

Issue 65 | August–September 2026

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conversations
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GRIEF

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MY
STORY

**Nkamo
Mpakanyane**

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WELCOME

by Laurelle Williams

This issue is all about **Green = Growth**. And let's be honest, real growth as a human being is often one of the most uncomfortable processes you'll ever experience. It stretches, challenges, and pushes you far beyond your comfort zone, but it's also where lasting transformation happens. Nkamo Mpakanyane's cancer journey is a powerful example of this. Despite years of misdiagnoses, she discovered an inner strength that had always been there. Read *Delayed but not denied*.

What I love most about writing is that you can assign a topic expecting a certain narrative, only to receive an article that takes it in a completely different direction. And often, it's different in the most beautiful way. It's a wonderful reminder that no two minds see the world in the same way. Each person brings their own experiences, perspectives, and voices, and that's where the heart of storytelling lies. Thank you to Dr Memory Bvochora-Nsingo for doing this in *An oncologist's story of burnout*.

How grief plants the seeds of who we are next is one of my favourite articles. I may be biased because I'm a runner, but running is still helping me deal with grief. Bonni Suckling, you're a treasure!

May you welcome growth as an ongoing verb in your life.

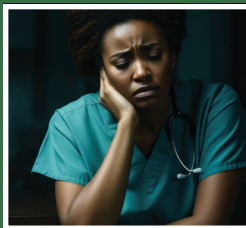
Green is a process, not a status. We need to think of 'green' as a verb, not an adjective.
– Daniel Goleman

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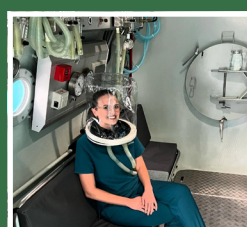
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PUBLISHED BY:
Word for Word Media
Florida Park, Gauteng
Tel: 011 763 5790
www.wordforwordmedia.co.za

DISTRIBUTED COURTESY OF:



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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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An oncologist's story of burnout

Dr Memory Bvochora-Nsingo explains that her burnout comes from working a job that never truly switches off.



I love my morning coffee. Every morning before work, I walk into the boardroom at Gaborone Private Hospital, sit with my colleagues, and allow the day to begin with laughter. Not polite laughter — real loud laughter. Many days, I'm one of the loudest people in the room. My colleagues often ask, "Ngaka, why are you always so jovial?" The truth is, I'm happy for many reasons.

I have patients who survived. Patients who were once very sick but are now in remission, with clear scans. Some who were carried into hospital, later walked out by themselves. They return smiling, breathing better, bleeding less, eating better, and living longer. These successes bring me genuine joy.

So no, I'm not burnt out because of my patients' deaths. Of course, losing a patient is painful. Every death leaves a name and a family. But today, I want to talk about the patients who live. That is what many people outside oncology don't always understand. They imagine the heaviness of this work comes only from death. But that isn't the full truth.

A lot of my patients live. And sometimes, that is exactly where the burnout begins.

FAR FROM WORK BUT STILL WORKING

Recently, I was sitting in a conference room in Spain. I was learning from colleagues, admiring new advancements, and imagining how we might bring some of those possibilities home. I wasn't wearing my hospital coat. I was in jeans and a T-shirt, far from the rush between patients and chemotherapy infusions.

Then my phone lit up. "Dumela Ngaka, remember we gave Kabo chemotherapy on Thursday? I've admitted her. She has a fever."

In an instant, Spain disappeared. The conference room, the slides, the

conversations — all gone. I was back with my patient, facing the consequences of my treatment decisions. I replied quickly, "What are her white cell counts?"

"Zero, Ngaka."

Zero. A number that can silence any room. Her white cells had been 3.5 when I ordered treatment. I had seen the result, weighed the risk, and made the call. Now, while I sat in Spain, my patient was fighting a fever with no white cells to protect her.

That was painful. The conference continued around me, but I was no longer fully there. Speakers presented, people networked, yet for the rest of the event I carried Kabo with me; texting updates about her temperature, antibiotics, cultures, blood pressure, pulse, and repeat blood tests. Part of me remained at her bedside.

THIS IS BURNOUT

Burnout isn't always a dramatic collapse. Sometimes it's sitting in a beautiful country at a professional conference, dressed casually, yet unable to relax. It's being physically away from work, but unable to leave the work behind.

The deeper lesson came later. I learned Kabo had felt like she had the flu for three days before coming to hospital. In oncology, flu isn't always flu. A fever after chemotherapy is never something to watch casually. Weakness, chills, sore throat, diarrhoea, vomiting, or sudden unwellness can become life-threatening when white cells are low. Infections move fast.

I found myself asking difficult questions: Had I become too familiar with chemotherapy? Had routine made me less careful when explaining danger signs? Had experience made me too comfortable? Had I omitted a prescription for protecting white cells?

I asked these questions not because I believe I was careless, but because oncology must never become casual. Cancer treatment can rescue and control disease. It gives patients time, comfort, dignity, and many precious years with their families. But it demands respect every single time. When it goes wrong, it can be the last thing that happens to the patient.

This experience reminded me that informed consent must never be a mere formality. It's real protection for the patient. Before every treatment, I now slow down to ensure patients truly understand the purpose, benefits, risks, and especially the warning signs. They must know that calling early is never a disturbance; what feels like flu after chemotherapy can be an emergency. Silence can be dangerous.

MY PROPHYLAXIS AGAINST BURNOUT

This is my daily practice: I begin each morning with real laughter and coffee shared with my colleagues. I carry both caution and hope with me into the department, still smiling, still laughing, grateful that so many patients live, and committed to protecting them as best I can in a job that never truly switches off. ☺



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.



FEAR: conversations worth having

Julianne Yates explores why talking openly about fear with family and loved ones is an essential part of navigating a cancer diagnosis.

Fear is one of the most predominant feelings that accompanies a cancer diagnosis. Regardless of the stage, location, and prognosis, cancer stirs fear in everyone. For patients it may be the fear of treatment, side effects, even death. And for families of these patients, there is fear for their loved one, as well as fear for themselves regarding their ability to care for their loved one, or their inability to change what is happening.

FEAR OF TALKING ABOUT FEAR

Fear is prominent, and understandably so. But what strikes me most with patients and their families, is the fear of talking about fear. I have seen so many families who don't want to talk to their loved one about what they are afraid of. They don't want to bring up the what ifs and the worst-case scenario, even though they themselves are grappling with these thoughts.

Some patients also struggle to talk to their family about their own fears. These fears can range from fear of treatment side effects, fear of their own ability to stay strong and withstand what is to come, fear of looking different or being treated differently, and fear of scan results and bad news.

There is a natural (and beautiful) tendency to want to protect the people you love. And you may often do this by avoiding the difficult, scary conversations. Often family members say that they don't want to burden their loved ones by speaking about what scares them. They don't want to upset each other by speaking about their deepest fears.

While the intention is good, the outcome is often that it leaves people feeling alone. And being alone with your fear makes it even more frightening. We often hear *Just think positive, Stay strong, or Everything will be alright* and while these phrases can be helpful, they can also close the door on connection. What speaks with more love and acceptance is *It's okay to tell me anything, and whatever happens I'll be here with you.*

OPEN THE HARD CONVERSATIONS

The magic happens when conversations are opened; when family members or loved ones get to say what they really feel, even when it's hard to hear.

Being told about someone's fear doesn't mean you have to solve it. All you have to do is witness it and be with them in it, so they are no longer alone. Strength comes

when you feel that you are truly seen and supported, even in your hardest moments. To know that you are not alone in your fear tends to diminish it to some degree.

I encourage everyone, be it someone fighting cancer or those supporting someone with it, open the door to the hard conversations. Allow the fears to be spoken because everyone has them, and speaking about them doesn't burden others, it fosters connection.

If you don't have someone to talk to, please seek the help of a counsellor. Fear will be there, understandably, but so will love, joy, connection, and hope.



MEET THE EXPERT

Julianne Yates is a psychologist with a special interest in palliative counselling. She has the privilege of working with people who have life-altering and terminal illnesses. She is incredibly passionate about working with patients as well as their families to help them manage the emotional and social struggles that their illness might bring. Together with a multi-disciplinary team, she ensures that her patients are supported in every way throughout their journey.



CANSA marks 95 years by expanding care, support, and hope

From patient-centred care and screening to counselling, advocacy, and a new Care Home, CANSA's 95th anniversary reflects an organisation that continues to evolve to meet South Africa's cancer burden.

Founded in 1931, the Cancer Association of South Africa (CANSA) has grown into one of South Africa's leading cancer organisations, with a national footprint spanning research, education, advocacy, screening, care, and support.

"As CANSA celebrates its 95th anniversary, we honour the past with gratitude, we serve in the present with compassion, and we continue building for the future with hope and determination," says CANSA CEO Elize Joubert.

