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CDC and NCI Study: Almost 12 Million U.S. Residents are Cancer Survivors

The number of cancer survivors in the United States increased to 11.7 million in 2007, according to a report released by the Centers for Disease Control and Prevention (CDC) and the National Cancer Institute (NCI), part of the National Institutes of Health. There were 3 million cancer survivors in 1971 and 9.8 million in 2001. The study, “Cancer Survivors in the United States, 2007,” was published March 11, 2011 in the CDC’s [Morbidity and Mortality Weekly Report](#).

To determine the number of survivors, the authors analyzed the number of new cases and follow-up data from NCI’s Surveillance, Epidemiology and End Results Program between 1971 and 2007. Population data from the 2006 and 2007 United States Census were also included. The researchers estimated the number of persons ever diagnosed with cancer who were alive on Jan. 1, 2007 (except non-melanoma skin cancers, which are fairly common and rarely fatal).

Among the findings of the study:

- Of the 11.7 million people living with cancer in 2007, 7 million were ages 65 years or older.
- Women make up a large proportion of cancer survivors (54 percent).
- Breast cancer survivors are the largest group of cancer survivors (22 percent), followed by prostate cancer survivors (19 percent) and colorectal cancer survivors (10 percent).
- Among all survivors, 4.7 million received their diagnosis 10 or more years earlier.

The authors note that the increase in the number of cancer survivors is due to many factors, including a growing aging population, early detection, improved diagnostic methods, more effective treatment, and improved clinical follow-up after treatment.

“There is now a growing number of people who have faced a cancer diagnosis which affects them and their loved ones – from the time of diagnosis through the rest of their lives,” Julia H. Rowland, PhD, director of NCI’s Office of Cancer Survivorship, said. “Unfortunately for many cancer survivors and those around them, the effect of cancer does not end with the last treatment. Research has allowed us to scratch the surface of understanding the unique risks, issues and concerns of this population. This report underscores the need for continued research, as well as for the development and implementation of best practices to provide optimal care and support for all cancer survivors.”

Cancer Rights Conference Coming to Ann Arbor in October

The **Cancer Legal Resource Center** (CLRC) will host a Cancer Rights Conference at the University of Michigan Comprehensive Cancer Center Ann Arbor on Oct. 21, 2011. This one-of-a-kind, free, conference will bring together cancer patients, survivors, caregivers, and health care professionals to learn about legal issues affecting persons with cancer such as employment, insurance, disability, estate planning, and education.

The October conference is sponsored by the Cancer Legal Resource Center (www.cancerlegalresourcecenter.org), a nonprofit organization that provides free information and resources about cancer-related legal issues. A national, joint program of the Disability Rights Legal Center and Loyola Law School Los Angeles, the CLRC has been in existence since 1997 and offers many services to persons facing legal issues after a cancer diagnosis.

The Cancer Legal Resource Center is seeking additional partners and sponsors from Michigan for the Ann Arbor event. For more information, to register for the conference, or to download a sponsorship and partner packet, visit www.CancerRightsConference.org or contact Monica Fawzy Bryant at 773-750-3063 (e-mail: Monica.Fawzy@LLS.edu).

MDCH Releases Pain & Symptom Management Report

The **Michigan Department of Community Health** (MDCH) Bureau of Health Professions has released the *FY 2009 Annual Report of the Michigan Advisory Committee on Pain & Symptom Management*.

In 2002, the Advisory Committee on Pain and Symptom Management established 18 recommendations aimed at improving pain and symptom management in Michigan. By September 2009, nearly all of these recommendations were accomplished through efforts of the committee and MDCH. As a result, the committee established eight new recommendations for completion between October 2009 and September 2011:

