggest that you see this person, or even a psychologist or counsellor outside of the practice, it's a good idea to follow their suggestion. This may unravel underlying feelings that you're not even aware of.

YOUR RELATIONSHIP WITH YOUR DOCTOR

As each person is different, so too are doctors and they may have different approaches and personalities. Your relationship with your doctor is important and you need to feel comfortable and supported by them.

If you find that the doctor that you are consulting with, is not giving you the emotional support you need, there is nothing wrong with going to see a different doctor. This is your right, and you don't need to worry about what they will think about you. This practise is accepted amongst medical professionals.

HEALING

Your emotional well-being is as important as your physical condition when it comes to living with cancer. It has been shown that coping better and feeling less stressed can benefit healing. That is why it's vital that you share everything that you're feeling with your doctor when you're sitting in front of them for that limited time. If you feel supported and less anxious, it will help you deal better with the journey going forward.

MEET THE EXPERT

Caroline Rich qualified as a radiographer in 1991 and work in the pharmaceutical industry for 25 years. Her area of expertise became oncology/haematology, and she started working in the NGO space in this field 13 years ago. She now works as a patient advocate, guiding and empowering patients and families through their cancer journey.

Finally on target

After eight years of changing treatment regimens to manage Stage 4 lung cancer, Bessie happily reports a major tumour shrinkage thanks to the targeted drug, osimertinib.

Bessie van Antwerp (73) lives in Weltevreden Park, Gauteng with her husband, Frans. They have two children and two grandchildren.

When Bessie was diagnosed with lung cancer in 2015, her concern was that it was related to the breast cancer she had been treated for (lumpectomy and radiation) in 1988. The doctor confirmed that it wasn't; it was a new primary cancer and the most common lung cancer: non-small cell lung cancer.

The reason she went to her GP was due to pain in her left arm. An X-ray led to a shoulder operation. After surgery, Bessie was gasping for air and more tests revealed that one of Bessie's lung had collapsed and treatment was provided.

"A month later I again struggled to breathe. We went to my GP again; I had blood tests and I was to see a specialist physician immediately."

A CT chest scan was done, and the specialist requested the previous scans from when Bessie's lung collapsed. The new CT scan showed fluid on the lung; three litres were drained and some sent for pathology, which confirmed it was Stage 4 lung cancer.

VARIOUS TREATMENTS

Bessie consulted with an oncologist and further testing was done. Bessie was told if she didn't have treatment, she would survive three months and if she had treatment, it would extend to 11 months. It was also explained that this cancer was common in women who never smoked.

The oncologist prescribed a targeted oral drug that Bessie took daily at the same time. Unfortunately, Bessie experienced terrible side effects: pimples all over her face. "Once that was under control, I was red all over, like I was burning from the inside and my skin was peeling off," Bessie recalls.

The treatment was stopped for two weeks but Bessie's children pleaded with her to take it again. So, Bessie asked the oncologist if she could start on a lower dosage and gradually get to the correct dosage. This plan worked, and Bessie was on the drug for three and a half years, going for regular scans, with the cancer remaining stable.

62 CHEMOTHERAPY INFUSIONS

In July 2019, the cancer progressed and the targeted drug was stopped and Bessie started a combination of chemotherapy. Within days, Bessie lost her hair, so her daughter helped shave her head and her son, who had long hair, shaved his head in support. "His gesture was so precious," Bessie says.

In February 2020, the chemo regimen was changed as the previous one wasn't effective anymore. By September that year, Bessie needed a chemo port as the nurses were struggling to find veins.

In June 2021, the regimen had to be changed again and again that September, which continued for nine months. All these changes were due the cancer progressing. In total, Bessie had 62 chemo infusions.

NEW TARGETED DRUG

In May 2022, Bessie was prescribed another oral targeted drug. This drug stabilised the cancer for just over a year, but then new nodules started to appear. The oncologist requested a biopsy to see if the cancer had specific EGFR mutations for the latest targeted drug, osimertinib.

In December 2023, Bessie's medical aid approved the new treatment regimen of osimertinib. This oral tablet must also be taken daily at the same time every day. Bessie takes it at seven in the morning.

Within three months, there was only 25% of the tumour left and all the new nodules were gone. When hearing this news Bessie cried tears of joy as it was the best news she had heard for a long time.

Currently, she is still on osimertinib and goes for three-monthly CT chest scans and a yearly PET scan. In May this year, the disease was stable.

"I have side effects but I think they are from the years of all the treatment I've had. The main one is leg cramps which I take magnesium, sea salt, and oral electrolytes for."

FAMILY EQUALS HAPPINESS

Bessie is so grateful to her family for their support. "My husband is incredible; he is my nurse. My children too. From the very beginning they asked me to not shut them out and reminded me that it isn't complaining but rather sharing," she says tearfully. "I've surpassed the lifespan the doctor thought I would have and for that I'm forever thankful."

She adds, "Happiness is my family and to see the progression of my grandson who is on the spectrum. Peace is to accept the things that I can't change and move forward and to know God is in control and that He gives us that peace."

Image supplied

Fuel for the fight

Dietitian, Meagan Atcheson, highlights the power of nutritional support in cancer care.

WHY NUTRITION MATTERS DURING AND AFTER TREATMENT

When facing a cancer diagnosis, treatment often becomes the central focus—whether it's chemotherapy, surgery, radiation, immunotherapy, or a combination. But one vital aspect of care that sometimes gets overlooked is nutrition. What you eat and how well you are nourished can play a significant role not only in how your body copes with treatment but also in recovery and quality of life afterwards.

THE IMPACT OF CANCER AND TREATMENTS ON NUTRITION

Cancer and its treatments can put your body under immense stress. Many patients experience unintentional weight loss, fatigue, changes in appetite, or side effects, such as nausea, altered taste, or difficulty swallowing. These challenges often make it difficult to consume enough food to meet your body's needs.

At the same time, your body requires more energy, protein, and nutrients than usual to repair tissue, support the immune system, and maintain muscle strength.

If nutritional needs aren't met, you are at risk of malnutrition, a condition that can weaken immunity, reduce tolerance to treatment, delay healing, and negatively affect overall well-being.

WHY NUTRITIONAL SUPPORT IS VITAL

Good nutrition during cancer is about more than kilojoules. It's about giving your body the right balance of macronutrients (protein, carbohydrates, fats) and micronutrients (vitamins and minerals) to cope with the physical demands of treatment.

- **Maintaining strength and energy:** Protein is especially important during cancer care. It supports muscle mass, aids recovery after surgery, and helps the immune system function optimally.
- **Improving tolerance to treatment:** Patients who are well-nourished often experience fewer complications, respond better to therapies, and have fewer interruptions in their treatment schedules.
- **Supporting immunity:** Overall nutrients like vitamin C, vitamin D, zinc, omega 3s, and iron help the immune system fight infections, which is particularly important when white blood cell counts are low.
- **Enhancing quality of life:** When patients are nourished, they often feel more energetic, recover quicker, and can better enjoy daily activities with their loved ones.

AFTER TREATMENT: NUTRITION FOR RECOVERY AND BEYOND

Nutrition remains important after treatment ends. Many survivors find they need extra support to rebuild strength, restore a healthy weight, and heal from side effects that linger.

A balanced diet helps reduce fatigue, improve digestive health, and support long-term well-being.

For some, there may also be specific concerns, such as osteoporosis, heart health, or maintaining a healthy body weight. Good nutrition after cancer doesn't only focus on recovery, it plays a role in reducing the risk of recurrence and protecting against other chronic diseases.