"This is a milestone that speaks not only to longevity, but to relevance, resilience, and continued impact," she adds.

FUTURE-FOCUSED

Joubert explains, "Today, we're not simply looking back at what we have achieved; we are actively building for the future."

A clear example is the establishment of a new CANSA Care Home in Pietermaritzburg, developed in response to a long-standing need for accommodation for out-of-town cancer patients receiving treatment in the region. The project follows the closure of the Schoonies Care Home in Richards Bay and is aimed at supporting patients who would otherwise struggle to access treatment because of the distance, cost, and practical burden of travel. For many patients travelling from distant parts of KwaZulu-Natal for

radiotherapy or chemotherapy, this kind of practical support can make the difference between completing treatment and defaulting on it.

This future-focused growth reflects CANSA's present-day mission: to ensure that no one affected by cancer has to face it alone.

PRACTICAL, EMOTIONAL, AND PSYCHOSOCIAL SUPPORT

Today, CANSA provides practical, emotional, and psychosocial support through Care Centres, virtual support platforms, screening services, counselling, support groups, public hospital Information and Support Desks, stoma support, medical equipment loans, wigs and prostheses, and assistance to vulnerable families. Its Tough Living with Cancer (TLC) programme also supports children, teenagers, young adults, and their families.

A cornerstone of this support is CANSA's Care Home network. In the past financial year alone, more than 2 000 patients stayed at CANSA Care Homes. During the same period, CANSA enabled home-based care for 965 patients and conducted over 2 000 home visits. TLC support provided accommodation to 779 parents and 189 children, while food parcels and toiletry packs were also distributed to families in need.

Counselling and emotional support remain central to CANSA's work. The organisation offers telephonic and virtual counselling in multiple languages, along with face-to-face and online support resources for patients, caregivers, and loved ones. Its latest service information shows that 1 920 patients were helped through 3 473 counselling and emotional-support sessions.

SCREENING AND EARLY DETECTION

Screening and early detection also remain key priorities. Across its Care Centres and outreach work, CANSA offers clinical breast examinations, Pap smears, prostate specific antigen (PSA) testing, skin examinations, and workplace wellness screenings. In the most recent reporting period, 8 709 cancer screenings were conducted, with 431 referrals made to health facilities for further follow-up and treatment.

"This ongoing work is strengthened through support from partners who share CANSA's commitment to improving cancer awareness, support, and access to care. Over the years, we have partnered with many organisations who have made us reach this milestone. Among these is AstraZeneca, whose grant funding support is helping to strengthen CANSA's visibility, outreach, and public education efforts in its



95th anniversary year. This includes support for branded visibility materials, educational resources, expanded outreach platforms and awareness initiatives designed to increase recognition of CANSA's services and extend its reach into communities that need them most," states Joubert.

CONTINUOUSLY EVOLVING

As much as CANSA's services are rooted in care, the organisation has continued to modernise the way it educates and connects with the public. In 2025, CANSA launched its WhatsApp Channel as a trusted platform for sharing credible cancer-related information, updates, and support.

It has also expanded its public education offering through its 'On the CANSA Couch' podcast series, which shares practical insights into lowering cancer risk, informed lifestyle choices, and patient care. Products that bear the CANSA Seal of Recognition are also featured on this podcast to raise consumers' awareness regarding products that lower cancer risk.

Recent campaigns further show how CANSA continues to evolve its awareness work in relevant and engaging ways. These include the PEP and CANSA 'Dry & Detect' towel initiative to promote breast self-exam education, the 'Check Them Out' campaign with Food Lover's Market, and the testicular cancer awareness campaign 'Check Your Package' with Takealot, and CANSA's partnership with the Hollard Daredevil Run, taking place annually

to promote awareness regarding prostate and testicular cancer.

CANSA further hosts an annual Volunteer Day to honour the volunteers who extend the organisation's reach, and World Cancer Day activities focused on people-centred care and the reality that every cancer experience is unique.



A POWERFUL FOUNDATION

While CANSA's current work reflects a responsive, multi-channel organisation,

its legacy remains a powerful foundation. In its early years, the association set out to establish a cancer register and cancer centres and clinics across the country.

By the 1950s, it had introduced educational programmes focused on early detection and healthy living, while also supporting cancer research in South Africa. The first CANSA Care Home was pioneered in Pretoria in the 1960s, laying the groundwork for the practical support model that remains so important today.

Over the decades, CANSA expanded community services, patient support, research sponsorship, and advocacy. It evolved from a traditional cancer association into a modern organisation combining research, education, and support with public engagement, policy advocacy, and increasingly accessible care services.

CANSA's work has also earned public and sector recognition over the years, including accolades for NGO performance, reporting, communication, and leadership, with further recognition noted in 2026 for excellence in cancer support services.

As CANSA marks 95 years, the message is clear: this is not only a celebration of the past, but a reaffirmation of purpose. In a country where the cancer burden continues to grow, CANSA remains committed to expanding practical support, deepening public education, promoting early detection, and ensuring that those affected by cancer are met with dignity, care, and hope. 



Visit www.cansa.org.za or contact the nearest CANSA Care Centre, call CANSA toll-free 0800 22 66 22 or email: info@cansa.org.za

Follow CANSA on Facebook: CANSA The Cancer Association of South Africa, Twitter: @CANSA (twitter.com/CANSA), Instagram @cancerassociationofsouthafrica, LinkedIn, TikTok (@cancerassociationza), Pinterest and WhatsApp Channel.



In addition to online resources and Facebook support groups, CANSA offers multi-lingual support on WhatsApp: 072 197 9305 for English and Afrikaans and 071 867 3530 for isiXhosa, isiZulu, siSwati, Sesotho and Setswana and free Tele Counselling per appointment on 0800 22 66 22 in English, Afrikaans, isiXhosa, isiZulu, siSwati, Sesotho and Setswana.



Delayed but not denied

After being assured by an oncologist that she didn't have cancer, Nkamo Mpakanyane was diagnosed with non-Hodgkin lymphoma a year later. She reflects on this journey.

Nkamogeleng (Nkamo) Mpakanyane (38) lives in Centurion, Gauteng, and has a 10-year-old son.

In December 2023, Nkamo was feeling unwell. She put it down to work-related stress as her commute to work was long. She also had a swollen neck gland which had been there for a year; a doctor said it was a reaction to the COVID vaccine and that it was nothing to worry about.

After a long day at work she wasn't feeling well (dizzy) so she went to casualty. The doctor wanted to admit her, but Nkamo declined though followed the doctor's order to get a sonar of the neck.

"The result said possible lymphoma. I didn't know what that was, so I googled it and when I saw it was cancer, I bawled my eyes out. I went back to the doctor at casualty; she calmed me down and admitted me," Nkamo explains.

A biopsy of the neck gland was done. Due to it being December, Nkamo was discharged and had to wait until January for the result. Her GP phoned the doctor saying it wasn't right to keep Nkamo waiting in limbo. The results were eventually released and showed no cancer, she was referred to a specialist physician.

"The physician told me that she doesn't know what to do as the CT scan shows lymphoma, but the biopsy doesn't and she can't find anything else wrong with me, so she needed to refer me to an oncologist," Nkamo explains.

ONCOLOGIST CONSULTATION

In February 2024, Nkamo saw an oncologist and after reviewing her results, he assured her that she didn't have cancer. When she asked about a new symptom she was experiencing (sweating but only from her head) while sleeping, he put it down to perimenopause and told her to get her hormones checked. She was only 35 years old.

"I was relieved as he told me what I wanted to hear that I didn't have cancer," she says.

Despite feeling exhausted, Nkamo carried on with life and started a new job. In May 2025, she took part in a company wellness day, and a nurse explained that her haemoglobin level was completely off and that Nkamo shouldn't have been walking around and needed a blood transfusion.

Despite taking tinctures to help with her so-called hot flushes, Nkamo still experienced them and because the swollen neck gland was still there, she immediately consulted with a new specialist physician.

LYMPHOMA DIAGNOSIS

Nkamo was admitted and two biopsies were taken: one from the neck and one from under her arm. The physician explained that there are many things that could impact the neck biopsy, such as a throat infection, hence why she is also doing a biopsy on an underarm gland too. Both glands were surgically removed and tested. A bone marrow biopsy as well as many other tests were also conducted.

"While we were waiting for the results, I was discharged and the surgeon explained that the lymph nodes were very matted (not bean shaped). I was called in to see the physician, and, in my mind, it wasn't cancer, as the oncologist assured me that it wasn't. I was expecting some weird autoimmune disease. She didn't waste any time and told me I had lymphoma. I kept on saying but he told me I didn't have cancer," Nkamo recalls.