1. Convene a special meeting of state medical schools to explore ways to improve pain management education in both the medical school curriculum, as well as the residency experience.
2. Present five to 10 comprehensive trainings on pain management to be offered to health care professionals and pre-professionals at key Michigan locations. The state should also make available such training as an online module and seek CME/CE sponsorship to make the training widely accessible.
3. Improve pain and symptom management of the elderly and those with advanced illnesses by impacting health professionals, patients in long-term care environments.
4. Increase the use of the Michigan Automated Prescription System (MAPS) by health professionals, and make the MAPS data and information regarding the use of controlled substances more available to health professionals.
5. Introduce a bill to establish a program to promote remediation of health care providers failing to appropriately prescribe or dispense controlled substances.
6. The MDCH Bureau of Health Professions should fully utilize its communication resources to disseminate pain management information to health care professionals, such as the Federation of State Medical Boards Model Guidelines on pain management, MAPS information, state-sponsored pain management trainings, and other resource information.
7. Develop and implement strategies designed to improve the public's knowledge, attitudes and practices regarding pain and symptom management.
8. The Department of Community Health, together with the Boards of Medicine and Osteopathic Medicine and Surgery, should determine that the practice of Interventional Pain Management is the practice of medicine. The boards should determine what specific practices of interventional pain management can be delegated to other health professionals.

To learn more, visit the MDCH pain management website at www.michigan.gov/pm.

Is PALB2 Genetic Testing Ready for Clinical Practice?

Submitted by Kara Milliron, Michigan Cancer Genetics Alliance

While the majority of breast cancer is considered sporadic, there are familial cancers that appear to have an inherited cause, passed down from one generation to the next. Epidemiological studies have reported that breast cancer risk is higher among first-degree relatives of women with breast cancer than among members of the general population.

Since the discovery of BRCA1 and BRCA2, there has been ongoing research to identify additional genes that contribute to breast and/or ovarian cancer in certain families. The PALB2 (partner and localizer of BRCA2) gene was recently discovered as a cancer-predisposing gene. The PALB2 gene codes for a protein which, as its name suggests, interacts with the protein produced by BRCA2. These proteins work together as tumor suppressors to repair damaged DNA and control cell growth and division.

Individuals with mutations in both copies of their PALB2 genes are at high risk for childhood cancers, such as Wilms tumor, medulloblastoma, and neuroblastoma. Individuals with one PALB2 mutation (mono-allelic carriers) have been reported to have a two- to three-fold increase in breast cancer risk. This translates into an approximately 18 percent to 35 percent lifetime risk of developing breast cancer by the age of 70, compared with a 12 percent risk in the general population. PALB2 mono-allelic carriers also have an increased lifetime risk of developing pancreatic cancer, although this exact risk is unknown.

Currently, there is some controversy regarding widespread use of PALB2 genetic testing in families with seemingly inherited breast and/or pancreatic cancers. Many clinicians feel that PALB2 testing is still in its infancy and that clinical testing for PALB2 mutations is premature. However, other clinicians feel that the information gained from PALB2 genetic testing would impact treatment and management decisions for at-risk patients. One of the main concerns that currently is halting the integration of PALB2 into clinical practice is that individuals may carry a PALB2 mutation and never develop cancer, for reasons that are yet unclear. In addition, there are individuals in PALB2-positive families who do not carry a PALB2 mutation and still develop cancer. This leads to the question of whether there is yet another factor at play in these families.

The risk associated with PALB2 mutations should be interpreted with caution. Management recommendations for those patients who are positive for a PALB2 mutation are still typically based on family history. Additional research is needed to elucidate the role that PALB2 plays in the world of hereditary breast and pancreatic cancer.

As with all genetic testing, it is highly recommended that an individual who is seeking PALB2 testing be appropriately counseled by a trained healthcare professional so that the patient understands the risks, benefits, and limitations of testing for PALB2 mutations.

For information on genetic services near you, visit www.migeneticsconnection.org/cancer/directory.html.

References:

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Stratton MR, Rahman N. The emerging landscape of breast cancer susceptibility. *Nat Genet* 2008; 40(1):17-22.

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CAPC and NPCRC Open National Palliative Care Registry

The Center to Advance Palliative Care (CAPC) and the National Palliative Care Research Center (NPCRC) have launched the National Palliative Care Registry, a repository of national data about the operational features (structures and processes of care) of U.S. hospital palliative care programs. The goal of the registry is two-fold: 1) assist palliative care programs in tracking the development of their programs from year-to-year; and 2) assist in standardizing structures and processes of care.

