Isssue 63 | April-May 2026

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## WELCOME

*by Laurelle Williams*

This issue's theme is ***Orange = Vitality***. Vitality represents *life force* and if there is one person who has an unforgettable and formidable life force, it's Siré Oosthuizen. I met her when I was in hospital; she is the physiotherapist who treated me. As we started chatting, she shared that she is a brain cancer survivor. Little did I know just how incredible her story is. The beauty of being in her presence, is her life force automatically makes you feel calm and her lightness is penetrable. Read *Perfectly fine*.

I'm not a big artificial intelligence (AI) fan (especially in my line of work) so I enjoyed the viewpoint of *AI in cancer care: helpful assistant or hidden risk?* This line says it all: *Long after the statistics fade, patients will remember whether someone looked them in the eye, noticed their fear, and stayed.* Thank you Dr Memory Bvochora-Nsingo for such an important reminder.

Dr Margie Venter covers another important topic *Cancer pain control: opioids as part of the plan* and debunks the common worries of using them.

> **The sky takes on shades of orange during sunrise and sunset, the colour that gives you hope that the sun will set only to rise again.**
>
> - Ram Charan

MY STORY

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- Perfectly fine



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MANDY STEENKAMP PHOTOGRAPHY
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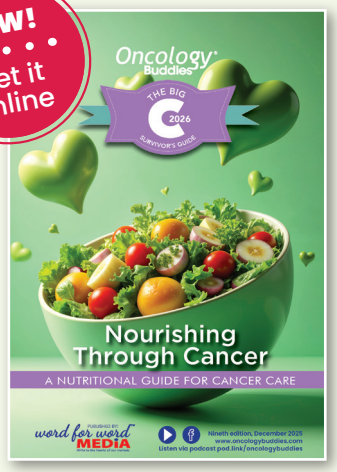
**PUBLISHER AND MEDIA SALES:** Karen Joseph
karen@wordforwordmedia.co.za

**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

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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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# Cancer pain control: opioids as part of the plan

**Dr Margie Venter discusses one of the most effective tools for treating cancer pain: opioids.**





Image by freepik.com

Of all the things people tell me affect their quality of life, fatigue and pain are the big ones.

Fatigue is tricky. As doctors, we often underestimate how much fatigue affects daily life. There is unfortunately nothing in a bottle that can be prescribed four times a day to magically fix it. It usually takes creativity, adaptation, and support to work around it.

Pain, however, is almost always treatable. Sometimes it takes one or two attempts to find the right recipe, but in most cases we can get it under control.

I have seen patients and families struggle with poorly managed pain, and the ripple effect is significant. Pain can take up the whole day. It leaves little space for anything else, never mind basic activities like getting dressed or into a car, let alone something enjoyable like a short walk. It affects appetite, mood, and sleep. It affects relationships. Families can feel helpless, not knowing how to make things better.

You might say, "It's not that bad, I can deal with it." Or you're like frogs in slowly warming water with the temperature rising so gradually that you almost forget what a pain-free day feels like.

## PAIN DESERVES ATTENTION

In a previous *Buddies for Life* article, Sr Rowan Robinson wrote about the different causes and types of cancer pain, and how stress and emotional strain can intensify the experience of pain.

## WHAT ARE OPIOIDS?

Opioids are a group of strong pain medicines that are commonly used to treat moderate to severe cancer pain.

They work by attaching to specific receptors in the brain and spinal cord, reducing the way pain signals are processed and perceived.

Morphine, the best-known opioid, is derived from the opium poppy plant. Other opioids, such as fentanyl and methadone, are made synthetically in a laboratory. Some are semi-synthetic, meaning they are created by modifying natural substances.

## HOW ARE OPIOIDS GIVEN?

There are many different forms:

- Syrup, drops, or tablets taken by mouth
- Long-acting tablets taken twice daily
- Patches that slowly release medicine through the skin
- In some situations, medication is given intravenously or under the skin

The choice depends on the type of pain, what is available, and what suits you, the patient, best.

## COMMON WORRIES ABOUT OPIOIDS

There are many myths and misconceptions about morphine and other opioids. Let's address some of the most common ones.

***"My pain is not bad enough for morphine."***

Sometimes a low dose of an opioid gives better, cleaner pain control than a mix of weaker medications.

***"If I start now, there won't be anything stronger later."***

Starting an opioid when you have pain does not make it ineffective later. The dose can always be adjusted if needed.

***"I will become addicted."***

Addiction is not a concern when opioids are used under medical supervision for cancer pain. Using medication regularly to treat real, physical pain is not the same as addiction.

***"I am allergic to morphine."***

True allergic reactions to opioids are very rare. Most people who believe they are allergic experienced side effects, such as nausea or itchiness, or received a high dose after surgery and felt unwell. When we start opioids for cancer pain, we start low and increase slowly.

***"Opioids are only for the end of life."***

Not true. Many people live well for years with cancer while using opioids to stay comfortable and active.

***"I can't use opioids because they cause constipation."***

It is true that all opioids cause constipation. Rather than avoiding good pain control, we manage constipation proactively and consistently.



## DID YOU KNOW?

**Oral morphine is also prescribed to suppress cough and help ease shortness of breath. It's often much more effective than using oxygen.**

## WHAT ARE THE COMMON SIDE EFFECTS?

Like all medications, opioids have side effects. The good news is that most are manageable.

**Nausea and vomiting**

This often lasts only a few days after starting treatment. It can be prevented or treated effectively with anti-nausea medication.

**Drowsiness**

Feeling sleepy can happen when starting opioids or increasing the dose. It usually improves within a few days. Let your healthcare provider know if you feel very sedated or if the grogginess doesn't settle.

**Constipation**

This is the big one. Unlike nausea and drowsiness, constipation doesn't go away on its own. Most people need daily laxatives while taking opioids.

**Other possible effects**

Itchiness, difficulty passing urine, sweating, and dry mouth.

## USING OPIOIDS WELL: PRACTICAL TIPS

Understand the possible side effects and be prepared. Use your laxatives. This can't be stressed enough.

Cancer pain is often constant or frequent. Taking your opioid regularly as prescribed, rather than waiting until pain becomes severe, gives much better control.

There are two main ways opioids are prescribed:

**1. Short-acting opioids**

For example, oral morphine syrup. These usually need to be taken every four hours because that is how long they last in the body.

**2. Long-acting opioids**

Such as long-acting morphine or oxycodone, taken every 12 hours.

Patches also fall into this category. Depending on the type of patch, they are usually changed either every three days, or every seven days.

Ideally both are prescribed: a long-acting medication for steady background pain, and a short-acting medication for breakthrough pain (temporary spikes of pain despite regular treatment).

If you're using oral morphine syrup to manage steady background pain, your doctor will explain how much extra you can safely take for breakthrough pain, while continuing with your regular four-hourly doses.

If you need frequent breakthrough doses, your doctor will likely adjust your regular long-acting medication.

Keeping a simple pain diary can be very helpful. Note when you have pain, what you took, and how well it worked. And most importantly, tell your doctor or nurse if your pain isn't controlled or if side effects are troublesome.

Pain control works best as a partnership. With regular, open communication and careful adjustments, most cancer pain can be managed well. When pain is well-controlled, there are simply more good days. Days where you can get through the to-do list and still have space for the want-to-do list.

## VALUABLE RESOURCES

- Download the CANSA booklet to help *Manage Cancer Patient's Pain in the Home*. (*cansa.org.za*)
- *Using oral morphine and common myths* (*palprac.org*)



### MEET THE EXPERT

**Dr Margie Venter** is an oncologist and palliative care doctor based in Stellenbosch, Western Cape. She is the Clinical Director of PALPRAC, the Association of Palliative Care Practitioners of South Africa, an organisation that provides national leadership and advocacy for the equitable provision of palliative care to all South Africans.



# AI IN CANCER CARE: helpful assistant or hidden risk?

**Dr Memory Bvochora-Nsingo reflects on artificial intelligence technology, trust, and the future of healing.**

Recently, a new patient walked into my consultation room with quiet confidence. She was accompanied by her elderly mother; a familiar sight, and a reminder that serious illness is rarely borne alone.

As we began speaking, I noticed how prepared she was. Kefilwe asked thoughtful, direct questions about her diagnosis and demonstrated a surprising ease with medical language. She understood timelines, treatment pathways, and the decisions that might lie ahead. When she spoke, she looked directly into my eyes (attentive and present), yet every so often her gaze drifted toward the phone in her hand. It was subtle, but unmistakable.

The device had already informed her, perhaps even calmed her before she arrived. In that moment, I realised there were not just three people in the consultation room. There was another presence: quiet, but influential. The phone was no longer merely a tool; it had become a presence. Artificial intelligence (AI) had entered the consultation long before I did.

Encounters like this are becoming increasingly commonplace, even here in Botswana, where information now travels faster than geography.

Patients arrive informed, empowered, and often reassured by what they have read. In many ways, this is progress. Knowledge can restore a sense of control at a time when life feels uncertain. Yet in a society where illness is carried collectively, information is only one part of the story.

As our conversation moved into the more difficult landscape of prognosis, I noticed a shift. Her voice softened, and the confidence that had carried her into the room settled into vulnerability. She already knew the statistics, or at least the probabilities AI had outlined for her.

## WHEN THE HUMAN ANSWER MATTERS

I turned gently toward her mother. "*Mme,* do you have anything you would like to ask?" She met my gaze steadily. "*Ngaka*…will my daughter be okay?"

As the question settled into the room, something quietly changed. Kefilwe placed her phone down and turned fully toward her mother. The screen that had held so much of her attention moments earlier was forgotten.

Some questions instinctively call us back to one another. I gently closed my iPad. In that moment, only the human answer mattered.

She was not asking for percentages or survival curves, but for reassurance, for honesty told with care.

Around us, the room grew still, and I assured her that we would walk this road together and that her daughter would receive the best care possible.

In that instant, medicine became human again.