WHEN FOOD ALONE ISN'T ENOUGH

While the goal is always to encourage a healthy, balanced diet, there are times when food alone simply isn't enough to meet nutritional needs. Side effects of treatment, reduced appetite, or difficulty eating can make it challenging to get adequate kilojoules and protein from meals.

In these cases, additional nutritional support can be valuable. Options, such as fortified foods, shakes, or specialised nutritional products, can help bridge the gap, prevent malnutrition, and give your body the best chance to cope with treatment and recovery.

TAKING NUTRITION SERIOUSLY

Nutrition should never be an afterthought in cancer care; it's a core part of treatment and survivorship.

Oncologists, dietitians, nurses, and patients all benefit when nutrition is prioritised from the very beginning of the cancer journey. By addressing nutritional needs early and proactively, we can improve outcomes, reduce complications, and enhance quality of life both during and after treatment.

Cancer treatment is a fight on many levels—but with the right nutritional support, your body has the fuel it needs to stay strong, resilient, and ready for healing.

MEET THE EXPERT

Meagan Atcheson is a registered dietitian who focuses specifically in oncology. She is a plant-centric foodie who promotes a nourishing approach to health and wellness using evidence-based research and guidelines only.

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Uterine and ovarian hereditary cancer syndromes

Slindokuhle Sibiya describes the hereditary cancer syndromes that increase the risk of uterine and ovarian cancer.

Cancer happens when cells in the body grow and divide in an uncontrolled way. There are many different types of cancer, usually named according to where they start.

Uterine and ovarian cancers affect the female reproductive system. Uterine cancer (also called endometrial cancer) starts in the lining of the uterus, while ovarian cancer begins in the ovaries.

Most cancers (about 85%) happen by chance. But in some cases, a person is born with changes in certain genes that increase their risk of developing cancer. These are known as hereditary cancer syndromes, and some can increase the risk for uterine or ovarian cancer.

While it can be frightening to know you're at a higher risk, learning about hereditary cancer syndromes can help you and your family take control of your health. Genetic testing, personalised screening, and preventive options can all support early detection and even prevention of cancer.

UTERINE AND OVARIAN HEREDITARY CANCER SYNDROMES

Hereditary cancer syndromes are caused by inherited variants (mutations) in genes that usually protect the body from cancer. These genetic changes can be passed from parent to child and may significantly increase the lifetime risk of developing certain cancers.

The two most common inherited conditions that increase the risk of ovarian cancer are Lynch syndrome and hereditary breast and ovarian cancer (HBOC) syndrome. Some people may also carry mutations in other genes, such as BRIP1, RAD51C, and RAD51D, which aren't part of a defined syndrome but still raise the risk for ovarian cancer. BRIP1 variants increase the lifetime ovarian cancer risk by around 5–15%, while RAD51C and RAD51D increase the risk by 10–20%.

Lynch syndrome also increases the risk for uterine cancer. Other less common hereditary syndromes like Cowden syndrome (caused by changes in the PTEN gene) and Peutz-Jeghers syndrome (caused by changes in STK11) can increase the risk of uterine cancer as well.

In the general population, the lifetime risk of ovarian cancer is about 1–2%, and for uterine (endometrial) cancer, it's around 3%. But for individuals with mutations in certain genes, these risks can be much higher. The risk figures provided are based on the 2025 National Comprehensive Cancer Network (NCCN) Guidelines:

- BRCA1: Ovarian cancer risk of 39–58%.
- BRCA2: Ovarian cancer risk of 13–29%.
- Lynch syndrome: Uterine cancer risk up to 60%; ovarian cancer risk 1–38% (depending on the specific gene).
- Cowden syndrome: Uterine cancer risk of around 28%, along with increased risks for breast, thyroid, kidney cancer, and melanoma.
- Peutz-Jeghers syndrome: Uterine cancer risk of around 9–10%.

These mutations also increase the risk for other cancers, so identifying them is important not only for managing uterine or ovarian cancer risk but for overall health planning.

GENETIC TESTING

Because these conditions are inherited, a person's family history is one of the most important clues. A history of breast, ovarian, uterine, or colon cancer, especially when diagnosed before age 50, may suggest the presence of a hereditary cancer syndrome.

Genetic testing can confirm whether someone has an inherited cancer risk. This information can help guide medical decisions for both the individual and their family members. First-degree relatives (parents, siblings, or children) have a 50% chance of carrying the same mutation, so testing can be life-saving for others in the family.

If you're found to have a hereditary cancer syndrome, there are several steps you can take:

- **Screening:** While there's no proven method that reliably detects ovarian cancer early, you may be monitored with regular pelvic exams, ultrasounds, and CA-125 blood tests. For uterine cancer, yearly endometrial biopsies may be recommended starting in your 30s.
- **Preventive surgery:** Some may choose risk-reducing surgery, such as removal of the uterus (hysterectomy) and/or the ovaries and fallopian tubes (salpingo-oophorectomy), once childbearing is complete. This can significantly lower cancer risk and reassure individuals.
- **Surveillance for other cancers:** People with hereditary cancer syndromes may also need additional monitoring for related cancers, like breast or colon cancer.

Every care plan should be tailored to the individual, based on their personal and family history, specific genetic variant, and life circumstances. This is where genetic counselling plays a key role.

GENETIC COUNSELLING

Genetic counsellors are healthcare professionals trained to guide individuals and families through the genetic testing process. They help assess cancer risk, explain test results, and discuss what they mean for medical care and family planning. They also provide emotional support and help patients make informed decisions that align with their values and goals.

A hereditary cancer syndrome doesn't just affect you; it affects the whole family. Through genetic testing, personalised care, and family communication, people at risk can take meaningful steps to protect their health and empower those they love to do the same.

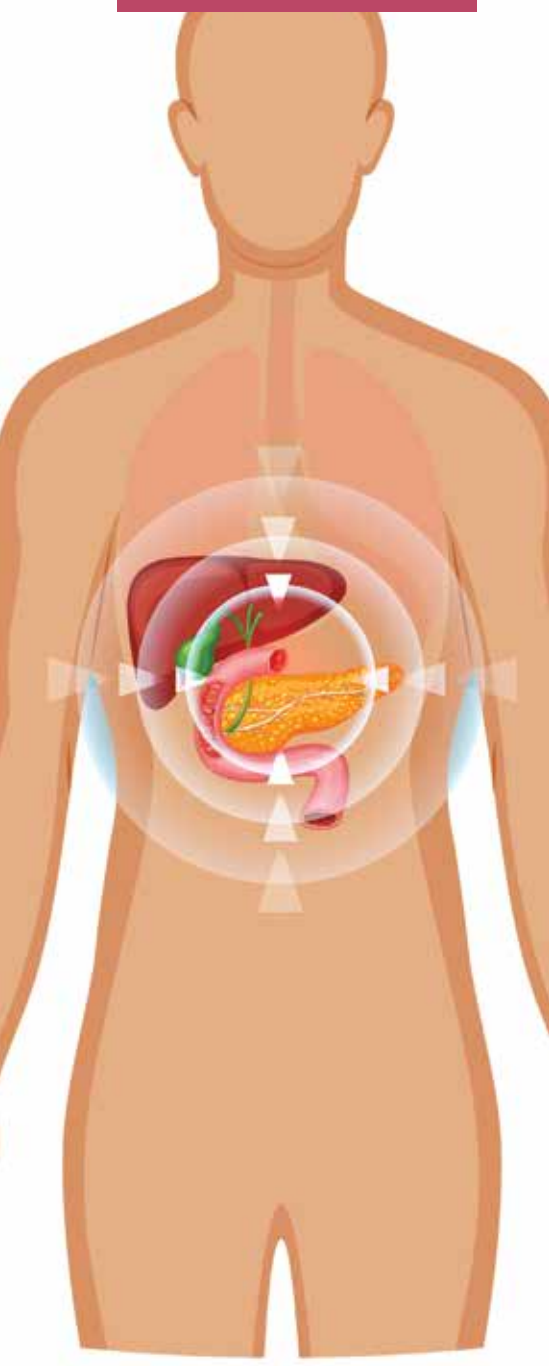
MEET THE EXPERT

Slindokuhle Sibiya is a first-year genetic counselling intern at the National Health Laboratory Service. As part of her training, she provides counselling in prenatal, paediatric, and cancer clinics across public hospitals.

