

CANCER RESEARCH FOUNDATION

The Mission of The Cancer Research Foundation Is To Help Find The Cures For Cancer Through Funding Laboratory and Clinical Research.

Connections

WITH FRIENDS

A Beautiful Gift for Cancer Research

JoAnne and Angelo Kopetas have worked with the Cancer Research Foundation for almost 15 years. Their firm does all of our printing and mailing and much of our design work. They are aware of our absolute dedication to funding only the highest quality cancer research projects in Chicago. They wanted to help us fund breast cancer research because it was a personal cancer: JoAnne and her sister, Connie Chrisos, both had breast cancer several years ago, and our executive director, Sharon Swanson, was diagnosed with breast cancer in 2003.

Every year, the women of the Kopetas' church raise money – which they award to worthy projects. In 2004, the Cancer Research Foundation was chosen to be a recipient of monies raised by the Philoptochos Society of the Holy Cross Greek Orthodox Church.

On a cold, snowy day in February, the Philoptochos Society of Holy Cross had its annual fund raising luncheon and fashion show. Under the chairmanship of Penny Lageotakes, these women put on a tasty and beautiful luncheon and fashion show at the Drury Lane Oakbrook. Through ticket sales, raffles and door prizes, they were very successful.

In March, at the Holy Cross Greek Orthodox Church in Justice, Illinois, a



\$10,000 check was presented to the Cancer Research Foundation by Father John Kalomas and Mirka Lenos, President of the Philoptochos Society, and Penny Lageotakes. This wonderful gift was earmarked for breast cancer research.

Through the direction of our medical advisors, we knew where to put the funds to work: Dr. Suzanne Conzen, at the University of Chicago Medical Center, has been a breast cancer researcher since we first named her a Young Investigator Award recipient in 1999. Dr. Conzen focuses on developing new treatments for large, inoperable breast cancers. She is convinced that even the most aggressive breast cancers can be killed, provided that critical survival signaling pathways in a tumor can be interrupted.

Each year, over 200,000 women in the United States are diagnosed with breast cancer. An increasing percentage of breast cancer patients are surviving each year. This type of cancer is **not** a guaranteed death sentence.

We're working on increasing the odds for each person diagnosed with breast cancer. This wonderful gift, and others like it, will make that happen.

Merle Goldblatt Cohen

Merle Goldblatt Cohen
President



A \$10,000 check was presented to the Cancer Research Foundation to Sharon Swanson by Father John Kalomas and Mirka Lenos, President of the Philoptochos Society, and Penny Lageotakes.



A Message From the Executive Director



In our last newsletter, I reported that I had been diagnosed with breast cancer on August 29, 2003. I finished my treatment on June 9, 2004, and am now cancer free. I am a survivor, just like most of the women who are diagnosed with breast cancer today.

I had my annual mammogram at the University of Chicago Medical Center in August, 2003. I got a follow-up call from their Breast Center, asking me to come back for a more sophisticated mammogram. I met Dr. Gillian Newstead, who looked at my new mammogram and asked me to stay for a sonogram, which I did. Two days later, I reported back for a breast MRI. Three days after that, Dr. Robert Schmidt performed a stereotactic biopsy of my breast. The next day, August 29th, Dr. Schmidt called to tell me that I had lobular breast cancer.

I was *amazed* that so much testing was done – to find an elusive breast cancer. Lobular cancer (lay language here) is like long thin needles of cancer cells distributed through the breast and not a solid tumor, making it more difficult to find. Dr. Newstead, Associate Professor of Radiology and Director of Clinical Services in Mammography, and Dr. Schmidt, Professor of Radiology and Director of Research Services in Mammography, had begun to save my life by finding my cancer.

Within minutes, I called Dr. Richard Schilsky, who is the Cancer Research

Foundation Medical Advisor and Professor of Medicine and Associate Dean for Clinical Research at the University of Chicago. In an absolute state of panic, I screamed at him “What to I do now?” He told me to come to the University of Chicago Medical Center today, right now. The very day I was diagnosed, I met Dr. Gini Fleming, Associate Professor of Clinical Medicine in Hematology/Oncology. Dr. Fleming became my oncologist, and she would coordinate my care during surgery, chemotherapy and radiation for treatment of my breast cancer.