## PARTNERSHIP: INNOVATION AND HUMANITY

AI can provide answers within seconds. It can analyse images, compare treatments, and expand access to knowledge in extraordinary ways. Used wisely, it's a powerful ally in modern oncology.

Yet cancer is never merely a biological event; it's a human experience that rearranges families, tests identity, and awakens fears few are prepared to face. Here, illness is shared across generations, carried within the quiet strength of community. Information alone can't guide a person through such a landscape.

The true risk is not that machines will replace doctors, but that medicine becomes increasingly efficient while quietly becoming less relational. That we begin to prioritise speed over presence and data over dialogue. Technology should sharpen our vision, not narrow it, freeing us to listen more deeply.

The future of cancer care must not be a choice between innovation and humanity, but a partnership of the two. AI will help us treat cancer with greater precision, but healing has never depended on precision alone. Long after the statistics fade, patients will remember whether someone looked them in the eye, noticed their fear, and stayed.

As medicine evolves, our task is not to resist technology, but to guide it wisely, ensuring that in our pursuit of innovation, we don't surrender the humanity that defines care.

Medicine has long been guided by a simple but enduring wisdom: *to cure sometimes, to relieve often, to comfort always.* In an age increasingly shaped by AI, those words feel less like history and more like instruction. A reminder that while technology may transform how we diagnose and treat, the deepest work of the physician remains profoundly human.

Even as machines grow smarter, the deepest calling of medicine remains unchanged to comfort; always.

**The future of cancer care must not be a choice between innovation and humanity, but a partnership of the two.**

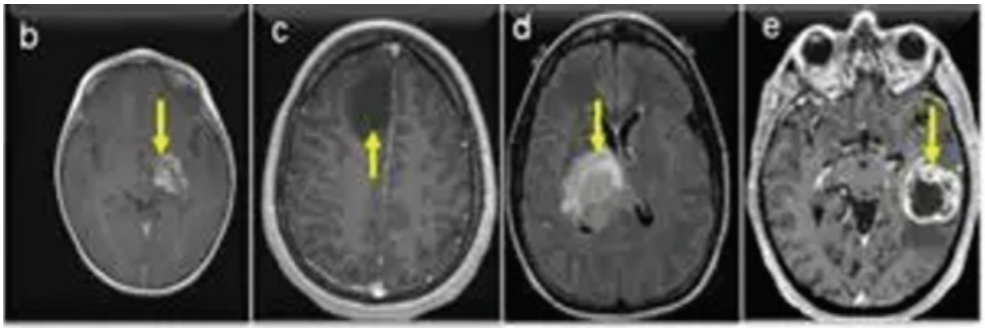


### MEET THE EXPERT

**Dr Memory Bvochora-Nsingo** is a clinical oncologist with 20 years of experience in radiation oncology and chemotherapy, specialising in the treatment of cancers of the cervix, breast, prostate, head and neck, and many others. She has worked for 16 years in Botswana, achieving significant success in both curative and palliative care, including end-of-life care. Currently, she works at Gaborone Private Hospital and is involved in government work as well.

Image by freepik.com

# ASTROCYTOMAS: what, where, how?




MRI images of the grades of astrocytomas (from low to high).

**Dr Cathryn Walton explains how astrocytomas, a type of brain cancer, develop and how they are treated.**

Receiving a diagnosis of a brain tumour can be an overwhelming experience, filled with great anxiety and uncertainty of *what now?* One of the most common types is the astrocytoma; they form 50% of all brain tumours diagnosed.

## WHAT IS AN ASTROCYTOMA?

An astrocytoma is a tumour that grows from brain cells called astrocytes; these are the cells in the brain that act as the dedicated support crew for the brain's main cells, the nerve cells (neurons). Astrocytes are star-shaped cells that provide nutrients, support and protection to the neurons, and so help the brain function correctly.

An astrocytoma develops when these astrocyte cells begin to grow and divide uncontrollably, forming a mass called a tumour. Tumours put pressure on the normal brain which causes the brain to struggle to function correctly.

Astrocytomas are part of a broader group of brain tumours called gliomas, which are tumours of the glial (support) cells in the brain. Astrocytomas can vary significantly; some are slow-growing and relatively contained, while others are aggressive and can spread into surrounding brain tissue.

## THE GRADING SYSTEM

To understand how an astrocytoma might behave and to plan the best course of treatment, doctors use a grading system established by the World Health Organisation (WHO). Tumours are graded from 1 to 4 based on how abnormal the cells look under a microscope.

**Grade 1 (pilocytic astrocytoma):** These are slow-growing, have clear borders, and are considered non-cancerous. They are most common in children and young adults and can often be cured with surgery alone.

**Grade 2 (diffuse astrocytoma):** Also slow-growing, but their edges tend to blend into the surrounding brain tissue, making them more difficult to remove completely. They have the potential to become more aggressive over time.

**Grade 3 (anaplastic astrocytoma):** These are cancerous (malignant) tumours. The cells are more abnormal and grow more rapidly than lower-grade tumours, actively invading nearby brain tissue.

**Grade 4 (glioblastoma):** This is the most common and most aggressive type of astrocytoma. These cancerous tumours grow very quickly, have a rich blood supply, and are very challenging to treat.

## SYMPTOMS

The symptoms depend entirely on its size and, crucially, its location in the brain, as different parts of the brain control different functions. It's important to remember that these symptoms can also be caused by many other conditions. So, the symptoms are often ignored or assumed to be just part of life and stress.

- Persistent headaches, which may be worse in the morning
- Seizures (first onset of seizures in adults must always be evaluated with a brain scan)
- Nausea and vomiting
- Changes in mood, personality, or concentration
- Memory problems
- Weakness, numbness, or tingling in an arm or leg
- Difficulties with speech or understanding others
- Vision problems (blurred or double vision)
- Balance problems or clumsiness

## TREATMENT

Treatment is highly-personalised and depends on the tumour's grade, size, location, and your overall health. A team of specialists, including neurosurgeons, oncologists, and radiologists, will collaborate to create a treatment plan.

**Surgery:** This is often the first step. The goal is to remove as much of the tumour as possible without harming healthy brain tissue. For Grade 1 tumours, surgery might be the only treatment needed.

**Radiotherapy:** This uses high-energy rays to target and destroy any remaining cancer cells after surgery or to treat tumours that can't be surgically removed.

**Chemotherapy:** This involves using powerful drugs to kill cancer cells. It can be given as a pill or through an intravenous (IV) drip and is often used alongside radiotherapy for higher-grade tumours and often after the radiotherapy to maintain efficacy of the management (keep it away for longer) .

**Targeted therapy and other treatments:** Newer treatments are being developed that target specific genetic mutations within the tumour cells, offering a more precise way to fight the cancer while sparing healthy cells.

## SURVIVORSHIP

Life after an astrocytoma diagnosis is a journey of recovery and adaptation. Survivorship begins at diagnosis and continues throughout your life. It focuses on managing the long-term effects of the tumour and its treatment to ensure the best possible quality of life.

Follow-up care is crucial. Regular MRI scans are needed to monitor for any signs of tumour recurrence. Rehabilitation may be necessary to regain skills affected by the tumour or its treatment. This can include physiotherapy to improve strength and balance, occupational therapy to help with daily activities, and speech therapy.

Living with the knowledge of a brain tumour can also take an emotional toll. Psychological support from counsellors, support groups, and loved ones is a vital part of the recovery process, helping you and your family navigate the challenges and uncertainties ahead.



**MEET THE EXPERT**

**Dr Cathryn Walton** first practiced as a GP for 10 years; she then qualified as clinical oncologist in 2015 and was in a group practice. In 2023, she opened her own practice, Bay Oncology, in Gqeberha, Eastern Cape with primary focus on breast cancer, melanoma and other skin cancers, sarcoma, CNS malignancies, paediatric radiation, and radiation of benign conditions.

Image by freepik.com

# Perfectly fine

**Siré Oosthuizen radiates joy and an uplifting lightness as she explains why she felt perfectly fine when diagnosed with Stage 3 astrocytoma brain cancer.**



**Siré Oosthuizen (29) lives in Alberton, Gauteng with her husband.**

The majority of Siré's primary school years, she suffered with migraines, so she would always have a migraine kit with her to manage them. Thankfully, the migraines stopped during high school.

It was in her first year of varsity that she started getting headaches again. At first, she thought it was due to studying and the strain on her eyes, so she went for an eye test towards the end of 2016. Though, her eyesight was good.

In 2017, Siré was in her second year of university and was about to start the second semester. While away on holiday, she got double vision and each time she got a headache, she would be nauseous and vomit; this would make her feel better.

Once she was back home, another appointment was made at a different eye specialist and various tests were done.

She was diagnosed with papilloedema (swelling of the optic disc caused by increased intracranial pressure) and sent for an MRI scan to find the cause.

Siré was informed that she had a cancerous brain tumour (8cm x 6cm x 3 cm), called an astrocytoma, located in the left frontal lobe.

"When I received the news, I was alone as my sister who was driving me was waiting in the car. The nurse looked at me and asked, 'Are you okay?' I replied, 'I'm perfectly fine. I know the Lord won't bring something like this on my path, if He is not planning on healing me or making a testimony of my story. And if I were to pass away, at least I'm going out with a fighting spirit.'"

## SHARING THE NEWS

She informed her close group of friends along with a lecturer. "When I saw them, they were all crying their eyes out and that was the only time I cried. Not for myself, but for them…to see the effect it had on them."

## BRAIN SURGERY

Siré, along with her parents, consulted a neurosurgeon. Surgery was discussed as well as all the side effects, which included change in personality, paralysis on the right side, speech impairment, seizures, and lack of sensation. The surgery took place in August 2017.

"Before the surgery, I was asked if I wanted a calming tablet. I declined as I was perfectly fine. The surgery took roughly seven hours, which was longer than expected, so when I came out of theatre I was coming to and was wheeled past my parents and I smiled.

When they came into ICU to see me, I said (in Afrikaans), 'Mom and Dad, that was the strangest experience ever'", Siré explains.