Image supplied

What is the Whipple procedure?

Dr Leanne Prodehl explains the intricate process of the Whipple procedure.



A Whipple procedure, also known as a pancreaticoduodenectomy, is a complex surgery removing multiple abdominal organs. The procedure, first described in the 1930s and refined in the 1940s, is named after the surgeon who described it.

The pancreas has two main functions: hormonal and digestion. One of the primary hormonal functions is control of blood glucose. It secretes insulin when the glucose is high and glucagon when it's low. The pancreas also produces and secretes enzymes crucial for digesting food, such as fats, carbohydrates, and proteins.

WHAT DOES A WHIPPLE ENTAIL?

A Whipple involves removing the head of the pancreas, duodenum (first and shortest section of the small intestine), lower bile duct, gallbladder, and often part of the stomach.

The surgeon then performs about three anastomoses (joins) to restore gut continuity. The surgery is complex and can take many hours.

It's usually done via an open approach with a cut on the abdomen but can also be done laparoscopically or robotically. While most surgeons are taught about a Whipple, it's usually done by surgeons who have sub-specialised in hepatopancreaticobiliary surgery.

WHEN IS A WHIPPLE PROCEDURE NEEDED?

The main indication for a Whipple is cancer. The most common being a cancer of the head of the pancreas; the others being cancers of the ampulla of Vater, bile duct, duodenum, and stomach. Less commonly Whipples are done for non-cancerous conditions, such as chronic pancreatitis or benign lesions, such as a solid pseudopapillary neoplasm.

Some benign conditions, such as intraductal papillary mucinous neoplasms, may have high risk features for becoming malignant and these also warrant surgery.

THE DISADVANTAGES

The main concern about the Whipple procedure is the associated high mortality and morbidity. Despite advances in surgery, the mortality remains at 2–5%. This is part of the rationale for high volume hospitals where outcomes are better.

THE MAIN COMPLICATIONS ARE:

- ***Pancreatic fistula*** – A leak from the join-site can lead to infections and bleeding.
- ***Delayed gastric emptying*** – This is where the stomach is slower than usual to digest food, limiting oral intake.
- ***Bleeding*** – There are many major blood vessels involved in the surgery and bleeding can occur and may need re-operation.
- ***Bile leak*** – This is less common than a pancreatic leak and is related to the biliary anastomosis.
- ***Infections*** – All surgeries on the gastrointestinal tract have a risk of infection. In the Whipple, this is higher if the patient was jaundiced and needed drainage prior to surgery.

In the long-term, diabetes and pancreatic enzyme insufficiency are common. Most people who have had a Whipple need to be on pancreatic enzyme replacement. Depending on how much stomach was removed, patients may need to eat smaller, more frequent meals.

INTENSE REVIEW BEFOREHAND

The decision to proceed with a Whipple is not taken lightly and involves review of both the tumour and patient. Involvement of the major blood vessels around the tumour may make it unresectable or may require chemotherapy before surgery. The surgery is usually not done unless all the cancer is expected to be removed.

A patient's fitness and nutrition are also important considerations for both surgery and recovery. Surgeons may recommend nutritional and physical pre-habilitation prior to surgery.

Most people will spend one to two weeks in hospital with the immediate post-operative period in ICU. The recovery even once home can take some time with fatigue and weight loss being the main symptoms.

HOLISTIC CARE TEAM

The care of patients undergoing a Whipple is multi-disciplinary and involves doctors, such as the surgeon and oncologist, dietitians, physiotherapists, and social and psychological support. Candidates for Whipples should be discussed in multi-disciplinary team meetings as part of their cancer care.

Despite the risks associated with a Whipple procedure, it's often the only way to achieve cure as chemotherapy and radiation on their own are unlikely to result in cure. There have been multiple advances in surgical techniques, equipment, and care post-operatively. The number of people globally who have had successful surgery number in the tens of thousands.

MEET THE EXPERT

Dr Leanne Prodehl is an upper gastrointestinal and hepatopancreaticobiliar surgeon at Charlotte Maxeke Johannesburg Academic Hospital with a special interest in oesophageal cancer and multi-disciplinary teams.

Whipple Warrior

Despite a severe complication from a nuclear medicine treatment, Maryke du Toit, who has metastatic pancreatic cancer, would have it again if she had the choice.

Photo by Mandy Steenkamp Photography | Follow @mandysteenkampphotography

Maryke du Toit (53) lives in Pretoria, Gauteng with her husband. They have three children, aged 28, 25, and 17.

In the peak of the COVID-19 pandemic, in June 2020, Maryke experienced an intense pain under her rib cage that radiated to her back. Even though she took muscle relaxants and rested, the pain worsened, so she went to casualty.

She was treated for abdominal pain while a sonar and CT scan were done and was diagnosed with pancreatitis, with the doctor commenting that her pancreas was a funny shape. Two days later an MRI was done twice; the diagnosis changed to pancreatic cancer.

"The diagnosis was a shock and unexpected! I always hoped to spare my children from such pain. My mother received a breast cancer diagnosis in her thirties and lived with the condition for over twenty years. She passed away when I was 22, which had a profound impact on my life," Maryke explains.

WHIPPLE PROCEDURE

Maryke underwent a Whipple procedure to remove the 5cm neuroendocrine tumour (NET) in the head of the pancreas. "It was an immensely gruelling surgery. I remained in ICU for four days. However, what made it worse was, it was during the height of COVID, when visitors were not permitted in hospitals and COVID-related fatalities were at a peak" Maryke adds.

When Maryke was discharged three weeks later, she weighed 42kg and could only eat small portions of mashed foods or baby food. She was given pancreatic enzymes to help with digestion. During a slow eight-week recovery, she experienced Whipple attacks (painful spasms) and gradually transitioned to solid food.

A side effect from the Whipple procedure is Type 3c diabetes (a type of diabetes caused by damage to the pancreas that isn't autoimmune which affects its ability to produce insulin). Maryke manages this with her diet. "I researched diabetes and nutrition, how to read food labels, identifying foods to avoid, understanding carbohydrate content, and so on. At first, I monitored my blood glucose every time after a meal. But now, five years on, I check it weekly, and last year August, I stopped taking pancreatic enzymes," Maryke says.

LIVER METASTASIS

In January 2021, a follow-up appointment showed a slightly elevated cancer marker, leading to a confirmed diagnosis of metastatic disease to the liver, but the pancreas was clear. "I was so sad...then the question of: what does metastatic cancer mean? What now? Looking back, I experienced some carcinoid flushing (a sudden reddening and warming of the skin, typically on face and neck, which is when NETs excrete hormones), so that was probably an early sign."

In April 2021, Maryke underwent a liver resection for five lesions. Three months later, the lesions were back, and she started octreotide hormone injections (every 28 days) as a new treatment to manage the symptoms and slow down the disease. This continued for 24 months, with Maryke having a few flushings in-between, and hair dryness and loss as a side effect.