One week later, we were planning a lumpectomy with my surgeon, Dr. Nora Jaskowiak, Assistant Professor of Surgery. I had the lumpectomy and 15 lymph nodes removed, most of which were malignant. Dr. Jaskowiak also found more cancer cells outside the operating field in my breast, and we planned a mastectomy later, to get rid of all these extra cancer cells. I had a CT scan and a bone scan, both of which showed no detectable cancer spread

Chemotherapy came next. Dr. Fleming was in charge. I had some strange reactions which landed me in the hospital more than once. I lost my hair, the palms of my hands and feet became bright red, as did my nails; I had rashes, nosebleeds, fevers and infections. I had trouble breathing and walking at the same time. My legs became weak, and I could not navigate steps without help. I lost much of my

personal lexicon and could not drag exact words out of my brain. I gave myself injections of a medicine to keep my white blood cell count high at one point, and injections to keep my red blood cell count high at another time. I took medicines to prevent nausea, and they worked. I was exhausted much of the time, but very seldom ill-feeling. The important fact is that all but one of my chemotherapy side-effects were temporary, and I knew that at the time I had them. When I was done with chemo, I was done with chemo side-effects.

My *only* lasting side-effect is lymphedema in my right arm and chest, swelling caused by the accumulation of fluids where I have no lymph nodes for the fluids to drain through. Two trained physical therapists, Diane Davis and Carol Miller at the University of Chicago, massaged the excess lymph fluid gone, and I now get my arm wrapped in bandages at night, and wear an elastic sleeve if my arm measurements are the tiniest bit larger than my unaffected arm.

Following chemotherapy I had my mastectomy. One of the most surprising things that I learned about breast surgery is that the anesthetics that Dr. Jaskowiak and my anesthesiologist used are very quick to wear off. Also, breast cancer surgery doesn't hurt. I had pain killers in my one day stays at the University of Chicago Hospital, but I went home with a prescription for Tylenol with Codeine – which I did not need. The “extra”

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Update on Breast Cancer Diagnosis at the University of Chicago Breast Imaging Center

*by Dr. Gilliam Newstead
Associate Professor,
Department of Radiology
Director of Clinical Services,
Mammography*

The diagnosis of breast cancer requires an integrated and multidisciplinary approach. New technology allows the radiologist to detect and evaluate breast cancer more effectively. The advent of digital mammography, enhanced ultrasound techniques, computer-aided diagnosis, and magnetic resonance imaging provide enhanced methods for diagnosis.

At the University of Chicago the team of breast radiologists, Drs Robert Schmidt, Charlene Sennett, Madonna Kral, Hiroyuki Abe and Gillian Newstead provide a full range of diagnostic services to about 20,000 patients each year.

Under the leadership of Dr Newstead, breast magnetic resonance imaging techniques have become an important addition to our methods of breast cancer detection. Last year we examined more than 600 patients with MRI, many of whom were referred for evaluation with a newly diagnosed breast cancer. Breast MRI allows more precise determination of the extent of cancer within the breast, and thus provides more accurate information to the treating physicians. Breast MRI allows the detection of breast cancer which is occult by other screening methods. We have embarked on a

funded program, led by Dr Funmi Olopade, to screen high risk women with digital mammography, whole breast ultrasound and MR imaging.

New MR research techniques have been developed under the guidance of Dr Gregory Karczmar. A team of researchers includes physicists Milica Medved, Cheng Yang, Marta Zamora and Sunny Arkani.

Programs currently include the investigation of high temporal resolution techniques for the evaluation of ductal carcinoma in situ, and high spectral and spatial resolution methods for evaluation of small breast lesions.

The breast diagnostic program is closely involved with the imaging research performed at the Rossmann laboratories. Multimodality Computer-aided diagnostic methods will soon be introduced into the diagnostic area.

Dr Robert Schmidt, in collaboration with Philips Medical Systems, will lead a program to evaluate a prototype whole breast ultrasound device. This machine will provide 3D breast images and may lead to a new way of screening the breast with ultrasound. Ultrasound screening could also be used in the future for the screening of women with dense breast tissue. Mammography screening in these women is limited, and small cancers may be obscured.

