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>> Welcome everyone and thank you for joining the American brain tumor Association's webinar series and thank you for participating in today's free web educational webinar. Our webinar today will address demystifying Palliative Care presented by Dr. Michael Chan. Please note that all lines are muted. If you have a question you would like to ask please type and submitted using the question box in the webinar control panel on the right-hand side of your screen. Dr. Chan will answer as many questions as possible at the end of the presentation. Tomorrow you will receive an invitation to complete a brief feedback survey. Please take a few minutes to share your comments about today's webinar. Your feedback is really important to us for future webinar development. We are starting to plan 2015 webinar schedule so we really appreciate your feedback. We are recording today's webinar and will post it to the ABTA website . You will also receive the webinar link in a follow-up email message once the webinar is available.

>> The American brain tumor Association is pleased to welcome you back to our webinar series. I webinar today will discuss demystifying Palliative Care . My name is Jillann Demes senior program manager here at the American brain tumor associated -- Association and on the delighted to introduce the speaker today, Dr. Michael Chan . Dr. Chan is a radiation oncologist at Lake the -- wait for school of medicine where he serves as their CNS radiation oncologist can't codirector of their gamma knife program and residency program. Thank you so much, Dr. Chan can you may now begin your presentation.

>> It is really an honor to be here today. As you know, my talk is on demystifying Palliative Care. Let's get right into it. One of the things that comes up is what is the difference between palliative care and hospice care. What it boils down to is hospice care is for end-of-life care. When someone has a life expectancy of up to six months. Palliative care can occur any time during the patient having a disease whether it be at the beginning, middle, or when it is time for hospice care. The palliative care is focusing on a more holistic approach. Things like how to deal with the disease emotionally and with family. When you look at the differences between hospice and palliative care hospice generally happens at home or at a hospice house and with relative care when usually gets involved -- involved at the hospital. Someone gets appellate to check care console and mix with a Palliative Care doctor. Hospice is really for end-of-life care. There is really no time restriction for pallets of care. With -- Palliative Care . Hospice is making some of the comfortable within their last days. Palliative care is where patients continue with treatment and focus on survival or trying to beat the disease. But they still have a part of their focus on palliative care. What do we mean by palliative care? What are our goals of palliative care? We focus on symptoms, emotional and social needs, spiritual needs, practical needs, and how to give support not only for the patient but for their family, friends, and caregivers. We think about symptoms of brain tumors. There can be a number. Obviously, headaches, neurological defects cost --, seizures can happen, fatigue, and memory problems. Today I'm going to talk a little bit about how -- some of the tools we use to manage symptoms and how the dock is manage symptoms and how some of these tools that we use can both be good but have side effects and how we try to find a balance with that. Steroids are sometimes a blessing and a curse. Steroids are a type of medication that can decrease swelling in the brain. When there are certain type of rape -- brain tumors backing calls swelling steroids can be beneficial in decreasing that swelling and symptoms caused by the swelling. It also reduces the likelihood of the seizures. It could cause problems with sleeping and make it difficult to sleep at night or commonly patients will

be able to fall asleep and wake up after a couple of hours and roll around in bed for hours at a time. Steroids can cause an increased appetite, oral thrush which is a fungal infection of the mouth, swelling in the legs, hands, and face, and to commit the bones weaker. When we do come off of steroids patients need to be tapered down instead of stopping them directly. Steroids are very common tool used by doctors to try to manage the symptoms of patients who have had brain tumors. Radiation is another tool used by doctors to manage some of the effects of brain tumors. Whole brain radiation is used for patients who have brain metastases and a portion of brain radiation is primarily used for partial brain tumors. Whole brain radiation, once again, is something that has benefits and toxicities. I am a radiation oncologist and when I treat patients with whole brain radiation we really go over what we can expect so we can decide as a team if it is something they want to do or may not be worth it. For some patients whole brain radiation could improve their survival time.

