

# Thry'vors News

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**Fall 2007**

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This is the 16<sup>th</sup> in a series of seasonal newsletters, from the Canadian Thyroid Cancer Support Group (Thry'vors) Inc. Your comments and suggestions are most welcome.

Please direct your comments to Newsletter Committee at [thryvors@sympatico.ca](mailto:thryvors@sympatico.ca)

## Tour of the University Health Network Pathology Laboratory

by: **Rita Banach**

In June 2007, I was extremely fortunate to have been given a tour of the pathology lab at the Toronto General Hospital by the pathologist-in-chief, Dr. Sylvia Asa.

We started the tour in the laboratory that is adjacent to the operating rooms. There is a small lab such as this in every hospital. While a surgery is taking place, the surgeon sends over the tissue or the organ he has removed for analysis. This analysis has to be done quickly and accurately, so that the surgery can be completed in a timely way and the patient is not under the influence of anesthesia any longer than necessary (the check usually takes about 20 minutes). In the case of thyroid cancer, the main issues at this point in time are to insure that the surgeon has not inadvertently removed all four (4) parathyroids (sometimes this cannot be avoided) and that lymph nodes are sampled for possible metastases. If cancer is found in the lymph node sample, this information is relayed to the surgeon so that he knows that more nodes should be removed until all those with metastases are removed. These studies are done on frozen sections of the tissue. In contrast, when examining a thyroid nodule itself, the freezing can alter the cells so that a diagnosis cannot be made. For this one must use smears and touch preps – that is, a small amount of tissue is smeared onto a glass slide to be examined under a microscope. However, this is really the same as doing cytology and most patients have cytology done pre-operatively on their needle biopsy, so very rarely is this intraoperative analysis performed on the actual thyroid nodule.

Once the surgery is completed, the whole organ and all the lymph nodes and other tissue removed (such as muscle tissue) are examined.



It happens every fall. Our daily routines are reestablished as everyone heads **'back to school'**. This issue presents lessons on the basics of pathology including Q & A teachings from a university professor and pathologist. Become an educated patient, you are your best health advocate.

Head outside to enjoy a crisp, colourful fall walk and nature's bounty of fresh fruits and vegetables – your healthy future depends on it.

Rhonda McMahon, *Editor*

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*Offering information and support*



A technician cuts out some parts of the overall tissue (based on its appearance) and puts sample tissue into tiny plastic mesh boxes called cassettes. The amount of tissue that fits into one cassette is about the size of a nickel or quarter. The rest of the thyroid and tissue goes into a labelled specimen jar (with preservative) and is stored for weeks or months or until such time that the pathologist is sure they will not need to re-exam it. Also, with the patient's prior consent, some sample tissue may be withdrawn for special research purposes and kept in a special spacey-looking cryogenic machine.

Dr. Asa continued the tour in the new laboratory on the 11<sup>th</sup> floor of the hospital. This spacious laboratory not only services the Toronto General, but also the other hospitals of the University Health Network (i.e. Toronto Western and Princess Margaret Hospitals). As well, they often consult on samples derived from patients in 15 hospitals in the Greater Toronto Area, and beyond.

We visited the cytology lab, where fine needle aspirate (FNA) is examined. Patients who undergo FNA biopsies, have cells withdrawn from their nodules with a needle that is emptied into a specimen container. That container arrives at this lab. Special machines put a sample of the aspirate onto a glass slide with a matching slide on top, sandwiching the sample between so that it can be handled easily. This labelled slide is then looked at by specialists who mark suspicious-looking features with a white dot on the glass (the dot is put slightly above the feature so as to not cover it). In the case of thyroid cancer, I was introduced to the technician who specializes in looking at these slides and identifying abnormal microscopic features of the cells. Sometimes, additional slides need to be made in a more labour-intensive way where special dyes are added. This is done in cases where very rare and unusual cellular features have been noted, in order to aid the process of identifying the type of cancer. The slides are then sent to a Pathologist for interpretation and final diagnosis.