These new diagnostic methods for breast cancer diagnosis should result in improved detection and more accurate assessment of the breast cancer patient.



At the University of Chicago the team of breast radiologists pictured from left to right: Drs Robert Schmidt, Hiroyuki Abe, Madonna Kral, Gillian Newstead and Charlene Sennett.



New Directions in Systemic Treatments for Breast Cancer



Dr. Gini Fleming
Associate Professor of
Clinical Medicine
Department of Medicine
Section of
Hematology/Oncology

There has been steady improvement in the diagnosis and treatment of breast cancer. Although the numbers of breast cancers diagnosed in the U.S. is no smaller, the numbers of women dying from breast cancer in the U.S. has decreased. More types of therapy are available, and better supportive care, such as anti-nausea drugs and growth factors, is available to counteract some of the side effects of therapy. But there is still much progress to be made!

Newer Anti-hormonal Therapy for Young Women

Although it is chemotherapy that is more intense, in many cases it is anti-hormonal therapy that provides the most benefit to breast cancer patients. For many years in the United States, this was not appreciated. In particular, anti-hormonal therapy was not thought to work in premenopausal women. We now know this is false. Young women whose tumors express hormone receptors will do poorly if they do not get anti-hormonal therapy. Dr. Fleming is U.S. Study Chair of an ambitious multinational cooperation spearheaded by the International Breast Cancer Study Group (IBCSG) to try to speed up the lagging development of hormone therapy options in young women. This study, nicknamed the SOFT trial, randomizes premenopausal women to tamoxifen alone, ovarian function suppression plus tamoxifen, or ovarian function suppression plus exemestane (a newer anti-hormone therapy). More information about this trial, as well as many other cancer clinical trials can be found at the NCI website www.cancer.gov.

Individualized Cancer Therapy

The treatments we have are effective for some breast cancers and not others. Why

can't we figure out ahead of time which treatments will work on an individual patient's cancer?

This is one of the important questions our breast cancer patients ask. It is a question researchers throughout the world and at the University of Chicago are working to answer. For breast cancer patients, some treatment choices are already based on the particular characteristics of a given cancer. Only tumors which have hormone receptors (Estrogen Receptor, known as ER, or Progesterone Receptor, known as PR) will shrink when treated with anti-hormonal therapies, such as tamoxifen or aromatase inhibitors. Only tumors which amplify the gene for Human Epidermal Growth Factor Receptor 2 (HER2) will shrink when treated with the monoclonal antibody trastuzumab (Herceptin®).

One way researchers have to learn about out how to predict what therapies will work for a specific patient's cancer is to perform some tests on a biopsy of a breast cancer, then treat the cancer with chemotherapy before final surgery. Treatment with chemotherapy before surgery is frequently done in any case in order to shrink the tumor and make surgery easier (or possible at all), and is sometimes called "neoadjuvant therapy".

Therapy for Young Women Whose Tumors do not have Hormone Receptors

Dr. Olopade is a researcher at the University of Chicago who has long had an interest in inherited breast cancer, and in the aggressive forms of hormone receptor negative breast cancer that often affects young black women both here in the United States, and in her native Nigeria. Some of these cancers may have defects in DNA repair making certain drugs that damage tumor

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Surgery for Breast Cancer:

Progress & Hope

By Nora Jaskowiak, M.D.



*Dr. Nora Jaskowiak
Assistant Professor
Department of Surgery*

As is in evidence throughout this issue, breast cancer is a common disease in which huge advances have been made in both understanding and treatment. Surgery for breast cancer is no exception. The evolution of surgical options for breast cancer has been dramatic in the last forty years, taking us from the radical mastectomy of the 1960's to the outpatient lumpectomy/sentinel node biopsy of 2004. These advances have benefited patients tremendously – minimizing pain and disability, decreasing hospital stays, speeding recoveries and facilitating implementation of adjuvant therapies, and aiding cosmesis.

In this brief article, I will touch on some of the major changes that have occurred in surgery for breast cancer. When I talk to patients about treatment options, we discuss options for the breast first, then the lymph nodes, then what the future holds. I will construct this discussion similarly.