Data entered into the registry are confidential; all reporting is aggregate and anonymous. Data entered during the current calendar year represent the previous calendar year. Annual registry data are archived on Dec. 31 of each year.

To be eligible to participate in the registry, a program must be: a hospital-based program that provides inpatient non-hospice palliative care or operated by the hospital or another entity contracted by the hospital. Registering your palliative care program is a free annual process. Each year, registered programs will:

- receive a premium listing (highlighted and with more complete information than a regular listing) in the [Provider Directory of Hospitals](#);
- be included in CAPC and NPCRC prevalence studies that are reported to policymakers, media, academia, and health care professionals.;
- generate in-depth, customized reports comparing their own program to the anonymous aggregate data of peer programs, information they can use to help secure needed resources; and
- have the ability to guide the development and sustainability of their program by tracking their program's structures and processes of care, year after year.

For more information, visit <https://registry.capc.org/>.

ACS Issues 2011 Report on Cancer Screening in U.S.

The American Cancer Society (ACS) has released "Cancer Screening in the United States, 2011: A Review of Current American Cancer Society Guidelines and Issues in Cancer Screening," the latest in its annual series of published reports on data and trends in the country's cancer screening rates, as well as select issues related to cancer screening.

The latest report, which appeared in the January-February 2011 edition of *CA: A Cancer Journal for Clinicians*, a peer-reviewed journal of the ACS, summarizes the current ACS guidelines, describes the anticipated impact of new health care reform legislation on cancer screening, and discusses recent public debates over the comparative effectiveness of different colorectal cancer screening tests.

In addition, the report's authors describe the latest data on the utilization of cancer screening from the National Health Interview Survey, as well as several recent reports on the role of health care professionals in adult utilization of cancer screening.

For more information on the 2011 report, visit <http://caonline.amcancersoc.org/cgi/content/full/61/1/8>.

Save the Date!



2011 MCC Annual Meeting
Wednesday, Nov. 9, 2011
8:30 a.m. – 4:30 p.m.

The James B. Henry Center for Executive Development
3535 Forest Road, Lansing

Information about the program will be sent to MCC member and partner organizations and posted at www.michigancancer.org as it becomes available.

Please note: The MCC Annual Meeting is open to representatives of all MCC member and partner organizations, as well as other interested comprehensive cancer control stakeholders.

Report Shows Continued Declines in Many U.S. Cancer Rates

Rates of death in the United States from all cancers for men and women continued to decline between 2003 and 2007, the most recent reporting period available, according to the latest *Annual Report to the Nation on the Status of Cancer*. The report also finds that the overall rate of new cancer diagnoses for men and women combined decreased an average of slightly less than 1 percent per year for the same period.

The drop in cancer death rates continues a trend that began in the early 1990s. The new report shows lung cancer death rates have decreased in women, more than a decade after rates began dropping in men. Among other findings:

- Incidence rates of childhood cancers (i.e., cancers occurring in individuals 19 years of age or younger), continued to increase, while death rates in this age group decreased.
- Overall cancer incidence rates in men were essentially unchanged. There was a very small uptick in prostate cancer rates, and if these rates were excluded from the analysis, there would be a continued decline in overall male incidence rates.
- Among men, incidence rates have declined for cancers of the lung, colon and rectum, oral cavity and pharynx, stomach, and brain (malignant only), while rates have risen for kidney, pancreas and liver cancers, as well as melanoma of the skin.
- Among women, incidence rates have decreased for breast, lung, colorectal, uterine, cervical, bladder, and oral cavity cancers, but have increased for kidney, pancreas, and thyroid cancers, as well as for leukemia and melanomas of the skin.
- Among racial/ethnic groups, cancer death rates were highest in black men and black women, but this group also showed the largest decline for the period between 1998 and 2007, compared with other racial groups.
- For new cancers, black men had the highest incidence rates in the 2003 to 2007 period studied. Among women, white women had the highest overall incidence rates.
- Breast cancer was the most commonly diagnosed cancer among women, regardless of race or ethnicity.
- The differences and fluctuations in death rates by racial/ethnic group, gender, and cancer site may reflect differences in risk behaviors, socioeconomic status, and access to — and use of — screening and treatment.