>> Patients with whole brain radiation who have brain metastases their symptoms can improve 50 to 75% of the time. It gets smaller 50 to 75% of the time. Half of the patients who respond to the whole brain radiation they are able to come off of the steroids -- the side effects of whole brain radiation is a combat -- per -- cause tiredness, cognitive changes, and hair loss. Once again, this could be a blessing or a curse. We are very judicious as to who we give whole brain radiation to and who we try to stave it off. Patients with brain tumors can have seizures. How do we manage seizures? Treatment to take down the seizures surgery or steroids, antiseizure medications, depending from state to state their different time periods where you cannot drive. A person who has a seizure and North Carolina cannot drive for six months after the seizure. The most common time to get a second seizure if you are going to get one will be during the first six months after the seizure. Which seizures are the one that require going to the hospital? If a patient has seizure one after the other together than those we would say go to the hospital. If somebody just has a partial seizure or a seizure were it is where their hands shake for 30 seconds, those generally do not have to go to the hospital. Another question commonly ask is when can patients come off of seizure medication. It is very controversial. Usually you keep people on an seizure medication for six months after the seizure. We're unclear how useful it is and we try to have them come off if they bother the patient. Sometimes you say you have to try if it is causing side effects that you might actually get a seizure. Some of the symptoms of brain tumors that can cause impairment. Radiation, chemotherapy, tumor, anti-seizure medications can all cause impairments. This graph goes to show when somebody gets whole brain radiation the likelihood of getting some sort of change in your cognition goes up after time. The longer you survive after whole brain radiation the more likely you are to feel something in terms of toxicity in terms of whole brain radiation. That is an incentive to hold off on if we can. There was a study out of MD Anderson in Texas that showed that if patients get radiosurgery and so the whole brain radiation the cognitive changes is a lot less.

>> There are some medications to use when can grow controlling symptoms. Patients who have memory problems from radiation there is a hot -- trial that shows Aricept can be effective. It was a randomized study that was done across many institutions looking at them and the which is another medication that can help with memory. When patients get that in conjunction with whole brain radiation they actually tested better on memory test after four months. If a patient is going to get whole brain radiation and they are concerned about possible memory deficits this is an option for them to use. Ritalin or methylphenidate is a medication where there is a randomized trials showing no benefit. It is commonly used with fatigue. Even though there is no benefit I have had patients for sure that you have benefited. It there is a population of patients who say they feel better. Our modafinil is another study -- drug where it has been tested for patients who have had radiation reduce fatigue. In this trial they actually showed that there was some benefit. It was in the patients who suffered the most from fatigue. This is a nether medication we can try in a patient with a fatigue

from radiation is really affecting the quality of life. So settle full of the medications that we used to help patients with some of the symptoms of radiation to the brain or their brain tumors. There are some emotional needs. Patients who have had brain tumors and especially patients who have had whole brain radiation can commonly gets oppression. This is something that families and patients their cells should be cognitive of especially and long-term survivors of brain tumor patients. The likely of getting depression at some point after that is 50%. The doctors have to be aware of this but the patients themselves should know because they don't always present with a feel very depressed. They can present with a combination of symptoms like fatigue, decreased concentration, weight loss, insomnia, slowing of the motor skills, and decreased motivation along with depression. These are symptoms to look for that we in the Palliative Care care setting really look for to try to focus on the holistic medicine for the patient. Not only are we trying to take care of their brain tumor but we are also trying to do with their symptoms and their emotional and social needs.

>> How do we deal with depression and brain tumor patients? We will consider psychotherapy. We have a PhD who is in charge of a number of counselors were patients we refer to them for depression or issues to adjusting and the patients can have counseling. They might be eligible for medications. I am not in favor of just going medications at somebody. I think when somebody is having depression it seems best to use a combination of things like counseling and psychotherapy along with the medications. Sometimes psychostimulants can really help like the Ritalin or arbuterol S&L. You would be surprised that some people feel a lot better. We actually do and commonly suggest to our patients to seek out support groups. I know a couple of the founders of the group Western North Carolina brain tumor support group. This is a great bunch who has seminars once a month and meet regularly. It is not just the patients but their families. They bringing guest speakers to talk about what's new for brain tumors and to provide support for each other. I have definitely seen some patients really benefit because it is hard to relate to actually having the symptoms of somebody with a brain tumor. Who can relate best but other people who have been through the same thing.

>> This is been helpful for a number of my patients who attend this or other support groups. Spiritual needs. It is common for pre-patients with brain tumors to actually end up feeling at some point in their life a sense of hopelessness, depression is -- guilt, and anger. Sometimes patients will bottle in. From the Palliative Care setting we try to get people to talk about it and bring it up because it is hard to address if we do not talk about it. Talking about it can be therapeutic itself.

