

so that sex is not painful—a common complaint among women who experience vaginal dryness.

Recommended: KY Silk-E or Replens.** Follow label instructions. **Important:** You must use such vaginal moisturizers for at least two months before judging results.

□ **Masturbate.** Yes, this simple action can be a powerful libido booster for women—partly because it turns out that sexual desire really is a “use it or lose it” function.

□ **Use lubricants.** Sexual lubricants help make sex more comfortable—painful sex is a common cause of low libido.

Recommended: Pjur Eros Bodyglide, which is a silicone-based, glycerin-free product. This combination offers several advantages, including a reduced risk for yeast infections or vaginal inflammation, compared with products that contain glycerin.

□ **Increase stimulation before and/or during sex.** When testosterone drops, some women need more stimulation to become aroused and to have an orgasm. The best method is to use a vibrator for clitoral stimulation. My sexual dysfunction patients report that the best vibrator is the Hitachi Magic Wand—it provides a very strong vibration. **Helpful:** Using an over-the-counter botanical oil with a vibrator has been shown in studies to increase a woman’s ability to have an orgasm. **Recommended:** Zestra Essential Arousal Oils.

□ **Exercise.** We know that exercise elevates mood, improves blood circulation and general health, and helps enhance body image. All of these factors can improve sex drive. **Recommended:** Any aerobic exercise, but especially walking and dancing because they are low-impact, low-stress exercise and can be fun to do. Aim to get out and walk (or dance) every day for at least 20 minutes. 🍎

**All the products mentioned in this section can be purchased from www.Drugstore.com, which ships its orders in a plain box labeled only with the company name.

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What Do All Those Cancer Stages Really Mean?

The numbers that doctors use tell more than most people realize.

Whenever we hear about someone having cancer, usually included in the news is what particular “stage” cancer he/she has.

In general, cancers with lower stages are easier to treat and have a more promising outlook than those with higher designations. But sometimes the numbers don’t tell the whole story. Other factors, such as your overall health and type of cancer, may affect prognosis and treatment.

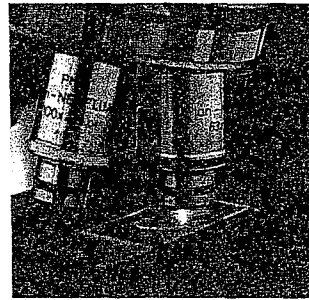
Important: Cancer staging is merely a guide. It determines how much cancer is in the body and where it is located to aid prognosis and treatment—but it cannot predict the result of a person’s battle with cancer. *What to consider when breaking down the numbers...*

TYPES OF STAGING

When a person is first diagnosed, and before starting treatment, he will have tests to determine the type and the extent of the cancer.

■ **Clinical staging.** This battery of tests measures how much cancer is present and helps the oncologist identify the best treatment. **Typical tests:** Physical exam, imaging tests (such as CT, MRI or PET scans or ultrasound) and tumor biopsies. For some cancers, results of other tests, such as blood tests, are also used in staging.

■ **Pathological staging.** This type of staging, also known as surgical



staging, is based on tissue obtained during surgery to remove the cancer and nearby lymph nodes. It delivers more precise data that’s used to predict responses and out-

comes. Pathological staging also occurs after *exploratory* surgery, which determines how much cancer is present in the body and may remove tissue samples.

Ideally, clinical and pathological staging should complement each other. However, not all cancers are staged by analyzing the size of the original tumor and whether the cancer has spread. For example, it’s not used for leukemia, because this cancer affects the blood and bone marrow, or brain cancer, which tends to spread throughout the brain only.

ELEMENTS OF STAGING

The American Joint Committee on Cancer, made up of academic physicians, epidemiologists, nurses and statisticians, developed the *TNM classification system* for staging most cancers. TNM stands for *primary tumor*, *regional lymph nodes* and *distant metastasis*. The TNM system was first developed in the 1940s and is continuously

Bottom Line/Health interviewed Sunil M. Patel, MD, a medical oncologist/hematologist and assistant professor in the general oncology department at the University of Texas MD Anderson Cancer Center and MD Anderson Regional Care Center—Katy, both in Houston. He is board certified in internal medicine, hematology and medical oncology. Dr. Patel’s clinical interests include solid and hematologic malignancies, with a focus on melanoma and cancers of the lung and breast.