Highlighting Changes in Brain Tumor Rates and Survival

Of particular note in the Special Feature Section was the finding that non-malignant tumors make up two-thirds of all adult brain tumors and one-third of childhood brain tumors, with meningiomas being the most common type of brain and other nervous system tumor in the United States.

Changes in diagnostic techniques have led to less invasive methods for diagnosing brain tumors, but also have had a strong influence on incidence rates over the past decades. Newer molecular studies have improved classification of brain tumors for treatment and prognostic purposes.

Also of note is the relative stability of long-term trends for tumors of neuroepithelial tissue, which arise from glial (support) cells in the brain and other tissues. Incidence rates for glioblastoma, the most common, as well as highly fatal, form of these malignant tumors, increased from 1980 through 1991, likely due to increasing use of aggressive diagnostic procedures in elderly patients. But, since 1991, the rates have been stable. The report's authors note that the relatively low variation in incidence and mortality rates for brain cancers over the past several decades suggest that external risk factors in the environment do not play a major role in this disease.

Co-authored by researchers from the North American Association of Central Cancer Registries, the National Cancer Institute (NCI), the Centers for Disease Control and Prevention, and the American Cancer Society, the *Report to the Nation on the Status of Cancer, 1975-2007, Featuring Tumors of the Brain and Other Nervous System* was published online March 31 in the *Journal of the National Cancer Institute* (www.oxfordjournals.org/our_journals/jnci/press_releases/kohlerdjr077.pdf), and in print on May 4, 2011.

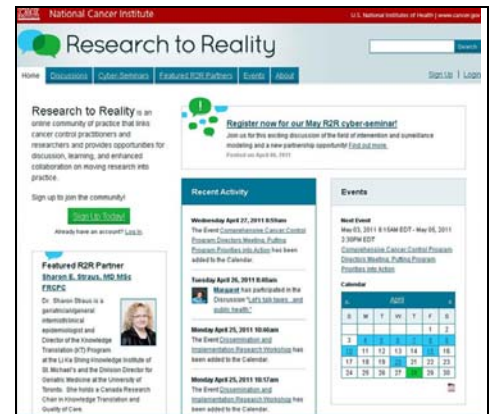
"It is gratifying to see the continued steady decline in overall cancer incidence and death rates in the United States — the result of improved methods for preventing, detecting, and treating several types of cancer," NCI Director Harold Varmus, MD, said. "But, the full repertoire of numbers reported today also reflects the enormous complexity of cancer, with different trends for different kinds of cancers, important differences among our diverse people, and different capabilities to prevent, detect, and treat various cancers. Moreover, as our population continues to age, we have an obligation to discover and deliver better ways to control all types of cancers."

Interactive Cancer Control Community of Practice Launched

The National Cancer Institute (NCI) has launched a free online community of practice linking cancer control practitioners and researchers. The website, [Research to Reality \(R2R\): Collaborating for Cancer Control](#), is designed to extend the work of [Cancer Control P.L.A.N.E.T.](#) and facilitate partnerships by engaging individuals and connecting organizations involved in cancer control. Those who are interested can visit the website to gather evidence-based information and discuss emerging issues related to the research and practice of cancer control dissemination and implementation.

Research to Reality has several interactive features, including discussion forums, community profiles, an events calendar, and monthly cyber-seminars that provide information about identifying and adapting evidence-based cancer control programs. The next cyber-seminar, on May 18 from 2:30 to 4:00 p.m., is "Modeling Impact: NCI's Cancer Intervention and Surveillance Modeling Network (CISNET)." Past cyber-seminars are archived on the site.

Future plans for Research to Reality include a mentorship program that will help a select cohort of public health practitioners build their capacity to identify and implement evidence-based cancer control and prevention interventions, with much of the information to be shared through the online community.