>> The goal of spiritual billing -- well-being or Palliative Care is for both the patient and caregiver. We try to educate patients about the to outcomes. I tried to tell patients best and worst case scenario. There is a very wide range so do something where we try to sit down and talk about goals that fit into the value systems of each patient. We try to encourage involvement and empowerment in making decisions. I've had patients who says, my 50th anniversary is coming up, what should I do? Or, I am wanting to take a trip back to my home country for a religious holiday, can I go? These are things were I whole team a family, patients, doctors, social workers route all have to be in communication with regarding some of these decisions. We do encourage support and guidance of the appropriate spiritual leaders that a patient may belong to. We encourage spiritual practices consistent with the beliefs like prayer, meditation, forgiveness, service, music. I know a former patient that had a very difficult type of cancer. They didn't have a long life expectancy both one of the goals was to do a cancer walk. She even had a backup person just in case she did not make the whole walk. She didn't. -- Did it. That was therapeutic for her. She had a real sense of accomplishment. She was doing something to help the fight against cancer.

>> How about practical needs? They are day-to-day things like driving. Only think about Palliative Care we think there's going to be some people that will not be able to drive that others we want to

take their independence back because that is an important part of who they are. One of the things we have to listen to is what is the law? And North Carolina have someone is have a seizure within six months by law they cannot drive. If somebody has a significant visual field cut, a big blind cut -- spot, and ophthalmologists will have to okay them to drive. Depending on the burden of tumor in the brain sometimes the treatment can impair the judgment and reaction time so that can be enough to cause someone to not drive. The medications can sometimes impair judgment and reaction time. How do we get people back to driving? Things like an ophthalmologist appointment. Is it significant enough for -- to affect someone's ability to drive? There is a driving rehabilitation assessment. They are companies out there that are trained to help assess how you are doing and when it is okay to get back on the road. Another thing that is relatively common for people who have a break tubers is disability. These are things that will help patients on quite frequently. Who is eligible for disability? You get it right away if you have a highly mid-late Nick Ring tumor. -- Budnick lit's dirge -- malignant brain tumor.

>> If brain tumors are progressive or recurrent after the initial treatment usually the patient will get disability very quickly. Also if patients are unable to return to the previous work or so which to a list of meeting job based on what has been causing the impairment. The radiation, Kenyan chemotherapy. Patients who will not need to get a lawyer people with Glioblastoma, brain the testes, brain tumor that has progress after primary treatment. Who will probably need a lawyer? Grade to go MOMA -- glioma with congenital changes. What I usually have found is that there are -- who generally succeeds in getting disability is the opinions of the treating physician that are really important. If you think that you need disability you want to talk to your oncologist about it. Make sure they put fine details in their medical a notes about what kind of deficits there are and the oncologist, if they're willing to say, I believe that this patient is permanently disabled, that is very helpful to the person who otherwise only has a list of diagnoses to look at. It is very important to have these things documented in medical records. These are things that we talk about when we are in the mode of thinking of Palliative Care not just treating the brain tumor . One of the other things is support for families, friends, and caregivers. It is not easy to be a family member for -- friend or caregiver to a loved one that has a brain tumor. There is a lot of things that a brain tumor can change. Sometimes people go from being highly independent to having things that are just not quite the same. Sometimes it is helpful for family to be educated which -- about what things may not be the same. Sometimes it is help for family members to get that same kind of counseling or psychosocial support, support organizations, home health can be helpful to help out with medications, and there is a lot of things on the Internet that can give us not only physical help but emotional strength.

>> E American Cancer Society is a great organization. They have something called I can cope. They put out educational classes for patients, families, and friends to learn how to cope with cancer. Ray tumors are not something that we know how to cope with. It can be difficult meeting with people who have been through or have dealt with a lot of cases can be helpful. American Cancer Society also has a great thing that they give gas cards for patients who have to travel far for the treatment. It depends on the county but I have left the phone number. Patients call of and they asked for your county and diagnose six. -- Diagnosis. I send patients for these all the time. The make a wish foundation is for pediatric pain date -- patients. They allow or tried to give a wish to a patient. I have had patients meet sports stars or go to Disney World and traveled to pretty exotic places. Patients may be referred by not only medical professionals but parents, guardians, and family members who have detailed knowledge of the condition. This is another great organization that is close to my heart because the founder of the organization is the son of one of my former patients. It is called take the fight. What they do is pair up college student from different universities with patients who have cancer and while the brain tumor is not necessarily -- it is the tumor type they are specialized in. They assign a personal consultant to each cancer patient who goes through things like a

consultation with radiation doctor or medical oncologist. Different treatment visits and needs visit -- regularly to go to the journey with them. Because they are right college students they look up what clinical trials or what type of things they might be looking for. It is something that really has a major focus on the holistic approach to treating brain tumor patients. Like what types of nutritional things and exercise might be helpful. One of the consultants actually help for my patient goes helped my patient apply for disability. The patient was not go with the computer but the consultant one. When you pair them up he was able to help this guy apply for disability and it really helped his quality of life. When someone has a concern on where the paycheck is going to come from it could have an effect on the quality of life.

