

The focus of this column is to describe published research studies of interest to professional oncology nurses.



## Cannabinoids May Be Therapeutic in Breast Cancer

Cannabinoids are a group of compounds synthesized exclusively by the Cannabis sativa plant, commonly known as marijuana. In 1990, the first cannabinoid-specific membrane (CB1) was characterized and cloned (Matsuda, Lolait, Brownstein, Young, & Bonner, 1990), which catapulted biomedical research on these unique compounds. Cannabinoids refer to both marijuana-derived compounds with the active ingredient of 9-tetrahydrocannabinol (THC) and also the synthetic molecules that activate the same primary targets as THC. Therapeutic properties of marijuana have been well established; however, the clinical use of either plant-sourced or pure cannabinoids remains limited. The anticachexia properties of cannabinoids are found in tetrahydrocannabinol (oral capsules of synthetically generated THC) and are used to manage weight loss, vomiting syndrome, and nausea and wasting associated with cancer treatment.

Preclinical evidence has indicated that these compounds demonstrate antitumor effects in several cancers, ranging from cell cultures to xenografted and genetically engineered mice (Velasco, Sánchez, & Guzmán, 2012). Antitumor action by cannabinoids depends on the deliberate blockade of tumor progression. They are known to inhibit uncontrolled cancer cell growth by halting cancer cell proliferation and by inducing cancer cell death by apoptosis. In addition, they are able to impair tumor angiogenesis and ultimately metastasis. Because the effects of cannabinoids are observed in many different types of cancer cell lines, they are considered to have general rather than site-specific tumor type affinity.

Breast cancer remains the most common malignancy among Western wom-

en (DeSantis, Siegel, Bandi, & Jemal, 2011). Mortality rates have dropped significantly since the 1990s because of refined adjuvant treatment, as well as earlier screening and prevention. However, certain breast tumors continue to be resistant to conventional regimens. Caffarel, Andradas, Pérez-Gómez, Guzmán, and Sánchez (2012) acknowledged the pivotal need to develop new therapeutic strategies that focus on three main breast cancer subtypes according to molecular profiles: hormone receptor-positive, HER2-positive, and triple-negative tumors. Laboratory evidence indicates that cannabinoids may demonstrate significant therapeutic effects for those subtypes.

The review provided resources demonstrating that cannabinoids modulate key tumor progression-related aspects of estrogen receptor (ER) or progesterone receptor (PR)-positive breast cancer cells. Cannabinoids also impair ER/PR cancer cell migration and culture invasion. That finding might indicate cannabinoid modulation of hormone-sensitive breast cancer metastasis.

Another histopathologic subtype of breast tumors are those that express the tyrosine kinase receptor HER2. Patient outcomes for those individuals have improved since the clinical use of trastuzumab for breast cancer began in 2006 when trastuzumab received U.S. Food and Drug Administration approval in combination with doxorubicin, cyclophosphamide, and paclitaxel for the adjuvant treatment of women with node-positive, HER2-overexpressing breast cancer. Strong preclinical evidence suggests that cannabinoids may be useful for the treatment of this patient population (Caffarel et al., 2010). Two different cell lines were injected either subcutaneously in immune-deficient mice or orthotopically in immune-competent FVB mice and treated with THC and/or

CB2 selective agonists. In both instances, a significant reduction in tumor growth was observed per animal (including those with lung metastases), as well as a reduction in the number of tumor blood vessels, indicating that THC impairs tumor angiogenesis.

No standard targeted therapy exists for triple-negative breast cancer. Prognosis for this cohort is poor, and intense efforts have been made to improve chemotherapy responses with a variety of agents. In vitro and in vivo preclinical evidence indicates that cannabinoids may play a future role in the treatment of this patient population as well. Synthetic cannabinoids have been tested in triple-negative breast cancer and all have produced an inhibition of cell proliferation. Cannabinoids in this setting impact cancer cell proliferation, as well as angiogenesis. Another important feature of these compounds is the low toxicity and high safety profile when used either as single agents or in combination with standard regimens.

Caffarel et al. (2012) suggested the introduction of clinical trials that would incorporate cannabinoids with standard regimens to achieve synergistic and therapeutic outcomes. As the review article indicated, cannabinoids have demonstrated antitumor activity in preclinical breast cancer models. Practicing oncology professionals need to be aware of the clinical potential of these agents, including antiproliferative, proapoptotic, antimigratory, and anti-invasive actions on cancer cells. Bench-to-bedside clinical practice is the assurance that patients will have access to current knowledge and the potential therapeutic benefit of enhanced, scientifically based clinical cancer care.