FDA Approves Gardasil Vaccine for Prevention of Anal Cancer

The U.S. Food and Drug Administration (FDA) has approved the vaccine Gardasil for the prevention of anal cancer and associated precancerous lesions due to human papillomavirus (HPV) types 6, 11, 16, and 18 in people ages 9 through 26 years. Gardasil is already approved for the same age group for the prevention of cervical, vulvar and vaginal cancer, as well as the associated precancerous lesions caused by HPV types 6, 11, 16, and 18 in females. It is also approved for the prevention of genital warts caused by types 6 and 11 in both males and females.

"Treatment for anal cancer is challenging; the use of Gardasil as a method of prevention is important, as it may result in fewer diagnoses and the subsequent surgery, radiation or chemotherapy that individuals need to endure," Karen Midthun, MD, director of the FDA's Center for Biologics Evaluation and Research, said.

Although anal cancer is uncommon in the general population, rates of the disease have increased over the past few decades (<http://seer.cancer.gov/statfacts/html/anus.html>), and HPV is associated with approximately 90 percent of anal cancer. The American Cancer Society estimates that about 5,300 people are diagnosed with anal cancer each year in the United States, with more women diagnosed than men. However, the largest increases in anal cancer have been seen among men. Men who have sex with men have the highest rate of this malignancy.

Gardasil's ability to prevent anal cancer and the associated precancerous lesions [anal intraepithelial neoplasia (AIN) grades 1, 2, and 3] caused by anal HPV-16/18 infection was studied in a randomized, controlled trial of men who self-identified as having sex with men (MSM). This population was studied because it has the highest incidence of anal cancer. At the end of the study period, Gardasil was shown to be 78 percent effective in the prevention of HPV 16- and 18-related AIN. Because anal cancer is the same disease in both males and females, the effectiveness data was used to support the indication in females, as well.

Gardasil will not prevent the development of anal precancerous lesions associated with HPV infections already present at the time of vaccination. For all of the indications for use approved by the FDA, Gardasil's full potential for benefit is obtained by those who are vaccinated prior to becoming infected with the HPV strains contained in the vaccine. Patients recommended for anal cancer screening should not discontinue screening after receiving Gardasil.

For more information, visit the FDA [Gardasil Product Page](#). News of the FDA's approval also was covered in the Feb. 23, 2011 edition of *JAMA* (Kuehn, BM. "New HPV Vaccine Indication." *JAMA*. 2011; 305(8):770.)

ACOG Says Family Health History is Important Screening Tool

All women should have a family health history on file, and it should be reviewed and updated regularly, according to The American College of Obstetricians and Gynecologists (ACOG). Family history screening is especially important in reproductive planning.

“Our goal is to help improve our patients’ health by promoting family history as a screening tool,” W. Allen Hogge, MD, chair of ACOG’s Committee on Genetics. Certain diseases and conditions run in families, such as breast and colon cancer, heart disease, type 2 diabetes, depression, and thrombophilias (blood clotting conditions). “If we know about the family history, then we can better help our patients identify their own risk factors, decide on certain screenings, and modify their lifestyle to prevent or minimize the problem.”

When a woman is planning a pregnancy, it’s an ideal time to review her family history, as well as her partner’s, Dr. Hogge said. In addition to obtaining the family and medical history of the woman and her male partner, it’s also important to include their ethnic backgrounds, any family or personal negative pregnancy outcomes they’ve had separately or together (e.g., miscarriages, preterm birth, or birth defects), and any known causes for infertility. Some couples may decide against pregnancy after genetic counseling and testing, choose to use donor sperm or eggs, or opt for preimplantation genetic testing of the embryos.

There are two standard methods that physicians can use to obtain family health histories: a questionnaire or checklist and a family pedigree.

The family history questionnaire is a common screening tool. Patients can complete them at home, thereby gaining extra time to contact family members and provide more accurate information.

The other family history tool, known as a ‘pedigree,’ ideally goes back three generations. The pedigree indicates the ages, health histories, and ethnicities of each family member, as well as the dates and causes of death. Of course, family history screening tools can be difficult or impossible to obtain for adopted individuals, and their usefulness may be limited for people with very small families.