The mother was told that because it was found above and below the diaphragm, it's likely to be Stage 3 or 4 non-Hodgkin follicular lymphoma.

"I was crying so much that she insisted I get a loved one to pick me up to ensure I got home safely. I'm forever grateful to her as she took great interest and got to the bottom of this," Nkamo expresses.

BREAKING THE NEWS TO FAMILY

It was Nkamo's parents who picked her up from the hospital. Her father took it badly and walked away; this was because he had lost his father and uncle to prostate cancer and his mother to lung cancer. He then came back and prayed for his daughter. He also later bought her the book *Fight of My Life: A Doctor's Battle with Cancer* that played a major role in her journey. Nkamo shared the news with her immediate family (except her son) and kept the matter private from everyone else. Her family pledged their full support. Her son was told at a later stage.

Despite waking up that night and crying continuously, Nkamo decided in the shower the next day that she was going to continue living her life and God will restore her.

TREATMENT

Nkamo was referred to another oncologist and her mother joined.

"My mom commented that she wasn't going to panic, but rather continue to pray over my life and trust God. The oncologist explained that the lymphoma I have isn't curable and I may relapse after treatment, but it can be managed and pushed into remission," Nkamo says.

The diagnosis was confirmed as Stage 3B; the proposed treatment was R-CHOP regimen (combines a targeted therapy drug with chemotherapy and a steroid) which Nkamo started in July and finished in November.

When Nkamo heard that chemotherapy was involved, all she could think about was how she was going to continue working, being a mom, and finishing her master's degree. She informed her boss and a schedule that would accommodate her was worked out.

After four sessions of R-CHOP, Nkamo ended up in ICU as she had sepsis caused by a bacterial infection, with her neutrophil count extremely low. She recovered and continued the last two cycles of R-CHOP.

In January 2026, Nkamo went for a check-up, and a PET scan showed full metabolic remission. Maintenance chemotherapy was proposed but Nkamo's medical aid declined because it wasn't covered. She was comfortable with this decision.

ONLINE SUPPORT GROUP

Nkamo adds that besides her faith, joining a Facebook group *Living with Lymphoma* really helped.

"It was on this group that I saw many survivors sharing studies that suggested maintenance chemotherapy doesn't push you any further in remission and some had relapsed during maintenance. By informing myself and asking questions I was grateful that the medical aid had made that decision. The case manager also highlighted that no clinically established evidence shows that maintenance therapy for follicular lymphoma prevents relapse. She explained that undergoing maintenance treatment for two years could further compromise my immune system without guaranteeing remission," she says.

GROWING INTO PROSPERITY AND LIFE

Nkamo has grown spiritually and matured tremendously during this life-changing event. "It pushed me to have more faith and trust in God and showed me to stop doubting myself. I completed a Master of Commerce and graduated in May; this showed me what I'm truly capable of," she says.

Nkamo sees green as symbolising prosperity, renewal, and life; she walks into this with the utmost confidence.



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



Why are male donors preferred over female donors for stem cell transplants?

Dr Lucille Sarah Singh answers the question of why male donors are preferred over female donors for stem cell transplants.



Let's get started by stating upfront that this has nothing to do with misogyny. The reasons are all tied up in biology and, more specifically, the remarkable changes that occur in a woman's immune system when she becomes pregnant.

Haematopoietic stem cells (harvested from the blood or bone marrow of donors) may carry with them antibody-producing immune cells which could cause short- and long-term complications after a transplant. Women who have been pregnant at any point in their life may carry high levels of these potentially problematic antibodies.

WHAT CHANGES IN A WOMAN'S IMMUNE SYSTEM WHEN SHE BECOMES PREGNANT?

All fetuses get 50% of their DNA from their mother and 50% from their father. During pregnancy, foetal cells can cross the placenta and enter the mother's bloodstream. This can stimulate the mother's immune system to produce antibodies to certain proteins on the surface of the foetal cells which the mother's immune system recognises as foreign.

These foreign proteins represent proteins from the father. The mother's immune system makes antibodies against these invaders in much the same way it would against viruses or bacteria. This process is called alloimmunization and is a natural response from a healthy and functional immune system. Even if the pregnancy was an ectopic pregnancy or resulted in a miscarriage, termination, or stillbirth, evidence of the foetal cells and DNA can be detected in the mother's blood and tissues for many decades or perhaps even lifelong.

WHY IS THIS IMPORTANT IN STEM CELL TRANSPLANTATION?

When analysing data from thousands of transplants worldwide, there is a clear association between an increased risk of graft-versus-host disease (GVHD) in recipients who receive stem cells from female donors who have had pregnancies.

This is thought to be due to pregnancy-induced immune memory in the transplanted cells from the donor. Ongoing production of allo-antibodies occurs which then attack the stem cell recipient's tissues and organs. GVHD causes inflammation and dysfunction to one or more organ systems. It commonly affects the skin, liver, and gut. At best this is a manageable short-term illness and at its worst, GVHD can turn into a chronic debilitating disease with resultant organ dysfunction and even death.

IS THERE AN UPSIDE TO HAVING THESE ANTIBODIES IN THE TRANSPLANT SETTING?

Interestingly, yes, as the same enhanced immune response may also increase the graft-versus-leukaemia effect. This means that these antibodies may have a role to play in destroying leukaemia cells. Again, the data supports this by showing a slightly reduced risk of relapse when donor cells from females who have been pregnant are used.

WHAT'S THE BOTTOM LINE? WOULD YOU CHOOSE A FEMALE DONOR WHO HAS BEEN PREGNANT?

The selection of the best donor for a particular patient is a nuanced and considered decision. It's guided by the urgency of the transplant, the underlying

disease or cancer that the patient is being transplanted for, and a multitude of other logistical factors.

The ideal donor would be a healthy identical twin, but this type of donation is exceedingly rare. A 10/10 sibling donor is the next preferable option, but every sibling carries only a 25% chance of being a 10/10 match even with the same biological parents.

When searching donor registries for potential unrelated matches, there is a hierarchy of factors that are considered. Younger donors trump older donors. Male donors trump female donors for the reasons detailed. Female donors who haven't been pregnant trump females who have been pregnant. These choices are all risk mitigating measures.

When the donor is a woman who has previously been pregnant and no alternative donor is available, the transplant can still proceed. The type of immune suppression post-transplant may be increased or optimised to decrease the chances of developing GVHD.

In conclusion, females who have had children can absolutely become stem cell donors. Thousands of successful transplants occur every year using stem cells from donors who have been pregnant.

MEET THE EXPERT

Dr Lucille Sarah Singh is a physician and clinical haematologist in private practice at Albert's Cellular Therapy (ACT) based at Netcare Pretoria East Hospital. She serves on the executive committees of the South African Clinical Haematology Association (SACHAS) and South African Bone Marrow Registry (SABMR) and is Director of the ACT Haematology Clinical Trial Unit at Netcare Pretoria East Hospital.



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GOING ON CANCER-FREE

We hear the incredible story of the resilient Zoey Da Silva and how immunotherapy became the breakthrough that gave her family the miracle they needed.

Zoey Da Silva (12) lives in Fourways, Gauteng with her mom, Melissa, and stepdad, Ricky. Her father is Paulo and her stepmom is Sarah. She has two younger siblings.

In 2020, Zoey was unusually tired, quite pale, and developed lumps on the sides of her neck. Melissa took her to their GP.

"He ordered blood tests which were inconclusive. He ordered more tests and shared them directly with a paediatric oncology team. We were asked to come in that same day. Zoey was admitted the following day to undergo a bone marrow biopsy and a biopsy of the neck gland. She was diagnosed with pre-B acute lymphoblastic leukaemia (B-ALL) at the age of six," Melissa explains.

Only being six, this bewildered Zoey and brought many new emotions.

"I was scared because everything was happening so fast, and I didn't fully understand why I was feeling so sick or what the doctors were going to do," she says.

Melissa adds, "Receiving that news on New Year's Eve, right in the middle of the COVID-19 pandemic, was surreal. Our world changed overnight. At first, it was a whirlwind of complex medical information, and we hardly had time to process our own emotions. However, we were blessed with an excellent team of doctors and nurses who guided us step-by-step. Their expertise and compassion kept us optimistic and deeply hopeful for a positive outcome."

Melissa reached out for psychological support for Zoey and the family. "It was vital for us to process the trauma and stay strong as a family unit," she says.

TREATMENT: A LONG AND GRUELLING ROAD

Zoey began nine months of intense chemotherapy in hospital. In October 2021, she underwent a donor stem cell transplant, followed by donor lymphocyte infusions (white blood cells from the original donor to patient) top-ups in ICU for another year.

"We thought we were finally in the clear, but in December 2022, Zoey relapsed. She started oral chemotherapy for 28 days, but by January 2023, it was clear it was unsuccessful. The relapse drastically worsened, with her leukaemia blast count jumping from 14% to 90%," Melissa says.