In April 2023, unfortunately the liver metastasis progressed. "This was really a tough moment for me. I took time to process, tried my best to handle things and be strong."

The next option was nuclear medicine: four rounds of Lutetium-177 (Lu-177) DOTATATE therapy, also known as peptide receptor radionuclide therapy (PPRT). Each round occurred every two months. Maryke didn't experience any adverse side effects. "This treatment was hope for me," says Maryke.

PERFORATED STOMACH ULCER

In September 2023, Maryke again experienced severe pain in her abdomen and recalls feeling a *pop* sound. She was rushed to surgery as she had a perforated stomach ulcer. "I remember thinking, today is not a good day to die. I'm not ready."

Once she recovered, she continued with Lu-177 treatments.

SEVERE COMPLICATION

"Unfortunately, during my sixth nuclear treatment, the Lu-177 and DOTATATE separated causing an abnormal biodistribution with a very prominent update throughout the bone marrow and no uptake in the liver metastases or kidneys. The pharmaceutical company was notified and investigated immediately. I was given injections to help with flushing it out my system. In addition, the South African Health Products Regulatory Authority (SAHPRA) was notified," Maryke explains.

"At that time, I felt perfectly fine and probably didn't completely understand the full consequences - I still travelled to Cape Town on a business trip, was out and about and living life as usual."

"Two weeks later, my blood counts dropped significantly low, and I was hospitalised, receiving blood and platelet transfusions as well as injections to increase white cells. As no positive responses were obtained, a bone marrow biopsy indicated permanent damage to my bone marrow, making a transplant the most viable option."

Maryke remained in isolation in hospital for three weeks and received further blood and platelet transfusions almost every second day.

Her brother, visiting from Australia, was tested to see if he could be a possible bone marrow donor, but he was only a 5/10 match, and with no eligible matches found in SA, the search continued abroad.

The mom of three carried on working from hospital. Commenting on this, Maryke says, "It helped me maintain focus and diverted my attention from my illness and surroundings."

The increased risk of infections led to another hospital stay and treatment for infection, shortly after being discharged.

Up until December last year, she continued with transfusions every week, and remained in isolation at home, when finally her white cell count started to increase after trying a booster injection once more.

Following continuous boosters, Maryke's bone marrow reignited. Due to this Maryke never needed a bone marrow transplant and was officially taken off the transplant list this January. "The haematologist explained that my case was unprecedented in their experience, and that they were gaining new insights as it represented a first-case scenario for them."

Maryke currently still takes injections to boost her red blood cells.

CURRENT HEALTH STANDING

"Despite the nuclear adversity, the Lu-177 treatments reduced the metastases by more than 80% since inception. I'm grateful and have no regrets, as I'm uncertain where I would have been without this treatment - still hoping to receive more in future, when the time is right."

Maryke has resumed octreotide hormone injections. Her most recent MRI scan indicated no disease progression.

FOCUSING ON MILESTONES

"The unwavering support I've received from my husband, sons, daughter, friends, family, doctors, and work colleagues has been my bedrock. Their encouragement and understanding have lifted me in moments of uncertainty, and their presence has made even the most daunting days feel possible. My husband's steadfast love and partnership has offered comfort and strength, while my children's devotion—each in their own way—has given me purpose and hope. Friends and family have surrounded me with warmth and laughter, even my work colleagues, through compassion and flexibility, have helped me maintain a sense of normalcy and belonging. It's this circle of support, that sustains me," Maryke says.

"One of the best sayings is *Faith over fear*. You must have faith that God is in control, and everything is in His hands. I know it's hard but without faith, it's even harder."

"What helps me cope, is to focus on milestones: special moments I get to spend with family, friends, and loved ones, like another Christmas, birthday or holiday. Celebrating my daughter's wedding this year filled me with immense gratitude, and my hope is to see my youngest son finish his matric year. It's in these moments—when hope quietly outshines uncertainty and gratitude becomes a daily practice—that's when my resilience flourishes." Maryke says.

For Maryke, the act of savouring each milestone, from family celebrations to simple togetherness, reflects the significance she places on these experiences. She gathers comfort from supporting others, understanding that compassion is both a gift and a lifeline. Each day, she chooses to embrace peace, to nurture harmonious relationships, and to let grace guide her gaze beyond the horizon of the unknown. Her journey is a reminder that courage is often woven from gentle threads: small acts of kindness, a steady belief in possibility, and that happiness is found not only in triumph, but in the art of cherishing every fleeting moment.

MEET OUR EDITOR

Laurelle Williams is the editor at Word for Word Media. She graduated from AFDA with a Bachelor of Arts Honours Degree in Live Performance. She has a love for storytelling and sharing emotions through the power of words. Write to *editor@buddiesforlife.co.za*

Lutetium-177 DOTATATE therapy

Dr Lizette Louw explains how peptide receptor radionuclide therapy using Lutetium-177 radiation targets neuroendocrine tumours.

WHAT ARE NEUROENDOCRINE TUMOURS?

Neuroendocrine tumours (NETs) are a group of rare cancers that originate in cells found throughout the body, and act as a bridge between the nervous and endocrine systems. The most common sites of origin are bowel, lung, or pancreas. Tumours are categorised as grade 1, 2 or 3 based on tumour cell growth rate, measured by the Ki-67 index on histology. A high Ki-67 indicates a faster-growing and more aggressive tumour.

THE CENTRAL ROLE THAT SOMATOSTATIN PLAYS

Somatostatin is a normal hormone which interacts with neuroendocrine cells via a receptor on the cell surface. Most NETs overexpress somatostatin receptors, and thus overreact to normal somatostatin stimulus, leading to excessive tumour growth.

Nuclear medicine makes use of a peptide which is a somatostatin analogue and binds to these somatostatin receptors, for both imaging and therapy for NETs. This analogue only binds to the somatostatin receptors but doesn't cause the same reaction inside the cell as somatostatin.

The somatostatin analogue available in SA is called DOTATATE. This DOTATATE can be linked to different types of radiation, depending if it's being used for imaging (PET/CT), or for peptide receptor radionuclide therapy (PRRT).

PRRT, in simple terms, is when the peptide (DOTATATE) binds to a receptor (somatostatin receptor) and carries radiation (Lutetium-177(Lu-177)) which is used for therapy. PRRT is often called targeted therapy, as it delivers radiation therapy predominantly to cells that DOTATATE binds to, without significant harm to healthy surrounding tissue.

Once the DOTATATE binds to somatostatin receptors, the Lu-177 is transported to the inside of the cell, where it emits beta particle radiation that travels only up to 2mm. This radiation damages the nucleus of the cell, thereby killing the cell, and/or slows down the cellular growth.

WHO WOULD QUALIFY FOR PRRT?

Patients with confirmed grade 1 or grade 2 NETs in who curative surgery isn't possible, and those who have progression of disease despite other treatments, would be considered.

Confirmation of DOTATATE uptake by the cancer cells with a DOTATATE PET/CT scan is, however, essential. The brighter the DOTATATE uptake in the cancer sites (more intense than in the normal liver), the more likely it's that the patient will benefit from PRRT. If there is very little or no DOTATATE uptake in the cancer sites, the patient will not benefit from PRRT, and other therapy options should be explored.

Patients must be in a reasonably good physical condition, with adequate bone marrow, kidney, and liver function. It's best for patient cases to be discussed at a multi-disciplinary meeting (MDM), where a group of specialists can collectively make decisions on the treatment plan.

HOW IS PRRT GIVEN?

Treatment consists of four cycles, given eight to 12 weeks apart. Blood tests to monitor bone marrow, kidney, and liver function is done prior to every cycle, to determine if it's safe to proceed or not.

