

Dear Friends,

Welcome to the first edition of the newsletter for 2016.



Anne M. Miller,
Volunteer Editor,
Brain Tumour
Support Service
Newsletter.

We have some really exciting and informative reading for you this edition, beginning with an article on benign brain tumours by Dr Martin Wood, a Neurosurgeon at the Mater Hospital Brisbane. Dr Wood explains that there are many different types of tumours that can occur, and that are classified according to how aggressive they are. Some of the common benign tumours are explored in more detail, along with some of the warning signs that can indicate the presence of a tumour, and the type of scan usually required for diagnosis.

Next we have an article by the Australian Pituitary Foundation on Pituitary tumours, - which can often be difficult to diagnose, - and yet which can have a huge impact on quality of life or life expectancy if left untreated or treated inappropriately. This article describes the common hormonal disorders which are associated with these tumours, some of the symptoms, and treatment options.

Our third feature article is by Lee Cubis, a Ph D Candidate in Clinical Psychology at Griffith University, which explores the practical considerations in adjusting to a benign or non-malignant brain tumour, including: the difference in psychosocial experience, reactions from others, how to explain your tumour to friends, family and work colleagues, and strategies for coping with a brain tumour as well as strategies to support someone else with this diagnosis.

Our final article is by Lauren Fulop, an Occupational Therapist at the Princess Alexandra Hospital, who offers some very practical support for getting back into daily activities after a brain tumour diagnosis. In order to manage the fatigue that is a common side effect of this type of diagnosis, Lauren offers some super practical tips around conserving energy, being active, sleep, managing stress, and relaxation.

Enjoy the articles as well as information on our upcoming Brain Tumour Information Sessions!

'Till next time stay happy, keep well and keep smiling.

Anne

**Volunteer Editor
Brain Tumour Support Service Newsletter**

*Are you related to someone famous?
It's possible! You have two parents,
four grandparents and so on. If you go
back ten generations you have 1024
ancestors. Twenty generations puts you
over the one million mark. One of those
'cousins' is bound to be famous.*

*If you have trouble finding someone who
served in World War I or 2, search for
the correct month and day of birth but
an earlier year. Many men overstated
their age at the time because they were
underage.*

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Brain Tumour Information Sessions

See page 3 for upcoming events or check our website or call 13 11 20 for details.

About the Brain Tumour Support Service

Information, referral and support to people who have a benign or malignant brain tumour, their families and friends.

The service provides:

- information about brain tumours and treatments
- referral to support and rehabilitation services as well as Cancer Council Queensland's practical support program
- regular meetings that provide opportunities to meet other people dealing with a brain tumour and hear health professionals discuss topics of interest
- regular newsletters offering up-to-date information, stories and support.

Get in touch!

Call us on 13 11 20

Email us at 131120@cancerqld.org.au

Visit us at cancerqld.org.au

13 11 20

Call **13 11 20** for cancer and brain tumour support information, emotional and practical support. Our cancer support advisors can also refer you to Cancer Council Queensland support programs and other community services.

This free and confidential service is available Monday to Friday 9am–5pm (excluding public holidays) and is provided thanks to the generous donations and support of Queenslanders

Donate now

Your donations help fund our research and support services for Queenslanders affected by brain cancer and benign brain tumours, including provision of the Brain Tumour Support Service.

Donate online at cancerqld.org.au or call our Donor Hotline **1300 66 39 36**

Brain Tumour Information Sessions

Date: August 4, 2016

Speaker: Lee Cubis

Topic: Communicating with Others about Brain Tumour

Outline of Presentation

- Challenges in communicating to others whilst managing emotions
- Coping with other people's reactions to your brain tumour
- Strategies for dealing with others' reactions
- Strategies for negotiating with employers, colleagues and/or lecturers around workload during treatment for brain tumour

Date: October 6, 2016

Speaker: Bianca Duncan

Topic: Fundraising - What, Why, How, When and Who?

Outline of Presentation

- How the fundraising arms of CCQ work
- The fundamentals of fundraising – including how to get started, and who is a fundraiser
- Explanation of how much time fundraising takes, what efforts are required, and what communication skills works best

To register, please visit: cancerqld.org.au/get-support/ccq-events/information-sessions/



Benign Brain Tumours

A short summary by Dr Martin Wood, Neurosurgeon at Brisbane Clinical Neuroscience Centre, Mater Hospital Brisbane and Lady Cilento Children's Hospital.



