

Oncology[®] Buddies



Your platform for cancer care

BE INFORMED

The infamous cancer ribbon

UNPACKING GRIEF

Why my grief only misbehaves after 10pm

KIDNEY CANCER

When is dialysis needed?

MY STORY

Thelma Lomkwane

Reaching contentment

KNOW YOUR CANCER

Colorectal screening

ANAL CANCER

SA's most ignored disease

HOT TOPICS

Can I use GLP-1 medications if I have cancer or am a cancer survivor?

DISTRIBUTED BY:



GET IT ONLINE

www.oncologybuddies.com

Scan the code to listen to our articles



**Make us part of
your patients'
journey to
health**

You and your patients
can rely on us for on
time delivery of all
pharmacy related
needs.

Contact us

Tel: 012 426 4000

WhatsApp: 012 426 4655

Email: info@medipost.co.za

Website: <https://shop.medipost.co.za/>



Want it? Need it? Medipost it.



WELCOME

by Laurelle Williams

Welcome to the first issue of 2026 where we are living in colour. We start off with **Blue = Contentment**. Our hope is that if you are reading this, you have started off the year with peaceful acceptance in some aspect in your life.

And if you haven't, here is inspiration of how Thelma Lomkwane is *Reaching contentment* after colon cancer.

Since March is Colorectal Cancer Awareness Month; we have a packed segment: *SA's most ignored disease: anal cancer; Colorectal screening; and Finding out I had Lynch syndrome.*

Keeping with the theme of colours, Nadia Booysen educates us on *The infamous cancer ribbon*. Did you know there are around 100 different coloured ribbons?

We have such good topics too: *What is personalised medicine? Can I use GLP-1 medication if I have cancer or am a cancer survivor? and When is dialysis needed in kidney cancer?*

Be like the bluebird who never is blue, for he knows from his upbringing what singing can do.

CONTENTS

Issue 62 | February–March 2026

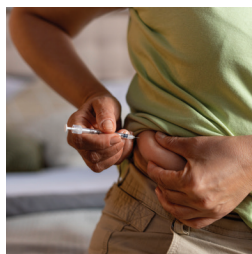


24 The infamous cancer ribbon

25 What is personalised medicine?



26 Nutrition-related side effects of chemotherapy



28 Can I use GLP-1 medications if I have cancer or am a cancer survivor?

29 SA's most ignored disease: anal cancer

32 Colorectal screening



Cover by:
MANDY STEENKAMP PHOTOGRAPHY
Follow
@mandysteenkampphotography



33 Sandra Keddie
- Finging out I have Lynch syndrome

34 When is dialysis needed in kidney cancer?

35 Eric and Thersia Vorster
- United in the fight



36 Genetic influences in multiple myeloma

37 Classical Hodgkin lymphoma

38 Why my grief only misbehaves after 10pm

39 The plot to clot

40 Why safe space matters

MY STORY

30
Thelma Lomkwane
Reaching contentment



PUBLISHED BY:
Word for Word Media
Florida Park, Gauteng
Tel: 011 763 5790
www.wordforwordmedia.co.za

DISTRIBUTED COURTESY OF:



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

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.

DISCLAIMER - PLEASE NOTE:

The views expressed in Oncology Buddies do not necessarily reflect the policy of the publishers and their contributors. Whilst every effort has been made to ensure that the information contained in the publication is correct, Word for Word Media cc cannot be held responsible for any errors or omissions.

word for word
MEDIA
Write to the hearts of our markets



@oncologybuddies

#spreadthehope



Have you ever wondered where the cancer ribbon originated? Nadia Booyesen shares her research.

It all started in the early mid-1900s, when the yellow ribbon was originally used in a United States military marching song, *Tie a Yellow Ribbon Round the Ole Oak Tree*. This was inspired by the wife of a hostage held in Iran from 1979-1981. She used the yellow ribbon to show support for hostages and to remind others of their service to their country. The symbol evolved later during the Gulf War into a reminder of all men and women serving their country abroad; this is according to Richard Cook from BBC News.

A decade later, AIDS activists turned the yellow ribbon red, and from then on every charitable health cause had one. It became so popular that *New York Times* referred the year 1992 as *The year of the ribbon*.

The specific meaning behind the ribbon depends on its colour/colours. Many causes often share colours.

THE SYMBOL OF THE RIBBON

The ribbon is a symbol of awareness and support, which could be viewed as supporting somebody with an illness in the same way relatives of cancer patients often shave their head (but less drastic). It has become such a widely known phenomenon that it hardly needs any introduction.

PINK FOR BREAST CANCER

Charlotte Haley was a 68-year-old woman, the granddaughter, sister, and mother of women who had battled breast cancer. Her peach-coloured ribbon loops were handmade in her dining room. Each set of five came with a card saying, "The National Cancer Institute's annual budget is \$1.8 billion, only 5% goes for cancer prevention. Help us wake up our legislators and America by wearing this ribbon."

This call for action was quickly followed by a reaction from *Self Magazine* and the editor, Liz Smith, who wanted to join forces. This movement drew the attention of Estée Lauder who felt strongly about femininity and nurturing of females which led to the evolution of the pink ribbon for breast cancer.

HOW MANY CANCER RIBBONS ARE THERE?

Anna Shaefer and Christina Shun from *Healthline* predict that there is an average of 40-50 major cancer type ribbons, but if you look at subtypes and variations the list can get to around 100 different colours.

The cancer ribbon isn't from one ancient tradition; it's a modern symbol that took off in the 1990s. It grew out of earlier uses of coloured ribbons for solidarity and became especially prominent with the pink ribbon for breast cancer awareness. The goal, however, remains: awareness, support, and care for all. 



MEET THE EXPERT

Nadia Booyesen is a cancer survivor and an oncology counsellor (BSW Hons (Social Work) (UP), BA Hons (Psychology) (Unisa), PGDip (PallMed) (UCT)) in private practice.

Serving in oncology is not a profession to her, but rather a way of life. She has a keen interest in mental health and believes that it's an underestimated and stigmatised topic.

What is personalised medicine?

Kusha Kalideen explains personalised medicine, its benefits and limitations.

Quite simply, personalised medicine is an emerging medical approach which aims to deliver the right drug to the right patient, at the right time, at the right dose, and through the right route of administration. This approach is transforming medical care and moves from the conventional one-size-fits-all approach treatment of patients to tailoring the treatment to the patient's specific characteristics.

Often referred to as precision medicine, personalised medicine has become increasingly important in the field of oncology.

Cancer is a complex and heterogeneous disease where even tumours from the same anatomical site, can be different. It's therefore no surprise that there is limited success in the conventional medicine one-size-fits-all approach which treats all cancer patients with the same treatment.

Advances in cancer research have provided greater understanding of the pathogenesis (biological process of how a disease develops) of cancer. Tumours have unique characteristics that can drive their growth, influence treatment response and clinical outcomes. By identifying these tumour-specific characteristics, known as biomarkers, of a patient and their tumour, oncologists can more effectively tailor a treatment plan for effective treatment and improved clinical outcomes.

BIOMARKERS

Biomarker testing, which is used to identify the unique characteristics, is a cornerstone of personalised medicine. The presence or absence of biomarkers can play a critical role in selecting appropriate treatment strategies.

Usually, biomarker testing is performed on tumour tissue or blood, however, other bodily fluids may also be evaluated.

Several technologies are used for biomarker testing (sometimes referred to as molecular diagnostics) which include genetic studies (next generation sequencing), immunohistochemistry, or immunoassays.

TAILORED TREATMENT PLANS

As a result of biomarker testing in personalised medicine, tailored treatment plans can include targeted therapy or optimal use of existing therapies.



Targeted therapies are designed to interfere with specific biomarkers that promote cancer growth. By focusing on abnormalities present primarily in cancer cells, these treatments are more effective in treating the tumour and may improve the quality of life during treatment as well as reduce damage to healthy tissues.

While targeted therapies for some cancers are widely used, there are more therapies that are receiving tumour-agnostic approval (where the therapy is approved based on the biomarkers of that cancer, not the site of the cancer).

Biomarker testing can be beneficial in traditional treatments (chemotherapy) as well, as these can help identify patients who are more likely to benefit from these treatments, optimising dose, improving outcomes, and avoiding ineffective therapy.

LIMITATION OF PERSONALISED MEDICINE

While there are several benefits to the personalised medicine approach, particularly in cancer care, there are limitations which need to be highlighted.

First, testing and targeted treatments can be costly (and may not always be reimbursed by medical insurers). Second, both testing

and targeted treatments may not be widely available or accessible in SA. Third, not all patients will have tumours with identifiable biomarkers, and tumours can evolve over time which can lead to resistance to treatment.