PRRT can be done as an out-patient at a facility with a radiation licence for Lu-177. Something for nausea is given first, as well as a once-off steroid dose to minimise inflammation caused by the radiation therapy. After this, a special amino acid infusion to protect the kidneys will be started and runs over four hours. The PRRT infusion is administered at any time after at least one hour of this amino acid infusion.

A scan is commonly done the day after treatment, but due to logistics this scan can be done even three to four days after treatment. This scan isn't a PET/CT, and appears blurrier than a PET/CT. The purpose of this scan is to visualise the absorption of treatment, and when the scans are compared after each cycle, it's an early indication of treatment response.

In other countries, this scan (done at a minimum of three-time points) is also used to calculate the amount of radiation absorbed in the whole body, but the skills and computer software for this is unfortunately not widely available in SA.

WHAT ARE THE SIDE EFFECTS OF PRRT?

The most common side effect is nausea related to the amino acid infusion, which is why the treatment procedure starts with anti-nausea medication first.

Most patients experience fatigue, which can last from a few days up to a few weeks. This is, however, usually mild. Some patients report pain in the areas of cancer, which happens because of radiation-induced inflammation in the cancer areas, causing swelling of those areas. This is unpredictable, and most patients need only mild to moderate pain medication.

Patients with functional tumours may experience a hormone surge during the PRRT infusion, with flushing and palpitations, but a life-threatening hormone reaction is extremely rare.

Bone marrow suppression may occur due to PRRT, even in patients who don't have cancer spread to the bones. In many patients, this is mild and temporary, and doesn't preclude them from further PRRT cycles. Severe bone marrow suppression is rare, occurs in only 1–2% of patients, and in most patients, the bone marrow makes a full recovery even though transfusions may be needed.

Myelodysplastic syndrome or bone marrow failure occurs in < 1% of patients and usually only months or years after the last PRRT. Risk factors for this includes patients who previously received chemotherapy, patients who had multiple PRRT cycles, older patients, and patients who have an unrelated underlying bone marrow problem.

WHAT IS THE MECHANISM OF BONE MARROW SUPPRESSION DUE TO PRRT?

Apart from the expected direct action on surrounding bone marrow due to cancer in or close to bones, the Lu-177 may separate from the DOTATATE peptide and settle within the bone marrow.

In patients with poor kidney function, the Lu-177 is cleared slower from the body, potentially leading to prolonged exposure to bone marrow and other tissues. However, studies show that the radiation-absorbed dose to bone marrow from a standard four-cycle PRRT protocol is below the threshold for permanent damage in most patients. It must be highlighted that PRRT generally causes far less bone marrow suppression than most types of chemotherapy, with a lower risk of myelodysplastic syndrome or future leukaemia.

RESPONSE TO PRRT

A DOTATATE PET/CT to assess treatment response is done after completion of the four PRRT cycles. Although PRRT doesn't offer cure in patients with metastatic NETs, it slows tumour growth in 80–90% of patients, reduces symptoms in up to 80% of patients within weeks of the first cycle, and thereby improves quality of life.

According to the NETTER-1 trial, there is about a 20-month interval before the disease progresses again. Less than 10% of patients will have progression while on PRRT.

WHAT COMES AFTER PRRT?

No two patients are alike. Further treatment would be best discussed at a MDM. Various options are possible, depending on the sites and extent of residual cancer after PRRT: octreotide injections for maintenance, everolimus, surgery, radiofrequency ablation of liver lesions, or even chemotherapy.

Should there be disease progression in the future, further PRRT cycles may be given, provided the patient has adequate bone marrow, kidney, and liver function.

FINAL THOUGHTS

Although the cost of PRRT per cycle is high (+-R100 000), the total annual cost is more affordable than high-dose octreotide, or other therapies with worse side effects.

PRRT is a well-tolerated and effective treatment choice, with minimal side effects. The treatment effect can last for months or even years.

Although every patient with a NET has a unique treatment journey, PRRT will benefit most patients.

MEET THE EXPERT

Dr Lizette Louw is a nuclear physician with a passion for oncology imaging and nuclear medicine therapy for NETs, thyroid, and prostate cancer. She is well-known and respected nationally and internationally. As a representative of the World Federation of Nuclear Medicine and Molecular Biology, she works closely with various international experts.

Diabetes and cancer

Dr Angela Murphy looks at the correlation between diabetes and cancer.

A diagnosis of either diabetes or cancer causes significant stress. There is no doubt that if both conditions are present this causes true distress. Although cancer isn't a typical complication of diabetes, there is an increase in the occurrence of cancer in people living with diabetes (PLWD).

In 2009, the American Diabetes Association and the American Cancer Society developed a consensus document to look at the following questions:

1. Is there an association between diabetes and cancer?
2. What are the biologic links between diabetes and cancer risk?
3. What risk factors are common to both diabetes and cancer?
4. Do diabetes treatments influence risk of cancer?

WHAT IS THE ASSOCIATION BETWEEN DIABETES AND CANCER?

We see an increasing incidence of both diabetes and cancer. It seems that the diagnosis of both conditions in the same person occurs more frequently than would be expected by chance.

Some cancers (liver, pancreatic, and endometrium) occur more commonly in the presence of diabetes and some cancers (prostate) are less common in the presence of diabetes. Other cancers (lung, kidney, non-Hodgkin lymphoma) haven't been conclusively shown to have an association with diabetes. Currently the association of cancer and Type 1 diabetes is not confirmed.

In addition to seeing an increase in the incidence of cancer in PLWD, it seems that diabetes increases the risk of complications and mortality from cancer.

WHAT BIOLOGICAL ASSOCIATION IS THERE BETWEEN DIABETES AND CANCER?

1. Hyperglycaemia

In the 1920s, scientist Otto Warburg observed that cancer cells consume large amounts of glucose as they rapidly divide and proliferate. This is now called the Warburg effect.

2. Hyperinsulinemia and insulin resistance

Certain cancers possess insulin receptors and stimulation of these by high levels of circulating insulin can directly affect the metabolism of cancer cells, promoting their growth. Insulin also stimulates insulin-like growth factor 1 (IGF-1) which promotes cancer cell growth and inhibits cancer cell death. Insulin increases the levels of oestrogen that the body is exposed to which in turn increases the risk of certain cancers, such as breast cancer.

3. Inflammation

Many pro-inflammatory substances (interleukin-6; tumour necrosis factor alpha, etc.) can induce malignant changes in cells and cancer progression. Both hyperglycaemia and hyperinsulinemia cause oxidative stress which in turn causes inflammation. The most common cause of chronic low-grade inflammation is obesity.

WHAT ARE COMMON RISK FACTORS BETWEEN DIABETES AND CANCER?

1. Obesity

Most people living with Type 2 diabetes are overweight or obese. As mentioned, obesity is a state of low-grade inflammation. The longer overweight or obesity is present, the greater the risk of developing cancer.

The Centre for Disease Control (CDC) in America lists 13 cancers more commonly seen in people living with obesity: oesophageal, breast in post-menopausal women, colon and rectum, uterus, liver, stomach, kidneys, gallbladder, ovaries, pancreatic, thyroid, multiple myeloma, and meningioma, a type of brain cancer.

2. Age

The incidence of most cancers increases with age with an estimated 78% of all newly diagnosed cancer occurring in people over the age of 55 years.

3. Gender

In general, men are slightly more at risk of developing cancer than women and in turn have a higher incidence of Type 2 diabetes.