Many women who present with early breast cancer have the option of saving the involved breast, an approach referred to as breast-conserving therapy. Beautifully done research studies with greater than twenty years of follow-up have proved that breast conservation, which entails lumpectomy followed by radiation, leads to long-term survival rates identical to more extensive operations (i.e. mastectomy). Breast conserving therapy is frequently chosen

by patients, with excellent outcomes. Advances in breast imaging, including the growing use of digital mammography, ultrasound, and MRI, are assisting in better defining extent of disease preoperatively and helping patients and surgeons make the most informed choices possible.

Another major advance, in patients who require (or desire) a mastectomy, is the growing number of options for breast reconstruction. Reconstruction can be done immediately (at the same time as mastectomy) or in a delayed fashion, depending on a number of factors. For many patients, immediate reconstruction at the time of mastectomy is a viable option and this is now routinely done in a way that preserves much of the natural skin of the breast, which is of tremendous benefit cosmetically. Excellent cosmetic results can also be obtained in cases of delayed reconstruction.

Surgical staging of the lymph nodes in the underarm (axillary) area has changed tremendously over the last decade. This is primarily because of the sentinel node biopsy technique. This procedure, originally conceived for the assessment of lymph nodes in patients with melanoma, has over the last decade become the standard of care for patients with early stage breast cancer in whom no abnormal lymph nodes are felt in the underarm area. The basic theory is that the lymph drainage from the breast to

the axilla does not go immediately to all 15-20 nodes that reside there, but drains preferentially to one or two “sentinel nodes” first, and that those nodes would be the most likely to show metastases, if any spread of disease has occurred. And the theory has proven correct through many well-done studies. So today, for many women, we can remove just one or two lymph nodes from the axilla, staging the cancer precisely and sparing many patients the potential serious side effects of complete axillary lymph node dissection, which include arm swelling (lymphedema) and nerve injury.

Breast cancer treatment in 2004 is a truly multidisciplinary undertaking, involving surgeons, medical oncologists, radiation oncologists, mammographers, pathologists, plastic surgeons, nurses, and social workers. All are critical to success. Surgeons, along with breast imagers, are among those who are the first to deal with patients when the cancer has just been, or is being, diagnosed. It is an incredible privilege and honor for me to be involved with patients in these early phases of diagnosis, decision making and treatment. Ongoing research will continue to help streamline surgical care of breast cancer patients, ultimately leading to better outcomes for many patients.



*Nancy with grand-daughter,
Blaise*



Collette




JoAnne



Kay and Kathy

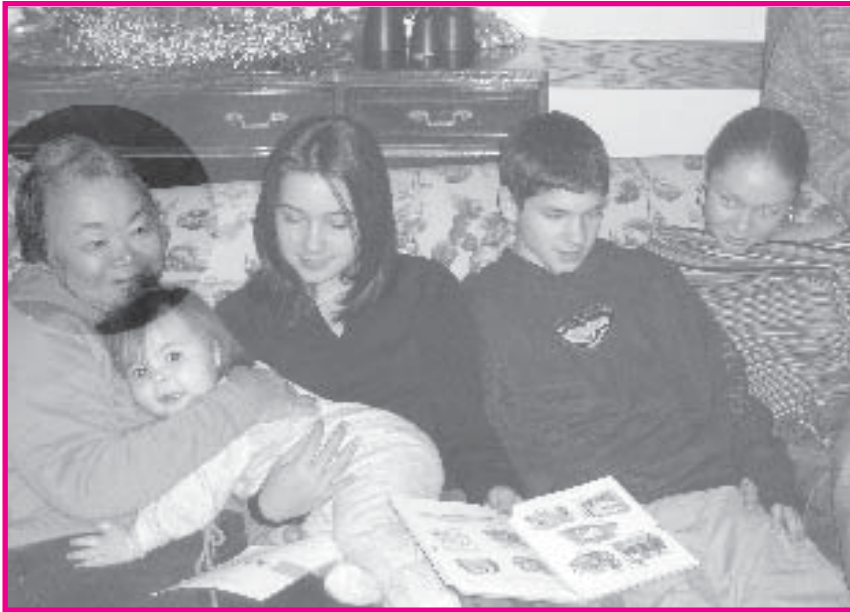


Deborah



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our emotions
and our l
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We were thrust into le
and our partner w
Working through the s
and fear unl
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No, we will lead the dance
moment, seeing, smelling
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We will be the lea
We have said "Yes" and j