Our next stop was in the large lab that receives the cassettes following surgery. The lab was filled with fancy machines, and highly trained individuals each working with one

patient's materials at a time. A special machine took each specimen from the cassettes and immersed them into hot wax which was then solidified into small blocks of wax. The size of each block was about one inch square, and a ¼ inch in height. Technicians worked with those small blocks and cutting machines that sliced each block into extremely thin slices (like a tiny baloney-slicing machine). Each tiny slice went onto a slide. Amazingly about 100 slices can be made from each wax block. Most thyroid have about 20 blocks or so, and usually only one section of each is made to examine thyroid tissue. After the individual slices are made, they go through another machine that removes the wax and stains the sample. The resulting sample is affixed to a glass slide similar to the ones used in the cytology lab. In some cases, the regular stains don't provide the whole answer, so more sections can be cut and special stains (known as "immunohistochemistry") are done on more fancy machines to add more information and help the Pathologist get the right answer.

Next we went to Dr. Asa's office to look at some sample slides. She has a fairly traditional-looking microscope on her desk, but she need not look into it as her specialized computer software projects the microscope image onto her nearby computer monitor. With a turn of the microscope's focusing mechanism, the image on the computer screen is magnified to the degree she requires. She showed me an example of a case where she was asked for a second opinion. The original lab had considered the sample to be that of a benign tumour – and so it did appear to be until Dr. Asa magnified the picture. At that point even I, a mere layperson, could easily see that the cells were not uniform in size and shape (as they should be). Instead some were quite large, misshapen and had unusual features. Good thing they asked her for a second opinion!

In all, it was a fascinating and very illuminating tour. A great many of the variety steps that our thyroid tissue goes through post-surgery, is handled by very specialized and fancy machinery. This machinery is very time-saving and cuts down on the number of possible human errors, (e.g. labelling is automated). As well, the human touch is still very much necessary as at each step a highly qualified specialist is involved in preparing and 'reading' tissue samples.

When we have surgery for thyroid cancer we are not only in the hands of a surgeon, but very importantly there is a whole team of technicians, cytologists and pathologists who determine our outcomes as well. We meet our surgeon, but rarely do patients have the pleasure of meeting their pathologist as I was privileged to do.

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## Ask Thry'vors Q&A—Thyroid Cancer Pathology

In this special edition of Ask Thry'vors, Dr. Sylvia Asa, MD, PhD. Pathologist-in-Chief of the University Health Network and Toronto Medical Laboratories answers patients' questions about thyroid cancer pathology.

### Q1. What is the difference between cytology and pathology?

**A:** Pathology is the study of disease. Pathologists examine human samples to determine the type and extent of disease, and to identify the correct treatment approach. They perform different kinds of studies depending on the material available.

Pathology started with autopsies; when a patient died, the Pathologist could identify the underlying problem. With the development of modern surgical procedures, diseases could be biopsied, and whole organs (like the thyroid) could be removed. This type of pathology is called "surgical pathology". The identification of cellular features of diseases then allowed Pathologists to be able to make a diagnosis based on only a few cells, and "cytology" came of age.

Today, in patients with thyroid nodules, the initial procedure is usually cytologic examination of aspirated cells that are obtained without an invasive procedure. If the lesion is worrisome or malignant on cytology, it is removed surgically

and the surgical pathology process determines the full characteristics of the problem. Sometimes even benign diseases are resected surgically and the tissues are still examined carefully by the Pathologist.

### Q2. What visible cellular characteristics differentiate thyroid cancer from other cancers?

**A:** There are a number of cellular characteristics that determine malignancy in the thyroid. They include the degree of differentiation of the cells (that is, how mature the cells are), their growth pattern (for example, if they invade into places that they should not be), and more subtle features such as changes in the nucleus. Pathologists train for several years to become familiar with the various structural and biochemical features that allow the distinction of benign from malignant thyroid cells, to distinguish aggressive or metastatic cancers that might be involving the thyroid by spread from other sites, and to identify metastatic thyroid cancer in other parts of the body.