4. Ethnicity

Statistics show that in the USA, African Americans develop and die from cancer more than other racial groups. This may be due to a variety of factors, such as socioeconomic status as well as genetic factors.

5. Smoking

Tobacco smoking causes over 70% of all respiratory cancers and is a strong risk factor in many other cancers. In addition, studies suggest that smoking is an independent risk factor for developing Type 2 diabetes and we know smoking will always worsen the complications of diabetes.

6. Alcohol

Even if alcohol is consumed moderately, it's associated with an increased risk of cancers, such as mouth, throat, gastrointestinal, and breast. Moderate alcohol consumption may be protective against the development of diabetes, but excess alcohol is a diabetes risk.

7. Sedentary lifestyle

There is a definite link between lack of physical activity and the risk of Type 2 diabetes and cancer.

DO DIABETES TREATMENTS INFLUENCE THE INCIDENCE OF CANCER AND CANCER PROGNOSIS?

Good glucose control lowers the risk of complications and possibly cancer too. The influence of the various drug treatments are as follows:

1. Metformin

At diagnosis all people with Type 2 diabetes are prescribed metformin and this is continued lifelong unless it can't be tolerated, or kidney function drops below a certain threshold.

Metformin reduces circulating levels of glucose and insulin by reducing the production of glucose in the liver. Studies have shown that metformin inhibits the growth and proliferation of cancer cell lines.

Other research has demonstrated that metformin can selectively kill certain cancer stem cells, improving the effectiveness of the anticancer regimen.

This has been particularly described in breast cancer.

There is significant evidence to show that PLWD who are on metformin are less likely to get cancer than PLWD who don't take metformin. Additional observational data also suggests that PLWD taking metformin who do develop cancer are more likely to go into remission.

Metformin is sometimes used as an adjuvant treatment in a cancer regimen even in people without diabetes, particularly with breast cancer therapy.

2. Thiazolidinediones

These are medications that work in the liver to treat insulin resistance. Pioglitazone is the only one available in SA. Results of studies are conflicting whether these drugs decrease, increase, or do not affect cancer risk.

3. Sulfonylureas

There is very little data to suggest any benefit or risk in this group of medications.

4. Incretins

These are the injectables liraglutide, semaglutide, and dulaglutide. They bind to the glucagon-like peptide-1 (GLP1) receptor which results in lower glucose levels and weight loss.

Liraglutide showed an increased risk of medullary thyroid cancer in rats. The risk of this cancer remains a black box warning. A study published in *The British Medical Journal*, in April 2024, calculated that there was very little increase in risk for thyroid cancer in patients using GLP1 receptor agonists. They report this would be 0.36 excess cancers per 10 000 person-years which compares favourably to a background incidence of cancer in diabetes of 1.46 per 10 000 person-years. However, if there is a history of thyroid cancer or a family history of thyroid cancer, the PLWD may still be advised not to use this therapy.

5. Insulin

As mentioned above, we know that high levels of insulin can be implicated in causing cancer. Naturally, PLWD who must inject insulin to treat their diabetes will be concerned. To date, there is no definite proof that insulin as a therapy causes cancer.

However, people living with Type 2 diabetes who are using insulin will often have other risks as well: longer duration of diabetes with insulin resistance, obesity, and older age.

One study also indicated a greater risk of developing cancer with higher doses of insulin. It's critical to acknowledge that cancer cells in a person living with Type 2 diabetes may have spent years being exposed to abnormally high endogenous insulin due to insulin resistance. Thus, it's difficult to blame the newly injected exogenous insulin to be the cause of any cancer.

HOW TO LOWER CANCER RISK IF YOU HAVE DIABETES

The most common cancers associated with Type 2 diabetes are breast, colon, and prostate. However, as noted previously, if the PLWD also has an increased body weight, there are many more cancers associated with obesity. Two main strategies are important: prevention and screening.

PREVENTION

There is always benefit in trying to improve the modifiable factors of lifestyle.

Weight

Keeping body weight to normal or near normal is protective. This will lower insulin resistance while improving glucose control. In addition, weight loss has been shown to decrease cancer risk.

DIET

Adopting a diet that supports weight management is essential. There is also value in choosing foods that lower inflammation and have less direct carcinogens. The World Health Organization recommends avoiding processed meat as much as possible. Processed meats (ham, bacon, pastrami, hot dogs, sandwich meat) are prepared by smoking, curing, salting, or adding chemicals. Red meat should be restricted to 500g weekly. In fact, a plant-based diet is less inflammatory and lowers cancer risk.

PHYSICAL ACTIVITY

Recommended activity is 150 minutes weekly ideally spread out over five days. This can be aerobic and resistance exercise.

STOP SMOKING

The connection between smoking and cancer has been established since 1963. Stop smoking!

REDUCE ALCOHOL

A woman can have 1–2 units daily and a man 2–3 units daily. One unit of alcohol is 340ml beer/cider; 120ml wine; 25ml spirits.

SCREENING

These recommendations are for the general population but if you are at higher risk for a certain cancer (family history, radiation exposure, etc.), then please chat to your doctor about your screening schedule.

BREAST – Start at age 40 with mammograms and generally every two years thereafter unless at higher risk. Monthly self-examination is also important.

CERVICAL – Screening starts at age 25. A Pap smear can be done every three years, but the newer human papillomavirus (HPV) screening can be done every five years.

PROSTATE – Age 40 is the recommended screening age in black men and 45 years in other races with an annual PSA blood test. Any abnormality or change in this would prompt further testing by a urologist.

COLON – Age 45 years with stool occult blood test or colonoscopy.

SKIN – Be aware of changes in your own skin. An annual check with your doctor or dermatologist is valuable.

LUNG – In smokers age 55–80 years (and this is even for ex-smokers), consider having a CT chest annually.

CLOSING REMARKS

There is a link between diabetes and cancer. However, scientists from Mount Sinai in the USA, who looked at diabetes and pancreatic cancer, are still not clear about what comes first – the cancer or the diabetes.

What we do know is that high blood glucose will increase cancer cell metabolism and growth so good glucose control is essential. We also know that certain medications are protective, especially metformin.

With a healthy lifestyle and avoidance of other risk factors, as well as regular cancer screenings, it should be possible for PLWD to lower the risk of a cancer diagnosis.

MEET THE EXPERT

Dr Angela Murphy is a specialist physician practicing at Sunward Park Medical Centre. She retains a special interest in endocrinology and a large part of her practice is diabetes and obesity. She is a member of the Society of Endocrinology and Metabolism of South Africa and the National Osteoporosis Foundation and is actively involved in diabetes patient education.

The effect of invalidation

Dr Michelle King discusses the important topic of when your emotions are unseen and how invalidation impacts your healing journey.

Living with a diagnosis of cancer often brings with it a whirlwind of emotions: fear, grief, anger, sadness, and hope. Not all these emotions are seen, even by those closest to you.

This is the bit that people don't talk about as it may be too painful or uncomfortable. Invalidation.

They are those moments when your emotional experiences are dismissed as exaggerated, inconvenient, or even irrational. Invalidation can come from well-meaning family or friends who don't understand. Or from healthcare professionals who focus only on your test results.

Sometimes it can come from within yourself.

FAMILY AND FRIENDS: *"BUT YOU LOOK FINE..."*

Emotional invalidation from loved ones can take many subtle forms.

- Minimising feelings: *"You just had a good scan—why are you still upset?"*
- Well-meaning fixes: *"Just stay positive!"* or *"Try an all-juice diet, it works wonders."*
- Comparisons: *"At least your cancer isn't like Aunt Mary's, hers is awful."*

These responses may come from love but end up making you feel unseen, unheard, and deeply alone.