"In February 2023, Zoey was readmitted for reinduction chemo, and things became incredibly scary. She went into septic shock and was moved to ICU. By March, she suffered a severe medical reaction that caused a seizure, resulting in her being intubated and put on a ventilator. It was a terrifying time, but



she fought through, and we were finally discharged for recovery at home at the end of March."

IMMUNOTHERAPY PRODUCES A MIRACLE

There was fresh hope on the horizon when a new immunotherapy was offered to Zoey. The only downside was it wasn't covered in full by their medical aid.

"In May 2023, Zoey was admitted for a 28-day cycle of a bispecific T-cell engager (BiTE) immunotherapy. By 29 May, she was stable enough to continue the IV therapy at home. In June, Zoey was minimal residual disease (MRD) negative (no cancer detected in the body); this was the miracle we needed!" Melissa explains.

Zoey completed a second round of the immunotherapy through July and August 2023, remaining MRD negative and back in complete remission.

SECOND STEM CELL TRANSPLANT SETBACK

Preparation for a second, higher-risk transplant requiring radiation commenced. But, in November, Zoey was admitted with severe graft-versus-host disease (GVHD) of the bowel and cytomegalovirus colitis. The second transplant was called off completely.

Her recovery took several months with many hospital admissions in between. But in June 2024, Zoey successfully completed her third round of immunotherapy.

"As of today, she remains completely all clear, in remission, and complication-free!" Melissa says.

UNITED IN RAISING FUNDS

Due to the medical aid only covering 75% of the cost, the remaining 25% was paid out of pocket with the support of family, friends, and the local community raising funds. "It's an incredibly expensive treatment, but it saved her life when traditional chemotherapy failed," Melissa adds.

MANAGING SCHOOL

Zoey's school was informed when she was diagnosed. "They were extremely supportive, and I'm so grateful for how much they accommodated me. During the first year of treatment, I did school online because COVID-19 was still around and my immune system was too weak. Due to the relapse and all the complications later, I had to be taken out of school entirely for my Grade 4 year."

Zoey went back to school in 2024 and is currently in Grade 6, due to repeating Grade 4.

Zoey adds that she wanted her friends and teachers to know as it made her feel less alone, with her friends sending her messages of support.

"It helped me feel like I was still a normal kid who belonged to a class, even when I was stuck in a hospital room," Zoey says.

13TH BIRTHDAY PARTY

Zoey is excited for her 13th birthday in August. "Becoming a teenager is a huge milestone, especially after everything. I want to celebrate it surrounded by my family and friends. I'm planning to go to Gold Reef City for a fun day out with all my school friends."

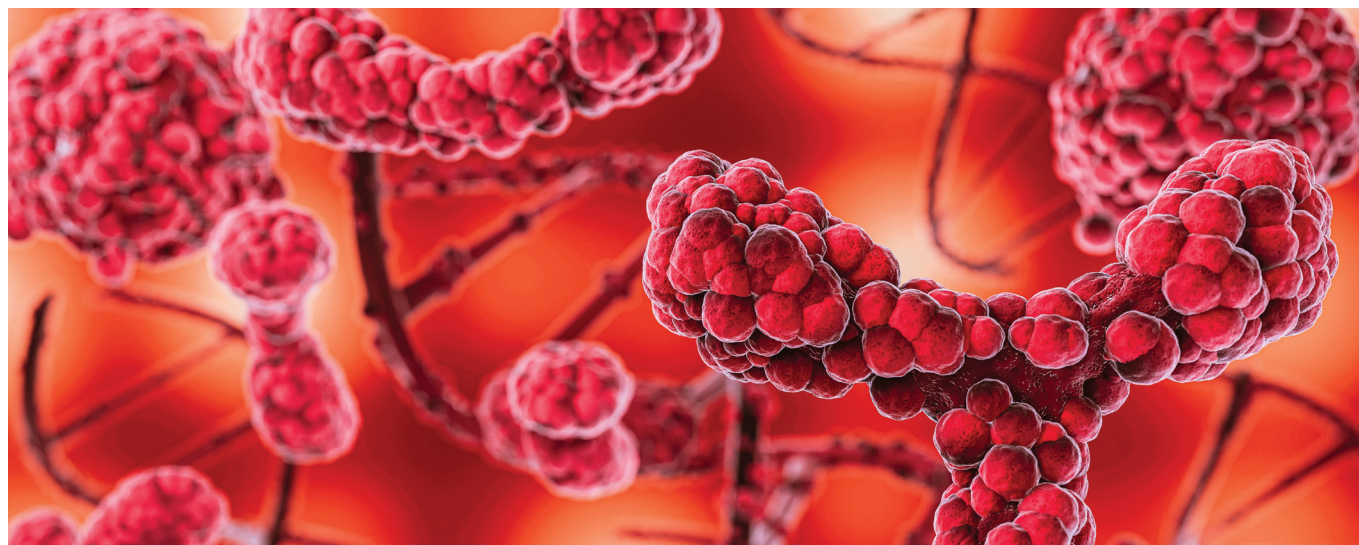
LESSONS LEARNT

When asked what lessons were learnt, Zoey responds, "Having cancer taught me that I'm much stronger than I ever thought I was. It also taught me to love the simple things, like being able to go outside, play with my siblings, and just go to school."

The lesson it taught Melissa is, "The power of hope, the miracle of modern medicine like immunotherapy, and the absolute resilience of the human spirit. It showed us that even in the darkest, most terrifying moments, you can find the strength to take just one more step forward."

This article is sponsored by Aspen Pharmacare in the interest of education, awareness, and support. The content and opinions expressed are entirely the patient's own work and not influenced by Aspen Pharmacare in any way. ZAR-SAR-07-26-00002 (07/2026)





MYELOFIBROSIS: blood factory under siege

Dr Romana Jassat unpacks myelofibrosis, a rare blood cancer, including its causes, symptoms, and treatment options.

Myelofibrosis, a rare type of blood cancer, belongs to a group of blood disorders known as myeloproliferative neoplasms (MPNs).

It's a complex disease with considerable variation in presentation, ranging from slowly progressive disease that remains stable for years to more aggressive forms that significantly affect quality of life and survival.

It affects the bone marrow, the soft, spongy tissue inside the bones where blood cells are produced. The bone marrow can be thought of as the body's blood factory. In myelofibrosis, this factory gradually becomes replaced by scar-like tissue, making it increasingly difficult to produce healthy blood cells.

There are two main forms: primary and secondary. Primary myelofibrosis develops on its own without a preceding blood disorder. Secondary myelofibrosis develops as a complication of other MPNs, most commonly essential thrombocythemia or polycythaemia vera. Regardless of how it starts, the result is progressive bone marrow scarring and impaired blood cell production.

IMPAIRED BLOOD PRODUCTION

The three major blood cell lines produced in the bone marrow are red blood cells, white blood cells, and platelets, all playing an essential role in the body.

When red blood cell production declines, you develop anaemia, which commonly causes fatigue. You may become dependent on blood transfusions. A reduction in platelet production may result in easy bruising and bleeding, while low white blood cell counts increase the risk of serious infections and hospitalisations.

The body attempts to compensate for failing bone marrow by producing blood cells elsewhere. The spleen (organ situated on the left side of the abdomen) often takes over

this role. This process, known as extramedullary haematopoiesis, causes the spleen to enlarge and may lead to abdominal discomfort and a feeling of fullness after minimal food intake.

WHAT CAUSES MYELOFIBROSIS?

Most cases of myelofibrosis are associated with acquired genetic mutations that develop during a person's lifetime. The three most common are the JAK2, CALR, and MPL mutations. These mutations aren't inherited from parents and can't currently be prevented. They lead to abnormal signalling within blood-forming stem cells, causing excessive stimulation of the bone marrow and inflammation. Over time, this contributes to the development of fibrosis, or scarring, within the bone marrow.

HOW IS MYELOFIBROSIS DIAGNOSED?

Diagnosis requires a combination of blood tests, molecular testing, and a bone marrow biopsy. Many patients ask whether a bone marrow biopsy is truly necessary. The biopsy provides crucial information about bone marrow structure, the degree of fibrosis, and the overall disease burden. It remains one of the most important investigations for confirming the diagnosis and assessing prognosis.

HOW IS MYELOFIBROSIS TREATED?

Treatment is highly individualised and depends on factors such as age, symptoms, blood counts, and genetic profile.

Supportive care remains an important part of management and includes blood transfusions and medications to stimulate red blood cell production.

One of the most significant advances in recent years has been the development of targeted therapies known as JAK inhibitors.

These medications can reduce spleen size, improve symptoms, such as fatigue, and significantly enhance quality of life for many patients.