### Q3. What is the procedure for doing a "frozen section" during thyroidectomy surgery? That is, is a sample of a node examined in the operating room, or in the pathology lab? Are pathologists on stand-by at all times, to have a look at slides of sample material (especially in cases where cancer has not been established previously by FNA)? Is 'frozen section' examination standard procedure during all thyroidectomy surgeries in all hospitals? How long does a 'frozen section' examination take?

**A:** Frozen sections are one method used by Pathologists to provide an intraoperative consultation to the surgeon. There are other techniques as well, including smears and touch preps that are more directed to analyzing the cytology of the tissue removed – the advantage of these is that they do not induce changes due to freezing of cells that happen when tissue is frozen so that a thin section can be cut to put on a glass slide. However the interpretation

of these preparations requires the expertise of a cytopathologist or a subspecialist with training.

During thyroidectomy, the surgeon removes the abnormal thyroid tissue. To do so, he/she must ensure that the parathyroid glands are spared, and this requires accurate identification of the parathyroid glands that can be very hard to recognize. Therefore there is usually need for a Pathologist to examine the tissue which the surgeon thinks is parathyroid; this is usually done by rapidly freezing the tiny biopsy, cutting a very thin section, staining it and examining it in the microscope to verify its identity. Pathologists are usually notified that they may be needed for a consultation when a surgery is booked; they then plan to be available and the entire procedure takes less than 20 minutes.

If the surgeon finds an enlarged and worrisome lymph node, the Pathologist can again examine it using frozen section technology to determine if thyroid cancer has spread; this will change the surgical procedure, since the presence of unsuspected spread will require the surgeon to do more exploration and resection of other involved lymph nodes.

The role of frozen section to identify thyroid cancer is highly controversial. With improvements in cytology, it has been shown that cytologic evaluation is actually more accurate than frozen section. This is because the subtle features of malignancy in thyroid cells are camouflaged by the freezing process that disturbs the appearance of thyroid cells. Frozen section is very helpful to identify some forms of cancer, and to determine the extent of spread of a cancer, but at the moment it is not very useful for the distinction of benign from malignant thyroid nodules. If a nodule is diagnosed as malignant on cytology, there is no need for further intraoperative evaluation. If cytology is not definitive, the best approach is to await the surgical pathology evaluation.

## Poem

by Jasna K. Schwind, 2001  
(with permission)

I am wounded.

I heal.

Like a tree that loses one of its limbs during a snowstorm  
I heal the wound.

Slowly

I heal.

And the scar remains.

Imperfect

the tree still reaches for the sun.

And proud

bends with the wind.

**Send us your poems.  
Email [thryvors@sympatico.ca](mailto:thryvors@sympatico.ca)**

**Q4. What is the procedure for examining the total tissue removed during thyroidectomy surgery? How many slices or parts of a nodule are examined to determine if cancer is present or not? How many pathologists normally look at one patient's slides to make the diagnosis? How much time does the total examination typically take?**

**A:** The examination of thyroid tissue removed at surgery is performed by a Pathologist who initially examines the tissue in its fresh state. This takes approximately 15 minutes, but may take longer in more complex situations. The Pathologist then determines how many sections are required to determine the correct diagnosis and to evaluate the full extent of disease. The number of slices varies, depending on the size of the tissue removed and the nature of the abnormality.

The tissue slices are then processed to preserve them and they are embedded into wax blocks. Thin sections of the wax can be cut (as thin as 2 micrometers thick!) and these are placed on glass slides. The tissue is stained so that it can be seen with a microscope.

The routine process takes from 24 to 72 hours, depending on the number of blocks and slides, and how busy the pathology laboratory is. In some cases, special stains are needed and these require another 24-48 hours to be completed, then the Pathologist can complete the analysis and issue the report.

Usually only one Pathologist does a single case. In some cases, if there is concern about the correct diagnosis, the Pathologist may ask for another opinion, sometimes from a colleague in the same institution, but often by referring the case to a thyroid expert.