By Deborah



Vicky with grandchildren



Connie



Karen



Barbara with grand-daughter, Lizzie



Jane



Sharon

invited,
arts, our minds,
our souls
bodies.
nothing was the same.
learning a new dance
as breast cancer.
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knowingly
courageous warriors.
hearts beating as one,
our stories
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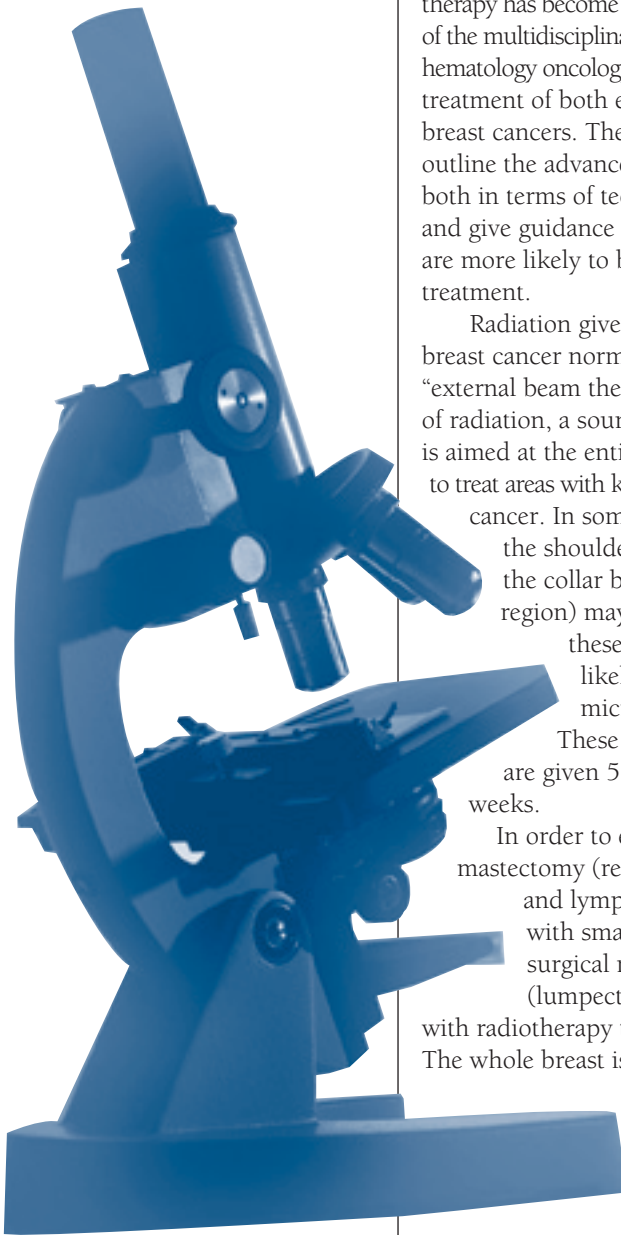
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Radiotherapy for Breast Cancer Patients:

Advances in technology and biology improve patient lives

Dr. Steven J. Chmura



Radiation therapy of breast cancer patients employs high-energy x-rays or particles (electrons) that directly or indirectly kill cancer cells. Radiation therapy has become an essential component of the multidisciplinary (surgical oncology, hematology oncology, pathology, radiology) treatment of both early and advanced breast cancers. The following essay will outline the advances in radiotherapy both in terms of technology and biology and give guidance as to which patients are more likely to benefit from radiation treatment.

Radiation given to women with breast cancer normally consists of “external beam therapy”. With this type of radiation, a source outside the body is aimed at the entire breast or chest wall to treat areas with known or suspected cancer. In some cases, areas under the shoulder (axilla) and above the collar bone (supraclavicular region) may need to be treated if these areas have a high likelihood of harboring microscopic cancer cells.