>> Caring bridge is an Internet website where patients can start a page for themselves. It is like a personal blog for a patient who is fighting cancer. It is a quick way to keep in touch with everybody. Sometimes it is a way of keeping everybody informed on what is going on with your life and where you are with the journey so people feel like they are with you and can send you support. It is something that I have seen help people in many ways.

>> We talked about the differences between hospice and Palliative Care care. Hospice is a part of Palliative Care care -- when decisions are being made. It's good to know hospice involves and has available to them. Often time cancer patients there is a time in the journey where there is time to think about whether it is time for hospice. Hospice does a very good job at pain and symptom control. They essentially have 24-hour access to nurses. They have home care and you could do hospice from an inpatient unit. Hospice commonly has chaplains and they can set up family meetings and court daycare -- coordinate care. They can help the family and the grieving process as well. Hospice is a very helpful thing when the time comes for it.

>> In -- even after we treat patients and some patients do very well for a very long time, we think from the Palliative Care side we try not to just say, that's great but we try to hold the patient's hand through the journey even through survivorship. I do not see my long-term survivor patients as much anymore but we still check in. Sometimes there is also lasting tumor effects or lasting effects of treatment. Sometimes patients need to rehabilitate some of the function that might have been compromised by surgery or treatment. Their effects on families and relationships and financial effects. That is something doctors never like to think about. That is a real thing. And the returning to work or school. Brain injury can continue to recover for several years after something like a brain tumor is dissected. Just because function has not returned after a month does not necessarily mean that it is forever. Brain injury can continue to recover gradually over years. There are some things were after a certain period of time it is much more gradual and commonly it is after a year there is still a major deficit while improvement it is not to the point where he can go away. There are some brain functions that can be relearned with rehabilitation. Even language function. There are effects of treatment like short-term memory loss can be common after brain radiotherapy, seizure medication kinds that he and depression and all of these things need to be addressed. Sometimes brain tumor patients have hormone changes. We need to address these so we can shift gears over time from concentrating on purely the tumor being gone or is it gonna come back to what is the things that are affecting the quality of life and what might be done about them.

>> Brain tumors can have effects on family and relationships. Some brain tumor patients who have had brain injury from the tumor can require 24 hour aide. Some brain tumor patients may have changes in their personality as a result of tumor treatment. And sometimes relationships with patients and their family can be stressed by everything that the family has to go through and the patient has to go through from the treatment to the diagnosis and that thereafter. Counseling is commonly recommended for both patients and their caretakers as a safe way to be able to have patients and their family talk a bout some sometimes difficult things that are ignored.

>> It can be very sad looking at how much it can affect the finances of the family. Some patients had to sell their house or go into debt to deal with all the costs. Unfortunately, treatments can be very expensive. One time a patient tell me how much they were asked for by the pharmacy for their Temodar and I almost could not believe it. Fortunately there are avenues where we can get financial supporter and sometimes get the drug company to give us medications for free or for less but regardless, it is something that can really affect the finances of the family. How about returning to work or school?

>> We do encourage patients and their family members if the patient was in school to keep in contact with the school during the treatment and early in the recovery process so they know that you are coming back and what a time I might be. There are protections, by law, for patients who have had brain tumors or cancer that may cause some changes in their ability to learn or cause changing -- changes in their learning process. What I would suggest is going to talk to your doctor because the doctor commonly has a social worker that can contact the school and for an individualized education program that will help to individualize the care based on the patient and what they can do what they might need help in. This is not something where you should feel the school is giving you a hard time but you do not know what to do. There are ways at the hospital or social workers can contact the school and there are laws to protect you. You can give a short time or have tutoring -- extra time or have tutoring.

>> This brings me to the point where it is time for questions.

>> Thank you so much, Dr. Chan. It was a wonderful overview of Palliative Care in showing that it is not what most people think it is. We appreciate that and we do have a lot of questions that are coming in. I just want to remind people that if you would like to ask a question please type it in and use the question box. This is located on the right-hand side of your screen. Let's start with some that we already have.