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Velasco, G., Sánchez, C., & Guzmán, M. (2012). Towards the use of cannabinoids as antitumour agents. *Nature Reviews. Cancer*, *12*, 436–444.

## Healthcare Access and Use Low Among Adolescent and Young Adult Cancer Survivors

Kirchhoff, Lyles, Fluchel, Wright, and Leisenring (2012) conducted a population-based study focused on healthcare availability as well as healthcare-seeking behaviors of long-term survivors of adolescent and young adult (AYA) cancer. AYA cancer survivors are at risk for developing delayed side effects related to systemic and local regional cancer treatment. Significant limitations to healthcare services were identified by this study that impact long-term surveillance, which is crucial for AYA cancer survivors. Healthcare outcomes for long-term survivors aged 20–39 years were compared to the same age cohort without a cancer diagnosis using the 2009 Behavioral Risk Factor Surveillance System (BRFSS) data. The BRFSS acquires data by use of random-digit telephone dialing to sample noninstitutionalized adults aged older than 18 years. Cancer survivorship questions were first included in 2009. A total of 979 people were interviewed who reported a cancer diagnosis between the ages of 15–34 years and were at least five years from diagnosis. That was imperative because the study focused on long-term survivors of AYA cancer who had completed treatment. Controls were the remaining 67,216 BRFSS participants with no cancer history. Adolescent patients with cancer commonly are included in childhood cancer survivor studies, mak-

ing AYA survivors aged 20–39 years underrepresented in the survivor literature.

Using multivariable regressions, relative risks and 95% confidence intervals were produced to examine survivor status on poor health indicators (e.g., uninsured, lack of primary healthcare provider, avoiding care because of the cost). The results demonstrated that 79% of AYA cancer survivors have health insurance; however, they are 67% more likely than controls to avoid medical surveillance primarily because of cost. About 22% of AYA cancer survivors reported no primary care clinician, 40% were without annual routine medical encounters, and 34% claimed not accessing health care primarily because of cost.

Reflecting on the aforementioned results, the lead author opined about cost factors being the most prevalent driver away from healthcare access in this population. However, many other mitigating factors may need to be considered to follow this population of cancer survivors and promote long-term health monitoring and maintenance. AYA cancer survivors are at high risk for developing serious, chronic long-term complications from prior cancer treatment and must be educated regarding the need for continuous health care. At the completion of the treatment trajectory for AYA patients with cancer, the oncology team must provide comprehensive educational care planning focusing on regular follow-up care with emphasis on survivorship. In addition, oncology professionals should educate primary healthcare providers about this patient population so they can facilitate appropriate care and screening

measures to manage potential long-term health-related issues. A recommendation for the creation of a customized survivorship care plan documenting details of the cancer diagnosis and treatment course could be helpful to facilitate care across all healthcare domains.

The developmental stage of AYA cancer survivors must be taken into account as well; the sheer logistics of arranging appointments, managing family obligations (e.g., the needs of young children), arranging time off from work, and seeking care in another demographic at a distance away from the original oncology team all may pose impediments to care. In addition, many AYA survivors may want to simply evolve psychologically by compartmentalizing their diagnosis and treatment in the past. The hope is that the Patient Protection and Affordable Care Act of 2010 will assist AYA cancer survivors in continuing health care by allowing young adults to remain on their parents' health plan until age 26 years; the act also provides insurance for preexisting conditions, eliminates coverage limits, and prohibits insurance companies from revoking insurance coverage retroactively. This pivotal study has provided invaluable information for the multiprofessional oncology team members caring for individuals with cancer along life's continuum.

Kirchhoff, A.C., Lyles, C.R., Fluchel, M., Wright, J., & Leisenring, W. (2012). Limitations in health care access and utilization among long-term survivors of adolescent and young adult cancer. *Cancer*, *118*, 5964–5972. doi:10.1002/cncr.27537

Susan Weiss Behrend, RN, MSN, AOCN®, is an oncology clinical nurse specialist in the Department of Nursing at Fox Chase Cancer Center in Philadelphia, PA. No financial relationships to disclose. Behrend can be reached at [swbehrend@comcast.net](mailto:swbehrend@comcast.net), with copy to editor at [ONFEditor@ons.org](mailto:ONFEditor@ons.org).

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