Siré's recovery after brain surgery is nothing short of a miracle. She recognised every family member who visited her and has no major side effects whatsoever. She was only in ICU for two days, then skipped high care and went straight to a normal ward for another two days.

## FURTHER TREATMENT

It was found during surgery that the tumour had spread to other lobes and was a Stage 3 astrocytoma. Due to this, Siré went on a daily oral chemotherapy pill in September 2017 until July 2018.

The side effects were nausea which she was prescribed medication to manage as well as hair loss all over her body.

She started six weeks of radiation (33 sessions) at the same time as chemotherapy.

## GAP YEAR

Her lecturer, whose husband had also battled cancer, advised Siré to take a year off from studying to give her brain a chance to fully recover. During this period, she experienced fatigue, short-term memory loss, and weight loss.

She was also given memory exercises from her oncologist so her parents could check if she was recalling words and objects.

Her hair was only shaved where the neurosurgeon cut, almost like an Alice band. Friends raised money by selling bandanas to buy Siré a wig. "I didn't really need it, but the gesture was beautiful," she says.

The hair still doesn't grow properly where the tumour was but Siré takes it in her stride.

## GOING BACK TO UNIVERSITY

Before Siré went back to study, she did a gun competency test (her family are hunters). "It's a hobby and was a good way to test if my brain was functioning properly," she says.

Her oncologist also wrote a report stating she is fit to continue studying physiotherapy.

In July 2018, Siré went back to university, starting the second semester.

Siré completed her studies in 2020 and did her community service in 2021. She got the first job she applied for. She disclosed the brain cancer when asked why there was a gap in her studying.

## MEETING HER HUSBAND

Once Siré was fully recovered, in 2018, she shared her testimony at church. Little did she know, it made such an impression on her future mother-in-law that she shared it with her son.



He then reached out to Siré to check how she was doing, and they formed a friendship then a romantic relationship and now have been married for four years.

## A HEART FULL OF GRATITUDE

Siré is thankful for how everything has turned out. "This has nothing to do with me. Technically, I'm not supposed to be here or even survived the op…but the fact that I'm a living walking testimony gives honour to the Lord. His grace, His goodness and healing hands. I'm thankful for the job I have, for my husband, for my family who grew closer. More thankful, I can't be," Siré says.



Photo by Mandy Steenkamp Photography | Follow @mandysteenkampphotography



### 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*

# Dealing with gli

## Dr Mia Hugo unpacks glioblastoma, the most common and aggre

### WHAT IS GLIOBLASTOMA?

Glioblastoma multiforme (GBM) is the most common type of primary malignant brain tumour in adults, accounting for almost half of all primary brain cancers.[1]

With the update of the World Health Organisation (WHO) classification of brain tumours in 2021, GBMs are now more commonly referred to as Grade 4 gliomas.

GBMs are the most aggressive of the primary brain tumours and a diagnosis brings families to a standstill.

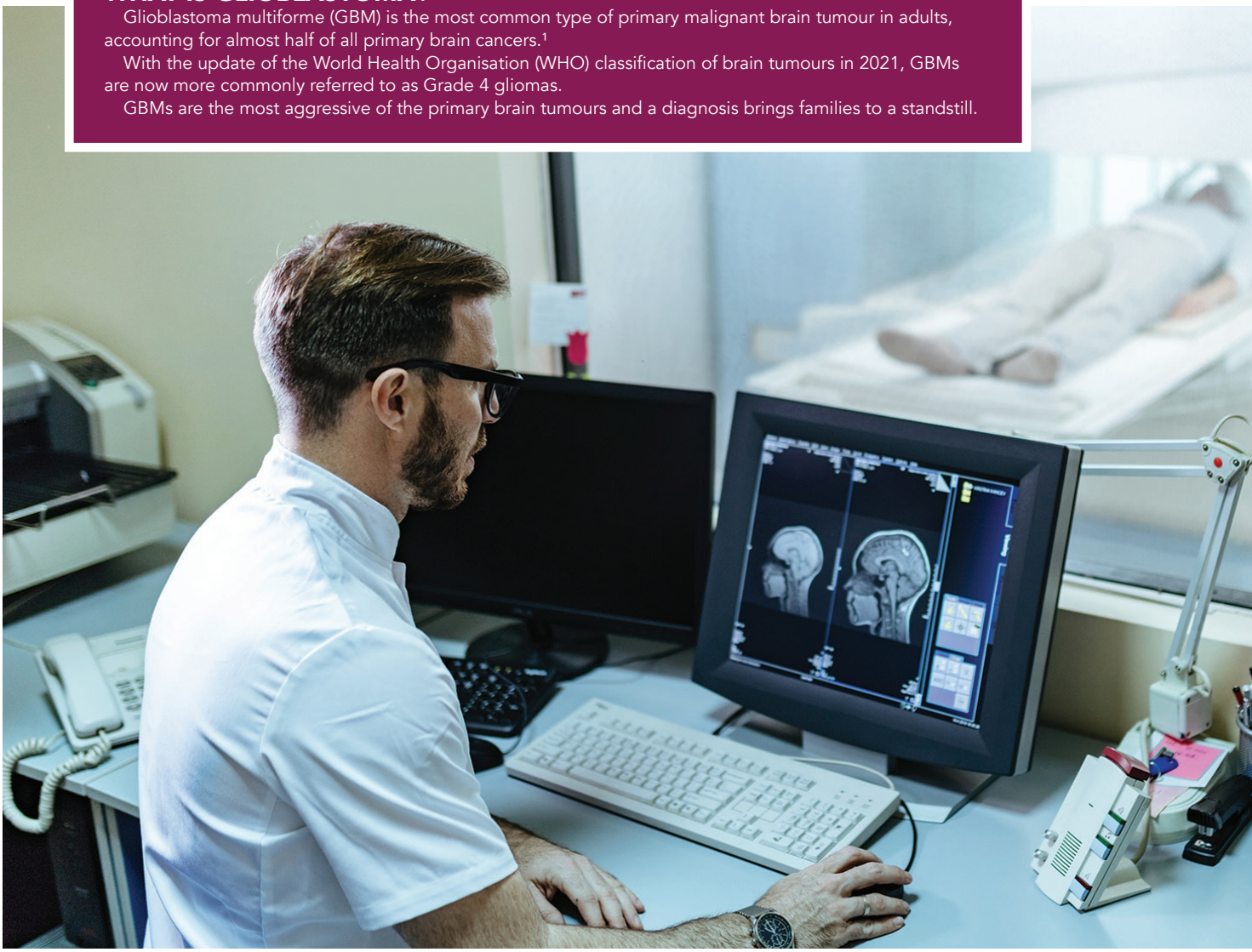


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### A LIGHTNING STRIKE OF A DIAGNOSIS

GBMs can occur at any age, but most commonly in adults over the age of 65. The majority of glioblastoma patients have no family history or identifiable risk factors. Some genetic syndromes like Li-Fraumeni syndrome may predispose patients to GBM (<1% of GBMs). Very rarely exposure to ionizing radiation as a result of radiation for childhood brain tumours or leukaemia may also be a risk factor for high-grade gliomas.[2]

The COSMOS epidemiological study showed no association between mobile phone usage and gliomas[3], nor is there an association with other lifestyle factors, such as smoking or alcohol consumption.[1]

In most cases, GBMs present out of the blue with no causative factor identified.

### DON'T IGNORE THOSE PESKY HEADACHES

The onset of symptoms is often over a short period of time, often weeks to months as GBMs grow quite quickly. The symptoms will vary based on the primary location of the tumour but most commonly presents with persistent or worsening headaches, nausea, vomiting, and new onset seizures.[4]

Dramatic symptoms include one-sided weakness, visual changes, or difficulties with speech. Other times, the symptoms can be subtle, such as changes in memory or personality or behavioural changes.

Unexplained and worsening headaches and other neurological symptoms need to be investigated.

### LOOKING UNDER THE HOOD

Concerning symptoms will initiate imaging: a CT or MRI of the brain. Should the CT brain show something suspicious, it should be followed by an MRI brain as it provides better soft tissue (brain) resolution.

# oblastoma

## ssive form of primary brain cancers.



Utilising MR spectroscopy and MR perfusion-weighted imaging to map metabolic activity helps differentiate between a low-grade or high-grade brain tumour which is important in determining next steps.[4]

### IT LOOKS LIKE A GBM – NOW WHAT?

The management of glioblastoma requires a multi-disciplinary team approach. This team is usually made up of a radiologist, neurosurgeon, pathologist, radiation oncologist, medical oncologist, specialist nurses, rehabilitation staff, and palliative care support.[6]

The first step is usually surgery. The goal of surgery is for maximal safe resection which involves removing as much of the tumour as safely as possible. Surgery serves multiple purposes: removal of the tumour can help improve symptoms and relieve pressure on the brain and, importantly, it allows the neurosurgeon to access tissue to confirm the diagnosis. Pathologists also now look for MGMT promoter methylation (which predicts chemotherapy response) and IDH mutations to categorise the tumour accurately.

Surgery is followed by radiotherapy due to the infiltrative nature of the disease. GBMs are notorious for being highly-infiltrative, with tumour cells that grow into the surrounding normal tissue beyond what the borders seem like on scan or in surgery.

Radiotherapy is targeted to the original site of disease as well as a margin that accounts for potential areas of tumour spread or infiltration around the tumour. The goal of radiotherapy is to both target any remaining tumour cells and to delay tumour regrowth.

For grade 4 gliomas, a typical course of radiotherapy is around six weeks of daily radiation, and it's delivered using highly advanced techniques to try and spare as much healthy, normal brain tissue as possible. For fit patients, a six-week course of 60 Gy is standard. However, for elderly patients, a shorter course of three weeks (hypofractionated radiation) can also be recommended.[6]

Radiotherapy is mostly given concurrently with chemotherapy. The standard chemotherapy remains an oral chemotherapy known as temozolomide. This is a tablet that is taken once a day whilst on radiotherapy and then for several months after the completion of radiotherapy.[5]

### BE PREPARED, BUT NEVER GIVE UP HOPE

Close surveillance following completion of initial treatment is important. Unfortunately, glioblastoma often recurs, with the highest risk in the first two years post treatment.