CAN MYELOFIBROSIS BE CURED?

At present, the only potentially curative treatment is an allogeneic stem cell transplant, where diseased bone marrow is replaced with healthy donor stem cells.

Stem cell transplantation carries significant risk, and it's generally reserved for selected patients with higher-risk disease who are fit enough to undergo the procedure.

CLOSING THOUGHT

The treatment landscape for myelofibrosis continues to evolve at a rapid pace. Newer therapies aim not only to control symptoms but also to target the underlying disease process itself.

While myelofibrosis remains a challenging condition, the outlook for patients has improved dramatically over the past decade. Advances in molecular testing, risk assessment, and targeted therapy are transformative. Increasingly, patients are no longer defined by the scars of the disease, but by the promise of modern medicine and the hope it continues to bring. 



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.

THROMBOCYTOPENIA IN CANCER

Dr Garrick Laudin sheds light on why thrombocytopenia can develop during cancer and its impact on treatment.

Thrombocytopenia is the medical term for a low platelet count. It's common in patients with both solid organ cancers (breast, lung, prostate, and colon cancer) and blood or lymph node cancers (leukaemia, lymphoma, and multiple myeloma).

WHAT ARE PLATELETS?

Platelets are microscopic blood cells whose normal number and function are important for the formation of blood clots at sites where blood vessels become injured. They are produced in the bone marrow, the major site of adult blood cell production, before making their way into the circulatory system.

In healthy people, up to one-third of circulating platelets may be found in the spleen. The spleen is a specialised organ that plays a key immune function by removing dying or aged blood cells. Normal adult platelet counts range between 150 and 450 billion platelets per litre of blood ($150 - 450 \times 10^9/L$). A full blood count can diagnose thrombocytopenia.

SYMPTOMS

Bleeding usually occurs when platelet counts become significantly low. However, somewhat counterintuitively, the exact correlation between platelet count and bleeding risk is relatively weak. Bleeding risk depends on platelet number, platelet function as well as any additional bleeding risk factors.

The World Health Organization grades the severity of bleeding symptoms from grade 1 to grade 4. Grade 1 is mild bleeding, such as petechiae (pinpoint red or purple spots on the skin) or mild epistaxis (nosebleeds). Grade 2 is moderate bleeding, such as mild blood loss or bruising, and is managed with local interventions and typically doesn't require blood transfusions. Grade 3 refers to severe bleeding, requiring red blood cell transfusions or causing a significant drop in blood pressure. Grade 4 bleeding is potentially fatal bleeding into the central nervous system (brain or eye) or severe blood loss, leading to shock.

WHAT PROCESSES LEAD TO THROMBOCYTOPENIA?

Thrombocytopenia can be understood through three mechanisms: decreased platelet production, increased platelet destruction, or platelet sequestration.

Reduced platelet production occurs when a cancer primarily involves or spreads to the bone marrow, interrupting normal platelet numbers. It may also occur when chemotherapy temporarily suppresses the bone marrow's ability to make platelets. Apart from traditional chemotherapy, immunotherapies and radiotherapy (involving large areas of bone marrow) may also affect platelet production.

In some patients, platelets are destroyed or cleared by the immune system faster than they can be produced. This occurs when the immune system mistakenly attacks platelets, a condition known as immune thrombocytopenia. Some

cancers, particularly lymphomas, can trigger this immune response.

The spleen, when enlarged, can also sequester (trap) excessive numbers of platelets, resulting in a reduced circulating platelet count.

HOW IS THROMBOCYTOPENIA DIAGNOSED?

Your doctor may request additional investigations to determine why the platelet count is low. These may include microscopic examination of a blood smear, a bone marrow biopsy, imaging studies assessing spleen size, or a review of your medications and cancer treatments.

HOW IS THROMBOCYTOPENIA TREATED?

In many cases, treating the underlying cancer allows the bone marrow to recover, and platelet counts to increase.

Sometimes your oncology team may need to delay chemotherapy, reduce treatment doses, or adjust treatment schedules to give the bone marrow time to recover.

If platelet counts become dangerously low or if bleeding occurs, platelet transfusions may be administered. These are temporary supportive measures while the underlying cause is being identified and treated.

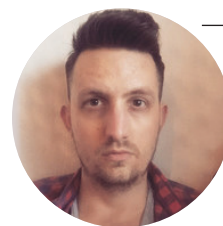
LIVING WITH THROMBOCYTOPENIA

If you have been diagnosed with thrombocytopenia, you should avoid contact sports or medications that may increase your risk of bleeding.

Simple measures, like using a soft toothbrush, may help prevent gum bleeding, while avoiding razor blades may reduce the risk of skin cuts. Discuss any medications you are taking with your oncology team, particularly anti-inflammatory drugs and anticoagulants as these may increase bleeding risk.

TAKE-HOME MESSAGE

Hearing that you have a low platelet count can be worrying, especially when you are already coping with a cancer diagnosis. Thrombocytopenia is a well-recognised complication of both cancer and its treatment. Regular blood tests, awareness of warning signs, and communication with your oncology team are key to staying safe. If you notice new bruising, bleeding, or any other worrying symptoms, seek medical advice without delay.



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.



STEREOTACTIC BODY RADIOTHERAPY

Prof Duvern Ramiah educates us on the quiet revolution in prostate cancer treatment: stereotactic body radiotherapy.

Imagine being told that your prostate cancer can be cured. Now imagine being told that the treatment will require a trip to hospital every weekday for almost two months.

For decades that was the reality for men receiving radiotherapy for prostate cancer. Thirty-nine treatments. Eight weeks. Countless journeys to the hospital. Time away from work, family, and the ordinary routines that make life feel normal.

But what if the same treatment could be delivered in just five visits?

That question has sparked one of the most important revolutions in modern prostate cancer care. The answer is stereotactic body radiotherapy (SBRT).

WHY FEWER TREATMENTS CAN BE BETTER

At first glance, SBRT sounds almost too good to be true. Instead of receiving radiation over many weeks, you receive a higher dose of radiation with extraordinary precision over just five treatments.

The remarkable part is that prostate cancer seems uniquely suited to this approach. Scientists have learned that prostate cancer cells are unusually sensitive to larger doses of radiation. In simple terms, prostate cancer behaves differently from many other cancers. Rather than needing dozens of small

doses, it can often be controlled just as effectively with a handful of carefully targeted larger doses. This insight changed everything.

THE EVIDENCE THAT CHANGED PRACTICE

In medicine, promising ideas are common. What matters is whether they stand up to rigorous testing.

One of the most important studies examining SBRT was the international PACE-B trial, published in *The New England Journal of Medicine* in 2024. Nearly 900 men with localised prostate cancer were treated and followed for years. The results showed that SBRT was just as effective as conventional radiotherapy schedules, with more than 95% of patients remaining free of cancer recurrence at five years.

For patients, this was a landmark moment. Shorter treatment was no longer simply more convenient; it was scientifically proven to work.

PRECISION ON A MILLIMETRE SCALE

The word stereotactic sounds intimidating, but it simply refers to extraordinary accuracy.

Modern radiotherapy machines use sophisticated imaging systems that locate the prostate with millimetre

precision before every treatment. Radiation is then delivered from multiple angles, allowing doctors to target the cancer while minimising exposure to nearby organs, such as the bladder and rectum. The oncologist or urologist may need to insert a gold marker into the prostate prior to radiosurgery to target the cancer with exactitude.

IS SBRT RIGHT FOR EVERYONE?

SBRT is most used for men whose cancer is confined to the prostate or immediate surrounding tissues and who are seeking curative treatment. Doctors also consider factors such as the aggressiveness of the cancer, prostate size, urinary symptoms, previous prostate procedures, and overall health.

The best prostate cancer treatment isn't the same for every man. The best treatment is the one that offers the highest chance of cure while preserving the quality of life that matters most to you.

WHAT ABOUT SIDE EFFECTS?

Whenever cancer treatment is discussed, patients naturally focus on two questions: *Will it cure me?* and *What will life look like afterwards?*

Most men tolerate SBRT remarkably well. Temporary urinary symptoms such as increased frequency, urgency, a weaker urinary stream, or mild burning when passing urine can occur during or shortly after treatment. Mild fatigue is also common. These symptoms generally improve over time and are often managed with simple medication.

All in all, SBRT compares favourably with treatment options for localised prostate cancer, such as prostate low dose rate (LDR) brachytherapy and robotic radical prostatectomy, without the need to go to theatre.

LOOKING AHEAD

The history of medicine is often told through dramatic breakthroughs: a new drug, a groundbreaking operation, or a miraculous discovery.

SBRT is different; its revolution is quieter. It doesn't change what we know about prostate cancer. It changes how efficiently, conveniently, and precisely we can treat it.

Five visits instead of eight weeks. The same goal. The same chance of cure. Less disruption to life. 