Furthermore, the interpretation of genetic and molecular test results can be complex and often requires expertise from multi-disciplinary care teams.

Considering the limitations, personalised medicine does represent a significant step forward in cancer treatment. While not all malignancies currently have identifiable or actionable biomarkers, ongoing research continues to expand the range of targeted treatment options available to patients.

To view references, visit oncologybuddies.com

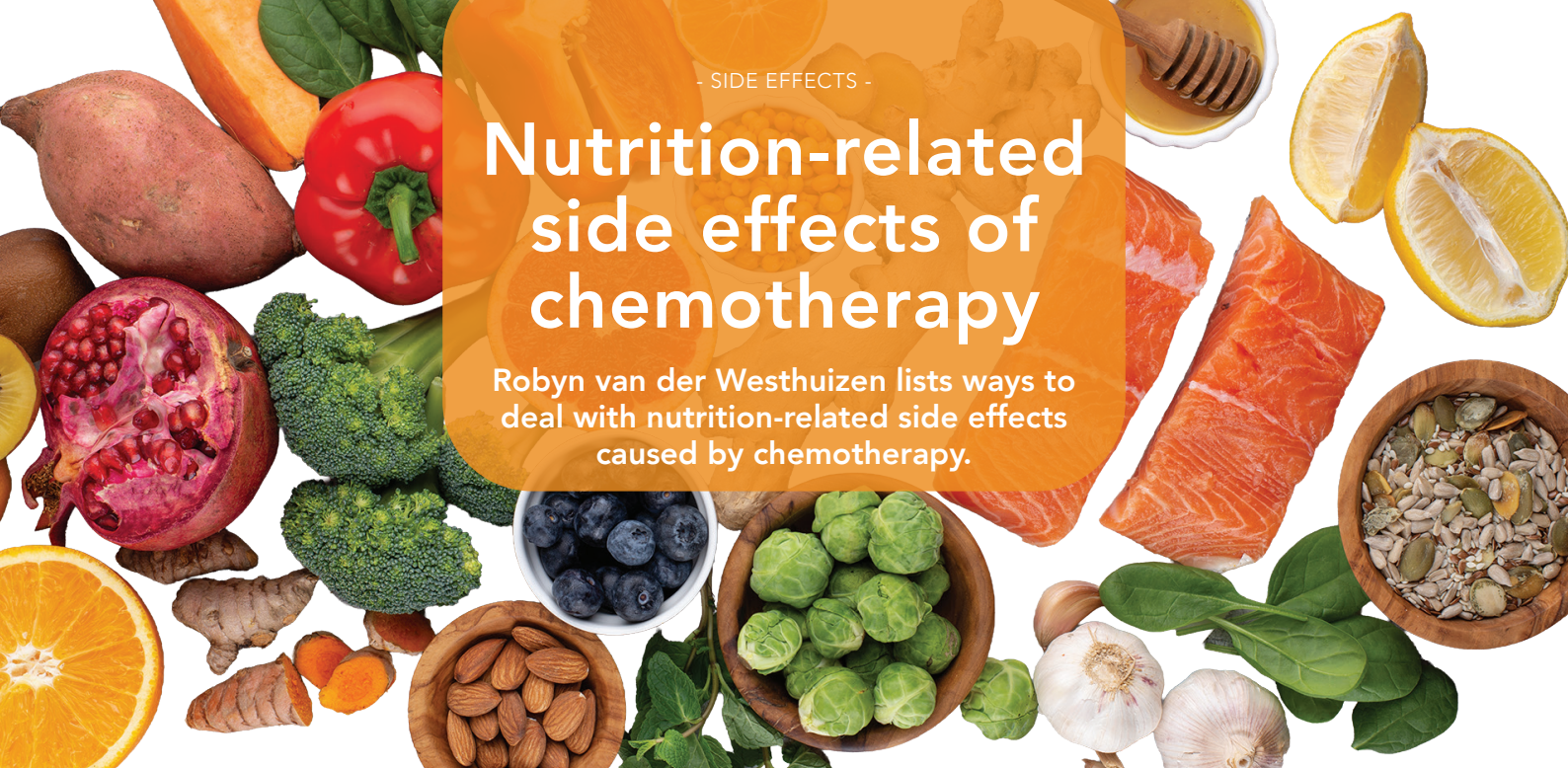


MEET THE EXPERT

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 Laboratories.

Nutrition-related side effects of chemotherapy

Robyn van der Westhuizen lists ways to deal with nutrition-related side effects caused by chemotherapy.



Chemotherapy targets cancer cells, but it can also affect healthy cells involved in digestion, taste, and appetite. These side effects may make eating difficult and can lead to weight loss, muscle loss, dehydration, and fatigue.

The goal of nutrition support during chemotherapy is to help maintain strength, body weight, and quality of life while making eating as manageable as possible.

POOR APPETITE AND EARLY FULLNESS

Loss of appetite and feeling full quickly are common side effects during chemotherapy. This may result from nausea, changes in taste, fatigue, or treatment-related inflammation.

When appetite is low, eating by the clock rather than by hunger is helpful. Small, frequent meals or snacks (5–6 per day) are usually better tolerated than large meals.

Choosing energy- and protein-dense foods, such as full-cream dairy, eggs, nut butters, and fortified meals, helps meet nutritional needs even when intake is limited. Limit large drinks with meals; have most fluids between meals so you don't fill up on liquid.

TIP

Meet your protein goals by adding a neutral flavoured protein powder to moist foods and/or fluids, such as breakfast cereals, soups, stews, tea, or smoothies.

NAUSEA AND VOMITING

Chemotherapy can irritate the stomach and trigger nausea or vomiting. Anti-nausea medication prescribed by the oncology team is essential.

From a nutrition perspective, small portions eaten regularly are often easier to tolerate. Bland, easy-to-digest foods, such as white toast, crackers, porridge, rice, or mashed potatoes may help.

Cold or room-temperature foods often cause less nausea than hot foods, as strong smells can worsen symptoms.

Sipping fluids frequently in small amounts helps prevent dehydration.

TASTE AND SMELL CHANGES

Taste changes are common and can include metallic, bitter, overly sweet, or bland flavours. These changes may reduce the enjoyment of food and lead to the avoidance of protein-rich foods, particularly red meat.

Using plastic cutlery may reduce metallic tastes. If beef is unappealing, use alternative protein sources, such as eggs, chicken, fish, dairy, beans, or lentils.

Mild flavourings, herbs, marinades, or sauces may improve palatability. Let hot dishes cool slightly; choose cold foods (yoghurt, smoothies, egg mayonnaise, cottage cheese, chilled fruit). Heat can intensify strong tastes.

SORE MOUTH AND MOUTH ULCERS

Chemotherapy can cause inflammation or ulcers in the mouth and throat, making chewing and swallowing painful.

Soft, smooth, moist foods are best tolerated, such as yoghurt, custard, scrambled eggs, mashed potatoes, soups, stews, and fruit purées.

Acidic, spicy, rough, or crunchy foods may worsen pain and should be avoided if they cause discomfort.

Eating foods that are cool or lukewarm rather than hot can reduce discomfort.

Maintaining good oral care is essential for supporting healing and reducing the risk of infection.

DIARRHOEA

Chemotherapy can disrupt the lining of the gut, impairing fluid and nutrient absorption. It may also alter the balance of healthy gut bacteria and increase bowel activity, causing the intestines to move more quickly and resulting in looser, more frequent stools.

Maintaining fluid intake is critical, using water, diluted juices, clear broths, or electrolyte drinks.

Small, frequent meals are usually better tolerated.

Low-fibre, low-fat foods, such as white rice, bananas, applesauce, cooked vegetables, and lean proteins, may help until symptoms settle.

CONSTIPATION

In some cases, treatment may slow bowel movement, while supportive medications, such as anti-nausea treatments, pain medication, and iron supplements, can worsen constipation.

Poor appetite, nausea, and changes in taste may reduce food and fluid intake, leading to low fibre intake and dehydration.

Fatigue can limit physical activity, and changes in daily routine or hospital stays can further disrupt normal bowel habits.

Gentle soluble fibre (oats, psyllium husk, cooked vegetables, or stewed fruit), adequate fluids, and light movement as tolerated can help support bowel regularity.

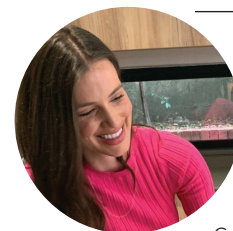
GUT-FRIENDLY JELLY

Give this gut-friendly jelly a try; mix it, chill it, and enjoy one teaspoon in your smoothie, oats, or yoghurt for a happy, easy-going tummy!