Treatment options at the time of recurrence are tailored to each case based on age, general health, tumour features, and response to previous therapy.

They can include: surgery, reirradiation with conventional or stereotactic radiation, chemotherapy/systemic therapy, clinical trials, or best supportive care.

### DIFFICULT DISEASE TO CURE

Despite advances in technology and diagnosis, it's still a difficult disease to cure. Early diagnosis and multi-disciplinary management are important, and research is ongoing looking for new treatments to improve outcomes.

Ongoing research looks at targeted therapy, vaccines, immunotherapy, and novel radiotherapy delivery techniques. Tumour treating fields (TTF) uses the delivery of low-intensity electric fields to the scalp in addition to radiation and chemotherapy, with the goal of slowing tumour growth in selected patients.[7]

Trials looking at personalised dendritic cell vaccines and CAR T-cells are showing some promise.[1] It's important for the treating team to consider participation in clinical trials, especially in recurrent GBM.

### OPTIMISE QUALITY OF LIFE

Glioblastoma is known to be an aggressive cancer and treatment goals are aimed at extending survival and allowing you to experience meaningful time and to optimise quality of life.

Good supportive care is essential from the start since the journey can be tumultuous for both you and your family. With such a high recurrence rate, it's best to both prepare for the worst but at the same time hope for the best, as there is a small group of patients who can have a good quality of life for more than five years between the initial diagnosis and recurrence, dependent on age, size and subtype at diagnosis.

Every patient's situation is unique, and open and honest communication with your medical team is valuable in choosing the right treatment path, both at the start of the journey and if there is a diagnosis of a recurrence.

To view references, visit *oncologybuddies.com*



### MEET THE EXPERT

**Dr Mia Hugo** is a radiation oncologist in private practice. She participates in weekly multi-disciplinary oncology team meetings for breast, urology, gastrointestinal, gynaecological, and head and neck cancers. She provides radiation to patients at Wits Donald Gordon, Netcare Milpark, Pinehaven and Olivedale hospitals, as well as at Busamed and 200 Rivonia Medical Centre.

Image by freepik.com

# My health, my right

**Gavin Lee recounts the uphill battle of getting his medical scheme to fund his radical cystoprostatectomy.**







Images supplied

**Gavin Lee (65) lives in Weltevreden Park, Gauteng with his wife. They have two sons and one grandson.**

In July 2025, Gavin noticed traces of blood in his urine; this prompted him to see his GP. A prostate-specific antigen (PSA) test was done and proved to be elevated and Gavin was referred to an oncologist. Here further imaging was done, and an MRI detected a tumour in his prostate as well as in his bladder. Biopsies were done on both which confirmed two primary cancers: Stage 2 muscle-invasive bladder cancer and Stage 2 prostate cancer.

Gavin admits the news came as a shock to him and he found it quite stressful and difficult to inform his family.

It was advised that he undergo a radical cystoprostatectomy that would remove the prostate and bladder and in turn treat both cancers. However, Gavin would live with an urostomy (an abdominal opening to urinate) for the rest of his life. Gavin accepted this immediately. "I accepted the fact that the radical cystoprostatectomy would save my life and the urostomy would become a way of life," Gavin says.

Since then Gavin has maintained a positive outlook.

At first, living with a urostomy bag took a while to get used to, especially the leaks, having to learn to sleep predominately on his back, the overnight overflow bag, as well as learning tricks on how to shower with it. But he adds, these were overcome early on. Thankfully, he hasn't had any side effects from the surgery.

## HOSPITAL PLAN HURDLE

For 20 years, Gavin has been a member of a medical scheme making use of their hospital plan option. When he was diagnosed, he knew there would be co-payments as that is the norm with a hospital plan.

However, he never knew that finding a specialist urologist who could perform a radical cystoprostatectomy and was contracted to the medical scheme would be such an uphill battle.

Gavin explains, "The medical scheme provided a list of doctors who were contracted in. However, all of them only performed prostatectomies (prostate removal) and not a radical cystoprostatectomy, which I needed. The urologist who diagnosed me referred me to a specialist laparoscopic and robotic surgeon who was proficient in the surgery I needed but she wasn't contracted to the medical scheme. This resulted in me having to pay 80% of the total bill which exceeded R100 000; payment had to be made upfront. Only 20% of the total bill was paid by the medical scheme which I thought was grossly unfair. I've been a member for over 20 years."

Gavin then challenged the medical scheme, stating the doctor he used was done involuntarily as they couldn't provide a specialist to do the procedure. He expressed his utter disappointment and that he would be left with no alternative but to take the matter further, if the decision wasn't reconsidered.

## CELEBRATING THE WIN

"Within two days of sending the letter, I received a reply stating that after consideration, the medical scheme would pay the doctor out of Prescribed Minimum Benefits (PMB)," Gavin says.

This was a huge relief for Gavin though he adds, "I had a positive outcome as I had the courage to challenge the medical scheme. But what about all those people who just accept what medical schemes decide and end up paying unnecessarily."

The medical scheme also covers the cost of all urostomy bags.

Gavin concludes, "My advice is: first of all, listen to your body. If something is not right, the warning signs are there, don't ignore them. Secondly, don't be fearful to take big medical schemes on."

## VALUABLE SUPPORT

Gavin would like to thank his wife, Gayle, for her amazing support and acceptance of his diagnosis. She assists with changing the urostomy bag up to three times a week, without hesitation.

"The support and encouragement I got from my sons, Devon and Gareth, gave me the positivity I needed. I would also like to thank my sister, Debbie, who flew in from Kenya to give me the support I needed. To all the friends who sent me well wishes and visited me in hospital, a huge thank you," Gavin says.

# Tongue reconstruction

## Dr Dimitri Liakos explains the surgical options for tongue reconstruction.

The tongue plays an essential role in everyday life. This highly mobile muscle in the mouth allows you to speak, chew, and swallow your food; important functions of everyday life.

But the tongue has so many more intricate functions. It allows you to taste your food, whether sweet or sour. It allows propulsion of food down the throat at the same time as it blocks the airways to prevent aspiration.

Anatomically it's made up of highly-specialised muscles and taste buds, making the anterior surface of the tongue feel somewhat rough. The underside of the tongue is made up of a smooth, wet mucosal layer.

### TONGUE CANCER

The most common causes of tongue defects arise from oral cancers. The most common cancer of the tongue is caused by squamous cell carcinoma. Risk factors include smoking, alcohol, and oral HPV infections which are now increasing the risk of tongue cancer in younger patients.

Patients with tongue cancer usually present with a non-healing ulcer, which can be painful. Otherwise patients may present with a painless lump in the neck, this is usually a swollen lymph gland.

Prevention is important. These preventative measures include cessation of smoking, decreasing alcohol intake, maintaining a healthy lifestyle, and getting vaccinated for high-risk HPV infection at a young age.

There are different modalities for treating tongue cancer, one being surgical resection. The size of the defect will determine the need for tongue reconstruction or not. If the defect is only 50% or less, usually we do not need to reconstruct the defect as this will allow adequate mobility and bulk for speech and eating. Larger defects will usually require some sort of a reconstruction.

### TONGUE RECONSTRUCTION

The aim of tongue reconstruction is two-fold: to maintain mobility of the tongue for speech and provide bulk to allow one to push food against the palate and therefore be able to swallow food.

Reconstruction of the tongue usually involves importing tissue from another body region; this is known as a flap. Local or regional flap options include donor areas from the submental area (directly under the chin), cheek, or even the neck. These options are not usually first choice options, but they can be used for smaller defects.

The gold standard option for a tongue reconstruction is a free flap from a distant donor area of the body. A free flap is a transplant of tissue from one area to another. The tissue needs to be re-vascularised (blood flow into and out of the flap needs to be restored). This is done by performing a micro-vascular anastomosis from the recipient vessels in the head and neck to the flap vessels (artery and vein). These vessels are usually very small (2-3mm), and great care needs to be taken.

If anatomically viable, a nerve coaptation may also be done to renew innervation into the flap. This will allow sensation back in the reconstructed tongue. These procedures are highly technical and can only be performed at specialised units around the country.

Flap donor sites most commonly include the forearm and thigh. Sometimes a skin graft is required to close the forearm donor site. However, it's sometimes preferred due to the thin nature of the forearm skin which allows a flexible and pliable flap.

### RECOVERY

After surgery, patients are generally cared for in ICU until they are healing well and allowed to drink and eat per mouth. Patients generally recover well and are able to return to their daily functions, depending on the size of the original defect size.

Any lesion in the mouth that is not healing or continues to grow, or lump in the neck should be seen to by an ear, nose, and throat (ENT) surgeon.



Image by freepik.com



### MEET THE EXPERT

**Dr Dimitri Liakos** is a plastic and reconstructive microsurgeon with special interest in oncology reconstruction. He is currently a consultant plastic surgeon at WITS Donald Gordon Medical Centre. The unit specialises in head and neck, breast, and other oncology reconstruction.