To view references, visit oncologybuddies.com

MEET THE EXPERT



Prof Duvern Ramiah is Head of Radiation Oncology at the University of the Witwatersrand. He has a private oncology practice in Johannesburg with a special interest in prostate cancer. He serves on South

Africa's Ministerial Advisory Committee for the Prevention and Control of Cancer and the International Committee of the American Society for Radiation Oncology (ASTRO), where he is one of ASTRO's inaugural Global Ambassadors.

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Your partner had a penile implant: what to expect

Lisa Welsh explains what a penile implant involves, what the different types mean for your experience together, and how to ease back into intimacy in a way that feels good for both of you.

If your partner has been through prostate cancer treatment and has had a penile implant as a result, you might be feeling a mix of things. Hopeful. Curious. Maybe a little nervous about what sex will feel like now. That's all completely normal, and you're not alone in wondering.

A BIT OF BACKGROUND

Erectile dysfunction is one of the most common side effects of prostate cancer treatment. Surgery, radiation, and hormone therapy can all affect the nerves and blood flow involved in erections. For many men, medication and other aids help. For others, they don't, or they stop working over time.

A penile implant is often considered when other options have been exhausted, and for many couples it becomes a genuine turning point. They're internal devices, so nothing is visible from the outside. There are two main types, and it's worth understanding the difference.

INFLATABLE IMPLANT

An inflatable implant is the more common option. It uses a small pump placed inside the scrotum to fill cylinders in the penis with fluid, creating an erection on demand. When you're done, the pump is pressed again to release the fluid. The result feels quite close to a natural erection, and the whole thing is completely discreet. Your partner controls when and how long the erection lasts, which for many couples brings back a sense of spontaneity that may have been missing for a long time.

MALLEABLE IMPLANT

A malleable implant works differently. It uses semi-rigid rods that keep the penis firm when needed. Your partner simply bends it into position for sex and back down afterwards. It's a simpler device with fewer

moving parts, and it's a good option for some men depending on their health and dexterity.

Neither type affects sensation, orgasm, or ejaculation. The implant addresses erection only. Everything else still works the way it did before.

WHAT MIGHT FEEL DIFFERENT

It's worth going in with realistic expectations, not because anything is likely to go wrong, but because knowing what to expect helps you both relax.

Some men find that the size or shape of their erections feel slightly different from before. This is normal and usually settles over time as the body adjusts to the implant. Sensation is intact, but the erection itself may look or feel a little different to what you both remember.

There's also an emotional adjustment. Your partner has been through surgery, recovery, and probably a fair amount of grief around his sexual function before deciding on this route. He may feel relieved, but also vulnerable. Patience matters here, from both sides.

BRINGING INTIMACY BACK, TOGETHER

Don't feel like you need to dive straight into sex the moment your partner is healed. That kind of pressure, even if no one is voicing it out loud, can make the first few experiences more anxious than they need to be.

Start with closeness. Touching, kissing, just being physically near each other without any agenda. Let desire build naturally rather than treating the implant as a starting gun.

When you do feel ready, take it slowly. Talk during and after. What feels good? What do you both enjoy? Treat this as a chance to rediscover each other rather than a test to pass.

It can also help to keep a sense of humour about the learning curve. The inflatable pump, for example, takes a little practise to use smoothly. Some couples find the early attempts a bit clunky. That's fine. It gets easier, and laughing together isn't a bad way to reconnect.

WHAT MANY COUPLES FIND

Research consistently shows high satisfaction rates among both patients and their partners after penile implant surgery. Many couples describe their sex life after an implant as better than it was before the erectile dysfunction started, partly because going through a difficult time together often brings a new level of honesty and closeness.

The spontaneity that the implant restores tends to be what partners appreciate most. No planning around a tablet. No managing an injection. Just presence and connection, when you both feel ready for it.

GETTING SUPPORT

If you're finding the emotional side of this harder to navigate, talking to a sex therapist who understands post-cancer intimacy can make a real difference. You don't have to work through it all on your own.

Visit mysexualhealth.co.za to find a professional who can support you both.



MEET THE EXPERT

Lisa Welsh is an accredited sex educator who focuses on helping people to experience more pleasure in their daily lives. She serves as the Communications Lead for My Sexual Health and the World Association for Sexual Health.

Prevention of gynaecological cancers

Dr Linda Rogers unpacks how gynaecological cancers are screened and can be prevented.

In 1736 Benjamin Franklin said, “An ounce of prevention is worth a pound of cure,” and this is still true today. Prevention is less costly in psychological, emotional, and physical suffering, as well as healthcare costs.

UNDERSTANDING SCREENING

This process is where a test or investigation is done to detect malignant transformation or pre-cancers early. Characteristics of a good screening test are that it should be highly accurate (sensitive and specific), be safe and acceptable to the population being screened, and be cost-effective.

Diseases which are suitable for a screening programme should be severe and common enough that they justify screening, and there should be a test which can detect disease before the patient becomes symptomatic, and an effective treatment for the disease when it's detected early.

CERVICAL CANCER

Cervical cancer is the most amenable to screening. This malignancy is responsible for the deaths of more young women aged 15–44 years in developing countries, such as SA, than any other malignancy.

Persistent infection with cancer-causing strains of the human papillomavirus (HPV) causes cervical cancer in women whose immune systems can't eliminate the virus, particularly smokers and those living with HIV infection.

Until recently, screening included regular Pap smears to all sexually active women. This test scrapes cells off the surface of the cervix, to be looked at under a microscope, and abnormalities are detected.

If you have pre-cancerous or dysplastic changes, you'll then be referred for colposcopy, where the cervix is looked under magnification. If high-grade abnormalities are present, you can undergo a loop electrosurgical excisional procedure (LEEP), which is a minor procedure to remove abnormal cells, therefore preventing you from developing cancer.

Nowadays, a more accurate version is to test for high-risk strains of HPV on a Pap smear. Women who test positive can also be referred for colposcopy, where abnormalities

can be detected and treated. This is known as secondary prevention but we're also now fortunate to be able to offer primary prevention, as several vaccines are available to prevent young people from acquiring HPV infection. One vaccine is offered free to all grade 5 girls in SA and is given at school.

Tertiary prevention involves all women who have symptoms, such as abnormal bleeding and discharge, being seen and examined, to have their cancer diagnosed and treated as early as possible.

90, 70, 90 APPROACH

The World Health Organization has called for a 90, 70, 90 approach to eliminate cervical cancer by the year 2030. Ideally, 90% of girls under the age of 15 should be vaccinated against HPV, 70% of women with abnormal Pap smears or HPV tests should be treated, and 90% of women with cervical cancer should be offered appropriate treatment.

Unfortunately, in SA we're a long way from this but Australia is set to achieve this goal as they have been vaccinating and screening their female population for years.

VULVA CANCER

Vulva cancer can be caused by HPV but can also arise in women who have skin diseases of the vulva, such as lichen sclerosus. There is no formal screening programme but it's vital that all immunocompromised women have regular check-ups to exclude HPV changes of the vulva skin, as well as of the cervix and anus.

Similarly, all women who have lichen sclerosus should have regular check-ups. Plus, meticulous treatment of their skin with potent topical steroid ointment, to prevent the severe itching, pain, and malignant changes that can occur as a result.

UTERINE CANCER

There are many different types of uterine cancer. The more aggressive types occur in older women; unfortunately, there is no accurate or cost-effective way of screening for these types.

However, the less aggressive types of endometrial cancer (most common type of uterine cancer) are becoming more common,

due to rising rates of obesity. They are also prevalent in post-menopausal women who have a wide oestrogen window (early menarche, late menopause, few/no pregnancies) and may have diabetes and/or high blood pressure. They can also occur in women with polycystic ovarian syndrome or Lynch syndrome.

It's important that all women over the age of 40 who have abnormal vaginal bleeding are appropriately investigated to exclude endometrial cancer and its precursor lesion, endometrial intraepithelial neoplasia.

OVARIAN CANCER

This gynaecological malignancy has the highest mortality rate, but it's less prevalent than cervical or uterine cancer in SA.

Due to this disease often presenting late, with vague non-specific symptoms, such as indigestion and changes in bowel habit, many studies have looked at ways to predict which women are at risk.

Two main tests can be done: a pelvic ultrasound to exclude abnormalities in the appearance of the ovaries, and a blood test for the tumour marker CA-125, which can be markedly raised in women with ovarian cancer. These tests haven't been shown to be efficient or cost-effective in the general population but are used in women who have genetic syndromes (BRCA) to detect ovarian abnormalities early.

Women with BRCA 1 or 2 should also be offered risk-reducing surgery, where their tubes and ovaries are removed between the ages of 40–45, when families are complete.