- 3 teaspoons of psyllium husk
- 150ml fruit juice
- Add lemon or lime to make it sour - if tolerated.
- Place in the fridge for 10 minutes before consuming.



MEET THE EXPERT



Robyn van der Westhuizen is a clinical dietitian who works at Life New Kensington Rehabilitation Clinic and Life Bedford Gardens Hospital, and runs NutraConnect, her own private practice that supports patients at home, including those needing palliative care during cancer treatment.

RESOURCE® Refresh

Lemon-Tea Flavour

Developed in collaboration
with oncology patients.

Oral nutritional
supplement designed
to manage symptoms
of mucositis or
dysgeusia during
oncology treatment

10g whey
protein/200ml
serving

300kcal/200ml
serving



Nappi Code: 3007375001

Shop at:



vitagene.co.za

takealot com
takealot.com

Learn
more:



**MY CANCER
MY NUTRITION**
Enriching your life through knowledge

www.mycancermynutrition.co.za

Nestlé (South Africa) Pty Ltd | 8 Anslow Crescent, Bryanston 2021 | South Africa | Tel: 086 009 6789 | www.nestlehealthscience.co.za

USE UNDER MEDICAL SUPERVISION

Can I use GLP-1 medications if I have cancer or am a cancer survivor?

Dr Michelle King unpacks when a cancer survivor is eligible to take GLP-1 medications.



GLP-1 agonists are currently all the rage. These include medications, such as semaglutide, tirzepatide, and liraglutide that have been widely popularised by celebrities for their weight loss benefits.

They were originally developed for people with Type 2 diabetes and later for management of obesity. These medications help balance blood glucose by stimulating insulin secretion and suppressing glucagon secretion; are cardiorenal protective; and anti-inflammatory.

Their weight loss benefit comes from delaying gastric emptying, so you feel fuller for longer. They work on two hormones: ghrelin and leptin; these hormones are related to hunger and satiety. The one that effects hunger, ghrelin, is easy to remember, as it's the one that makes your stomach growl.

At therapeutic dosages, many patients were shown to lose up to 20% of their body weight.^{1,2,3}

The downside is the gastrointestinal side effects, such as nausea, vomiting, and diarrhoea. In addition, because they delay gastric emptying, they can have a negative effect on anaesthetic outcomes when going in for surgery.

The other negative is that, for many people struggling with obesity, when you stop the medication, you can regain the weight you lost. Lifestyle modification is essential for long-term weight management, as well as the potential long-term use of GLP-1 medication.

WHO SHOULD NOT USE THIS MEDICATION?

When this medication first came out, there was a lot of concern that there was an increased risk of pancreatic cancer and medullary thyroid cancer associated with their use. Later studies have failed to show that this was true.⁴ A recent study published in *Lancet*, 2025 showed that there was no overall increase in risk of cancer related to GLP-1 use.⁵

However, if you have a diagnosis of pancreatic cancer, you should avoid using the drug because of the increased risk of pancreatitis.

Secondly, it's generally advised to avoid GLP-agonist medication while in active treatment as it can worsen nausea and vomiting and affect the absorption of oral chemotherapeutics.

In addition, with rapid weight loss, you lose muscle mass too, which, if you are receiving chemotherapy, can result in increased side effects.

WHAT ABOUT SURVIVORSHIP?

Obesity and high body fat can contribute to the recurrence of certain cancers, such as colon, rectum, gastric, hepatocellular, gallbladder, pancreatic, kidney, oesophageal, meningioma, thyroid, endometrial, ovarian, and post-menopausal breast cancer. With the higher your body mass index (BMI) is, the greater your risk.⁴ So, losing weight will reduce the risk of recurrence.

Additionally, studies are showing that the GLP-1 agonists may decrease the risk of certain types of cancer which are related to obesity (colorectal and hepatocellular cancer).⁴

WHO QUALIFIES FOR TREATMENT?

Many people lose weight during active cancer treatment, so if your BMI is normal, you would not be a candidate for treatment.

However, if you are obese (BMI greater than 30) or have a BMI greater than 27 and one comorbid condition, such as Type 2 diabetes, hypertension, or high cholesterol, you would qualify for treatment. Unfortunately, despite their health benefits, medical aids do not pay for GLP-1 agonists, so you would have to pay out of pocket.💸

To view references, visit oncologybuddies.com



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

SA'S MOST IGNORED DISEASE: ANAL CANCER

Dr Mark Faesen advocates why South Africa needs a proper anal cancer screening programme for at-risk populations.

Despite South Africa's status as home to the world's largest population living with HIV, the country has made no progress in addressing anal cancer screening and prevention. The absence of anal Pap smears and proper cancer screening guidelines leaves at-risk populations vulnerable, with this disease receiving almost no attention.

HIV significantly elevates the risk of anal cancer, but other at-risk groups include those with sexually transmitted infections and human papillomavirus (HPV), the cause of this potentially deadly disease.

Almost no data exists on the prevalence of anal cancer in SA, and no efforts are made toward prevention or treatment. This healthcare gap, particularly for those at high risk, calls for the initiation of a screening programme for this disease.

WHY THE NEED FOR A SCREENING PROGRAMME?

Anal cancer in the general population is rare and therefore not cost-effective to screen. However, screening for anal cancer should be as routine as cervical cancer screening for women living with HIV, women who have other HPV-related diseases, such as genital or peri-anal warts, and all women with a history of pre-malignant or malignant lesions either on the cervix or the vulva.

Men who are living with HIV and have genital warts are also at increased risk for HPV-related abnormalities in the anal canal and should also undergo anal cancer screening.

The need for anal cancer screening in SA is clear, yet no one has taken the initiative to start screening. The incidence of anal cancer in SA is unknown, as it's not being tracked or reported. Many patients living with HIV in SA don't realise that they are at risk of contracting anal premalignancies or malignancies.

FUNDING

A key step toward improvement requires funding for anal cancer screening. With the right resources, we can raise awareness and offer life-saving tests to those who need them most.

The challenge isn't just medical, it's structural. Currently, no public sector healthcare provider in SA offers anal cancer screening, and the private sector is similarly lacking in resources and guidelines for the disease.

The lack of awareness among healthcare professionals only exacerbates the problem, with many medical staff unaware of the risks and the correct procedures for anal cancer screening.

Although this type of screening is growing globally, SA lags behind the United States and Western Europe, where they are well established.

At-risk individuals need education to prevent the disease through screening and early treatment of premalignant lesions, which requires the backing of the public health sector.

IMMEDIATE ACTION NEEDED

This situation requires urgent, collective action from the South African National Department of Health and the medical community. A co-ordinated, well-funded effort to bring anal cancer screenings and education to the forefront of South Africa's health agenda is necessary to save lives and prevent further tragedies.

It's time for change, and it starts with research, education for healthcare providers, and funding for life-saving screenings.



MEET THE EXPERT

Dr Mark Faesen is a specialist gynaecologist and reproductive medicine specialist. He works with the Clinical HIV Research Unit (CHRU) in its cervical cancer screening and prevention clinic. He recently started raising awareness about anal cancer screening in SA. His pioneering work includes conducting anal Pap smears for high-risk patients visiting the HIV clinic and pushing for funding to establish comprehensive screening programmes.



Reaching contentment

Thelma Lomkwane is content
with life after colon cancer.
She shares her story.

Thelma Lomkwane (59) lives in Soweto, Gauteng with her husband. They have three adult children and two grandchildren.

In November 2022, Thelma went for a routine check-up. Her blood count was extremely low, so she was admitted to hospital where she received 10 pints of blood and to find the cause. She underwent scans; bleeding in the colon was found so a biopsy was done.

The doctor told her the biopsy tissue was cancerous. At first, she didn't comprehend, and it was only when she asked the nurse (who was with him when he broke the news), if he meant she had cancer. The nurse said yes.

"For two hours, I was hysterical but then I pulled myself together and phoned my husband and asked him to come to the hospital so I could break the news to him," Thelma explains.

The doctor suggested surgery the following week, but Thelma told him she wanted a second opinion. She was referred to a colorectal surgeon, who looked at her history, scans, and biopsy result. In the new year, he confirmed it was colorectal cancer and that surgery was indeed needed.

SURGERY

Before surgery, Thelma consulted a pulmonologist for two weeks to strengthen her lungs. She has always battled with her chest, especially in winter.

The colorectal surgeon explained that he has a good surgery success rate with no colostomy bags needed though he can't guarantee it.