# Chronic lymphocytic leukaemia (CLL) Patient Journey

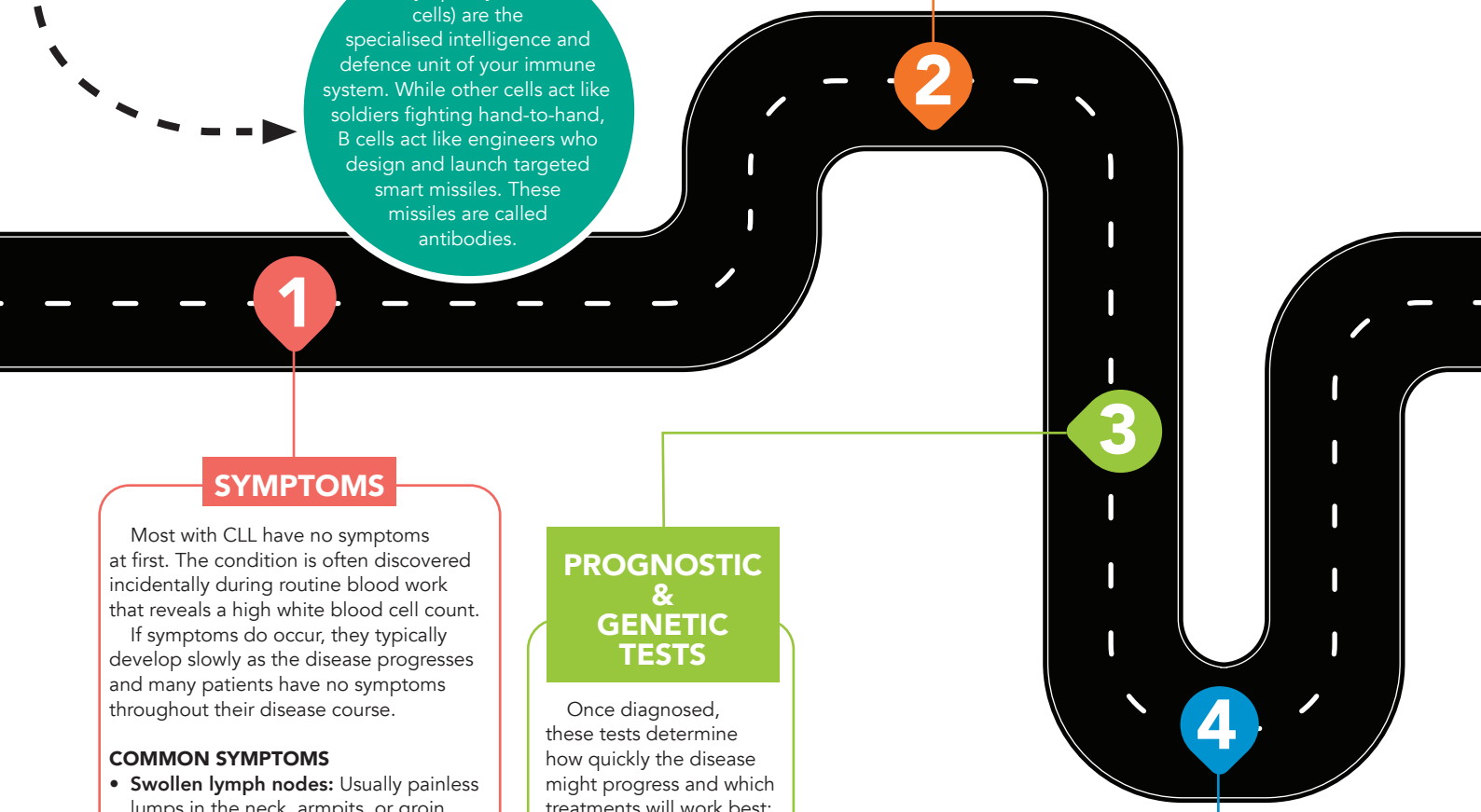
compiled by Dr Jaimendra Singh

## WHAT IS CLL?

CLL is a blood and bone marrow cancer that begins in the white blood cells called **B-lymphocytes**. It's the most common form of leukaemia in adults, typically affecting people over the age of 60.

Unlike acute leukaemias that progress rapidly, CLL develops very slowly. Many patients live for years without needing treatment and the majority will have a normal lifespan.

B lymphocytes (B cells) are the specialised intelligence and defence unit of your immune system. While other cells act like soldiers fighting hand-to-hand, B cells act like engineers who design and launch targeted smart missiles. These missiles are called antibodies.




## DIAGNOSIS AND INVESTIGATION

Diagnosing CLL is unique because it can often be confirmed through blood tests alone, without more invasive procedures like bone marrow biopsies.

**INITIAL DIAGNOSTIC TESTS**

**Complete Blood Count (CBC) with Differential:** This measures the number of red cells, white cells, and platelets. A hallmark is a high count of B-lymphocytes.

**Peripheral Blood Smear:** A pathologist examines a drop of blood under a microscope to look for abnormal cells. In CLL, these appear as smudge cells which are fragile leukaemia cells that burst during the slide preparation.

**Flow Cytometry:** This is the *definitive test* for confirming CLL. It identifies specific proteins (markers) on the surface of white blood cells to prove they are cancerous B-cells.

## SYMPTOMS

Most with CLL have no symptoms at first. The condition is often discovered incidentally during routine blood work that reveals a high white blood cell count.

If symptoms do occur, they typically develop slowly as the disease progresses and many patients have no symptoms throughout their disease course.

**COMMON SYMPTOMS**

- **Swollen lymph nodes:** Usually painless lumps in the neck, armpits, or groin.
- **Fatigue and weakness:** Persistent tiredness that may not improve with rest.
- **Abdominal discomfort:** A feeling of fullness or pain below the ribs on the left side, often caused by an enlarged spleen.
- **Frequent infections:** Such as recurring colds, flu, or skin infections, due to a weakened immune system.
- **Easy bruising or bleeding:** Including nosebleeds or bleeding gums, caused by low platelet counts.
- **Shortness of breath:** Often a result of anaemia (low red blood cell count).
- **Fever:** Persistent high temperature without a clear infection.
- **Night sweats:** Severe, drenching sweats that may require changing clothes or bedding.
- **Unintentional weight loss:** Losing more than 10% of body weight over six months without trying.

## PROGNOSTIC & GENETIC TESTS

Once diagnosed, these tests determine how quickly the disease might progress and which treatments will work best:

**Fluorescence In Situ Hybridization (FISH):** Checks for chromosomal abnormalities like deletions (17p or 13q) that influence the outlook.

**IGHV Mutation Analysis:** Determines if the immunoglobulin gene is mutated. A mutated IGHV generally indicates a slower-growing form of the disease while an unmutated type is more aggressive and doesn't respond to chemotherapy but responds to targeted treatments.

**TP53 Mutation Testing:** Identifies mutations that may make the cancer resistant to standard chemotherapy.

## TESTS FOR STAGING

**Physical Exam:** A doctor feels for enlarged lymph nodes, liver, or spleen.

**Imaging (CT or ultrasound):** Not always required, but checks for internal enlarged organs or nodes if symptoms are severe.

**Bone Marrow Biopsy:** While not strictly necessary for diagnosis, it may be done to see how much of the marrow is involved before starting treatment.

**Once a diagnosis is made, you'll be assessed by a clinical haematologist or medical oncologist.**

- **1/3 require treatment at diagnosis:** You already have symptoms or blood counts that meet the criteria for active disease.
- **1/3 will eventually require treatment:** You don't have symptoms, so you start in *Watch and Wait* but become symptomatic or show disease progression, such as rapidly rising white cell counts or falling haemoglobin later in life.
- **1/3 will never require treatment:** You have a very slow-growing form of disease and may live a normal lifespan, eventually passing away from causes unrelated to CLL.

## WATCH AND WAIT

Watch and wait is an active process, not a passive one. You'll typically have:

- **Regular check-ups:** These usually occur every three to six months initially, though they may become less frequent if the disease remains stable.
- **Blood tests:** Monitoring trends in your CBC, specifically looking at white blood cell counts, platelets, and haemoglobin.
- **Physical exams:** Doctors check for swelling in your lymph nodes (neck, armpits, groin) and spleen.

## TARGETED THERAPIES

- Treatment is typically divided into ***fixed-duration therapy*** (taken for a set period, like one year) and ***continuous therapy*** (taken indefinitely). The choice is a major decision point. Neither is objectively better for every patient; instead, they offer different lifestyle and clinical benefits.

### FIXED-DURATION THERAPY

Examples: venetoclax + obinutuzumab (1 year) or venetoclax + ibrutinib (15 months).

**PROS**

- **Treatment-free interval:** Allows you to finish therapy and live life without daily CLL medication.
- **Lower resistance risk:** Finite exposure reduces the chance of cancer cells developing mutations to the drug.
- **Deep remission:** Higher rates of Undetectable Measurable Residual Disease (uMRD).

**CONS**

- **Intensive start:** Requires a logistically complex five-week ramp-up and IV infusions (obinutuzumab).
- **Relapse risk:** Disease may eventually return once treatment stops, requiring future monitoring. High-risk limits: may be less effective for those with 17p deletion or TP53 mutations compared to continuous drugs.
- **Renal issues:** Not suitable for patients with significantly impaired kidney function due to tumour lysis syndrome (TLS) risk.

### CONTINUOUS THERAPY

Examples: zanubrutinib, acalabrutinib or ibrutinib.

**PROS**

- **Simplicity:** Typically involves taking 1–2 pills daily without complex IV schedules or frequent hospital visits.
- **Proven for high-risk:** Often the preferred choice for patients with aggressive genetic markers like del(17p), TP 53, and unmutated IGHV. .
- **Immediate control:** Quickly brings high white blood cell counts down with fewer early-treatment risks like TLS.

**CONS**

- **Chronic side effects:** Long-term use can lead to hypertension, bleeding, or atrial fibrillation.
- **Drug resistance:** Continuous exposure can pressure cancer cells to mutate, making the drug stop working overtime.

5 6 7 8

## TREATMENT

Treating CLL isn't based on the diagnosis alone, but on the presence of active disease.

**Treatment is triggered by symptoms, such as:**

- **B-symptoms:** Unintentional weight loss (>10% in six months), drenching night sweats, or persistent fevers.
- **Marrow failure:** Worsening anaemia (fatigue/shortness of breath) or low platelets (easy bruising/bleeding).
- **Physical changes:** Massive or painful enlargement of the spleen or lymph nodes.
- **Autoimmune issues:** Anaemia or low platelets caused by the immune system (AIHA/ITP) that don't respond to standard steroid treatment.
- **Extranodal involvement:** CLL cells affecting other organs like the skin, kidneys, or lungs.
- **Lymphocyte doubling time (LDT):** An absolute lymphocyte count that increases by more than 50% in two months or doubles in less than six months.