Use of the oral contraceptive pill is another strategy which can be used to prevent both ovarian and uterine cancer. 

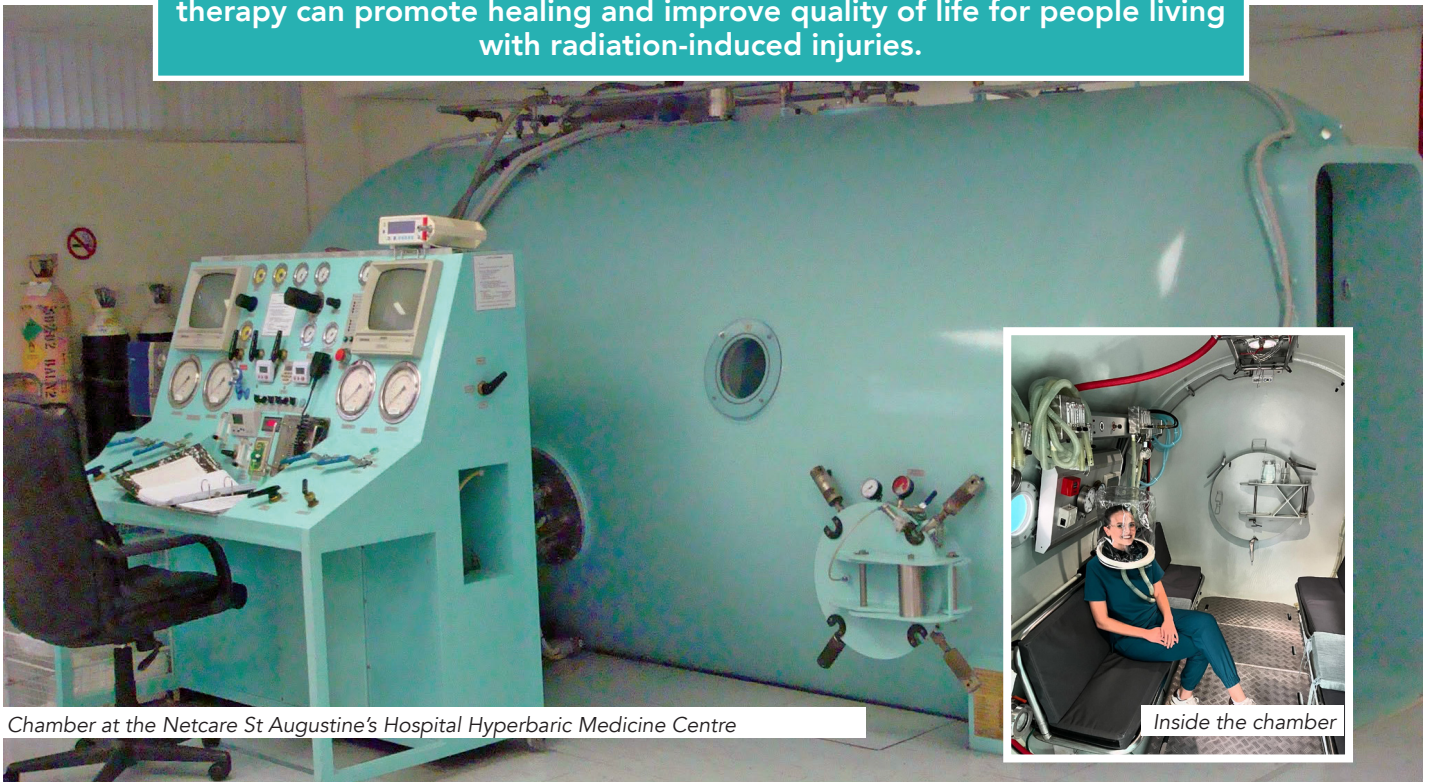


MEET THE EXPERT

Dr Linda Rogers, a gynaecological oncologist, has worked as a senior specialist in the Department of Obstetrics and Gynaecology at the University of Cape Town (UCT) and Groote Schuur Hospital (GSH) since 2009. She is assistant editor of the *South African Journal of Gynaecological Oncology* (SAJGO) and is a member of the South African HPV Board.

HEALING WITH HYPERBARIC OXYGEN THERAPY

Dr Steph Osborn and Dr Nicola Bodley explain how hyperbaric oxygen therapy can promote healing and improve quality of life for people living with radiation-induced injuries.



Chamber at the Netcare St Augustine's Hospital Hyperbaric Medicine Centre

Inside the chamber

WHAT IS HYPERBARIC OXYGEN THERAPY?

Hyperbaric oxygen therapy (HBOT) increases delivery of oxygen to the body by providing pure oxygen in an enclosed space with higher-than-normal air pressure. It offers a proven way to address radiation-induced injuries, bringing relief, and restoring quality of life for many.

RADIATION-INDUCED INJURIES

Radiation therapy saves lives in cancer treatment, yet it can leave lasting tissue damage that causes real suffering: pain, dysfunction, and emotional strain long after treatment ends.

EARLY VS DELAYED INJURIES

Early radiation-induced injuries arise within weeks, often from acute inflammation affecting skin, mucosa, or organs like the bladder, leading to temporary pain or irritation that typically improves with time.

Delayed injuries emerge months to years later due to progressive fibrosis (excessive thickening, hardening, or scarring of connective tissue in the body), vascular damage, and tissue hypoxia (when the body's cells and organs don't receive enough oxygen to function properly), resulting in chronic, debilitating conditions that profoundly impact daily life.

COMMON RADIATION-INDUCED INJURIES

These late effects are all too common and challenging:

- Head and neck: Xerostomia (severe dry mouth impairing speech and nutrition), dysphagia (painful swallowing), and mandibular osteoradionecrosis (jawbone death causing exposure and infection).
- Pelvic area: Radiation cystitis (bladder pain, bleeding), proctitis (rectal bleeding, urgency), and fistulae (abnormal tracts between organs).

- Skin and soft tissue: Non-healing wounds or skin ulceration and necrosis (uncontrolled, premature death of body tissue or cells). Surgery in previously radiated areas also carry high risks of poor wound healing, infection, and flap failure due to compromised blood supply. Pre-operative HBOT (typically 20 to 30 sessions) enhances tissue oxygenation, promotes the formation of new blood vessels, and strengthens healing capacity, significantly improving surgical success and should be considered prior to any surgery in a previous radiation field.

HOW HBOT HELPS

In a pressurised chamber at 2.4 ATA (equivalent to 14m of seawater), breathing 100% oxygen allows plasma to carry far more oxygen to damaged tissues, up to 2 000 times normal levels. This stimulates new blood vessel growth, reduces swelling and tissue fibrosis, combats persistent infection, and halts the progression of dead or dying tissue, directly countering radiation-induced hypoxia.



MEET THE EXPERTS

Dr Nicola Bodley (BSc Physio, MBBCh, DA(SA), MMedSc, hyperbaric doctor) has a background in oncology and a special interest in the benefits of hyperbaric oxygen therapy for delayed radiation injuries. She is a qualified medical doctor with a diploma in anaesthetics in addition to her hyperbaric training. She is patient-centred and compassionate and is committed to supporting people throughout their healing journey.

Dr Steph Osborn (MBChB (Tuks), hyperbaric doctor) is passionate about evidence-based hyperbaric medicine, wound care, and patient education. After qualifying as a doctor through the University of Pretoria, she completed her hyperbaric training through Stellenbosch and later training in dive medicine. She provides a holistic approach to care, providing safe and efficacious treatments.

WHAT DOES HBOT TREATMENT INVOLVE?

The standard treatment protocol consists of 30 to 40 treatments. Treatments are daily (Monday to Friday) and are 90 minutes in duration. You will never be alone in the chamber; you will be with other patients. This often becomes a sense of community and support.

There is always also a medically trained attendant (paramedic or nurse) inside the chamber. You can either lie or sit comfortably in the chamber. You will experience mild ear pressure as the chamber is pressurised (this is like what you may experience in an airplane and is managed in the same way).

Some people may struggle with confinement or claustrophobia, but trained staff are there to support you. You may be given a mild anti-anxiety tablet if needed.

REIMBURSEMENT AND REFERRAL

You don't need a referral for hyperbaric oxygen therapy; you can come for a consultation where you will discuss your condition to see whether you will benefit from hyperbaric oxygen therapy. It's preferred to work together with your oncologist and other specialists.

Hyperbaric oxygen therapy is often fully reimbursed by medical aid and doesn't come from your oncology benefit or savings; it is funded from your hospital benefits.

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How grief plants the seeds

Bonni Suckling beautifully reflects on how grief has planted the seeds of the person



2026

COMRADES MARATHON
THE ULTIMATE HUMAN RACE
Proudly photographed by Action Photo SA

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In June I crossed the finish line of my ninth Comrades Marathon. Nine. Even saying that out loud feels a little surreal because every single year, somewhere around 70km, I become absolutely convinced that this was a terrible life choice. Like...the worst ever.

