

# Beating the killer within



One woman dies of ovarian cancer every two days in New Zealand, yet few women seem to even know what the symptoms are.

BY GERALDINE JOHNS/PHOTOS BY DAVID WHITE

Every cancer has its day – or maybe even its month. August has daffodils to highlight the illness as a whole. October, with its plethora of pink ribbons, is breast cancer awareness month. There's Movember for prostate cancer, and on it goes.

Not many people know September is gynaecological cancer awareness month – symbolised by a teal ribbon – and nor, until it has progressed to a dangerous stage, do many women know they have one particularly sinister type – ovarian – at which late point, long-term survival rates are just 30%.

Lisa Finucane is having a crash course in ovarian cancer, its treatment and outcomes. It's been an exercise of necessity for the 48-year-old Aucklander after she was diagnosed with ovarian cancer last Christmas. Finucane – described by her specialist as a “sensible, down-to-earth woman”, was both breast and cervical cancer-aware and was regularly screened for both. But she had no knowledge about the cancer she actually had. (See story page 26.)

Ovarian cancer is often referred to as the silent killer. There is no screening test for it and it can be either genetic in origin or sporadic. Symptoms are often dismissed as vague and difficult to pinpoint. And it certainly doesn't enjoy the public profile of other cancers.

For all that, ovarian cancer is a big killer. It rates as the fourth-leading cause of cancer deaths in New Zealand women – behind lung, breast and colorectal cancer. One woman dies of the disease every two days, with annual deaths totalling 188. In terms of incidence, it's the second-most

common women's cancer (290 new cases are reported each year, compared with 170-180 for cervical cancer).

Of the three main types of ovarian cancer, epithelial ovarian cancer – which arises from the cells lining the ovary – is the one most women present with.

**“You can't dress up ovarian cancer in the same way as you can with breast cancer. Your tits are 'in-your-face', so it's a very out-there topic.”**

From her rooms at Ascot Central Women's Clinic in Greenlane, Auckland, Dr Ai Ling Tan champions the call for more education – both of women and general practitioners – in the early detection of ovarian cancer. “It's not uncommon for us to see women who know nothing about it,” she says.

Many of her patients present with the disease when it is at an advanced stage and therefore more difficult to treat.

It's not just that the profile is low; it's also that, by association, fund-raising success and awareness is, too. In Australia, a leading specialist has gone as far as to say the breast cancer lobby's “pink steamroller” is diverting funding and public awareness from ovarian cancer and contributing to low survival rates.

Dr Orla McNally – director of oncology and dysplasia at the Royal Women's Hospital in Melbourne – says the “vast difference” in profile and charitable support given to the two diseases plays a part in Australian survival rates. About 53% of New South Wales women with ovarian cancer are alive after five years, compared with 91% with breast cancer.

“You can't dress up ovarian cancer in the same way as you can breast cancer. Your tits are 'in-your-face', so it's a very out-there topic,” McNally told the *Sydney Morning Herald*.

“The majority of women with the disease [breast cancer] go on to survive and talk about it and lobby for it. The majority of women with ovarian cancer die within five years.”

Tan is a gynaecological oncologist, one of just five in New Zealand: three are in Auckland, another two in Christchurch. Ideally, we'd have eight such specialists for our population.

After completing her medical degree at Adelaide University, Tan underwent post-graduate training in obstetrics and gynaecology at National Women's Hospital in Auckland and Brighton General Hospital in England. She subsequently did sub-specialty training in gynaecological oncology (surgery, chemotherapy and radiotherapy) to obtain formal certification in that field

Lisa Finucane  
and her dog  
Desmond:  
“Cancer is a  
bastard.”



and now practises publicly and privately – at Ascot and Auckland City Hospital. She is also a member of the New Zealand Gynaecological Cancer Foundation.

Tan wants to publicise the importance of early detection, but says “anything gynaecological doesn’t get a lot of publicity. It’s very personal and women don’t like to talk about it.” There’s a lot of guilt, too, she says. “Especially with gynaecological cancer, women may think it’s their fault. They say, ‘Was I promiscuous; did I bring it on myself; was it my lifestyle; was it me?’”

The answer is no. Most often there is no known cause of ovarian cancer and no lifestyle or dietary factor to which it can be attributed. In about 10% of cases there is a familial link. The potential to develop a

hereditary type of ovarian cancer has been identified in women who have a gene mutation known as BRCA1 or BRCA2.

There’s no data to suggest screening would reduce mortality in this group. “What does reduce mortality is having risk-reducing surgery before symptoms develop,” says Tan. “Let’s say you have a person who’s got the BRCA1 and she has tested positive for the mutation. Usually, we would recommend she has her tubes and ovaries out at age 40.” Such a procedure decreases the risk of developing ovarian cancer by 95% – and reduces the woman’s chances of developing breast cancer. However, says Tan, insurance companies don’t cover such a procedure under these circumstances, deeming it a preventative measure.