### CHEMOTHERAPY VS TARGETED THERAPIES

Modern treatment has shifted away from traditional chemotherapy toward targeted therapies that specifically attack cancer cells with fewer side effects.

While chemotherapy attacks all rapidly dividing cells, targeted therapies target specific proteins or pathways that allow CLL cells to survive and have fewer side effects.

- **Chemotherapy:** Non-specifically kills fast-growing cells (cancer, hair, gut, blood).
- **Targeted treatments:** Targets specific mutations or proteins (BTK, BCL-2) to stop cancer growth while sparing more healthy cells.

### ADMINISTRATION & DURATION

- **Chemotherapy:** Usually delivered via IV infusions in fixed cycles (six months).
- **Targeted treatments:** Taken as a daily pill (maintenance) or fixed-duration oral/IV combinations.

### EFFICACY

- **Chemotherapy:** Less effective for high-risk patients (those with TP53, del(17p) mutations or unmutated IGHV CLL). Used mainly in young, fit patients with mutated CLL.
- **Targeted treatments:** Shown to be superior in nearly all clinical trials, offering longer remission and better survival even in high-risk groups.

### SIDE EFFECTS

- **Chemotherapy:** Severe cytopenias, hair loss, nausea, vomiting, infections, risk of myelodysplasia.
- **Targeted therapies:** Irregular heartbeat, hypertension, bleeding.

## Did you know?

**Early treatment of asymptomatic CLL hasn't been shown to improve survival.**

## SUPPORTIVE THERAPIES AND SCREENING

Patients with CLL have a significantly higher risk of developing secondary cancers, particularly skin, lung, and prostate, due to long-term immune system dysfunction. Standard cancer screening should be followed, but with critical modifications to account for this increased risk.

### SUPPORTIVE THERAPIES

Because the cancerous B-cells don't function correctly, the immune system is weakened, making patients more susceptible to infections. To minimise infections, the following are recommended:

- Vaccines: flu, pneumonia, and shingles.
- For severe recurrent infections, immunoglobulin infusions are considered.
- Rarely prophylactic antibiotics and antivirals are considered.


*References*

- *Blood Cancer United (formerly Leukemia & Lymphoma Society) booklet on CLL*
- *Mayo Clinic guide on CLL for patients*
- *CLL Society guide for patients*
- *Cleveland Clinic CLL guide for patients*



This patient journey is sponsored by BeOne Medicines South Africa in the interest of education, awareness, and support. The content and opinions expressed are entirely the HCP's own work and not influenced by BeOne Medicines in any way.


BeOne



# Understanding G-CSF and bone pain

**Dr Jasmine Ramiah eases the distress of experiencing bone pain after receiving a granulocyte colony-stimulating factor injection.**

Granulocyte colony-stimulating factor (G-CSF) is one of oncology's silent yet impactful heroes. There are several indications and whether used after chemotherapy or for stem cell mobilisation, G-CSF significantly reduces the risk of febrile neutropenia (fever and low neutrophil count) or termed neutropenic sepsis by stimulating the bone marrow to produce neutrophils. There are, however, unwarranted uncomfortable side effect profiles which include bone pain.

## WHAT IS G-CSF?

G-CSF is a haematopoietic growth factor implicated in proliferation and differentiation of neutrophil precursors in the bone marrow. Common preparations include filgrastim, lenograstim, and pegfilgrastim.

The indications for these agents include the routine administration following myelosuppressive chemotherapy to reduce infection risk and maintain dose intensity.

By accelerating bone marrow recovery, G-CSF allows you to recover your individual white cell count (WCC) therefore resuming the chemotherapeutic regimens. This, however, comes at a price and your clinician needs to balance the clinical indication versus toxicity profiles.

## WHY DOES BONE PAIN OCCUR?

Bone pain associated with G-CSF is reported, according to the literature, in up to 20–40% of patients and is dependent on both the dosing and formulation. The pathophysiology is not fully elucidated, but several mechanisms are proposed:

1. **Marrow expansion:** G-CSF stimulates rapid proliferation of granulocyte precursors. This increased cellular activity within the confined medullary expanse may raise intraosseous pressure, resulting in discomfort.
2. **Cytokine release:** G-CSF induces secondary inflammatory mediators, such as interleukins and prostaglandins, which may sensitise nociceptors within bone causing discomfort and pain.
3. **Stem cell mobilisation effects:** In higher-dose settings (peripheral blood stem cell collection), pain may be more pronounced due to intense marrow stimulation.

The pain typically described by patients is a deep, aching, or pressure-like sensation and most commonly affects the sternum, pelvis, lower back, and long bones; areas rich in proliferative capacity and active marrow.

## WHEN DOES IT HAPPEN?

The symptoms typically occur within 24–72 hours of administration and may last several days. Pegylated formulations, due to their longer half-life, can produce more prolonged symptoms in some patients.

Importantly, patients must be informed that the bone pain is generally self-limiting and not indicative of pathology, such as metastases, but rather indicative of the activity of the drugs.

The utility of G-CSF is limited in myeloid malignancies owing to the potential stimulation of the initial clone.

## MANAGEMENT STRATEGIES

Reassurance is key. Educating patients before administration significantly reduces anxiety if pain develops and assists with tolerance.

First-line treatment typically includes paracetamol (acetaminophen) and non-steroidal anti-inflammatory drugs (NSAIDs) if platelet count allows and may be escalated according to the pain ladder.

In cases of more severe discomfort, antihistamines such as loratadine have been explored, based on the hypothesis of histamine-mediated pathways, though evidence remains mixed. Short courses of opioids may be considered in select patients bearing in mind the side effect profiles.

## CONCLUSION

While G-CSF-related bone pain can be distressing, it is usually transient and manageable for the majority of patients.

Importantly, its presence reflects active marrow recovery rather than a pathological process, such as metastases or disease recurrence, and may be viewed as a positive sign that the body is responding to treatment.

Proactive education, early symptom management and intervention, and reassurance remain the cornerstone in optimising patient experience during supportive oncology care.



## 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.

Image by freepik.com

# Composing a new chapter

## Graeme Sacks shares how music has been his healing companion through years of living with Hodgkin lymphoma.



Image supplied

**Graeme Sacks (57) lives in Johannesburg, Gauteng with his wife.**

Music is a big part of Graeme's life; he had a successful career as a professional musician until he was diagnosed with Hodgkin lymphoma (HL) in 2012. However, the song didn't end there. Throughout the 13 years of relapses and new treatment regimens, music was a constant which instilled calm, gave him hope, and helped his healing process. This prompted him to return to university, in 2017, and complete a Master's in Music Therapy. He now uses music to help others.

### HODGKIN LYMPHOMA DIAGNOSIS

For over a year, Graeme consulted various GPs as he had flu-like symptoms, fatigue, and difficulty breathing. In 2012, he was rushed to casualty as he was unable to breathe properly and was diagnosed with Hodgkin lymphoma (HL).

"I was X-rayed for the first time and the growth showed up on the scan. The tumour was pushing against my superior vena cava (known as SVC syndrome) which prevented blood from being drained from my brain; my head had swelled up constricting my breathing," Graeme explains.

In spite of the diagnosis, Graeme was partly relieved to have found out why he had been feeling sick for so long. "I had put my exhaustion and illness down to burnout and overwork. It was good to know that it wasn't my fault. But I was also terrified. You don't know anything about cancer until it affects you. I had heard the terms chemotherapy and radiation before, but I had no understanding of what they actually entailed."

### 13 YEARS OF ONGOING TREATMENT AND RELAPSES

Graeme first received the standard first-line treatment for HL which is a combination chemotherapy protocol. The side effects were nausea, fatigue, and chemo brain.

Within six months, Graeme relapsed and had to start a new treatment plan. For the past 13 years, due to the advanced stage disease, he has had ongoing relapses and undergone various treatments: broad-spectrum radiation followed by another combination chemotherapy protocol for three months. Unfortunately, he had to stop this protocol due to severe side effects.

He then had a small tumour surgically removed, followed by targeted radiation. This remission was short-lived too.

In 2016, Graeme had an autologous (using own cells) stem cell transplant which was unsuccessful. He was then prescribed an immune checkpoint inhibitor (ICI), a type of immunotherapy, for two years which put him in remission for six years.

In late 2024, Graeme relapsed again and was put on an antibody-drug conjugate, a targeted therapy, for a year. A partial response was seen at first but later declined.

### PSYCHOSOCIAL SUPPORT AND WELL-BEING

Graeme admits that the ongoing relapses have been extremely tough on his mental health. "I have an amazing therapist and couldn't get through any of this without her. I feel it's so important to have someone to talk to who isn't a friend or family. Therapy has been life-changing and has taught me how to be a better human and how to function better in the world. It was also one of the reasons I decided to study further and become a therapist myself," Graeme says.

"My wife has played a huge role too. We've developed a relationship where we communicate safely on any topic, no matter how difficult or uncomfortable. Meditation has helped and so has mild exercise. I'm not a sporty person and don't do gym but I enjoy long walks. I've tried to get over the guilt of not exercising or meditating when I'm not up to it or too busy."

He adds, "Studying music therapy has also taught me coping skills that I use both with my clients and for my own benefit. With that said, there are times when I feel despair and like giving up. I really abhor the hero narrative associated with cancer patients and survivors. I'm human, I'm vulnerable and sometimes it just becomes too much to deal with. We don't have to feel strong all the time."

### CURRENT TREATMENT PLAN

Graeme is currently on another immunotherapy ICI, and has recently completed 18 cycles of targeted radiation. He is waiting to undergo an allogeneic (using cells from a donor) stem cell transplant. This is dependent on finding a suitable donor (his family member wasn't a full match) and medical aid authorisation. His hope is that it will take place in the next few months.