Thankfully, surgery went well where a section of the large intestine was removed and re-joined; a colostomy wasn't needed.

INFECTION

Unfortunately, Thelma picked up an infection in hospital, suspected to be from dirty utensils; a second surgery was needed.

For three months, she consulted a wound specialist where the wound was drained, cleaned, and treated.

DIET

After surgery, Thelma was on soft foods for a week then started on solid foods.

It was advised to Thelma to cut down on red and processed meat and rather eat fish and chicken. She needed to include more greens, fruit, and use pure virgin olive oil.

"I admit I struggle with not eating red meat; I try to eat it only once a week, but find we eat it more than once a week."

THE CHOICE OF CHEMOTHERAPY

The stage of the cancer was confirmed as Stage 2B, so Thelma was referred to an oncologist.

"I was counselled before and given the option to do chemotherapy as a preventative measure or not. I chose to be proactive and went ahead with it," she says.

Once the infection had cleared, chemotherapy commenced in May until September.

Thelma explains, "During chemotherapy, I struggled to eat and had to get a special stomach suspension to gargle with. Every time I touched steel utensils or cold stuff, I would get a shock, so I wore woollen gloves. Midway through treatment, one chemotherapy drug was stopped to alleviate this side effect. The skin on my hands also turned darker; my oncologist prescribed Lanolin Anhydrous BP cream, which I still use today."

She goes on to say, "I have high blood pressure but funny enough it was the most stable during chemotherapy."

INCISIONAL HERNIA

During chemotherapy, Thelma developed an incisional hernia (a protrusion of tissue or organs through a weakened abdominal wall scar following surgery).

Before she could undergo a reconstructive procedure, she needed to recover from chemotherapy.

In November 2023, the hernia was pushed back and kept in place with a mesh. The colorectal surgeon performed this operation.

SUPPORT

Thelma is grateful for the support she got from her husband and children. She adds that a work colleague, whose husband had blood cancer, embraced her in love, care, and prayer.

Her friend from church also played a big role by taking her to chemotherapy.

Her advice is to be open as "you never know who is going to support you and to always keep a positive mind."

She adds, "Also, when you go to the toilet, look at your stool colour. It's your own mess and can tell a lot about what's going on. Looking back, there were signs like blood in my stool, but I thought it was haemorrhoids."

CURRENT HEALTH AND WELL-BEING

Thelma is well and still goes for follow-up appointments with the oncologist. She will only see the colorectal surgeon in 2027. Her GP advised that she needs to lose weight. Her oncologist agrees, and this is her goal for 2026, with the help of a dietitian.

"I'm content; whatever happens to me, I'll deal with, accept, move on, and keep the faith, as I did when I was diagnosed."



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@wordforwordmedia.co.za



COLORECTAL SCREENING

Dr Thobile Goba-Mjwara gives us a rundown on what is needed to implement a colorectal cancer screening programme in SA.



Colorectal cancer (CRC) accounts for about 10% of all malignancies, making it the third most common cancer worldwide. Incidence rates and mortality are, however, increasing in low and middle-income countries while stabilising in high-income countries. In recent years, CRC has been diagnosed at an earlier age with patients presenting with more advanced disease.

The incidence rates of CRC are rapidly increasing in SA. Targeted screening and surveillance programmes for individuals with known colorectal cancer-causing mutations have resulted in increased life expectancy.

SANCAPS

The South African National Cancer Prevention Services (SANCaPS) was established to implement national systems for identifying individuals with inherited cancers, improving their clinical management, and reducing the overall disease burden.

In SA, black patients develop CRC at a younger age than other race groups. It has been postulated that this may have a molecular or genetic basis with a higher propensity towards microsatellite instability (MSI) and hereditary non-polyposis CRC (HNPCC) amongst black patients.

RISK FACTORS

- Family history of CRC
- Obesity
- Hyperlipidaemia
- Physical inactivity
- Diet (increased consumption of red and processed meats and a protective effect with the intake of calcium, fibre, vitamin D, fruit, and vegetables)
- Smoking
- Moderate to heavy alcohol consumption
- Diabetes

The risk conferred by a family history of CRC is dependent on the number of affected relatives and the age of diagnosis of the affected family members (younger ages conferring a higher risk).

SCREENING MODALITIES

Stool-based tests are reliant on the detection of blood within the gastrointestinal tract (GIT).

Guaic faecal occult blood tests (gFOBT) detect hidden blood in the stool, whereas faecal immunochemical tests (FIT) detect human globulin.

Blood-based tests, or liquid biopsies, for detecting CRC and precursors, have been shown to increase screening uptake. They offer a non-invasive, safe, acceptable, and convenient mode of screening.

IMAGING

Computed tomographic colonography (CTC) allows for the visualisation of premalignant and malignant colorectal lesions through 3D and 4D reconstructions.

Colon capsule (CC) is a variation of small bowel video capsule enteroscopy, utilising a wireless capsule-housed camera to image the large intestine.

Colonoscopy is considered the gold standard for the detection of colorectal neoplasia and CRC. It offers a one-step screening process allowing the detection, diagnosis, and treatment of CRC.

GUIDELINES FOR A SCREENING PROGRAMME

The International Agency for Research on Cancer (IARC) guidelines recommend that 95% of the target population be invited to screening, with a minimum uptake rate of 45% and follow-up colonoscopy rates of 85%.

Treatment for early-stage disease (Stage 1) is both cheaper and more effective than treating later-stage disease (Stage 2 and beyond).

Training and building capacity for the early diagnosis of CRC and establishing referral pathways and access to the multi-disciplinary management of CRC is an essential start to implementing a screening programme in SA.

The American College of Gastroenterologists (ACG) and the European Society of Gastrointestinal Endoscopy endorse screening with FIT or colonoscopy from the age of 50 in those with an average risk of CRC and younger in those with first-degree relatives (high risk) with CRC.

SOUTH AFRICA

The current practise in SA is an individualised risk-based referral for CRC screening. CTC, MR colonography, and CC are restricted to some tertiary hospitals, academic centres, and private healthcare institutions.

At present, large private healthcare funders cover biennial FIT testing between ages 45–75 years and additionally cover screening by means of colonoscopy.

In all patients with a first-degree relative with CRC or an advanced adenoma, screening should begin at age 40, or 10 years before the youngest diagnosis in the family, and at an even younger age (35–40) for black patients.

SANCaPS has advocated for the identification of inherited cancers by associating data processing between the National Health Laboratory Service (NHLS), Corporate Data Warehouse (CDW), and the National Cancer Registry.

Furthermore, SANCaPS recommends mandatory testing for mismatch repair genes in all CRC diagnosed <60 years of age to identify genetic MSI tumours.

To view references, visit oncologybuddies.com



MEET THE EXPERT

Dr Thobile Goba-Mjwara is a clinical oncologist at

Oncocare Specialist Oncologists in Durban and Hillcrest, KwaZulu-Natal. She completed her specialist training in

Radiation Oncology (FC Rad Onc) and Master of Medicine in Radiation Oncology (MMED) in 2021 at Tygerberg Hospital, Stellenbosch University. She has a special interest in breast-, gynaecological-, and prostate cancer.



Finging out I have Lynch syndrome

After being diagnosed with endometrial and then colon cancer, Sandra Keddie underwent genetic testing for Lynch syndrome which was positive. She tells her story.

Sandra Keddie (61) lives in Hillcrest, KwaZulu-Natal with her husband.

LEARNING ABOUT LYNCH SYNDROME

It was through her cousin that Sandra first learnt about Lynch syndrome, a hereditary cancer-predisposition syndrome that significantly increases the likelihood of developing several different cancers and sometimes at an earlier age than typically expected.

"My cousin was diagnosed with endometrial cancer, in 2024, and when she was speaking to her doctor about her family history, it was uncovered that her son (who was living in Australia) had a section of his colon removed at a young age due to cancerous polyps being found. He was tested for Lynch syndrome and found to be positive. My cousin then undertook the genetic test and was also found to be positive. Because I had already had two Lynch syndrome-related cancers, it was highly probable, that I, as a family member, was also positive," Sandra explains.

ENDOMETRIAL AND COLON CANCER

At age 49, Sandra was diagnosed with Stage 1 endometrial cancer and 10 years later, at 59, she was diagnosed with colon cancer. The endometrial cancer caught her by surprise, having undergone an investigative procedure only five years prior when her gynaecologist told her she was pristine inside. She opted for a full hysterectomy instead of a partial one due to her age and the risk of ovarian cancer.

The colon cancer was also not an obvious diagnosis to her symptoms of a deep, lingering tiredness that stretched back to five years before the diagnosis and heart palpitations, bouts of arrhythmia, and severe leg cramps at night that began three years before diagnosis.