There are well over one hundred different types of brain tumour that can occur. All tumours arise due to unregulated proliferation of a particular cell in the body, and most tumours are classified according to the cell from which they originate. In the brain, tumours are graded

according to how 'aggressive' they are, using a grading scale of 1-4 (the 'WHO' grading scale) with grade 1 tumours being the least aggressive, and grade 4 the most aggressive. This scale generally refers to the rate of growth of the tumours, and their tendency to recur after treatment.

It can however be misleading in terms of how significant a tumour diagnosis is to a patient, and brain tumors are difficult to partition into those that are 'benign' versus those that are 'malignant', as we do in other parts of the body. For example, some grade 1 tumours may be 'benign' in the way they grow and do not spread, but very difficult to treat effectively due to location (e.g. an optic chiasm glioma, or some skull base meningiomas). On the other hand, there are some grade 4 tumours that grow very rapidly and have potential to spread, but they may often respond well to appropriate treatment, with the possibility of cure (e.g. medulloblastoma in children).

In general, it is considered that those tumours that are WHO grade 1-2 are considered 'low grade' or 'benign', whereas those that are grades 3 or 4 are considered 'high grade' or 'malignant'. When thinking about benign brain tumours, there are those that arise within the brain (so-called 'intrinsic', or 'intra-axial' brain tumours) and those that grow from structures close to, or around the brain (called 'extrinsic' or 'extra-axial'). Let's look at a few of the more common benign tumours that can occur.

Intra-axial tumours:

Gliomas – tumours that arise from the 'glial' cells that support the network of nerve cells in the brain are called gliomas. Those that are considered low-grade include some astrocytomas, oligodendrogliomas (Fig. 1) and ependymomas. They can all typically present in the same fashion, either by causing raised pressure in the brain (causing headaches or blurred vision), or by interfering with the function of the part of the brain in which they arise (which may manifest as an epileptic fit or weakness of a part of the body).

Fig.1 – An oligodendroglioma in an adult, in the area that controls leg movement

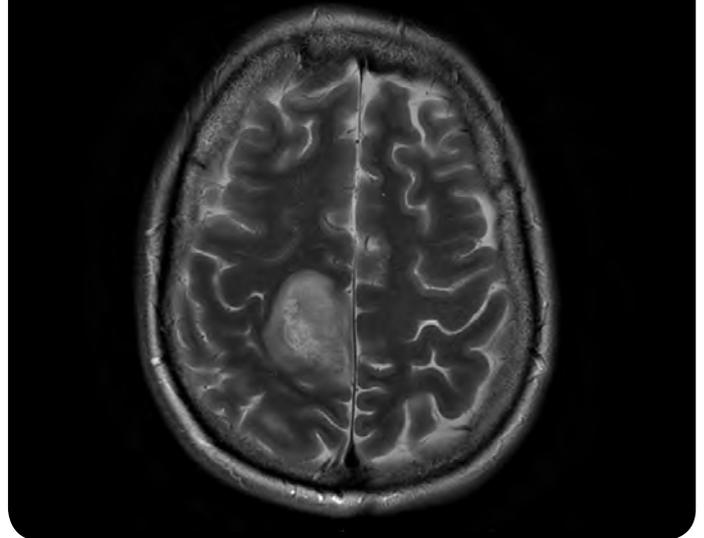


Fig.2 – A pilocytic astrocytoma in a child



Even though these gliomas are considered 'benign', they can often be difficult to cure due to their location within the brain and the risk to important structures if they are removed. Sometimes they can recur despite complete removal. They do however grow at a slow rate and patients can often live for a long time with these tumours. Some low-grade glial tumours are very amenable to removal and cure, and these are more commonly seen in childhood. One example of this is a pilocytic astrocytoma (Fig. 2). If these can be removed, this usually results in a cure for the patient.

Extra-axial tumours:

These tumours include those that arise from the brain's coverings (meningiomas), from the nerves that come out of the brain (for example an acoustic neuroma that arises from the balance nerves), or from the pituitary gland (pituitary adenomas).

Meningiomas can present in the same way as the intra-axial tumours above, because they can grow large and put pressure on the brain (Fig. 3), or they can cause irritation of the brain surface leading to epilepsy. Often they are found by accident if they are small, when the patient has a head scan for some other reason.