FROM DOCTORS: A MATTER-OF-FACT DISMISSAL

Doctors can unintentionally invalidate you when they:

- Focus on your lab results without acknowledging how scared you are.
- Rush appointments, cutting off any discussion about your feelings.
- Respond to your emotions with medical advice instead of empathy. For example: *"You're anxious? Let me prescribe you some..."*

Research shows that when healthcare providers offer validating communication (simple acknowledgement and reflective listening), it improves emotional well-being and makes it easier for you to talk about the difficult things.

SELF-INVALIDATION: YOUR INTERNAL CRITIC

Sometimes the harshest voice is your own. Thoughts like:

- *"Why am I crying? Everyone else handles this better."*
- *"I shouldn't feel tired after chemo—it's not that bad."*

These are forms of self-invalidation. The problem with this negative self-talk is that it builds shame, cuts off self-compassion, and deepens emotional distress.

WHY INVALIDATION HURTS

Studies show that validating responses build emotional resilience, while invalidation does the opposite; it fuels stress and anxiety. Emotionally-invalidating environments can lead to depression, anxiety, reduced self-esteem, and even slow down the healing process.

SELF-VALIDATION

Here's how to practise:

1. **Notice your self-talk**
   Listen for thoughts starting with *"I should"* or *"I need to just..."*, these often signal internal criticism.
2. **Label the emotion**
   "I feel exhausted, scared, frustrated." Identifying the emotion reduces its power.
3. **Understand its source**
   Ask yourself: Why now? *"I'm tired because of chemo", "I'm scared because of the scan results."*
4. **Respond with compassion**
   Speak kindly: *"This is really hard, and I'm doing the best I can."*
5. **Journal or reflect**
   Writing can be therapeutic and can reinforce self-kindness.

GETTING OTHERS TO LISTEN: PRACTICAL TIPS

With family and friends

- Open with emotional honesty: *"I'm sharing this with you because it matters to me."*
- Invite curiosity, not judgment: *"Can you help me understand how you're seeing this?"*
- Set boundaries: If their response is dismissive, it's okay to say, *"That doesn't help me feel heard."*

With doctors

- Say how you feel: *"I'm really worried about recurrence—can you talk me through the numbers?"*
- Ask for emotional space: *"Can we spend a minute on how I'm coping?"*
- Take a trusted partner: A friend or family member can hold space for emotional needs when consultations feel rushed.

WHY VALIDATION MATTERS

When others validate you, you feel less alone, more understood—and better able to ask for help. Healthcare teams who remain emotionally present empower you to speak up, report symptoms, and engage in shared decision-making.

Validation isn't a luxury, it's a lifeline.

FINAL TAKEAWAY

For those of you on a cancer journey, validation is not optional, it's survival. Validate yourself, by listening to your emotions with kindness and curiosity. Invite others to do the same. With honesty, clarity, and boundaries.

When your feelings are held, acknowledged, even in the face of uncertainty, you can reclaim agency over your life. And that is healing too.

MEET THE EXPERT

Dr Michelle King is a psychiatrist with a special interest in chronic pain and palliative care. She is dedicated to improving quality of life for patients through compassionate, evidence-based approaches. She currently serves as President of the Pain Society of South Africa (PAINSA). Visit *michellekingpsychiatrist.com*

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The power of a mother's intuition

Bonni Suckling depicts her mother's intuition in a fictional monologue of her late son, Jed Brady Thomas-Suckling.

THE KNOWING

My name is Jed. I liked Buzz Lightyear, *Ben10*, *Cars*, my family, and my stinky dog. I liked playing with my Bakugan dinosaur eggs and watching cartoons. I liked it when the sun came in through the curtains in the morning and made shapes on my blankets. I liked smooth peanut butter, but not the crusts. I loved throwing stones in the river with my dad and watching them bounce. *Boing, boing, boing, PLOP*! I was nearly four years old.

I was busy being me, doing all my little boy things, when something started to feel strange inside my body. My legs didn't always listen. Sometimes my head felt heavy and *ouch*. But I didn't know the words for that yet. My mom saw it first. Not in a big, loud way. Just in little things, like the way I walked wobbly, or when I stopped laughing like I used to. I didn't laugh loud cos it made my head feel sore. Sometimes I got very cross for no reason at all.

But she knew.

It felt like a whisper in her chest, tugging at her again and again.

Mom says: *"It wasn't one big moment. It was lots of little ones, a stumble here, a tantrum there, a strange look in his eyes. I couldn't explain it properly. I just knew something wasn't right. I knew my child. And I knew I wasn't paranoid, even though I was told I was…again and again."*

She took me to the doctor, a lot of times, even more than a lot. She asked questions. She pushed for answers. People told her it was probably nothing.

But the whisper inside her kept getting louder.

One day, the doctor sent us for a scan. Maybe cos mom was making a noise with her outside voice and tears. They took pictures to look inside me.

And that's when our whole world cracked.

Mom says: *"Nothing prepares you for that moment. I wasn't expecting brain cancer, not in my sweet boy who was still in nappies at night and crawled into bed with me. I thought maybe it was his ears, or something with his balance. But a tumour? That word didn't live in my world. Until it did."*

THE PROTECTION

After that, she held my hand really tight. I think maybe her own legs didn't want to walk anymore. But she stood up anyway. She stood up for me, sometimes with her outside voice, again and again.

Sometimes her eyes were wet and red and puffy. But her mouth kept smiling big; my mommy smiled big for me.

Mom says: *"Looking back now, I realise what that feeling was… intuition. That deep, quiet knowing that something is wrong, even when no one else can see it yet. It's not loud. It doesn't come with flashing lights or a checklist. It's more like a pull in your chest, a whisper that doesn't go away. It shows up in the middle of the night, in the way you watch your child breathe, or how you notice the way they don't laugh quite the same. It's not magic. It's motherhood. It's the part of you that's wired to notice the tiny shifts, to feel what can't yet be named. It's the invisible thread between a parent and their child, and when something tugs on that thread, you just know.*

I should have pushed more. I let them reassure me when something inside me wasn't at peace. That stays with me. I did what I could with what I knew at the time. And once I truly understood, I didn't stop. I fought with love. With hope. With everything I had."

THE REALITY

I don't live here with my mom, dad, and stinky dog anymore, not here on earth. But I live in how my mom speaks now (with her outside voice). She can be so loud about childhood cancer. I live in the way she helps other parents trust that little voice in their hearts.

Mom says: *"Jed taught me that being a mother means listening to the things that can't be measured. The things that don't show up on blood tests at first. He made me believe that love isn't just a feeling, it's a sense. And it's powerful. Please trust that. That whisper might be the only early warning there is."*

And if you're a doctor, or a nurse, or a teacher, or just someone who hears a parent say, *"Please help"*. Listen. With more than your two ears.

Listen with your heart. Because sometimes, love knows what science doesn't. Not yet.

MEET THE EXPERT

Bonni Suckling is the founder of Rainbows and Smiles Foundation. In 2022, she completed her Paediatric Post Grad Diploma, a testament to her dedication to improving paediatric healthcare. She has played a pivotal role in establishing paediatric palliative care support groups, offering solace and guidance to families. She is also a gym instructor and endurance athlete.

Images by freepik.com

Importance of genetic testing in prostate cancer

Kusha Kalideen unpacks why genetic testing helps determine prostate cancer treatment, specifically with the use of the targeted drugs, PARPi.