>> Someone is asking about the depression medication and wondering if you have a list of medications that should or should not be used and would that be something that you would share or is that something that they would have to go directly to their physicians for.

>> That is a great question. Unfortunately there is not a textbook answer. The best suggestion I have is that they should talk to their doctor if they are having some difficulties with depression. Having said that, there are several things that we do when someone is having depression when they have had a brain tumor. First thing you do is make sure that it is not caused by anything else. I will send patients for a thyroid test which can be affected by brain radiation to make sure it is at the proper level. If that is contributing to it you want the thyroid level to be corrected. I will also have patients -- my first-line medication is a selective serotonin reuptake inhibitor. Something like Paxil or Zoloft. It can take a few weeks to kick and so it is something where we try them out on that and make sure that it is something that is -- no that it is something that will help right away. I will often ask them about their fatigue levels because if they are having some depression but their biggest thing is they are really tired we may try something like Ritalin or on modafinil in. Ritalin tends to be cheaper even though the on modafinil has a little bit more of a benefit in the study. If the insurance company will cover it we will try it that if not we will start with Ritalin. We had a patient were the Ritalin did not work in any way. Regardless, it is something where having -- finally, I think that medications do go hand-in-hand with counseling. In today's medicine throwing pills that it's medical conditions is almost a knee-jerk and sometimes it we lose what we knew had help.

>> As a therapist on the other side of it, we really appreciate the idea that yes medication is good but in conjunction with counseling it works better. We thank you for your support. They can always call

ABTA Careline -- Careline and speak to a therapist. We like when doctors support the work and social work of psychology does.

>> Another question, people are concerned about pain relief. How do you work with families getting the balancing act on medication.

>> That is a very good question but it is also a difficult question. There is not a recipe answer for works for every person but with regards to pain relief we usually have to look at the source. For example, if the source is caused by cancer so some patients have brand tamers because that brain metastases will have cancer elsewhere and cancer related pain can be quite debilitating. That pain can be bad enough where we really have to focus on making sure that is under control. One thing we have found is when someone is in pain that is greater than what they would grade on a scale from 0 to 10 that effects the quality of life enough where they are pretty tired just dealing with the pain all the time. Even without having anything else to deal with. And that kind of scenario it is important to and what we do is try to optimize pain regimen by having both the long acting Panamanian vacation and short acting for break her. Having the long acting gets their body used to having pain medications around and when it gets bad we use the breakthrough to help him deal with that. Essentially, if it used in this way it is less likely that somebody ends up being and the quote unquote comatose. Unfortunately it is even trickier in patients who have pain from brain tumors because pain can calmly be from headache. We do have to make sure that it is not from swelling from a tumor because if it is, often times something like a steroid may be very helpful in helping with headaches because it gets to the root of the problem. Now, some people have had chronic headaches after having had a brain tumor. That is something where it may actually be best to see a specialist in pain management or neurology that specializes in dealing with headaches. What they will do is try to deal with or come up with a medication regimen using combinations of regimens -- medications that is not just your standard narcotic. Those are best managed in this setting of being referred to a headache specialist. It is not been easy thing. There is a whole family of medications like gabapentin that helps to deal with neuropathic pain which can sometimes can be used in conjunction with the standard every day narcotic medication to hit the pain from two different sides. The pain is a very difficult thing to deal with. It is not uncommon that if someone is having a really severe pain it is that they end up not being seen by a pain specialist who can try to optimize that pain regimen without effecting other portions of the quality of life as much as possible.

>> Someone is asking about how to locate Palliative Care hospice provider. I know we have discussed this further earlier soaking you dress this -- can you address this?

>> Hospices for end-of-life. Hospice is generally located anywhere patient is. They are very easy to find. The oncologist will be able to help direct you to a hospice program that is close to where the patient lives. Hospice is for end of life. Palliative Care is the holistic thinking. Not every hospitals going to have that. It is a trend now that Palliative Care is becoming more more popular. More more hospitals are having them. At this time they are more common in the academic centers like the big University hospitals but they are becoming more more popular where they are being available in a lot of other places. What I would suggest is to ask the oncologist, are you offering consultations with a Palliative Care doctor at the center if not, do you have a way of referring me to one. If you are looking for one you can find them on the Internet but generally and very commonly with the University hospital because those are where the Palliative Care has their training programs for Palliative Care medicines.