These radiation treatments are given 5 days/week for 5-6 weeks.

In order to eliminate the need for mastectomy (removal of the breast and lymph nodes) in patients with small breast cancers, surgical removal of the tumor (lumpectomy) is combined with radiotherapy to the entire breast. The whole breast is irradiated because previous studies have shown that small amounts of tumor cells can lie outside the main

area of tumor. This is followed by a focused beam (boost) to the small area of the breast where the tumor was felt or seen on mammogram. Numerous randomized studies across the world consistently demonstrated that the need for mastectomy is eliminated by treating patients with lumpectomy and radiation without compromising curability. In fact, recent data suggest that patients undergoing lumpectomy and radiation have a slight improvement in survival compared to those receiving surgery alone.

In the past 30 years we have seen a revolution in the delivery of x-rays as therapy for breast and other cancers. These technologic revolutions have decreased skin reactions resulting in an excellent cosmetic outcome in the hands of a well trained surgeon and radiation oncologist. Furthermore, these technologic improvements may explain the increased cure rates seen in modern groups of both early and advanced breast cancer patients.

At our institution, every breast cancer patient receives “customized” or 3D radiation treatments. Each patient undergoes a planning CT-scan which shows us where the heart, lung, breast, and bones are in relation to the tumor. Using this information along with knowledge of tumor motion, we can employ our sophisticated x-ray delivery machines (linear accelerators) to shape the dose of radiation uniquely for the tumor and individual patient thereby avoiding radiation to some of the heart and lung. This is especially important in women who have received a significant amount of chemotherapy that may already damage those organs. In addition, we employ computerized patient setup



procedures to ensure that each patient is in the correct treatment position each day before radiation is delivered. Soon, these patients will be treated with techniques that synchronize delivery of radiation with each patient's breathing cycle to further reduce the dose of radiation to these organs.

Over the past 100 years, scientists have discovered that ionizing radiation (IR) kills both normal and tumor cells primarily by damaging the genetic information (DNA) essential to the growth of both tumor and non-tumor tissues. Currently, because there is no effective "monitor" of DNA damage, most patients are treated with the same dose of radiation. This dose was chosen to most likely benefit the largest percentage of patients without causing harm. Yet, despite the technological advances in radiotherapy, little is understood why some patients completing radiation treatments have tumor recur either in the breast or on the chest wall (following mastectomy in advanced cases). However, we do know that the same kind of tumor in different patients exhibits a wide and varied response to radiotherapy. Because of this a minority of patients may be successfully treated with a lower dose of radiation than the standard dose that is currently employed. On the contrary, other patients receiving the standard dose of radiation may be treated with too low of a dose to cure their particular tumor.

While increasing the dose of radiation to the breast or chest wall may improve the probability of tumor cure, this also would increase toxicity to normal tissues such as heart and lung, nearby. Thus, identifying patients most

likely to benefit from treatment, and determining whether a curative dose has been delivered to the tumor, could potentially increase the efficacy of radiotherapy and limit toxicity. Our laboratory is currently developing a system to predict not only the response of patients to radiation, but the amount of damage done to both tumor cells and normal cells. We believe that the development of sensitive and specific cellular-level "monitors" of the biological effects of IR will be invaluable clinical tools to both identify breast cancer patients that require higher radiation doses and/or the addition of medicines to augment the effects of radiation, such as chemotherapy or hormonal therapy to optimize clinical outcome. A cellular monitor of IR could also be employed to limit morbidity both in patients who will respond well to radiotherapy and in those who will not benefit from further cytotoxic treatment.

In addition to technological improvements in tumor cell imaging and determining accurate radiation dose, over the next 10 years, we will develop new classes of "targeted" molecules aimed at processes unique to tumor cells. These "small molecules" may represent an entirely new class of chemotherapy that can be combined with radiation to improve patient survival and quality of life. At the University of Chicago these technological and biological advancements discussed here are being not only developed but implemented as quickly as possible for the benefit of our patients.



*Dr. Steven J. Chmura
Assistant Professor
Radiation and Cellular Oncology*



Changes

by Sylvia M. Watson, R. N.
Clinical Nurse, Department of Medicine,
Section of Hematology Oncology

We have gone from an age of keeping our Breast Cancer illness behind closed doors to telling family, friends and co-workers.