**I**n the general population, the earlier the detection, the greater the chances of successful treatment, says Tan. She advocates self-monitoring and the adoption of what is known as the Beat acronym to personally detect symptoms early.

The Beat initiative, launched in Britain in 2008, is now recognised internationally. The first three letters identify the most common symptoms in women diagnosed with ovarian cancer, namely:

**B** is for bloating that is persistent and doesn’t come and go,  
**E** is for eating less and feeling fuller,  
**A** is for abdominal pain, and  
**T** is for telling your GP.

Other symptoms include a change in bowel habits, increased urgency or frequency of urination, and fatigue.

# ‘I thought I was starting the menopause’

One minute she has a head full of hair; the next she’s as bald as a bullet.

“Really,” says Lisa Finucane, after whipping off her wig and abandoning it on the pavement table she sits at, “if I can’t do it in Ponsonby, where can I?” And nobody blinks an eye.

The sun shines, which explains Finucane’s spontaneous act: it’s too hot. Besides, even in clement temperatures, wigs have a tendency to itch – which only worsens as the mercury rises.

Finucane, 48, has ovarian cancer. She has had a hysterectomy and has almost completed an 18-week course of

chemotherapy: six five-hour sessions of drugs administered via drip, with fortnightly breaks. Punctuating each period is a rotation of blood tests, plus regular monitoring by an oncologist.

Although Finucane has what is described as an atypical cancer, which may or may not be sensitive to chemotherapy, she has embraced the “Roundup” treatment, as she calls it. “Even if it only *may* help, I wouldn’t want to miss that chance. I didn’t want this to come back in one year or 10 years or 20 years and know I’d passed up on this option.”

One of the first signs the drugs were working, her friends joked, was her hair falling out by the handful. In the end, she shaved the last of it off.

A wig with no scalp to sit on is a forlorn and lifeless thing, but Finucane denuded casts a noble character. She was diagnosed with stage 3 low-grade serous carcinoma of the ovary last December. (Most cancers have four stages, with stage 4 the most advanced.)

She didn’t see it coming. The head of communications and external relations at the University of Waikato had, until then, enjoyed abundant good health. There is no history of cancer in her family; in fact, she and her father not so long ago decided that what would kill them would be a stroke or a heart attack.

Last November, Finucane attended a conference in Melbourne. “And I

couldn’t eat anything. I felt permanently full. I realised I was also bloated. I thought I was starting the menopause.” She then remembered a regular check-up with her GP earlier in the

year. Her doctor noted her ovaries could be “a little swollen” and advised an ultrasound abdomen scan with her next mammogram.

“My GP certainly gave me the right advice, but I had no sense of urgency back then,” says Finucane. “And because I’m so busy, I didn’t get around to it.”

But back home from Melbourne, she decided she had better do just that. The mammogram was fine; an abdominal

scan was anything but. It was followed by an immediate unscheduled trans-vaginal scan. “And that’s when I realised all was not well. They didn’t quite look me in the eye any more, and [the sonographer] said, ‘I’ll just get my supervisor to check this.’”

She was referred to gynaecological oncologist Dr Ai Ling Tan, who sent her for an MRI scan. The next seven days were the longest and loneliest of her life – during which time she convinced herself she was riddled with cancer. She chose not to tell anybody. “I’d half written my eulogy. I was going to have a pre-funeral funeral in January.”

So when Tan told her she had ovarian cancer, there was a degree of relief – albeit based on ignorance. “All I could think was: ‘Thank God – no secondaries.’ But I didn’t know how bad ovarian cancer is.”

Twelve days before Christmas, Finucane – who is single and has no children – had a total hysterectomy; the chemo started in February. She has been spared an excess of unpleasant side effects (nausea, muscle ache, insomnia, fatigue) that some patients endure.

In addition to the conventional treatment, she is exploring a few additional avenues. A Catholic, she embraces the support of her faith – particularly through her two aunts, who are nuns. As well, “I’ve got my name [down with]

a number of prayer groups, I’ve been given healing stones, there are people saying rosaries for me and I’m having reiki therapy”. This, she says, is because she believes the stronger she is in mind and body, the better she can deal with her health.

Tan doesn’t take issue with alternative approaches to treatment, as long as the “mainstay” treatment – surgery followed by chemotherapy – comes first. “If complementary treatment has demonstrated benefits for the patient and has minimal risks, and the patients have made [an] informed choice and given informed consent, I do not oppose their use.

“But I do have a problem when people ignore mainstay treatment and spend lots of money [going] to somewhere that I know they’re not going to succeed.

“I’ve had experience with people coming back from South America, almost dead [and with] no money ... But if someone wants to do meditation; embark on a healthier diet – fruit and vegetables and supplements; and include exercise – pilates or yoga – then I am fully supportive of this holistic approach.”

Shortly before Finucane’s diagnosis, one of her best friends was diagnosed with melanoma. It swiftly progressed

and he died in March, on Finucane’s birthday. She delivered the eulogy – the day after her second round of chemotherapy. “Cancer is a bastard,” she told fellow mourners.