Then something magical happens. You catch a peep of the finish line. Now, my friends, there is nothing glamorous about the Comrades finish. NOTHING! It looks like a war zone. Thousands of broken, limping

soldiers, wrapped in silver space blankets, are wandering around lost yet euphoric. Nobody looks pretty. Everyone smells questionable.

But every face is smiling. Why? Because the finish line means you have made it. The hard part is over. A stranger hangs what is essentially a little coin on a string around your neck and suddenly you feel like you have conquered the world.

WE HUMANS LOVE FINISH LINES

We count down to birthdays, holidays, retirement and, for families affected by cancer, often the last chemotherapy treatment. We tell ourselves *If I can just get there...* because we believe there will be relief waiting on the other side.

OUTRUNNING GRIEF

I think that's why, after my son Jed died, I spent years trying to outrun my grief.

of who we are next

she is today, quietly awarding her invisible medals every day.



I was Forrest Gumping heartache. Never really knowing where I was trying to get to. The funny thing about trying to outrun grief is that no matter how fast you run, grief has already crossed the finish line and is quietly waiting for you there.

So, I kept searching. Maybe after his funeral? Maybe after the first Christmas (when there wasn't even a tree)? Maybe after his birthday? After the first year?

One year quietly became five. Five

became 10. This year became almost 15. The strangest thing about grief is that it feels like yesterday and 15 years ago at the same time. It's all mushed together.

I realised you can't outrun grief. It doesn't matter how strong you are, or how hard you train. How busy you keep yourself. How many books you read. How many tears you cry. There is no finish line. There is no medal waiting at the end.

GRIEF ISN'T A RACE

Oddly enough, accepting that became one of the most freeing moments of my grief. I stopped comparing my journey to everyone else's. I stopped wondering why someone else seemed to be further ahead in healing and I was stuck in complicated grief. But grief isn't a race. It's love with nowhere to go. While I was busy looking for a finish line, grief was quietly handing me different medals.

THE INVISIBLE MEDALS

Nobody clapped the first time I walked past the boys' toy aisle and saw Buzz Lightyear (Jed's favourite toy) without falling apart. There wasn't a medal the first time I saw a little six-year-old boy with wild curls and chubby cheeks and managed to smile instead of cry. Nobody cheered the first time I laughed so hard I nearly peed myself before guilt came running after me.

There wasn't a podium waiting for me the day I realised I'd spent an entire afternoon talking about Jed and, somehow, for the first time, the smiles outnumbered the tears. Those were medals too. They just didn't come on ribbons. And somehow...they became the most beautiful medals of all.

WHEN HOPE JOINS IN WALKING WITH GRIEF

Then one day a newly bereaved parent sat opposite me. I didn't have the right words. There aren't any. But I knew how to stay. I knew how to sit in the silence without trying to fill it. I knew that sometimes the greatest gift you can give another grieving parent is simply not being afraid of their pain. That is when I realised something had changed.

Not my love. Never my love. Not even my grief. My grief is still there because my love is still there. But somewhere along the route, hope had quietly joined us. It didn't arrive with fireworks. It didn't knock on the door. It didn't announce itself. It simply started walking beside my grief.

I still wish I could tell Jed about my ninth Comrades medal; I wonder if he would be proud? I wish I could tell him how many kilometres his memory has carried me through. In the darkest parts of the race, I feel him with me. I can picture his wild curly hair bouncing beside me, *Keep going, mama, you got this!*

THE SEEDS GRIEF PLANTED

I miss my son more than words will ever explain. I always will. But maybe that's exactly the point. The finish line I spent years looking for doesn't exist because my love for him doesn't have one either.

Instead, grief has quietly planted something I never expected. Compassion. Courage. Patience. Perspective. Hope. Not the loud, dramatic kind of hope that tells us everything happens for a reason. The quieter gentle kind.

Perhaps grief never intended to give us a finish line after all. Perhaps the greatest medals we will ever earn aren't made of metal. Perhaps they're the ordinary, invisible victories nobody else sees. Walking past Buzz Lightyear. Laughing without apologising. Saying your child's name with more smiles than tears. Holding another grieving person's hand because someone once held yours.

Maybe those are our medals. And if you are reading this while wondering where your finish line is, perhaps stop looking for it. Instead, look for today's medal.

It might be much smaller than you expected. Maybe today your medal was simply getting out of bed, even though your heart feels completely broken. Maybe it was having a shower. Maybe it was making a cup of tea. Maybe it was saying your child's name out loud.

Or maybe it was simply getting through today. Those are medals too. And I promise you...they are enough. 



MEET THE EXPERT

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

Images supplied

ANIMAL LESSONS IN BOUNCING BACK

Dr Andrew Robson looks at how animals bounce back after illness and why humans should allow themselves the same compassion.



Illness can be a daunting journey, whether for humans or animals. I've been fortunate enough to see the incredible resilience animals have as they recover from serious illnesses or surgery. Their resilience serves as a powerful reminder for humans navigating their own health challenges, particularly those experiencing cancer.

During my mom's breast cancer journey, I often found myself leaning on my experience with pets. I found that understanding how animals recover can inspire humans to approach their healing journeys with the same compassion and determination.

Many of these points are commonly spoken about in any self-help book or social media posts, but these are the most important lessons I have learned from my animal patients and from my personal experience with my mom.

FACTORS CONTRIBUTING TO RECOVERY IN ANIMALS

Animals, much like humans, experience a range of emotions and physiological responses when faced with illness. Research shows that the recovery process in animals involves several factors, including their environment, support systems, and innate resilience.

1 | ENVIRONMENTAL FACTORS CONTRIBUTING TO RECOVERY

Just as a comforting environment can aid human recovery, the same is true for animals. Studies indicate that animals in stress-free environments, where they feel secure and loved, show improved recovery rates. For instance, dogs undergoing any form of treatment whether that's recovering from medical or surgical intervention, often respond better when they are in familiar environments, surrounded by their families.

This highlights the importance of creating a supportive atmosphere, which can be easily translated to human experiences. A nurturing environment, be it through family support or therapeutic spaces, can significantly impact emotional and physical healing.

2 | SUPPORT SYSTEMS

The presence of a reliable support system is crucial for recovery in both animals and humans. In veterinary medicine, we are fortunate in that home care of pets is like that of children or toddlers. This often means owners are especially attentive and patient with their pets.

This mirrors the human experience, where emotional support from friends, family, or support groups can enhance resilience during medical treatments, especially in a cancer journey. The act of sharing emotions, fears, and triumphs fosters a sense of belonging and strength.

3 | RESILIENCE AND ADAPTATION

Animals are naturally resilient and have an innate ability to adapt to their circumstances. This is evident in how they respond to treatment and recover from illness. Research suggests that animals possess a remarkable capacity to bounce back, often showing signs

of joy and playfulness despite their struggles. This resilience can be attributed to their ability to live in the moment and their instinctual drive to seek comfort and safety.

Humans can learn from this instinctual response. Acknowledging your emotions and allowing yourself to experience them can help facilitate healing. Embracing joy, even in small moments, can significantly enhance your overall well-being during challenging times.

COMPASSIONATE HEALING FOR HUMANS

The journey through illness isn't just about physical recovery, it's also about emotional and mental healing. Just as animals require compassion and care, so do we as humans. Here are ways to cultivate compassion during the healing process.

1 | PRACTISE SELF-COMPASSION

It's essential to treat yourself with the same kindness you would offer a friend or a beloved pet. When faced with illness, allow yourself to feel the range of emotions that come with it (fear, sadness, joy). By acknowledging these feelings without judgment, you create space for healing.

2 | BUILD A SUPPORT NETWORK

Seek out support from friends, family, or support groups. Sharing experiences and emotions can alleviate feelings of isolation and foster a sense of community. Just as animals thrive in supportive environments, humans benefit immensely from connections that provide comfort and understanding.

3 | FOCUS ON THE PRESENT

Much like animals, humans can benefit from living in the moment. Engaging in mindfulness practices, such as meditation or deep breathing, can help ground yourself and reduce anxiety about the future. This practice encourages you to appreciate the small joys of life, promoting a positive outlook.

4 | CELEBRATE SMALL VICTORIES

Last but certainly not least, during hardship count every win. Just as you celebrate the milestones in an animal's recovery, you must also recognise your own achievements, no matter how small. Each step forward, whether it be a good day, a successful treatment, or a moment of laughter, deserves acknowledgment. This fosters motivation and reinforces your resilience. 



MEET THE EXPERT

Dr Andrew Robson is a veterinarian with a Master of Science degree from Wits University. Based in Johannesburg, Andrew provides 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.