>> I would also encourage them to call the social workers here if they are not at one of the larger institutions. You can go to our website at [www.abta.org](http://www.abta.org) . Our social workers can help direct them to a Palliative Care program. It is a good thing that they are becoming more widely accepted. If we

have this conversation in a year or two may be more community hospitals will have them. The next question is, how do you reduce the side effects of radiation therapy?

>> That is a great question. There are a few things that we can think about. First of all, the radiation technology is getting better so that if someone has a brain metastasis instead of whole brain radiation we can do a waste -- what we call [ Indiscernible ]. It is a shotgun approach versus a stereotactic radiosurgery that is more like a sniper taking care of what is there. He sniper Pro's will not effect -- affect cognition. You're limited to how big a tumor is and how many tumors there are. There is a good number of patients with brain metastases that are going to be eligible for that. What you do is postpone the radiation therapy for as long as possible. There is also some of the medications that we have talked about. It is not unreasonable to give that a shot. To try to help with the side effects of radiation that there might be. There are so much more controversial radiation techniques that are very high technology and sometimes very expensive. Without any proof and benefit yet. One of them recall proton therapy. There are some thoughts that proton therapy might have some role in treating patients where there is potential for certain structure of the brain that may be important for country -- cognition. There is an experiment -- experimental technique. It is highly experimental and I would certainly not do this as a clinical study. Aching can sometimes be helpful for patients who are -- it is thought to be related to memory so if you limit the dose of radiation to the hippocampus to someone's memory than dash both of those technique's are experimental and if someone is it interested in that I would encourage them to go in a clinical study because it is unclear what kinds of technique's would be beneficial to patients. One of the things that is happening in the US is there's all the expensive technologies are driving up the cost of healthcare. It would be helpful to know that that might help but otherwise it is a very controversial topic which, at this point, we cannot say if there is no benefits at all.

>> We have time for one last question. How do you bring up the topic of Palliative Care when people still associated with hospice?

>> With my patients I always give them an idea of a range for how someone's life expectancy is. They commonly want to have an idea of what to prepare for but then also what is the best case scenario, were so case scenario, average. That is something that we talk about multiple times. With knowing that, we will often preface the issue of Palliative Care as this is not because we think that it's the end is near but because our first philosophy in our team is to take care of the whole patient and not just the tumor. It is the patient I answer to knock the tumor. With that, there are a lot of things that are involved with a patient and their quality of life. One of the things that is most difficult is when we make a referral to our psychosocial oncologist, a patient may say I don't want to see a shrink. There is nothing wrong I don't need it. The thing is, the likeliness is there may be nothing wrong but it is something where everybody who has had this type of treatment does have to do an adjustment process. We found that for some people it can be helpful to meet with a counselor or psychosocial oncologist. Because for some people it may be helpful. It is essentially of to the patient and their family on whether they want to take us up on it or not. It is our job as part of their care team to let them know that that is part of what we offer.

>> Great conclusion. That is all the time we have for today, thank you for joining us and think you Dr. Chan. For more information on Palliative Care or any of the brain tumor topics please visit our website or call all were licensed healthcare professionals at 800 866 800-866-2282.

>> Thank you for having me.

>> We invite you to continue to check back at our website [www.abta.org](http://www.abta.org) for brain tumor related topics and our webinar series. Our next to Webb news on Wednesday from 1 PM to 2 PM central time. Leaving well with and be on a brain tumor. Please join Elizabeth Sharewood of the University

of North Carolina nurse survivorship and integrative medicine programs and oncology for a BTA's webinar on living well, with and be on a brain tumor. Living with them beyond a brain tumor diagnosis can have multiple challenges and stressors for patients and can givers. -- Caregivers. Ms. Sharewood will discuss helpful strategies for approaching wellness and teach skills for living mindful -- mindfully with a brain tumor diagnosis. Wednesday the 10th 2 PM to 3 PM central time please join Ronald Warnick of the University of Cincinnati brain tumor Center as he presented webinar discussing instances rates, risk factors, tumor classification and presenting symptoms of Mina Gomez. He will explain the role of imaging as well as various treatment options including surgery, radiation, and chemotherapy. The presentation will also explore clinical trials and future advances. This concludes our webinar. Thank you for joining us and please be sure to complete the feedback survey you will receive shortly following the session. You may now disconnect.

>> [ Event Concluded ]