"I understand now that these symptoms were a result of low iron initially and finally a low haemoglobin due to continual but microscopic blood loss," Sandra says. "After a bout of tests, an endoscopy and colonoscopy provided the answer: a tumour in my colon, one that had apparently been growing quietly for years. My diagnosis was unclear, Stage 3 maybe 4."

GENETIC TESTING

In May 2025, after surgery and chemotherapy for colon cancer, Sandra decided to take the genetic test for the Lynch syndrome gene. Although, there is currently no cure for the genetic condition, understanding that you have Lynch syndrome, allows you to be able to choose to go for more regular and intense screening for earlier cancer detection.

"I had a call with a genetic counsellor prior to her sending out a saliva test pack in the post. It took six weeks for the test to come back, this confirmed that I was positive. I informed family members who could be affected by the same genetics and my next discussions on the way forward took place with my oncologist as I was still undergoing follow-up care," Sandra explains.

Sandra's medical aid covered the cost for testing for the MSH6 Lynch syndrome gene, which was the mutation found in her cousin.

This was cheaper than testing for all five of the Lynch syndrome genetic mutations.

POSSIBLE PRECAUTIONS

When asked if she knew earlier, what precautions would she have taken, she responds, "Doing my regular cervical screening was the right thing to do but I could've gone for more regular colon screenings. Also, I could've informed my doctors, allowing them a better understanding and perspective when reviewing my results or suggesting a variety of possible tests more regularly. I was fortunate that the endometrial cancer was detected early, but not so fortunate with the colon cancer."

"Knowing I have Lynch syndrome would also have confirmed my decision with regard to having a full hysterectomy or to leave my ovaries behind. Ovaries are important in balancing hormones and delay the onset of menopause and so removing them was a big decision, but now I don't have to be concerned about possibly developing ovarian cancer which is a risk with Lynch syndrome."

CURRENT HEALTH

Post treatment, Sandra is cancer free. She suffers ongoing shingles, a chemo side effect. but she is concentrating on keeping healthy while undertaking regular screenings for Lynch syndrome cancers. 

WHEN IS DIALYSIS NEEDED IN KIDNEY CANCER?

Dr Daleen Geldenhuys helps us understand when dialysis is needed in kidney cancer treatment.

WHAT IS DIALYSIS?

Dialysis is a life-saving treatment that filters waste products and excess fluid from the body when one or both kidneys fail to do so. There are two ways to perform dialysis:

1. **HAEMODIALYSIS**, which uses an external machine to filter blood, using a special intravenous catheter or an arteriovenous fistula (created by a vascular surgeon to provide long-term venous access), in a dialysis centre.
2. **PERITONEAL DIALYSIS** uses the lining of your abdomen (peritoneum) as a natural filter which can be done at home, using a special indwelling catheter into the abdominal cavity.



WHAT IS THE FUNCTION OF THE KIDNEYS?

The kidneys are vital organs designed to remove toxins and waste, products of cellular function, in the blood. Kidneys balance minerals, such as sodium, calcium, potassium, and other minerals. Kidneys regulate volume of fluid in the body. Together with the lungs, the kidneys are responsible for the careful balance of the acidity or pH of our blood.

Blood pressure control in the body is intricate and the kidneys form part of blood pressure control.

Kidney dysfunction can cause dangerously high blood pressure. Kidneys also produce the substance, erythropoietin, that stimulates red blood cell production, therefore patients may develop anaemia (low red count) because of kidney failure.

The kidney is a complex structure. You can live with only one kidney, provided it's functioning optimally to take care of all the functions of both kidneys.

WHEN ARE KIDNEY CANCER PATIENTS PLACED ON DIALYSIS?

Both acute and chronic kidney failure patients are offered dialysis. Acute failure implies that the condition is reversible, and you may only need dialysis for a short period.

It also means that if nothing is done quickly, you may not survive. The increased blood flow through one kidney, after removal of the diseased kidney, may be too strenuous for the remaining kidney and it may lead to acute failure. It may adapt over time and recover, or it may not.

If both kidneys are removed, you'll need

dialysis immediately and this will be lifelong.

Chronic kidney failure implies that the condition isn't reversible, and you may need lifelong dialysis. Mild chronic dysfunction may have been present at the time of surgery, related to other injury prior to the diagnosis.

WHY IS THERE AN INCREASED RISK OF KIDNEY FAILURE IN KIDNEY CANCER?

Kidney cancer can be a silent disease for a long time. Patients aren't always aware that there is a slow-growing mass. Not all patients with kidney cancer have blood in their urine and the disease is often diagnosed late when the disease is advanced.

If detected early, the urologist may remove part of the kidney but when it's bigger or involving the middle part of the kidney where the blood vessels and ureter are, the whole kidney will be removed.

If the other kidney is healthy, this may be uncomplicated but if you have impaired kidney function in the opposite kidney, dialysis may be inevitable.

Rarely cancer is in both kidneys simultaneously though removing both kidneys necessitates dialysis.

WHAT TO DO TO ENSURE OPTIMAL FUNCTION OF KIDNEYS OR REMAINING KIDNEY?

Your kidneys should always be on your mind and although acute or sudden kidney failure is symptomatic, chronic kidney failure isn't. Kidney health is important even if you have two kidneys.

Controlling blood glucose in patients with diabetes and controlling blood pressure in patients with high blood pressure will help in

delaying kidney failure. Both these diseases, alone or in combination, will place you at higher risk to develop kidney failure.

Be careful of products claiming to be natural as certain products may be responsible for kidney dysfunction.

Hydration is important, especially on hot days.

Most importantly, the use and abuse of pain medication, which is readily available is responsible for most kidney injuries. Non-steroidal anti-inflammatories and chronic use of paracetamol-containing pain medication can damage kidneys and when a patient has a nephrectomy (surgical removal of all or part of a kidney) for kidney cancer, the other kidney can't cope on its own.

Always consult a doctor when pain medication is needed for chronic pain. All medication can be potentially harmful to the body. Don't assume if the label says herbal or natural, that it's safe.

Always confirm supplements with your nutritionist, dietitian, and health practitioner to ensure safety. If you feel unwell, especially after a kidney has been removed, contact your health practitioner to do a simple blood test that can be life-saving.



MEET THE EXPERT

Dr Daleen Geldenhuys is a specialist physician and medical oncologist who works at West Rand Oncology Centre at Flora Clinic and the ICON Unit at Johannesburg Surgical Hospital. She treats patients with all types of cancer and enjoys clinical research, and is a member of SASMO, SASTECS, ESMO and ENETS.

United in the fight

Eric and Thersia Vorster share how they were forced to upgrade their medical aid to get Eric treatment for Stage 4 kidney cancer.



Eric Vorster (67) lives in Heidelberg, Gauteng with his wife, Thersia. They have three children and seven grandchildren.

STAGE 1 KIDNEY CANCER

In early 2016, Eric was diagnosed with Stage 1 kidney cancer. He had no symptoms, but it was picked up during a sonar regarding his prostate. His prostate was deemed healthy though further check-ups were proposed. A CT scan confirmed the left kidney was riddled with cancer.

A nephrectomy (removal of the whole kidney) was done in March 2016. Before surgery, Eric had his last cigarette after smoking 20-a-day for 40 years.

No further treatment was needed with Eric routinely going for follow-ups.

PROSTATE CANCER

A year later Eric was diagnosed with early-stage prostate cancer and underwent brachytherapy (44 pellets). This was successful; however, the major side effect is erectile dysfunction. Eric once again was diligent with his follow-ups.

STAGE 4 KIDNEY CANCER

In late 2023, at a yearly follow-up, a scan showed three lesions on the right kidney. Eric was referred to a urologist who specialises in robotic surgery to remove the lesions. Eric's medical aid wouldn't cover the cost.

A family member, who is a nurse in the USA, told him about cryoablation (a procedure in which an extremely cold liquid is used to freeze and destroy abnormal tissue). After inquiring with his oncologist, he was referred to an interventional radiologist who was able to perform the procedure, in December 2024, on one of the lesions which was big enough; it was successful. Though, the other lesions were still there.

Further biopsies were done as lesions were picked up on his back, behind his ear, and a wart-like growth on his forehead. The results confirmed metastatic kidney cancer. The growth on his forehead was surgically removed and he underwent radiation for the lesions on his back and behind his ear.

PROPOSED TREATMENT

Due to Eric only having one cancerous kidney, chemotherapy was ruled out as that remaining kidney wouldn't handle that strain, which would mean lifelong dialysis.