We have gone from accepting what the physicians states as “this is the way” to asking about other modalities. And when not satisfied with his or her response, we aggressively seek other opinions. We have evolved to a very savvy clientele that now wants to know about all aspects of our disease.

We have demanded from the medical community better surgical options. We know what we want in terms of treatment modalities, how we want to be treated, and where we will be treated.

In regard to treatments, we now have clinical trials available for our

particular Breast Cancer. Whether it’s ER/PR/Her 2 neu +/-, we are asking the questions that 20 years ago we never would have considered. What are my chances with my family background of getting this disease? We have opened the doors of knowledge by wanting to know. To this the medical community has responded by complying with all the genetic markers of assisting us in making pertinent decisions regarding our care. We now are in command of our own destiny. We have come a long way in opening the doors of knowledge for ourselves and future persons with this disease. It is a disease that has made women strong, assertive, powerful, and energized to live long, productive lives. And that we’re doing everyday.



New Directions in Systemic Treatments for Breast Cancer

(...continued from page 4)

DNA, such as cisplatin, particularly effective. Dr. Olopade is launching a revolutionary trial to treat large breast cancers with a chemotherapy containing cisplatin before surgery. Extensive tumor biopsies will be obtained prior to chemotherapy, and, with modern gene expression array technology, they will be tested for a multitude of factors to try to predict which ones benefit most from this therapy.

Importance of Steroids

Dr. Conzen is working on a related project here at the University of Chicago. Her laboratory published groundbreaking work showing that in breast cancer cell culture, corticosteroids can decrease the effectiveness of chemotherapy, although nobody knows if this is relevant to patients

or not! Corticosteroids are routinely given prior to chemotherapy to prevent nausea or prevent allergic reactions. (These are, by the way, not the same sort of steroids that have been making Olympic news....) Dr. Conzen is looking at expression of genes related to cell death in tumors in a biopsy before treatment, and then a second small biopsy after chemotherapy (with or without steroids). The goal of the Breast Cancer Program at the University of Chicago is to get permission from patients for research biopsies on ALL patients getting neoadjuvant therapy, as part of the larger goal: to study tumors so that we can eventually predict which tumors will shrink!

Survivor Issues

As more women survive breast cancer, issues for survivors become ever more important. Can we preserve fertility in young women? Can we prevent second cancers, such as ovarian cancers, in those at high risk? Can we identify other family members who are at risk for cancers? Can we avoid premature osteoporosis? Do our treatments cause loss of memory or other higher function (“chemobrain”)? Can we improve screening with MRI for subsets of women? These are among the many issues that University of Chicago teams of researchers are tackling. We believe that, working with our patients, we can make breast cancer much less of a threat for future generations of women.



A Message From the Executive Director

(...continued from page 2)

cancer cells leftover from my first surgery were *gone*. Yea!

Radiation was my last treatment, and the absolute most fascinating. The radiation for me was external. My Radiation Oncologist, Dr. Rachana Singh, directed that a custom cradle be made of my upper body and head, in which I would lie during radiation treatments; my torso was “tattoo-ed” with India ink – markers for the field to be radiated. For 28 weekdays, I had radiation treatments. Because of the body cradle, my position was exact for each treatment, and the radiation beams, directed by computers within the linear accelerator, were exact for each treatment. My only side-effect was a sunburn, which faded in a couple of weeks. The day after my last treatment on June 9th, 2004, my husband and I went on a weekend trip. I was feeling great. I had won!

Of course, I had “won” nothing by myself. All of my doctors, and all of my medical care were at the University of Chicago Hospitals. I will forever be in debt to the caring nurses and doctors who made me healthy. I was at work at the Cancer Research Foundation office during every week of my treatment, but not necessarily on top of my game. It would not have been possible to go through this cancer treatment without the encouragement and understanding of Mrs. Goldblatt, CRF Chairman, Merle Goldblatt Cohen, President, Stanford Goldblatt, Vice President, and the Trustees.