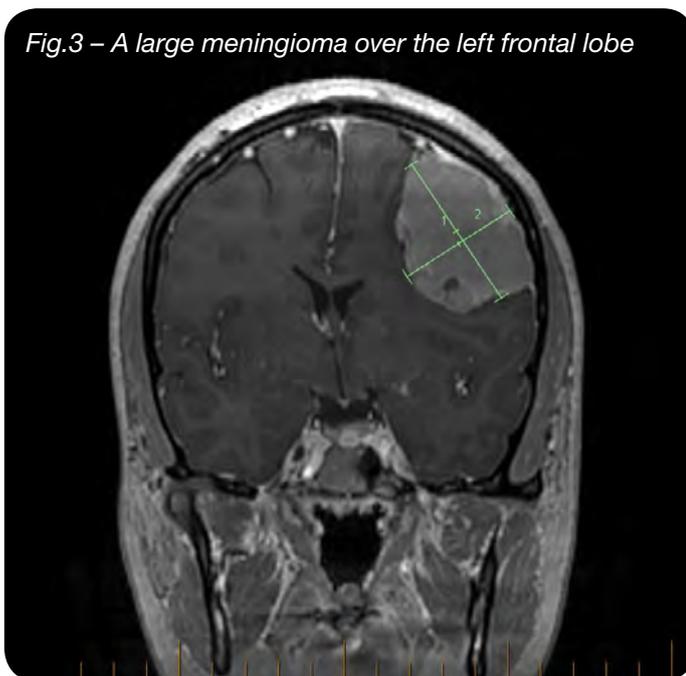


Fig.3 – A large meningioma over the left frontal lobe

Acoustic neuromas (more properly called vestibular schwannomas) typically present due to a gradual loss of hearing on the affected side, sometimes with balance problems or ringing in the ears.

Pituitary adenomas can interfere with hormone production, leading to problems either from overproduction of a particular hormone (e.g. growth hormone causing acromegaly), or to hormone deficiency.

Less commonly these can present with visual problems due to compression of the optic nerves that lie above the pituitary gland.

All of these types of tumours usually require an MRI scan for diagnosis, although with acoustic neuromas the diagnosis is often suggested after an abnormal hearing test. These tumours are all usually treatable with surgery, but also sometimes with radiotherapy as an alternative treatment. Some can be simply observed if they are small and some pituitary tumours can be treated with medicines. In general, surgery to treat these types of tumour often takes some time to recover from, and there may be a need for physiotherapy to help restore physical function. Follow-up scans are usually required for a number of years to ensure that the tumours do not recur (although it would be unusual for this to occur).

The decision of whether or not to treat a particular tumour revolves around the threat to the patient from the tumour if left untreated (progressive disability or potentially a threat to life) versus the risk from surgery. Even though these tumours are benign, surgery to treat some of them can be very dangerous with a significant risk to function. This is usually due to a combination of the size of the tumour and being in a delicate location with lots of important surrounding structures. The considerations will be different for every individual patient.

Warning signs:

Any tumour arising inside the head (benign or malignant) can cause symptoms of raised pressure. Typically these symptoms are headache, nausea and vomiting and blurred vision, which progress rather than go away with time. New onset of epileptic seizures is a potential warning sign that something is irritating the brain substance and this would usually prompt referral for a brain scan. Gradual loss of hearing on one side can suggest problems outside the brain at the back of the skull (e.g. an acoustic neuroma) and should prompt referral for a hearing test and sometimes lead to an MRI scan. Recurrent vomiting in children, especially if associated with headaches and unsteadiness on their feet, should always lead to further investigation to exclude a tumour.

Summary:

There are many different types of low-grade or benign brain tumours and this article has only scratched the surface. Many present in subtle ways but are very treatable and potentially curable if detected early. Unexplained symptoms, particularly those that do not resolve over time, should always prompt consultation with your GP in the first instance.

Your GP has better access now, more than ever before, to imaging studies of the brain (CT or ideally MRI scanning) and prompt referral to a specialist should be sought if abnormalities are found. As specialists, we have increasingly efficient online access to scans performed from all across the state, and we can usually have a look at imaging studies rapidly to aid efficient access to care for patients, or provide reassurance where that is all that is required. In many circumstances monitoring and reassurance may be the order of the day, but sometimes surgery and other treatment modalities may be necessary.