Finucane completes her treatment this

month. She continues to commute between her Waikato workplace and her Auckland home.

In her eyes, the cancer is an experience, rather than a calamity. The business with the wig is not a one-off: she left it in a restaurant once when it got too “scratchy” and had to retrieve it the next day.

Besides, she’s not bothered about being bald. “I figure the more people know about ovarian cancer, the more women know about the symptoms, the better.

“And having no hair makes me realise how much we obsess about how we look, and no one really minds.” ■



Lisa Finucane

**“I’d half written my eulogy. I was going to have a pre-funeral funeral in January.”**

Many women will be familiar with some, or all, of these symptoms at some stage – for benign reasons. But if they are frequent and severe – and persist – it's important to see your doctor, says Tan.

A doctor can order a cancer antigen 125 (CA125) blood test – which detects a protein found in greater concentration in ovarian cancer cells – and an ultrasound. However, unless there are definite symptoms, the CA125 test is not specific enough, and CA125 levels may be raised for a variety of reasons.

Tan distributes a wallet card, prepared by the Gynaecological Cancer Foundation. It emphasises the Beat approach – but clearly, many of her patients are beyond the early detection stage by the time they see her.

The foundation – just three years old – is run as much on hope and good faith as it is on charity. General manager Sarah Hutchings operates it from her Auckland jewellery store. “We’re desperately trying to raise funds, but it’s a real struggle,” says Hutchings, who has a health background. The foundation wants to raise funds to increase the profile of gynaecological cancer – but people don’t know enough about it to donate and corporate sponsorship is particularly difficult to secure. The truth remains that “there’s only so much money to go round”.

The Cancer Society of New Zealand calls it “cancer clutter”. About 80 charities registered with the Charities Commission have the name “cancer” in their title, says society chief executive Dalton Kelly. Add to that the number of organisations with cancer-related objectives, such as Sweet Louise and Rowing for Prostate. “For a population the size of New Zealand, having 80-plus organisations does seem too much,” says Kelly.

**T**wo years ago, the society established an umbrella group called Cango, which covers the seven major cancer organisations – including the Gynaecological Cancer Foundation. Its aim, says Kelly, is to rationalise their efforts. “We recognise cancer clutter is an issue and we want to make sure the cancer dollar is used wisely.”

Major crises, such as Christchurch’s earthquakes, can further stretch charitable efforts. After the Victorian bushfires of 2009, Kelly says, many Australian organisations cancelled their appeals. “The whole idea is that if there is a crisis, you can use what you’ve set aside for a rainy day. Right now, it is a rainy day. But for gynaecological cancer, they don’t have reserves.”

Australian GPs give patients ovarian cancer symptom diaries, says Tan. Women displaying Beat symptoms are asked to



**Dr Ai Ling Tan:**  
Women say, “Was I promiscuous. Did I bring it on myself?”

monitor and record them for a month. If the symptoms are significant and persistent, they are urged to get back to their doctor. “If you’ve got something objective [like the diary], you can say, ‘Oh my gosh, this is not right. Let’s get onto it.’”

It is all too easy to blame a GP for failing to diagnose in time. But Tan says that is neither right nor fair. “It’s always very easy to blame people. And GPs have a lot of people they see; they don’t only see people who might have ovarian cancer.”

Women also need to get appropriate care. Tan supports a multidisciplinary approach – using pathologists, radiologists, gynaecological oncologists, medical oncologists and nurse specialists. They

need to liaise with psychologists and social workers, too, she says. She also calls for more specialised pathologists. “Reproductive organ pathology – women’s pathology – is one they get wrong, unless they do it all the time.”

Despite the low long-term survival status, Tan says we needn’t call ovarian cancer the silent killer. “Calling it the silent killer means there’s nothing we can do. It means we’re not proactive, that we’ve got no say in this matter. In actual fact, we have some say, and that’s what this Beat acronym is doing.” ■

*New Zealand Gynaecological Cancer Foundation: [www.nzgcf.org.nz](http://www.nzgcf.org.nz)*

## Ovarian cancer facts

- A smear test will not detect ovarian cancer. Even if a woman has regular smears and clear results, it does not mean ovarian cancer has been excluded.
- There is no screening test for ovarian cancer. Women are instead urged to monitor their own bodily changes – especially using the Beat acronym (see page 25) – and to see their doctor if symptoms persist longer than a month.
- Women who have a familial history of either ovarian or breast cancer may be advised to have risk-reducing surgery before symptoms develop. This can involve the removal of the tubes and

ovaries at the age of 40 – significantly lowering the risk of getting ovarian cancer by more than 95%, and also reducing the chances of breast cancer.

- It’s well-known that ovarian cancer is a cancer of developed countries. It has a high incidence in Caucasian women. In New Zealand, Ministry of Health cancer patient survival statistics note it’s the only cancer for which Maori outcomes are better than those of non-Maori.

- Protective measures include using oral contraception, having a tubal ligation and hysterectomy, and having children.