### UNNECESSARY, ADDED STRESS

Sadly, Graeme says that in some ways his medical scheme has caused him more stress and anxiety than the cancer. "They have covered a lot, but not without endless fights and hours on hold on the phone. I pay nearly R20 000 a month for medical aid and at the moment I'm still paying R4000 per treatment and many other co-payments. There are amazing new treatments available today, but the pharmaceutical companies charge exorbitant fees for them. Medical schemes make enormous profits and have no real concern for their clients' well-being."

### HOW MUSIC HAS HELPED

"Music has been a crucial part of my recovery and mental health. Listening to music in hospital helped me to connect with my childhood and family memories. I went for singing lessons with a friend during recovery and discovered the absolute joy of using my voice. It was calming and empowering (and encourages healthy breathing habits)," Graeme explains.

"I often improvise freely on guitar or vocals without any goals or judgement. The music sometimes comes out angry and dissonant, sometimes sad and mournful, and other times beautiful and joyful. It's all a reflection of my state and it often gives me insight into myself. I also write songs. Both my cancer and my music therapy studies have deepened my songwriting and my playing."

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# Tumour lysis syndrome: too fast, too furious



**Dr Romana Jassat explains tumour lysis syndrome and the treatment typically used to manage it.**

Cancer therapies are evolving at a rapid pace. Modern therapies are now more powerful than ever before, targeting tumours with precision and often producing dramatic and impressive results. While we celebrate and marvel at the advancements in cancer care, we are often reminded of the double-edged nature of cancer therapy that physicians are faced with: the delicate balancing act between fighting cancer effectively and minimising the risk to those we treat.

Tumour lysis syndrome (TLS) is an anticipated but serious side effect of cancer treatment. It's an oncological emergency that occurs when large numbers of cancer cells break down (usually at the start of therapy), releasing their cell contents into the bloodstream. Tumour lysis syndrome often develops quickly, hence early detection, monitoring, and instituting preventive measures are essential to prevent long-term consequences.

## HOW EXACTLY DOES IT OCCUR?

Cancer cells, much like all living cells, contain elements such as potassium, phosphate, nucleic acids, and uric acid. All cancer therapy is aimed at killing cancer cells. However, when this occurs rapidly, the surge of these substances flooding the bloodstream may overwhelm the body's regulatory mechanisms and this can have serious and dramatic consequences.

This is particularly true for haematological cancers, especially those that are high-grade (aggressive in nature), rapidly dividing (fast-growing cancers), and are known to be chemo-sensitive (known to quickly and effectively respond to a certain chemo regimen). Patients who have pre-existing kidney problems, the elderly, or those with large and bulky disease are known to be at risk for the development of tumour lysis syndrome.

## WHAT ARE THE SIGNS TO WATCH OUT FOR?

Initial bloodstream abnormalities will be detected by your doctor on routine monitoring. These include metabolic derangements, such as an elevated potassium (hyperkalaemia), elevated phosphate (hyperphosphatemia), decreased calcium (hypocalcaemia), and an elevated uric acid level (hyperuricaemia). It's important for your doctor to recognise these abnormalities on routine blood testing earlier rather than later, as these may serve as warning signs for what is to come.

## WHAT ARE THE SERIOUS COMPLICATIONS FROM TLS?

The cornerstone of tumour lysis syndrome treatment is early recognition by your healthcare provider. If some of the earlier signs are missed, this may result in serious consequences such as heart rhythm abnormalities (arrhythmias), seizures as well as the development of kidney failure. These complications can be avoided by being cognisant of the earlier bloodstream abnormalities (biochemical changes) which often precede the more serious clinical manifestations.

## PREVENTION AND MANAGEMENT OF TLS

A key element in the initiation of chemotherapy should include a formal assessment and evaluation to identify any potential risk factors for the development of tumour lysis syndrome. The subtype of cancer (high-grade lymphomas, Burkitt lymphoma or acute leukaemia) may also assist in this stratification.

The adage *prevention is better than cure* still rings true in this setting, where aggressive hydration with fluids to flush out substances before they crystallise in the kidneys is essential. In addition, prompt management of elevated uric acid levels with appropriate drugs is equally important. Allopurinol and rasburicase are both used to control uric acid but have different mechanisms of action. Allopurinol prevents the formation of new uric acid while rasburicase breaks down existing uric acid into a substance that is easily eliminated by the kidneys. It's also essential to notify a specialist renal physician earlier rather than later, should there be evidence of kidney damage as dialysis may be necessary in some circumstances.

## FINAL THOUGHT

Tumour lysis syndrome reminds us that progress in cancer care comes with new and unique challenges. As therapies advance and become more effective, the ability to deal with the side effects and complications from these very therapies should also evolve. As healthcare professionals, we have a responsibility to our patients to anticipate, recognise, and manage these complications, and in so doing, provide holistic cancer care.



**MEET THE EXPERT**

**Dr Romana Jassat** is a specialist physician and clinical haematologist who completed her training at the University of the Witwatersrand. She practices at Alberts Cellular Therapy (ACT), Pretoria East, and consults weekly at the ABJ Oncology practice in Vereeniging.

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# Control fluid, control diarrhoea.

- **Racecadotril** has a ***rapid onset of action*** after the thirtieth minute of administration.[1,6]
- **Racecadotril** has ***no effect*** on intestinal transit.[2,5]
- **Racecadotril** has proven efficacy with good tolerability.[2,3,6]
- **Racecadotril** plus ORS is effective in the management of acute diarrhoea.[4]
- **Racecadotril** is a more effective adjuvant than smectite or probiotics for acute diarrhoea in children < 5 years old.[7]
- **Racecadotril** plus ORS improves recovery rate vs ORS alone or with placebo.[1,8]
- **Racecadotril** is a supplement therapy for treatment of acute diarrhoea in children.[1,4]
- **Racecadotril** has similar efficacy to loperamide with fewer adverse events, including rebound constipation.[2,3,6]




**ORS:** oral rehydration solution.

**References: 1.** Eberlin M, Mück T, Michel MC. A comprehensive review of the pharmacodynamics, pharmacokinetics, and clinical effects of the neutral endopeptidase inhibitor racecadotril. Frontiers in pharmacology. 2012 May;3:93. **2.** Prado D. A multinational comparison of racecadotril and loperamide in the treatment of acute watery diarrhoea in adults. Scand J Gastroenterol. 2002;37(6):656-661. **3.** Vetel JM, Berard H, Fretault N, et al. Comparison of racecadotril and loperamide in adults with acute diarrhoea. Aliment Pharmacol Ther. 1999 Dec;13(Suppl 6):21-26. **4.** Gallelli L, Colosimo M, Tolotta GA, et al. Prospective Randomized Double-Blind Trial of Racecadotril Compared with Loperamide in Elderly People with Gastroenteritis Living in Nursing Homes. Eur J Clin Pharmacol. 2010;66(2):137-144. **5.** Schwartz JC. Racecadotril: a new approach to the treatment of diarrhoea. Int J Antimicrob Agents. 2000;14(1):75-79. **6.** Lecomte JM. An overview of clinical studies with racecadotril in adults. Int J Antimicrob Agents. 2000;14(1):81-87. **7.** Gutiérrez-Castrellón P, Ortíz-Hernández AA, Llamosas-Gallardo B, et al. Efficacy of racecadotril versus smectite, probiotics or zinc as an integral part of treatment of acute diarrhea in children under five years: A meta-analysis of multiple treatments. Gac Méd Méx. 2015;151:329-337. **8.** Guarino A, Ashkenazi S, Gendrel D, et al. European Society for Pediatric Gastroenterology, Hepatology, and Nutrition/European Society for Pediatric Infectious Diseases evidence-based guidelines for the management of acute gastroenteritis in children in Europe: update 2014. Journal of pediatric gastroenterology and nutrition. 2014 Jul;59(1):132-152.

**HIDRASEC® Infants 10 mg** granules for oral suspension. Each sachet contains 10 mg of racecadotril. **Registration Number: South Africa:** S1 47/11.9/0011. **HIDRASEC® Children 30 mg** granules for oral suspension. Each sachet contains 30 mg of racecadotril. **Registration Number: South Africa:** S1 47/11.9/0012. **HIDRASEC® Adults 100 mg** capsules. Each capsule contains 100 mg of racecadotril. **Registration Number: South Africa:** S1 47/11.9/0013.

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# Bone health and fitness for treatment in older adults

**Dr Lara Greenstein and Dr Garrick Laudin highlight the key factors for caring for older adults with cancer.**

People are living longer and are therefore more likely to live with cancer for longer or be diagnosed and treated at an older age. Cancer care isn't solely about treating the malignancy itself, but rather caring about the whole person and ensuring that you're fit enough to tolerate therapy and recover from side effects.

Chronological age alone shouldn't decide cancer treatment. Many older adults are strong and independent, while others have a reduced physiological reserve known as frailty. This means that an illness, a fall, or treatment can have a much bigger impact than expected. Frailty is not synonymous with chronological age.

## FITNESS READY

Improving your fitness for treatment can make a meaningful difference. Even small interventions can help you tolerate treatment better and recover more quickly.
Key areas include:

- Physiotherapy or exercise programmes
- Nutritional support
- Optimising chronic illnesses
- Falls prevention strategies

## BONE HEALTH

An often-overlooked aspect of cancer care in the older adult is bone health. Bones become weaker and thinner with age and sometimes the cancer itself or the treatment thereof exacerbates this problem.

Weaker bones increase the risk of having a fracture, even after a fairly minor trauma. A fracture can be devastating for an older adult, leading to immobility, hospitalisation, chronic pain, and the inability to live independently.

Weak bones result from several factors, including reduced mobility, steroid use, poor nutrition, vitamin D deficiency, and cancer spread to bone.

Many are unaware that they have osteoporosis (bones gradually lose strength, often without pain or symptoms) until a fracture occurs. Cancer and cancer treatment can worsen bone loss, making early recognition and treatment essential.