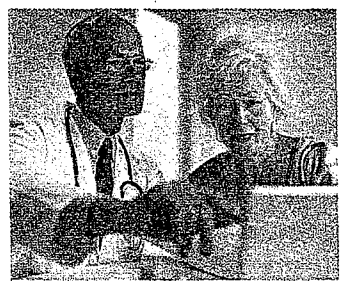


revised based on new discoveries and treatments for different cancers. *It looks at three main factors...*

■ **T** indicates the size of the primary (original) tumor and whether the tumor has penetrated into nearby tissue.

The higher the T number, the more dangerous the tumor with regard to size and whether it has penetrated nearby tissue. A T1 tumor is relatively small... a T2 or T3 tumor will be larger... and a T4 tumor is the largest and/or has penetrated the deepest.

The actual sizes of tumors with different T numbers will vary depending on the type of cancer. A T1 tumor of the breast, for example, will be less than two centimeters (about an inch), whereas T2, T3 and T4 tumors are larger. *Other T values...*



TX means that the tumor can't be measured at the time of diagnosis. For example, tests might indicate that cancer has spread to one or more lymph nodes, but imaging tests that would visualize the tumor haven't yet been done.

T0 means that there's no evidence of a primary tumor. This doesn't mean that the tumor doesn't exist. It just means that it can't be located.

Tis means that a tumor is *in situ* (precancerous). Cancerlike cells are present, but only growing in the most superficial layer of tissue.

■ **N** describes whether the cancer has spread to regional (nearby) lymph nodes. The more lymph nodes with evidence of cancer, and the farther away these nodes are from the original tumor, the greater the extent of the spread.

N1, N2 or N3 describes the size, location and/or number of lymph nodes involved and indicates how the cancer has spread. Higher numbers indicate a greater degree of lymph node involvement—and, in most cases, a poorer prognosis.

The N numbers don't necessarily indicate the exact number of

lymph nodes with signs of cancer. A designation of N3 could mean that cancer is present in several lymph nodes... in one very large lymph node... or in bilateral lymph nodes (for example, in both sides of the neck). *Other N values...*

NX means that the regional spread of the cancer cannot be determined because the lymph nodes cannot be evaluated.

N0 means that there's no cancer in nearby lymph nodes, a very promising finding.

■ **M** describes the spread (or metastasis) of cancer to distant areas of the body. Cancers that have spread beyond the regional area of the original tumor can sometimes be treated but are rarely cured. The risk for recurrence is high.

However, there are exceptions. With colon cancer, for example, the cancer often spreads to the liver. Between 10% and 20% of these patients can be cured with a combination of surgery, radiation and/or chemotherapy.

M1 indicates that a cancer has spread out of the immediate area to distant organs or tissue. **MX** means metastasis can't be evaluated. A designation of **M0** means that no distant metastases were found.

CRUNCHING THE NUMBERS

Once these TNM system values are determined, they are combined to come up with an overall stage number for the cancer (I to IV for most cancers). *Examples...*

A woman might be diagnosed with a T1, N0, M0 breast cancer. This means that the primary tumor is less than two centimeters in the largest dimension (in any direction)... there's no lymph node involvement... and the cancer hasn't spread to distant areas of the body. This would be considered stage I cancer.

Or a woman could have T3, N2, M0 breast cancer. This would indicate a large tumor that has spread

to nearby lymph nodes but not to other parts of the body. This would be designated a stage III cancer.

GRADE: A FOURTH FACTOR

For some cancers, other factors may affect staging. Oncologists might consider a tumor's *grade*—how abnormal the cancer cells look (usually assigned 1 to 4) under a microscope. Cancers with more abnormal-looking cells (a higher number) tend to grow and spread faster...

■ **Normal cells.** After a biopsy—or, in some cases, after the removal of the entire tumor—a pathologist examines individual cells. The more the cells resemble normal tissue, the less aggressive the cancer is likely to be.

■ **Abnormal cells.** Conversely, the cells might look highly abnormal.

STAGING AND TREATMENTS

People with the same stage and type of cancer tend to have similar survival rates and often respond similarly to treatments. Staging allows oncologists to make an accurate prognosis and helps to identify the best treatments.

Examples: Women with T1, N0 breast cancer (stage I)—small primary tumor and no cancer in lymph nodes—tend to do well. Those with T2, N0 breast cancer (stage II)—larger primary tumor and no cancer in lymph nodes—do almost (but not quite) as well. The slight difference in outcome is reflected in this stage difference.

For most cancers, the treatment options include surgery, radiation or chemotherapy or a combination of the three. The choice of specific treatments depends on both the tumor type and stage.

A CRITICAL STEP

For a person with newly diagnosed cancer, getting clear information regarding the type of cancer and stage is critical. Occasionally, doctors disagree about the diagnosis or stage in a given situation—a second opinion can give you a different perspective. ●

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