Lloyd, my husband, and Cindy and Mary, our children, cocooned me through every day of every week. Our friend, Susie, drove me to work and back home every single day so that I wouldn't be susceptible to contagious infections

carried by people on mass transit, my former mode of transportation. Our friends fed us and flowered us and gave us love and hope – the silver lining.

Since I was diagnosed with breast cancer, I have met so very many other women who were also like-diagnosed. We have photos of some of them in this newsletter – *cancer survivors, all of us*.

With the exception of Dr. Singh, who is now practicing medicine at Princeton University, all of my doctors have agreed to write about their specialties in this newsletter. Dr. Steven Chmura is now directing breast cancer radiation at the University of Chicago, and writes about radiation oncology. We hope you'll find the articles interesting and informative.

*Sharon Swanson,
Executive Director*

Special Occasion and Memorial Acknowledgement

Gifts honoring the memory of someone dear who has died, or gifts in celebration of birthdays, anniversaries, a new home, a new baby or many other special occasions arrive at the Cancer Research Foundation daily.

This represents a current philanthropic trend in gift giving. Caring individuals and companies are making donations to CRF in someone's name, in lieu of client or staff gifts. It's truly a way to demonstrate that it is better to give than to receive.

Now it's even easier to give: In addition to personal checks and cash, **you can charge your gift to VISA, MasterCard or American Express** – by mail, or by phoning our office, or by going to our website www.cancerresearchfdn.org. Every contribution will receive a timely, personalized acknowledgement from CRF.

For further information, contact the Cancer Research Foundation at (312) 630-0055.



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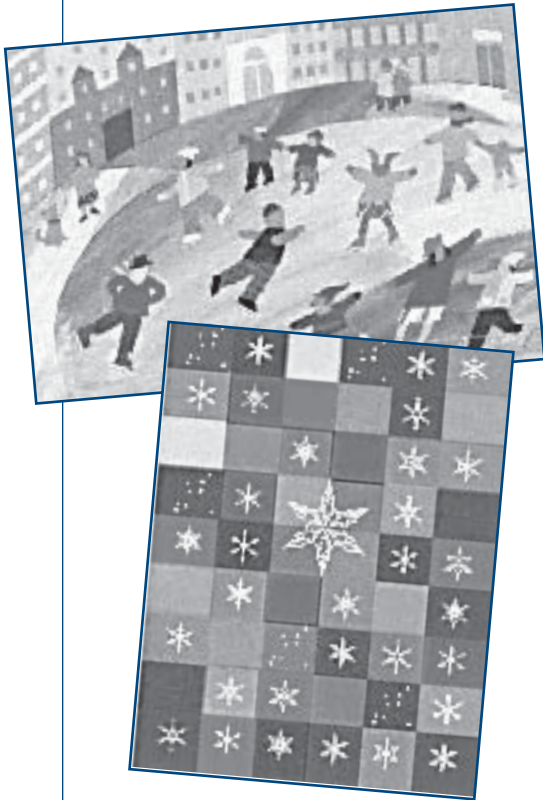
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Holiday Cards

We have beautiful holiday cards – several are pictured here.

The Cancer Research Foundation has been partners with Heartfelt Charity Cards for over 14 years. Heartfelt Charity Cards offers our donors and friends an opportunity to send quality holiday cards that benefit the Cancer Research Foundation.

To view card selection, go to our website www.cancerresearchfdn.org or call (800) 464-7880.

We also have all-occasion cards available through the website and phone number.



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Cancer Research Foundation

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As a responsible member of the community, the Cancer Research Foundation believes in accountability. We think the more you know about our trustworthy stewardship of funds, the more willing you will be to invest in the future through the Cancer Research Foundation.

Every year, the Cancer Research Foundation files a report with the Internal Revenue Service, IRS Form 990 (Return of Organizations Exempt from Income Tax). This report is available for public inspection in our office. We also make it available by mail, at a nominal cost.

Cancer Research Foundation financial records are audited annually. This report is reprinted in its entirety and included each year in one of our newsletters.



The Cancer Research Foundation is an Illinois 501 (C) (3) not for profit corporation, operating in Chicago. Our mission is to help find the cures for cancer through research. We welcome memorial contributions and gifts in honor of special celebrations. Contributions are deductible to the full extent allowed by law.