The only other option, given by his oncologist after his case was discussed in a multi-disciplinary meeting, was to go on pazopanib, an oral targeted anti-cancer drug.

"I was told this drug will stop the cancer from spreading and growing but will never get rid of it," Eric says.

In mid-2025, the oncologist prescribed the drug, but Eric's medical scheme declined it. "My oncologist did everything she could, she wrote another motivation letter and it was declined again. She referred the appeal to Campaigning for Cancer, however, the medical scheme still declined it. We were in her rooms when she told them to refer it to the Council of Medical Schemes (CMS)," Eric explains.

The medical scheme explained that the plan Eric was on, doesn't cover this medication and if he wanted it covered he would have to upgrade his plan, which would be an additional +-R7000 a month.

"What frustrated us was that we had an amount of R360 000 available in our oncology benefit, but they said that was only for chemotherapy and radiation. The response from CMS was taking long and obviously we got scared so we were forced to upgrade. We are pensioners and now are paying almost R17 000 a month for the two of us."

"A week later after upgrading, we got a response from CMS saying the medical scheme has to pay for the medication, however, they also gave them three months to appeal. I couldn't wait that long before I start treatment with the cancer spreading as fast as it is," Eric says.

Currently, the cost of his pazopanib (60 tablets) is R40 700 a month; the scheme is covering the full cost of this. Since September 2025, Eric takes two tablets (800mg/day) at the same time, every morning, on an empty stomach.

Eric plans to take the case to the Ombudsman.

SIDE EFFECTS

Last year, further lesions were found in Eric's stomach; they were surgically removed.

Since being on pazopanib, he feels good and is hoping for a positive outcome when he has his CT scan in April.

The side effects are high blood pressure (he had high blood pressure before), fatigue, dizziness, pins and needles in his feet, and lack of strength.

Thersia adds that he also has mood swings. "Out of nowhere, he'll get quiet and then I know I must be careful what I say or else he gets snappy. I think it's underlying anger," she says. "Luckily I've learnt to read him and work around it."

Despite this, she adds that since the metastatic diagnosis, their communication has gotten better and as believers, they believe there is a purpose in all of this. 

Genetic influences in multiple myeloma

Lisa Mertens gives a brief outline of genetic influences in multiple myeloma.



Multiple myeloma is a blood cancer that affects the bone marrow, the spongy-looking centre of the large bones. The word myeloma refers to marrow, while multiple myeloma explains that this cancer typically affects multiple bones in the body.

SMALL ERROR WITH BIG EFFECTS

New blood cells are constantly needed to maintain a steady supply. The body forms an estimated 10 billion white blood cells per day. This takes place in the bone marrow, where blood stem cells use the genetic reference information (deoxyribonucleic acid (DNA)) to produce the different types of blood cells.

White blood cells defend the body from potential threats. Plasma cells are a white blood cell subtype and multiple myeloma begins from a single abnormal plasma cell. A small error in the genetic reference information can produce an abnormal plasma cell. The abnormal cell is unable to build a useful antibody to help the immune system fight infection and instead produces a myeloma protein (M protein), also known as paraprotein. Para indicates something that is abnormal.

POTENTIAL DAMAGE FROM BONE DISEASE

Like a row of dominoes falling, the error repeats. The abnormal plasma cell multiplies, and more abnormal cells wander through the bone marrow and produce large amounts of paraprotein. The build-up of abnormal plasma cells and paraprotein cause the medical problems for the patient.

Often myeloma bone disease (MBD) develops, which weakens the bones so severely that they can break with little pressure. Myeloma bone disease mainly

affects the bones in arms, legs, skull, spine, ribs and hips, as well as around the shoulders.

Multiple myeloma has different subtypes, depending on the changes in the abnormal plasma cell and the shape of the paraprotein.

Understanding the genetic influences and the myeloma subtype is valuable for prognosis and clinical treatment strategy.

GENETIC INFLUENCES: INHERITED AND NEW

A combination of inherited and environmental factors is expected to contribute to myeloma.

Genetic errors can be passed on by one parent or both parents. Inherited changes in genes, such as BRCA1, BRCA2, BCMA or in genes responsible for DNA damage repair can increase the risk for myeloma.

If a family member develops this cancer, the risk for close biological family members increases slightly, even though myeloma is less likely to be inherited. Studies show that the inherited genetic risks differ between population groups. For example, African Americans in the USA are more likely affected by myeloma than other groups. This may be due to several factors but needs to be further investigated with a higher number of patients from different racial groups included in clinical studies.

Environmental influences can also cause genetic errors. This can be exposure to a high dose of radiation, a toxic substance (such as benzene, asbestos, some pesticides), or a virus.

Genetic information can be permanently changed, which increases the risk for errors in plasma cell production.

Certain job groups have a higher risk to develop myeloma if their work routine exposes them to chemicals, industrial dust, or fumes.

Apart from environmental factors, lifestyle aspects, such as low physical activity and excess body weight, also influence the risk to develop this cancer.

HIGHER RISK WITH AGE

Increasing age is important in myeloma, because most cases are diagnosed in patients over 65 years. As the body ages, it experiences small genetic changes over time, which can collect and tip the scale towards a genetic error. This is a normal part of aging and highlights the importance of preventative cancer screening.

Common early symptoms that a doctor may want to investigate further include ongoing bone pain, bone fractures after minor injuries, and symptoms related to kidney function.

The scientific research into the causes and risk factors for multiple myeloma is ongoing, which means that constant efforts are made to understand how genetic errors in plasma cell formation drive the cancer. A major focus is to identify and establish new treatment strategies for myeloma patients.



MEET THE EXPERT

Dr Lisa Mertens obtained a PhD in

Genetics at Stellenbosch University and works remotely for CeGaT, a CLIA

laboratory headquartered in Germany. Her special

interests are cancer vaccine research, fertility genetics, and hereditary genetic conditions.

She is passionate about advocating for preventative cancer screening.

CLASSICAL HODGKIN LYMPHOMA

Dr Sharlene Parasnath explains the treatment landscape and patient journey of classical Hodgkin lymphoma.

Classical Hodgkin lymphoma (cHL) is a cancer of the lymphatic system and one of the great success stories of modern oncology. It's highly curable, even when diagnosed at advanced stages.² Yet, in South Africa (SA), many patients still present late, with Stage 3 or 4 disease, often after weeks or months of unexplained fevers, weight loss, night sweats, and lymph node swelling.³

EPIDEMIOLOGY AND DISEASE BIOLOGY

Hodgkin lymphoma has a bimodal age distribution, affecting young adults and again those over 60.¹ In younger patients, the disease often arises in individuals who are otherwise healthy. At the same time, in older adults, co-existing illnesses can complicate treatment.

The hallmark of cHL is the Reed–Sternberg cell, which originates from B-lymphocytes but loses many normal immune functions.¹ These abnormal cells are surrounded by a microenvironment of inflammatory cells that both fuel and hide the tumour, a key reason immunotherapy has become such an exciting area of progress.⁴

DIAGNOSTIC JOURNEY

Diagnosis relies on excisional lymph node biopsy and immunohistochemistry to confirm classical subtypes, such as nodular sclerosis, mixed cellularity, and lymphocyte-depleted HL.⁵

Staging with computed tomography (CT) or positron emission tomography (PET)-CT scans determines the extent of disease and guides therapy.⁵

In SA, limited access to PET imaging often means that decisions depend on CT findings and clinical risk factors.⁶

TREATMENT LANDSCAPE FOR STAGE 3 AND 4 CHL

In the state sector, treatment is guided by drugs on the national Essential Medicines List. The mainstays remain doxorubicin, bleomycin, vinblastine, dacarbazine (ABVD) chemotherapy protocol and, in selected younger and fit patients, bleomycin, etoposide, doxorubicin, cyclophosphamide, vincristine, prednisolone, dacarbazine (BEACOPP) protocol.⁷

For most young patients with good organ function, chemotherapy is well tolerated, and 70–80% achieve long-term remission.¹⁹ However, older patients face unique challenges, which include increased risk of toxicity, particularly from bleomycin and anthracyclines.²⁰

Adjustments to regimens and careful monitoring are crucial for maintaining safety while achieving disease control.

Unfortunately, a proportion of patients with advanced disease remain refractory or relapse after initial therapy.⁸ For these patients, salvage chemotherapy, such as ifosfamide, carboplatin, etoposide (ICE) or gemcitabine, dexamethasone, cisplatin (GDP), is used to re-induce remission, followed by autologous stem cell transplantation (ASCT), available at several tertiary centres across SA.⁹

ASCT offers the best chance of durable remission, with success rates of 50–60% in eligible patients.¹⁰

PATIENT JOURNEY AND QUALITY OF LIFE

Living with Hodgkin lymphoma is not only about surviving but about maintaining dignity and hope through treatment. Younger patients may face disruptions in studies, work, or fertility planning. Older adults often contend with frailty, comorbidities, and reduced social support.