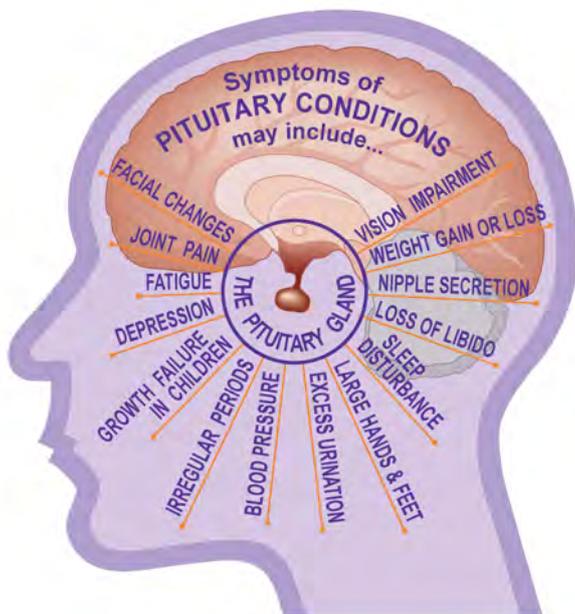
Pituitary Tumours

By Australia Pituitary Foundation Ltd

Although pituitary tumours may be “benign”, some are very dangerous and if left untreated or not treated satisfactorily, have a huge impact on quality of life and life expectancy.

The Pituitary Gland is sometimes referred to as the master gland as it regulates the function of other glands in the Endocrine System.

Pituitary disorders are difficult to recognise and are typically associated with a delayed diagnosis because of the often insidious onset of the varied and non-specific clinical features.



However, certain clusters of symptoms can give an indication of possible pituitary dysfunction. Patients may have chronic headache and visual symptoms, particularly deteriorating peripheral vision. There may be symptoms of primary hormone hypersecretion, such as hyperprolactinaemia, acromegaly or Cushing's disease, whereas hypopituitarism may present with non-specific symptoms such as fatigue, loss of vitality, menstrual irregularities, loss of libido and erectile dysfunction. More rarely, a patient may complain of increased thirst and passing large volumes of urine as a result of diabetes insipidus (lack of anti-diuretic hormone).

Recent studies have reported an increased prevalence of pituitary tumours, with about 1 in 1000 people having a clinically significant pituitary tumour. This equates to

around 20,000 Australians affected at any one time. In addition, increasing use of rapidly improving imaging techniques mean that pituitary 'incidentalomas' are now frequently encountered in clinical practice. Magnetic resonance imaging will reveal a pituitary lesion in 10% of individuals. While Cushing's disease and acromegaly meet the Australian definition of a 'rare disease', prolactinoma and non-functioning adenomas are not rare conditions.

Acromegaly

Acromegaly is a hormonal disorder that results from too much growth hormone in the body. The growth hormone triggers your liver to produce an important metabolic hormone called "Insulin like growth factor - 1", commonly called IGF-1. When IGF-1 levels are consistently high, this can cause excessive bone, tissue and organ growth. Over time, this leads to changes in a person's appearance and health. Without treatment, acromegaly can lead to serious illness and significantly reduce life expectancy.

Cushing's Disease

This results from excess ACTH secretion from the pituitary gland. This hormone stimulates the adrenal glands to release too much cortisol into the blood stream. The build-up of cortisol causes extensive disruption and damage to the body. High levels can lead to dysregulation of the hormonal system, immune system and body metabolism. This can cause a wide range of symptoms, which can vary widely between patients, from distinctive weight gain around the torso to high blood pressure and even diabetes.

Non-Functioning Tumour

Non-functioning pituitary adenoma (NFPA) is the second most common type of pituitary tumour - accounting for between 30 and 50% of cases. As the name suggests, these tumours do not produce an excess of hormones. Often patients present with blurring of vision or loss of peripheral vision. Generally this occurs when the tumour grows larger than 1cm in diameter (at this size, the tumour is called a macroadenoma) and presses on the optic nerve. Depending on the size and growth, the tumour may invade the cavernous sinus and involve other cranial nerves.