Although many adult-onset health problems have complex genetic and environmental interactions, obtaining that information in a family history can help patients modify their diet, lose weight, or exercise to improve their outcome or delay the onset of symptoms.

“For instance, if you are at high risk for developing heart disease, then you need to watch your blood pressure and keep your cholesterol levels in the healthy range,” Dr. Hogge noted.

Committee Opinion No. 478, “Family History as a Risk Assessment Tool,” is published in the March 2011 issue of *Obstetrics & Gynecology*. [Abstract](#) [Full paper](#)



Learn more about your family health history.

Visit the Family Health History section of the Michigan Cancer Consortium website at www.michigancancer.org/familyhistory.cfm.

MDCH Offering Clinicians Cancer Family History Guide Tool

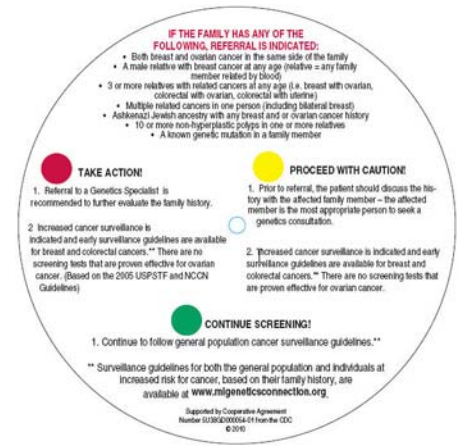
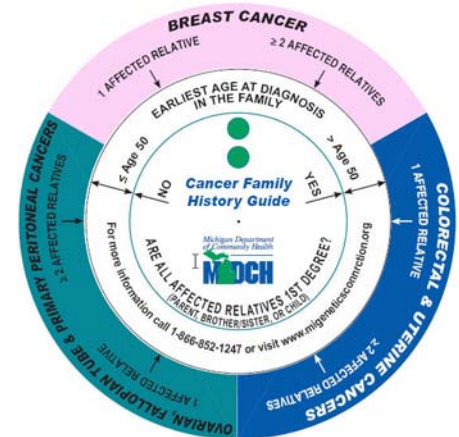
The Michigan Department of Community Health (MDCH) is offering Michigan healthcare providers its Cancer Family History Guide, a hand-held risk assessment tool designed to be used with patients who have a family history of breast, ovarian, colorectal, or endometrial (uterine) cancer.

Modeled after a standard obstetrical pregnancy wheel, the tool was developed by certified genetic counselors at MDCH, with input from the Centers for Disease Control and Prevention Office of Public Health Genomics and the Cancer Genomics Best Practices Steering Committee. The recommendations in the tool are based upon guidelines from the U.S. Preventive Services Task Force, the Evaluation of Genomic Applications in Practice and Prevention Working Group, the National Comprehensive Cancer Network, and the Society of Gynecologic Oncologists Education Committee.

Providers can use the tool to identify patients at risk for two hereditary cancer syndromes — Hereditary Breast and Ovarian Cancer (HBOC) syndrome and Lynch syndrome (often called hereditary nonpolyposis colorectal cancer or HNPCC). It can be used quickly, enabling the provider to address a family history of breast, ovarian, colorectal, or endometrial cancer in a patient in two minutes or less. If a significant family history is reported, the guide indicates that a referral for genetic counseling and further evaluation is appropriate, as are increased screening and consideration of management options.

Risk assessments with the guide should include only first- and second-degree relatives (i.e., mothers, fathers, sisters, brothers, children, aunts, uncles, grandparents, or grandchildren). The tool is not appropriate for use with patients who have personal histories of breast, ovarian, endometrial (uterine), colorectal, fallopian tube, or primary peritoneal cancer.

If you would like to know more about the Cancer Family History Guide, would like to disseminate it within your health system, or would like a copy for yourself, please contact Jenna McLosky, MS, CGC, at 517-335-8826 (e-mail: mcloskyj@michigan.gov) or visit www.migeneticsconnection.org/cancer_tool.shtml.