The side effects of chemotherapy (fatigue, nausea, hair loss, and infections) are temporary but emotionally taxing.¹¹

Multi-disciplinary support, including counselling, physiotherapy, and nutritional care, plays an essential role.

OUTCOMES AND PROGNOSIS

With access to chemotherapy and transplant services, more than two-thirds of patients with Stage 3 and 4 Hodgkin lymphoma can be cured.¹² Those who relapse after transplant face poorer outcomes, but global advances are transforming this space.

New drugs, such as CD30-targeted antibody–drug conjugates and checkpoint inhibitors, can restore remission even in heavily pre-treated patients.¹³

Unfortunately, these therapies aren't yet included in South Africa's Essential Medicines List and remain inaccessible to most patients in the public sector.¹⁴

Earlier use of such agents has been shown to improve response rates and quality of life, underscoring the need for advocacy and policy evolution.

FUTURE DIRECTIONS

The future of Hodgkin lymphoma care lies in personalised therapy, tailoring treatment based on individual biology, biomarkers, and early response.¹⁵

PET-adapted strategies already allow clinicians to de-escalate or intensify therapy according to early metabolic response, minimising toxicity while preserving cure rates.¹⁶

Integration of novel agents earlier in therapy, particularly for high-risk or older patients, holds great promise.¹⁷ Additionally, supportive care interventions (infection prophylaxis and fertility preservation) are enhancing quality of life during and after treatment.¹⁸

LOOKING AHEAD

With early diagnosis, access to chemotherapy and referral for stem cell transplantation when needed, most patients can look forward to recovery. As new therapies become more accessible, outcomes for patients will continue to improve.



MEET THE EXPERT

Dr Sharlene Parasnath is Head of Clinical Haematology and Haematopoietic Stem Cell Transplantation at Inkosi Albert Luthuli Central Hospital and UKZN in KwaZulu-Natal. She is passionate about teaching haematology and making haematology services available to all South Africans.



ONCOLOGY

This article is sponsored by Takeda Oncology in the interest of education, awareness, and support. The content and opinions expressed are entirely the healthcare provider's own work and not influenced by Takeda Oncology in any way.

- References:**
1. Ansell SM. Hodgkin lymphoma: 2025 update on diagnosis, risk-stratification, and management. *American Journal of Hematology* 2024; 99(12):2367–2378.
 2. Yung L, Linch D. Hodgkin's lymphoma. *The Lancet* 2003; 361(9361):943–951.
 3. Antel K, Levitan C, Mohamed Z, Louw VJ, Oosthuizen J, Maartens G, et al. The determinants and impact of diagnostic delay in lymphoma in a TB and HIV endemic setting. *BMC Cancer* 2019; 19(1):4.
 4. Weniger MA, Küppers R. Molecular biology of Hodgkin lymphoma. *Leukemia* 2021; 35(4):968–981.
 5. Verburgh E, Antel K. Approach to lymphoma diagnosis and management in South Africa. *South African Medical Journal* 2019; 109(10):715–6.
 6. M Vorster AD, A Brink, S Mkhize, J Holness, N Malan, M Nyakale, J M Warwick, M Satheke. Appropriate indications for positron emission tomography/computed tomography. 2015. *SAMJ* 2015; 106(1):106–122.
 7. Viviani S, Zinzani PL, Rambaldi A, Brusamolino E, Levis A, Bonfante V, et al. ABVD versus BEACOPP for Hodgkin's Lymphoma When High-Dose Salvage Is Planned. *New England Journal of Medicine* 2011; 365(3):203–212.
 8. Randall MP, Spinner MA. Optimizing Treatment for Relapsed/Refractory Classic Hodgkin Lymphoma in the Era of Immunotherapy. *Cancers* 2023; 15(18):4509.
 9. Mender JH, Friedberg JW. Salvage Therapy in Hodgkin's Lymphoma. *The Oncologist* 2009; 14(4):425–432.
 10. Micallef I, Desai S. Outcomes of Autologous Stem Cell Transplant for relapsed or refractory classic Hodgkin lymphoma in the era of PD-1 inhibitors. *Medical Research Archives* 2025; 13(2):11.
 11. Clinic C. Chemotherapy Side Effects. In: 9500 Euclid Avenue, Cleveland, Ohio 44195 | © 2026 Cleveland Clinic: Clevelandclinic; 2024.
 12. Li Y, Sun H, Yan Y, Sun T, Wang S, Ma H. Long-Term Survival Rates of Patients with Stage III–IV Hodgkin Lymphoma According to Age, Sex, Race, and Socioeconomic Status, 1984–2013. *The Oncologist* 2018; 23(11):1328–1336.
 13. Reyad D, Yassin FK, Bayoumy M. Brentuximab Vedotin in Pretreated Hodgkin Lymphoma Patients: A Systematic Review and Meta-Analysis. *Blood* 2015; 126(23):3866–3866.
 14. The National Department of Health P, Republic of South Africa. Standard Treatment Guidelines and Essential Medicines List for South Africa. In: Edited by The National Department of Health P, Republic of South Africa. ; 2024.
 15. Aoki T, Steidl C. Novel insights into Hodgkin lymphoma biology by single-cell analysis. *Blood* 2023; 141(15):1791–1801.
 16. Phillips EH, Iype R, Wirth A. PET-guided treatment for personalised therapy of Hodgkin lymphoma and aggressive non-Hodgkin lymphoma. *The British Journal of Radiology* 2021; 94(1127):20210576.
 17. Evens AM, McKenna M, Ryu Y, Tiger YK, Upshaw JN. Hodgkin lymphoma treatment for older persons in the modern era. *Hematology* 2023; 2023(1):483–499.
 18. Machet A, Poudou C, Tomowiak C, Gastinne T, Gardembas M, Syschenko T, et al. Hodgkin lymphoma and female fertility: a multicenter study in women treated with doxorubicin, bleomycin, vinblastine, and dacarbazine. *Blood Advances* 2023; 7(15):3978–3983.
 19. Flerlage JE, Metzger ML, Bhakta N. The management of Hodgkin lymphoma in adolescents and young adults: burden of disease or burden of choice? *Blood* 2018; 132(4):376–384.
 20. Barrett A, Collins GP. Older patients with Hodgkin Lymphoma: Walking the tightrope of efficacy and toxicity. *Frontiers in Oncology* 2023; 12.

Why my grief only misbehaves after 10pm

Bonni Suckling candidly shares why after 10pm, her brain clocks out of logic and into her feelings.

Hello. I'm Bonni. I'm your new grief columnist. I have qualifications and have done the respectable adult things. I can tick boxes and fill in forms and sit in rooms where people say words like *stakeholder*.

But my most devastating credential is this: I'm the mother of a dead child. Yes. *Dead*.

It's a horrible word. It's blunt. It's uncomfortable. It makes people shift in their chairs. But that's the reality of loving someone who is gone. It's harsh. It's final. It's not poetic.

I'm going to use honest language for honest things. Because grief is not gentle; it's raw and awkward and often deeply inconvenient.

GRIEF DOESN'T EXPIRE

My son, Jed, died fifteen years ago. Which sounds like a long time. Long enough for people to assume I'm *better now*. Long enough for grief to *surely* have expired. Like milk. Or yoghurt. Or sympathy. It hasn't.

If you're reading this, there's a good chance you also carry grief. Maybe it's a child. Maybe it's your husband. Your sister, mother, or friend. Someone who should still be here. So, this column is about us.

GRIEF IS ALWAYS WITH ME

All day. Everywhere. After fifteen years, it has somehow learned how to behave during daylight hours. It's still there. It never leaves. It just knows how to be polite.

By day, I'm impressively functional. I run a foundation, Rainbows and Smiles, for children with cancer. I'm a gym instructor. I send emails about organising things and speak in almost full sentences. I nod wisely in meetings and even laugh at jokes that aren't funny. I look like someone who has it together.

Grief comes along for all of that. It just sits quietly. Hands folded. Mouth shut. Like a well-mannered child in a waiting room. I'm a responsible adult.

GRIEF AFTER 10PM

But after 10pm, grief gets naughty... unfiltered. The house goes quiet. The kettle is off. The world stops needing me. Netflix asks, "*Are you still watching?*"

And grief stretches. "*Right,*" it says.