Prolactinoma

A prolactinoma is the most common type of hormone-secreting pituitary tumour. Symptoms of prolactinoma result from too much prolactin in the blood (hyperprolactinaemia) or as a result of the prolactinoma pressing on surrounding tissues. High prolactin levels stimulate the breast tissue to produce milk - mostly in women, but it can also occur in men. In addition, the hormone reduces the secretion of sex hormone (oestrogen and testosterone) levels resulting in a low sex drive (libido) and infertility. Women can have irregular periods and sexual dysfunction while men can experience erectile problems and sexual dysfunction.

“I had a lot problems in getting my medications balanced right. It has taken time for me get life back to normal. I now live a relatively normal life, except I have to take a lot of tablets and be very aware of being sensible and not overdo things i.e. late nights, big weekends.”

Other benign conditions close to the pituitary gland are:

Craniopharyngioma

A craniopharyngioma tumour usually grows above the pituitary gland. These tumours gradually invade into surrounding areas of the brain, such as the pituitary gland, optic nerve and hypothalamus, damaging these tissues and causing compression-related symptoms or hormone disturbance. They look similar to a cyst and contain a dense, oily fluid as well as calcium deposits. The tumour is composed of embryonic pituitary gland cells, and due to the slow growing nature, symptoms often don't begin until the tumour is about 3cm in diameter.

Rathke's Cleft Cyst

Rathke's cleft cyst is a type of craniopharyngioma. It is a slow growing sac or cyst, filled with a dense and oily fluid. They occur during the formation of the pituitary gland,

when a remnant of the Rathke's pouch (the place where two areas of the embryo fuse to make the gland) remains as a cleft. A cyst can develop from this cleft.

Treatments

A multi-disciplinary approach to care is required and may require input from various specialties including Endocrinology, Radiology, Pathology, Ophthalmology, Neurosurgery and Radiation Oncology.

Neurosurgical expertise is the single biggest determinant of a good outcome with lower complication rates. The success rate is higher in the hands of a neurosurgeon who regularly operates (>20/year) on such tumours. The initial referral should be made to an Endocrinologist who is part of an established multi-disciplinary team.

For more information please visit the Australian Pituitary Foundation website www.pituitary.asn.au | Email support@pituitary.asn.au | Phone **1300 331 807**

“Patience. Patience. Patience. The road is long, windy and bumpy but the ride gets a lot easier eventually. Listen to your body and be assertive with health practitioners. Nobody knows your body better than yourself, so monitor and report the changes.”



Adjustment to Benign or Non-malignant Brain Tumour

Article by Lee Cubis - PhD Candidate in Clinical Psychology, Griffith University

A diagnosis of brain tumour, whether benign or malignant, has the potential to stop you in your tracks. The brain is such an important organ as it is our control centre. A brain tumour has the potential to impact on virtually any area of functioning, including: physical changes; sensory and motor disturbance; headaches and seizures; changes in thinking skills and memory; emotional reactions and behaviour; as well as the threat to life. Whether benign or malignant, a diagnosis of brain tumour can leave a substantial psychological impact.

It is important to acknowledge that no two people diagnosed with brain tumour will report the exact same experience, as everybody varies substantially in regards to their tumour size, type and location of the mass, treatment regime required, ongoing effects of treatment and other factors such as pre-diagnosis functioning and personality. It is common to ask yourself questions such as: What is happening here? What does this mean for me? What will the future hold?

Is there a difference in psychosocial experience?

Research indicates that 30 – 50% of people with brain tumour experience ongoing significant distress whether the tumour is benign or malignant. This distress can be present at diagnosis, treatment and all the way through the journey of living with brain tumour. Changes in physical or cognitive ability, loss of valued roles (e.g. work, independent parenting) and fear or uncertainty around recurrence are some of the concerns that may contribute to feelings of anxiety and/or depression following brain tumour.

Although the research is mixed, there does not appear to be a substantial difference between people diagnosed with benign versus malignant brain tumour when it comes to psychological wellbeing. Given that a benign brain tumour and associated treatments (e.g. surgery, radiotherapy, steroid therapy) have the potential to leave people with ongoing challenges with fatigue, memory, concentration, seizures, mobility and restrictions on driving, it is not surprising that levels of psychological distress are high.

Feeling distressed is certainly a normal part of adjusting to a diagnosis of brain tumour; however if you find that you are experiencing ongoing high levels of distress, anxiety and/or depression there is help available to assist you in managing this.