Protecting bone health supports strength and mobility during treatment. Practical steps include:

- Eating balanced meals with adequate protein and calcium.
- Maintaining vitamin D levels, often with supplementation.
- Participating in gentle weight-bearing and strengthening exercise.
- Reducing fall risk by addressing balance, vision, dizziness, and home hazards.
- Reviewing medications that may increase falls or bone loss.
- Treating osteoporosis when diagnosed.

Caring for older adults with cancer means looking beyond the diagnosis. By considering strength, mobility, bone health, and daily function, care can be tailored to support safety, independence, and treatment aligned with what matters most to each person.

## BLOOD CANCER AND THE OLDER PATIENT

Most blood cancers are seen in older patients, with a median age at diagnosis of 69 years reported in 88 167 patients from a European patient registry (HAEMACARE). The most common lymphoid cancers were multiple myeloma, chronic lymphocytic leukaemia, and diffuse large B-cell lymphoma, whereas the most common myeloid malignancies were acute myeloid leukaemia, myeloproliferative neoplasms, and myelodysplastic syndromes.

Given the older median age of patients with blood cancer, they remain underrepresented in clinical trials and subsequent decisions about treatment in the day-to-day setting are complex and challenging. However, as more older patients are enrolled in clinical trials, the body of evidence related to their treatment becomes clearer, and older patients may therefore receive more intensive treatment based on their physical fitness.

## GOALS AND APPROACH

A 2018 review article from *The American Society of Haematology* provides practical goals and an approach for assessing frailty and treatment in older patients with blood cancers:

- Stage the patient's age: This includes actively screening and quantifying frailty with disease specific assessment tools like the Geriatric Assessment in Haematology (GAH) tool and the International Myeloma Working Group Frailty Index (IMWG FI).
- Tailor treatment goals and treatment plans: Specific chemotherapy for older patients may require adjustment in doses to prevent toxicity, particularly heart toxicity. Patients who are fit and healthy should receive treatment with the intent to cure.
- Improve strength and nutrition: Treatment and multi-disciplinary support in the key areas listed above.
- Screen and address social support
- Reduce polypharmacy (concurrent use of multiple medications (typically five or more) by a single patient).
- Screen and assess cognitive impairment.

By systematically addressing aspects of frailty, comorbidities, and social factors, your doctor can improve treatment tolerance, reduce complications, such as fractures and falls, and enable appropriately intensive therapy based on your physiological fitness rather than just chronological age.



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**MEET THE EXPERT**

**Dr Lara Greenstein** is a geriatrician at Helen Joseph Hospital in Gauteng. She is the vice president of the SA Geriatrics Society and the Academic Head of Geriatric Medicine at the University of the Witwatersrand. She has a passion for teaching.

**MEET THE EXPERT**

**Dr Garrick Laudin** is a specialist physician and clinical haematologist affiliated with The University of the Witwatersrand, who currently practices at Chris Hani Baragwanath Academic Hospital. His special interests are the hyperinflammatory syndromes associated with haematological malignancies, the haemolytic anaemias, and bone marrow failure syndromes.

# My grief and I have commitment issues

**Bonni Suckling reflects on how removing a sentimental silver necklace became a quiet step forward in her ongoing journey with grief.**




My grief and I have been in a long-term relationship. Fifteen years. At this point we should probably have matching tattoos and a joint savings account. But lately things have been tense between us.

The current conflict started with a silver necklace. For fifteen years, my son's name, Jed, has rested against my chest on a little silver chain. This name pendant that has seen things: hospital corridors, triathlons, marathons, and plenty of very ordinary days. It has bounced on my chest and quietly told the world: there is a boy called Jed in my life. It has been my constant.

Years ago, when I was a bridesmaid for my little sister, I quietly asked her if I should take off my necklace. I knew the wedding party was meant to look the same. She took my hand, looked right at me, and said softly, "You have the most beautiful necklace, please wear it." I have never forgotten that.

My fingers know exactly where to find Jed's name without looking. Like checking for your phone. Without meaning to, I turned it into my own small fidget spinner.

Except recently…the necklace started annoying me. Not emotionally. Physically.

After fifteen years of loyal service, the links are worn, and the metal has started picking fights with my skin. Sharp little jabs from broken links. Continuously. I'm not built for pokey things. I remove clothing labels and perform emergency wardrobe surgery for an annoying tag.

So, this necklace situation became complicated. At first, I did what any reasonable grieving mother would do. I ignored it. Because obviously the correct response to being repeatedly stabbed in the collarbone by your child's memorial jewellery is to suffer quietly and carry on. Emotional logic.

But the necklace was persistent. Poke. Poke. Poke. Scratch. Scratch. Scratch.

## NAKED, EXPOSED, AND FULL OF GUILT

And so…one night, very quietly, very reluctantly…I took it off. I felt exposed and naked. Vulnerable. Empty. I sat on my cold bedroom floor, crying for a long time afterwards. Bubble snot moment.

Friends…the guilt. The moment that necklace left my neck, my grief sat bolt upright and said, *Oh. So, this is what we're doing now? Moving on, forgetting.*

Suddenly my brain was hosting a full irrational meeting, voices, loud and internal.

*How can you take off his name? What kind of mother does that? You are over it, at least people will "think" you are. Confirmation, you have moved on.*

Grief doesn't believe in reasonable explanations. It doesn't care about worn metal links or sensory issues. It would very much prefer you always remain visibly heartbroken, just to be safe.

But here is the honest part. Alongside the guilt, was relief. Not emotional relief. Physical relief. My neck was suddenly naked and, quite frankly, living its best shamelessly poke-free life. I have more freckles than I remember on my chest.

It turns out you can love your child with your whole shattered heart and enjoy not being repeatedly stabbed by jewellery. Who knew?

## THE SMALL SHIFTS

If you are reading this while carrying your own loss (your husband, wife, child), you may recognise this strange terrain. Not the necklace specifically. But the moment when something small shifts. When you pack away the hospital file. When you move their shoes. When you move your dad's floating trophies (the ones he bragged about your whole life) to the garage. Their precious things.

Then you must sit down afterwards because your hands won't stop shaking. Parts of your person leaving the nest. Memories in files, shoes, trophies, necklaces. It feels disloyal. As if grief is standing in the corner with its arms folded.

For a long time, I believed my grief required visible proof. Proof I was still Jed's mother. Proof that my love hadn't softened with time. The necklace became part of that proof.

Taking it off, even for the most practical and slightly stabby of reasons, felt loaded with meaning my rational brain knew wasn't entirely fair.

## LOVE DOESN'T LIVE IN THEIR THINGS

What I'm learning, very slowly and gently is this: love doesn't live in the metal. Jed isn't more present when the necklace is on. He isn't less loved when it's off. He lives in the permanent rewiring of my heart, in the way I still notice the small-boy energy in hospital wards, and in my work that grew from the crater his life left behind.

If you've ever felt guilty for a small step forward. If you've ever removed the necklace, packed away their toys, or given away the clothes of someone you love more than oxygen, please hear this from someone who has sat in that exact tender space: Your love isn't measured by what you wear or what you keep. Your healing isn't a betrayal. Your person isn't kept alive by your suffering. Maybe, your ache has softened into something tidy or inspirational. Present but neat.

Loving our people changes the architecture of our hearts but our commitment to them remains beautifully stubborn.



### 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.

# What dogs can tell us about early detection

**Dr Andrew Robson shares insight on compensation in sick dogs, which highlights how important early detection is.**



## ANIMALS ARE MASTERS OF ADAPTATION

In veterinary medicine, the term compensation is often used. The quiet ways animals adjust long before disease becomes obvious. A dog developing arthritis doesn't wake up one morning suddenly lame. Instead, the signs build gradually. They hesitate before jumping into the car. They sleep a little more. They avoid stairs. They become slower.

Yet when the diagnosis is made, owners often say, "But it happened so quickly." In reality, it didn't. The disease had been brewing for months, sometimes years. The dog was coping. Adjusting. Compensating, until it could no longer hide it.

Cancer in humans can follow a similar pattern. Early disease rarely arrives dramatically. It appears in small changes, persistent fatigue, unexplained weight loss, altered appetite, a new lump, a change in bowel habits, a cough that doesn't resolve. These symptoms are often subtle at first. The body adapts. Life continues. We explain things away: stress, ageing, being busy.

Then, when a diagnosis is made, it can feel sudden. Rapid. Out of nowhere. But often, it has been developing quietly.

One of the most important lessons animals teach us is that small changes matter. In veterinary consultations, when an owner says, "He's just not himself," we pay attention. That sentence frequently precedes a meaningful diagnosis. Subtle behavioural or energy shifts are early indicators that something deeper may be happening.

## EARLY DETECTION

You are allowed to take your own subtle changes just as seriously.

Early detection is not about anxiety or hypervigilance; it's about awareness and consistency, responding to persistent changes rather than dismissing them, and participating in recommended screening, even when you feel well.

National screening guidelines are designed to detect cancer before it becomes advanced. Mammograms for breast cancer, Pap smears for cervical screening, colorectal cancer screening from midlife onward, discussions around prostate screening, and low-dose CT scans for high-risk smokers all exist to identify disease in its earlier stages.

Screening does not prevent every cancer, but it significantly improves the likelihood of finding it sooner, when treatment options are broader, and outcomes are often better.

In animals, routine health checks allow us to pick up small masses before they ulcerate or metastasise, weight loss before it becomes severe, and dental disease before full mouth extractions are necessary to curb decay and infection. Early detection is rarely dramatic. It is the result of paying attention over time.

Fear can delay that attention. Many people avoid screening or postpone medical appointments because they are afraid of what might be found. That reaction is deeply human. But in both veterinary and human medicine, we see repeatedly that earlier diagnosis usually offers more choice.

## CHOICE MATTERS

Dogs remind us that illness often begins in whispers, not loud Grey's Anatomy type emergencies. The question is not whether every small change is serious because most are not. The question is whether you are willing to notice patterns, to act when something persists, and to value prevention as much as treatment.

What feels sudden is often simply the moment compensation ends.





### 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.

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