CDC Promotes National Colorectal Cancer Control Program in March 2011 Edition of *Gastrointestinal Endoscopy* Journal

By invitation, the Centers for Disease Control and Prevention (CDC) Division of Cancer Prevention and Control submitted an article to *Gastrointestinal Endoscopy* in celebration of National Colorectal Cancer Awareness Month.

The article, which was published in the March 2011 edition of the journal, describes how the CDC, public health, and providers are working collaboratively to increase the utilization and quality of population-level colorectal cancer screening in the United States. Its focus is on the Colorectal Cancer Control Program (CCRP), a CDC public health initiative that includes two components: 1) a screening provision, supporting clinical service delivery for low-income, under-insured persons, and 2) a screening promotion, involving activities to encourage broad, population-level screening. The authors describe in detail the collaborative efforts to increase screening adherence to 80 percent of the population.

This is the first publication on the CRCCP and the collaborative work it is doing with grantees and partners to increase population-level colorectal cancer screening in the United States. The article can be [accessed online](#) via the *Gastrointestinal Endoscopy* website or [downloaded as an Adobe Acrobat PDF file](#).

May

Sun	Mon	Tue	Wed	Thu	Fri	Sat
1 6th Internatl. Conf. on Health Issues in Arab Communities (Syria)	2 6th Internatl. Conf. on Health Issues in Arab Communities (Syria)	3 6th Internatl. Conf. on Health Issues in Arab Communities (Syria)	4 6th Internatl. Conf. on Health Issues in Arab Communities (Syria) ----- Mich. BCCCP, WISEWOMAN Program, and MCRCEDP Annual Meeting (Traverse City)	5 6th Internatl. Conf. on Health Issues in Arab Communities (Syria) ----- Mich. BCCCP, WISEWOMAN Program, and MCRCEDP Annual Meeting (Traverse City)	6 6th Internatl. Conf. on Health Issues in Arab Communities (Syria)	7 6th Internatl. Conf. on Health Issues in Arab Communities (Syria)
8	9	10 <i>Webinar:</i> "Weight Changes After Cancer Treatment: Why is it Happening, and What Can I Do About It?" (1:30-2:30 p.m. ET)	11	12 <i>Webinar:</i> "Understanding the Importance of Clinical Trials: What You Need to Know" (1:30-2:30 p.m. ET)	13 "Comprehensive Breast Care 2011" Seminar (Grand Rapids)	14
15	16 Michigan Health Policy 2011 Spring Forum: "The Snyder Administration's Health Priorities" (East Lansing)	17	18 Michigan Consumers for Healthcare Advancement Coalition Meeting	19 Origins of Cancer Symposium (Grand Rapids)	20 Origins of Cancer Symposium (Grand Rapids)	21 20th Annual Komen Detroit Race for the Cure (Detroit)
22	23	24	25	26	27	28
29	30	31				

2011

June

Sun	Mon	Tue	Wed	Thu	Fri	Sat
			1 <i>Webinar:</i> "The Challenges of Coping with Cancer and Other Health Problems" (1:30-2:30 p.m. ET)	2	3	4
5	6	7	8	9	10	11
12	13	14 <i>Webinar:</i> "Stress Management for Caregivers: Taking Care of Yourself Physically and Emotionally" (1:30-2:30 p.m. ET)	15 Michigan Consumers for Healthcare Advancement Coalition Meeting	16 <i>Webinar:</i> "Advances in the Treatment of Metastatic Colorectal Cancer" (1:30-2:30 p.m. ET)	17	18
19	20	21 Tobacco Cessation and Addiction Recovery (Ypsilanti)	22 MCC Board of Directors Meeting (Okemos) ----- <i>Webinar:</i> "Money Matters: Finding Resources to Manage Cancer Treatment Costs" (1:30-2:30 p.m. ET)	23	24	25
26	27	28	29 <i>Webinar:</i> "Legal Issues and Cancer: Understanding Your Legal Protections in the Workplace" (1:30-2:30 p.m. ET)	30		

2011