"Everyone's asleep. We can be honest now."

Grief after dark has no social skills. It waits until I'm in my pyjamas, with one sock on, a face full of oily night cream, and no emotional armour left. Then it starts asking questions. Do you remember how they laughed? Do you wonder who they'd be now? I tell it to stop; it doesn't.

Daytime grief is polite. Night-time grief is feral. It reminds me that while the world has moved on, my heart keeps time in *before* and *after*. It reminds me that I'm a mother to a child who does not grow older.

But I suspect your grief does this too. I suspect yours behaves beautifully in public. Lets you function. Allows you to be strong. Smiles politely at people who say, "*You're doing so well.*"

And then, when the lights go out and the world goes quiet, it finally takes off its shoes and climbs onto the bed with you.

Because night is honest. Night is where you don't have to perform. Night is where love has nowhere to hide. And here's the strange part: I don't hate those moments.

Because those late-night conversations are where our people live now. In memory. In wondering. In the ache that proves love didn't die with them.

GRIEF AFTER 10PM IS NOT A FAILURE

It's proof. Proof that you loved. Proof that you still do. Proof that your heart remembers, even when the world forgets.

So, if your grief misbehaves after dark, you're not broken. You're just quiet enough to hear it.

And maybe...just maybe...that's when love speaks the loudest. 



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.



The plot to clot

Dr Jasmine Ramiah expands on deep vein thrombosis in cancer.

March is
Deep Vein
Thrombosis
Awareness
Month

For most people, a cancer diagnosis brings a flood of new information and unfamiliar medical jargon in addition to the emotions.

One important but often overlooked complication of cancer is the increased risk of developing blood clots or thrombosis, particularly a condition called deep vein thrombosis (DVT).

Understanding why and how this happens, how to recognise the warning signs, and what can be done about it can help you feel more informed and empowered during your cancer journey.

WHAT IS A DVT?

A DVT occurs when a blood clot forms in a deep vein, most commonly in the leg, but sometimes in the arm or blood vessels within the body. The danger of a DVT lies not only in the clot itself, but in the possibility that part of it can break off and disseminate to the lungs, causing a pulmonary embolus (PE) which is a serious and potentially life-threatening condition that requires urgent medical attention.

CANCER INCREASES THE RISK

If you're living with cancer, you're at a significantly higher risk of developing blood clots than the general population owing to the biology of the malignancy.

Cancer can alter the body's normal clotting mechanisms, increasing the propensity for thrombus formation. In addition, many cancer treatments contribute to this risk. Chemotherapy, targeted therapies, and hormonal treatments can affect how blood flows and clots. Surgery, hospital admissions, reduced mobility, dehydration, and the use of central lines or ports for the administration of chemotherapeutic agents can further increase the likelihood of thrombus formation.

While certain cancers (pancreatic, lung, stomach, and brain cancers) are known to carry a particularly higher risk to developing thrombus, blood clots can occur in patients with any type of cancer.

SYMPTOMS

Symptoms can sometimes be subtle and easy to miss, however, variable and patient specific. You may notice swelling in one leg or arm, pain or tenderness that may feel like a cramp or muscle strain, or warmth and redness of the skin over the affected area.

A PE may cause sudden shortness of breath, chest pain that worsens with deep breathing, a rapid heartbeat (tachycardia), dizziness, or coughing up blood (haemoptysis). Urgent medical attention should be sought, should these symptoms arise.

DIAGNOSIS

Diagnosing a blood clot usually involves imaging modalities, such as a doppler ultrasound to detect thrombi within the deep vessels of the limbs, while a CT scan may be performed if a PE is suspected.

Blood tests can also help guide doctors, such as a coagulation screen including a D-dimer, but imaging is essential for confirming the diagnosis.

A D-dimer test is incidentally elevated in the presence of cancer and hospitalised patients.

TREATMENT

Treatment in patients with cancer focuses on preventing the clot from growing, reducing the risk of it disseminating to the lungs, and stopping new clots from forming. This is usually done with blood-thinning medications, referred to as anticoagulants, which may be administered through several routes, such as oral, intravenously, or subcutaneously.

The choice of administration will be determined by the clinician and depends on patient expectations and comorbidities or other risk factors. In some cases, injections are preferred because they may be safer or more effective with certain cancers or treatments.

Treatment typically continues for several months and sometimes for as long as the cancer remains active.

The choice of medication, route of administration, and duration of treatment is carefully tailored to each patient, taking into account the type of cancer, bleeding risk, renal function, and other drug interactions.

While not all blood clots can be prevented, there are practical steps that can reduce the risk. Staying as mobile as possible, even with gentle walking, helps improve circulation. Staying hydrated through consuming enough liquids to avoid dehydration is important, especially during treatment. You may be advised to wear compression stockings or to take preventative blood thinners during high-risk periods, such as after surgery or during hospital stays.

Most importantly, you should feel encouraged and supported to report any new or unusual symptoms to your healthcare team without delay.



MEET THE EXPERT

Dr Jasmine Ramiah is a clinical haematology subspecialist at Inkosi Albert Luthuli Central Hospital. She expanded her expertise and qualified as a haematopathologist in 2024. This dual training has sharpened her diagnostic acumen and enriched her clinical perspective, allowing her to integrate precise pathology insights with patient-centred haematology care.

Why safe space matters

Dr Andrew Robson describes the lessons learnt from creating stress-free spaces for animals that humans should follow.



Across species, one truth remains consistent: healing is deeply influenced by the environment in which it occurs. In veterinary medicine, creating stress-free spaces for animals is not viewed as an optional comfort, it's an essential part of care. Animals often show us that safety and calmness are prerequisites for recovery. These same principles apply just as powerfully to humans, particularly those living with cancer.

Stress triggers a cascade of physiological responses designed for short-term survival, not long-term healing. Elevated stress hormones can impair immune function, disrupt sleep, disturb gut health, intensify pain perception, and slow recovery. In animals, prolonged stress is associated with poorer prognoses, behavioural withdrawal, and delayed healing.

A stress-free or safe space is not defined by comfort alone. It's an environment where the nervous system can relax. Environments where there is predictability, reduced sensory input, and a sense of control. For animals, this may mean quiet surroundings, gentle handling, familiar scents, or the ability to retreat and rest without interruption.

Importantly, safety is not only physical. Emotional and psychological safety play a critical role in how the body responds to illness. Animals exposed to constant unpredictability or fear often display heightened anxiety or, conversely, complete shutdown. This is not weakness; it's a biological protective mechanism, one which we should aim to avoid.

HUMAN SAFE SPACES

For humans facing cancer, the parallels are striking. The experience of diagnosis, treatment, uncertainty, and repeated medical intervention can place the body in a prolonged state of alert.

Many people feel pressure, internal or external, to remain strong, positive, or composed at all times. While resilience is admirable, constant vigilance comes at a cost. The body cannot remain in survival mode indefinitely without consequence.

Safe spaces allow that vigilance to soften. They create moments where the nervous system can relax, even if it's only for a moment. This may look different for each person: a quiet room, a trusted relationship, a routine that brings predictability, time away from expectations, or simply permission to rest without explanation. These spaces do not remove illness, but they can change how illness is experienced.

NO APOLOGIES FOR REST

One of the most powerful lessons from animal care is that rest is not something that must be earned. Animals instinctively withdraw when overwhelmed or unwell, conserving energy for healing. They do not apologise for needing quiet or softness. Humans, by contrast, often struggle to grant themselves the same grace, especially in the context of serious illness.

Yet from a physiological perspective, gentleness matters. Reduced stress supports immune function, improves sleep quality, and

enhances the body's ability to repair itself. Creating both emotional and physical safety is not a sign of surrender, but rather a form of active care.

Safe spaces are also protective. They offer refuge from constant decision-making, from explaining your experience to managing other people's discomfort. Within these spaces, it becomes possible to feel fear, sadness, or fatigue without judgment. This emotional honesty, like physical rest, is part of healing.

For those living with cancer, creating or seeking out safe spaces is not indulgent. It's biologically sound and emotionally valid. Safety allows the body and mind to do what they are designed to do when given the chance: rest, adapt, and heal at their own pace. 



MEET THE EXPERT

Dr Andrew Robson is a veterinarian with a Master of Science Degree from Wits University. Based at Oaklands Veterinary Hospital in Johannesburg, Andrew forms part of a multi-

disciplinary team of veterinary professionals dedicated to providing the highest standard of care to small animal patients and their families. With a strong interest in companion animal medicine, animal physiology, and client education, he is passionate about strengthening the human-animal bond and supporting pet parents through evidence-based, compassionate veterinary care.