Reactions from others

Something that may differ between people with benign versus malignant brain tumour is the reaction from friends or family. It is not uncommon for loved ones to breathe a great sigh of relief when the results come back and the tumour is benign. There may be a tendency for people to think that once the diagnosis and treatment phase has finished that the problem has been solved and it is time to move on. Whilst this may be the case for some, for many people with benign brain tumour this time is only the beginning of making sense of a new reality. Comments from others such as “You’re just lucky it’s not malignant” can unintentionally leave somebody with a benign brain tumour feeling as though their experience is not valid.

Although the effects of benign brain tumour are largely not visible from the outside, it is important to acknowledge that the person may be struggling to adjust to a new way of living with significant ongoing symptoms. Similarly, friends and family may be very eager to look after their loved one in order to help them compensate for any difficulties that have arisen from the brain tumour. Whilst this help is valuable and appreciated, some report feeling overwhelmed or stifled by offers of support at every corner. The best way to provide the most valuable forms of support without invalidating or overwhelming somebody is to use clear and open communication. For the person with benign brain tumour, communicating your needs or wants to those around you can be a great way to manage these issues.

Explaining your brain tumour to friends, families and work colleagues

When asked to reflect on their journey, people living long term with benign brain tumour often express that they wish that they had been more proactive in maintaining their social networks early on. Everybody is different in terms of what information they wish to disclose to others. Some people with benign brain tumour find that explaining their tumour and its ongoing effects to their friends, families and work colleagues helps to let them know how it is impacting on them (i.e. fatigue, physical limitations, emotional wellbeing). This helps to manage others’ expectations of you, ensures that any support you do receive is appropriate and allows you to remain connected with these networks in a meaningful way.

There are many ways in which you can communicate this information to those around you. For some people, they choose to phone key people in each family or social group to communicate news and updates; others will communicate news face to face with close family and friends and then share news on social media to save time and energy (e.g. a Facebook update); others will write a detailed email every few months with updates and send these around to their extended networks. You may like to delegate the role of “news bearer” to somebody else in the family who will then pass on news and updates to others via your preferred method. There is no “right” or “wrong” way to communicate this information.

Ensure that you take the time to decide who you wish to tell what information, and then plan the ways you would prefer to share this information with these people.

Strategies for coping with brain tumour

- As much as possible, try to keep some sense of normality through maintaining a routine of activities. You may need to come up with new ways to do things or new routines depending on your current situation.
- Be proactive in keeping up with your valued social groups (e.g. family, close friends, colleagues etc.) even if you are presently unable to continue with your previous group activities. There are always new ways to do things!
- Select the news that you wish to share with others and allow them to provide practical and emotional support (and explain what helps and what doesn't).
- Develop practical strategies to manage ongoing effects (e.g. keeping a diary, having a good sleep routine, good diet and exercise).
- Practice relaxation and mindfulness exercises. Contact the Cancer Council Helpline for further information on guided activities.
- Seek emotional release through talking or writing and allow yourself to “cry it out”!

Strategies to support somebody with benign brain tumour

- Take the time to understand what the person is experiencing with their ongoing symptoms and emotional wellbeing.
- Try not to invalidate or downplay the seriousness of the diagnosis of benign brain tumour.
- Encourage open communication around what is helpful and what is not.

- Give the person space to discuss their challenges, fears and emotions if they wish.
- Support the person with brain tumour to maintain their sense of normality by continuing with regular activities. If physical, cognitive or logistic issues make this difficult; brainstorm a new way to do things (e.g. meet for coffee if the person is not up for tennis at the moment; assist with transport if they are unable to drive).

Getting support

Getting support is integral to managing distress related to your brain tumour. The Cancer Counselling Service offers a free and confidential telephone and face-to-face counselling service to help people with brain tumour and those close to them. People can be referred to the service or find out about support and referrals to specific agencies by calling Cancer Council on **13 11 20**.

Staying Connected after Brain Tumour research

Griffith University in collaboration with Cancer Council Queensland is researching the effects of brain tumour on social and psychological wellbeing, as well as the ways that people with brain tumour stay connected to others. Participation involves a 45 minute interview either over the telephone or in person (if you reside within 2 hours of Brisbane).

If you would like to know more about the Staying Connected after Brain Tumour research, or would like to take part, please contact Lee Cubis on **lee.cubis@griffithuni.edu.au** or **0438 208 783**.