Metastatic castration resistant prostate cancer (mCRPC) is an aggressive, advanced form of prostate cancer associated with poor prognosis. While treatment options are limited, a class of cancer drugs, known as poly (ADP-ribose) polymerase inhibitors (PARPi), has shown improved survival and reduced disease progression in a subset of prostate cancer patients. As a result, PARPi have been approved for use in prostate cancer patients who have mutations in DNA repair genes.

HRR GENE MUTATION

Homologous recombination repair (HRR) is a type of DNA repair that relies on several genes working together, the most well-known of which are BRCA1 and BRCA2.

In cancer cells, PARPi targets the DNA repair system and forces cells to use HRR. If there are mutations in the HRR genes, the HRR can't function properly, and DNA can't be accurately repaired. Eventually inaccurate DNA repair compromises the function of a cell, forcing the cell to induce cell death. Patients with mutations in HRR genes are therefore eligible for PARPi and genetic testing of the HRR genes is required.

HRR gene mutations aren't only acquired to cancer cells but can also be inherited. Importantly, PARPi therapy is beneficial in patients with both inherited HRR mutations or acquired HRR mutations.

The recommended method for genetic testing of the HRR genes is known as next generation sequencing (NGS), which allows several HRR genes to be analysed simultaneously. NGS is used for the identification of inherited or acquired mutations, however, different samples are needed depending on the source of the mutation.

GERMLINE VS SOMATIC TESTING

Germline testing refers to testing for inherited gene mutations that have implications to immediate family members. Genetic counselling is therefore required prior to germline testing to provide information about testing, what the possible results may be, and the implication of those results on immediate family members.

Conversely, somatic testing refers to testing for acquired mutations and uses the tumour tissue for genetic testing. On occasion, somatic testing can identify inherited mutations and germline testing may be recommended. A comparison between the types of tests is provided in Table 1.

Patients can be referred for germline or somatic testing or both based on certain criteria highlighted in clinical practice guidelines for prostate cancer.

Table 1: Germline and somatic testing for PARPi eligibility in prostate cancer.

	Germline testing	Somatic testing
Source of mutation	Inherited	Acquired
Samples used for testing	Whole blood/buccal swab	Tumour tissue
What information does this test provide?	Identify mutations that can: • Confer an increased risk of cancer • Guide therapy decisions	Identify mutations that can: • Guide therapy decisions
Who should be tested?	Recommended for patients who meet certain clinical criteria specified in treatment guidelines	Recommended for all metastatic prostate cancer patients, patients who may be eligible for clinical trials and/or targeted therapy
When is testing recommended?	As soon as possible post-diagnosis	Prior to treatment
Minimum set of genes to be tested?	ATM, BRCA1, BRCA2, CHEK2, HOXB13, MLH1, MSH2, MSH6, PALB2, PMS2, RAD51D and TP53 NGS is the preferred testing methodology	ATM, BRCA1, BRCA2, CDK12, CHEK2, FANCA, PALB2, and RAD51D NGS is the preferred testing methodology
Differences in testing?	Germline testing doesn't identify somatic mutations	Somatic testing doesn't always identify germline mutations

TAKEAWAY MESSAGE

Genetic testing has become an important tool to identify the most effective treatment in prostate cancer and clinical management. Most private laboratories in SA offer genetic testing, using NGS for prostate cancer, as well as genetic counselling for patients requiring germline testing.

It's important to highlight, however, that genetic testing isn't always covered by medical funders and clinicians may be required to provide motivations for genetic testing.

MEET THE EXPERT

Kusha Kalideen is a medical scientist specialising in molecular testing of solid tumours to aid in diagnosis, prognosis, and therapeutic options in cancer patients. She currently works at Lancet Labortaries.

Images by freepik.com

To view references, please visit oncologybuddies.com

The air we share

Dr Andrew Robson sheds light on how environmental carcinogens not only affects humans but companion animals too.

As a veterinarian in SA, I have studied, observed, and treated many animals whose illnesses were not caused by bacteria, viruses, or injury, but by the environments they live in.

Cancer is not just a human disease, and our companion animals can act as canaries in the coal mine when it comes to environmental carcinogens. Studying these cases offers valuable insights into human cancer risks and, more importantly, how to prevent them.

PETS AS EARLY WARNING SYSTEMS

Our pets share our homes, gardens, and often our food. They breathe the same air, walk on the same floors, and rest on the same furniture. But because of their shorter lifespans and faster metabolic rates, they may develop cancers linked to environmental exposures far sooner than humans.

Patterns seen in veterinary oncology, specific tumours in certain breeds or in pets from certain areas often mirror human data, sometimes even before human studies confirm the risk.

COMMON ENVIRONMENTAL CARCINOGENS AFFECTING PETS

- **Second-hand smoke:** Linked to nasal tumours (especially in long-nosed breeds) and lung cancer in dogs, as well as lymphoma and oral squamous cell carcinoma in cats. Cats are especially vulnerable because carcinogens settle on their fur and are ingested during grooming.
- **Pesticides and herbicides:** Organophosphorus, organochlorines, pyrethroids, and carbamates are commonly used in tropical and developing countries. Acute exposure can cause poisoning, but chronic low-dose exposure carries serious risks. These agents can damage DNA through biotransformation via oxidation and hydrolysis, increasing cancer risk. In pets, such exposures have been associated with malignant lymphoma and transitional cell carcinoma (bladder cancer) in dogs.
- **Air pollution:** Long-term exposure to particulate matter (PM2.5), nitrogen oxides, and volatile organic compounds is linked to higher rates of bronchogenic carcinoma (lung cancer) and nasal tumours in dogs. Pets near busy roads, industrial zones, or areas with frequent coal or wood burning are most at risk.
- **UV radiation:** Extended sun exposure in white or lightly pigmented cats and dogs is strongly associated with squamous cell carcinoma, particularly on ear tips, eyelids, and the nose. UV-B radiation damages DNA in skin cells, leading to mutations that can cause cancer.

TRANSLATING VETERINARY FINDINGS INTO HUMAN HEALTH INSIGHTS

Investigating cancer clusters in animals often uncovers environmental factors affecting people too. For example, dogs exposed to herbicide-treated lawns have a higher risk of malignant lymphoma, a finding echoed in human studies.

In addition, in communities near high industrial emissions, both pets and people show increased rates of certain respiratory cancers. These parallels are not coincidence. They reflect shared biology and shared exposures, reinforcing the importance of environmental health in cancer prevention.

PREVENTION STARTS AT HOME

- **Second-hand smoke:** Avoid smoking indoors or near pets. If you smoke, change clothes and wash hands before handling them.
- **Pesticides and herbicides:** Minimise or avoid organophosphorus, organochlorines, pyrethroids, and carbamates in the home or garden. Use pet-safe alternatives and restrict access to treated areas until safe.
- **Air pollution:** Keep pets indoors on days with poor air quality or visible haze. If you live near industry, exercise pets during times when emissions are lower, such as early morning.
- **UV radiation:** Limit sun exposure for at-risk pets during peak UV hours (10am–3pm). Use pet-safe sunscreen on vulnerable areas or provide shade and indoor rest.

THE SHARED HEALTH FUTURE

Human and veterinary medicine increasingly recognise the value of a *One Health* approach, where the health of people, animals, and the environment are interconnected. Tracking cancer trends in companion animals can help identify hazards earlier, act sooner, and protect more lives, both human and animal.

Our pets cannot choose the air they breathe or the chemicals they encounter. But we can. Protecting them from proven carcinogens often means protecting ourselves at the same time.

MEET THE EXPERT

Dr Andrew Robson, a veterinarian based in Mpumalanga, holds a Master of Science Degree and has a special interest in companion animal health and well-being. Passionate about improving pet health and fostering the human-animal bond, he is also a proud dog dad.

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