Getting Back into Daily Activities

By Lauren Fulop, Occupational Therapist, Princess Alexandra Hospital

A diagnosis of a brain tumour cancer can greatly affect your ability to engage in your activities of daily living. Depending on the location, size and spread of the tumour, people can experience diverse changes in their physical functioning, thinking abilities, emotions and behaviour. Occupational Therapists (OTs) focus on improving a person's ability to carry out everyday tasks and become as independent as possible. OTs may assess a person's home as well as their physical, thinking and emotional abilities and find ways to make living easier.

OTs work closely with doctors, nurses, physiotherapists, speech therapists, social workers, psychologists and most importantly you, to help identify and work towards your goals. For example, returning to work and driving, preparing a meal, improving your sleep or showering yourself.

Both anecdotally and in the research, fatigue is a side effect that can interfere with your ability to engage in such tasks.

According to the National Comprehensive Cancer Network (NCCN), cancer-related fatigue is defined as "a distressing, persistent, subjective sense of physical, emotional, and/or cognitive tiredness or exhaustion related to cancer or cancer treatment that is not proportional to recent activity and interferes with usual functioning." (1)

Here are a few practical tips that you can try to help manage fatigue and get back into your daily activities:

Fatigue Management	
Energy Conservation	<ul style="list-style-type: none"> • Set priorities for the day. • Plan your activities across the day and week so that you have a balance of work and rest periods, alternate easy and difficult tasks, avoid rushing and rest before you get tired. • "Work smarter not harder" - think about different areas of your life and consider ways of making tasks more manageable: <ul style="list-style-type: none"> - Self-Care: Sit to shower/ dress or dry yourself, use adaptive aids to help such as a dressing stick. - Work or productivity: Consider a gradual return to work i.e. work part time first then slowly build up your hours, allow for rest breaks. Talk with your doctor about continuing or returning to work. - Cooking: Use simple menus with fewer steps, prepare in bulk and freeze portions for use on busier days, buy pre-cut meats. - Cleaning: Don't do it all at once, use long handled dustpans and buckets on wheels, sitting to iron.

Fatigue Management	
Activity Enhancement	<ul style="list-style-type: none"> • Being active can reduce your fatigue. Talk to your doctor before starting any exercises. Inactivity can result in having less strength which then leads to feeling more fatigued. • Consider a graded return to exercise such as starting with 5-10 minutes of light exercise 2-3 times per week, and slowly increasing it to 15-30 minutes 3-5 times per week. • Consider talking to your OT or physiotherapists for an exercise program suitable for you.
Sleep	<ul style="list-style-type: none"> • Ensure you get enough sleep. • Go to bed when feeling drowsy at night so that you "catch the sleep wave", but try and get up at the same time each morning to establish a routine. • Prepare yourself for sleep by using a pre-sleep routine every night that helps you to relax. • Minimise naps after 2pm in the afternoon. • Reduce or eliminate alcohol, caffeine, nicotine or spicy foods. Ideally, try not to consume these after 4pm.
Stress Management	<ul style="list-style-type: none"> • Stress (worry, fear, frustration) can contribute to fatigue. It is important to recognise the situations that cause stress and how to reduce and manage stress better. • Delegation - some people feel that unless they do the job, it won't be done right. Perhaps re-examine this belief and allow others to help and assume responsibility rather than being a "superman" or "superwoman" • Distraction - do things you enjoy. Studies have shown that distracting activity can help decrease fatigue. It is therefore important to take time to do the things you enjoy.
Relaxation	<ul style="list-style-type: none"> • Relaxation can mean different things to different people. There are formal and informal ways to relax such as deep breathing, relaxing muscles, visualisation or listening to calming music. • Consider talking to your OT, social worker or psychologist if you would like to know more about stress management and relaxation tips.



(1) Mock V, Atkinson A, Barsevick A, Cella D, Cimprich B, Cleeland C, Donnelly J, Eisenberger MA, Escalante C, Hinds P, Jacobsen PB, Kaldor P, Knight SJ, Peterman A, Piper BF, Rugo H, Sabbatini P, Stahl C, National Comprehensive Cancer Network. NCCN Practice Guidelines for Cancer-Related Fatigue. Oncology (Williston Park) 2000; 14: 151-161.



Further information and support can be provided at any Cancer Council Queensland office throughout Queensland or by calling 13 11 20.

cancerqld.org.au