**Q5. Do thyroid cancer cells found within the thyroid have different characteristics than thyroid cancer cells found elsewhere, such as in lymph nodes or distant metastases?**

**A:** Usually thyroid cancer cells look the same whether they are in the thyroid or they have spread to other parts of the body. However, sometimes they become more aggressive and look more worrisome as they spread. The parts of a thyroid cancer cell that are similar to the normal thyroid are called “markers” of that cancer, and Pathologists use them to confirm that the distant cells are indeed from the thyroid. We have found that cancer cells often change some of their biochemical features as they become more aggressive, and we use these changes as “markers” of behaviour.

**Q6. Why is papillary thyroid cancer more likely to be multi-focal and spread to lymph nodes whereas follicular cancer (when it does advance) more likely to spread to distant sites?**

**A:** We do not understand this phenomenon very well. It is likely that the different genetic events that cause thyroid cancer are responsible for the different behaviours of these cancers.

**Q7. Is there a progression of cell development from highly differentiated to poorly-differentiated over time? That is, do thyroid cancer cells start out as papillary and change to tall cell, or columnar, or hürthle over time? Why do some cells mutate this way, and why does this happen in some people and not others?**

**A:** In North America, most thyroid cancers are detected early and they are usually well differentiated cancers. However we know that if not detected and allowed to grow, some of the differentiated cancers can progress to more aggressive cancers. The differences are likely due to different genetic changes. The most common changes are the genetic mutations or chromosomal rearrangements that cause differentiated thyroid cancers, and only a few cancers suffer additional genetic alterations that cause progression. However, there are some cancers that start with the bad mutations that make them more aggressive.

**Q8. What is the difference between normal hürthle cells and those that represent carcinoma?**

**A:** There is no such thing as a “normal” Hurthle cell. Hurthle cell change (more correctly called “oncocytic change”) is a cellular reaction to stress or irritation. Oncocytic cells are seen in inflamed thyroids as well as in thyroid cancers. The basis for the change is thought to be in the DNA of the tiny cellular organelles called “mitochondria”. This change also is found in some tumour, but the genetic changes that cause tumour are not in mitochondrial DNA, they are in the nuclear DNA of the cells.

**Q9. In regards to making a diagnosis of a type of thyroid cancer, what percentage of cell type is standard for a description? For example, at what point does the**

description change from ‘papillary carcinoma with hürthle cell features (or changes)’ to ‘hürthle cell carcinoma’.

**A:** There are different criteria for classification of different tumour types. It is generally accepted that 75% of a tumour must have a feature such as “Hurthle cell change” or “clear cell change” to be called by one of those names, however, only 30 to 50% of a tumour must have tall cell features to be called a “tall cell papillary carcinoma”.

**Q10. What other information do you think would be interesting or helpful for patients to know, in regards to the work of pathologists in the diagnosis of thyroid cancer?**

**A:** Pathologists are key to the correct and accurate diagnosis and prognosis of thyroid cancers. They are the ones who determine the diagnosis of malignancy, the classification of tumour type, and the extent of spread. They are involved in identifying markers that will predict the response to therapies and ultimately the patient’s prognosis. The outcome of the Pathologist’s work will guide the other doctors in deciding if surgery is indicated, how much surgery to perform, whether or not to give radioactive iodine, and whether other therapies are indicated.

As a general rule, patients do not meet their Pathologist, and many are completely unaware of the involvement of Pathologists in their care. However, as with other Physicians and Surgeons, they too have varying degrees of experience and expertise.

**Reponses provide by :**

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## Liz Pearson’s Top 10 List of Foods with Biggest Health and Nutritional Punch

**With permission from Liz Pearson.**

For the entire article please see: “Eat these and be healthy!” by Liz Pearson. Toronto Star. March 8, 2007. Available on the web at: [www.thestar.com/Special/article/188904](http://www.thestar.com/Special/article/188904). For more information visit Liz Pearson’s website at [www.lizpearson.com/](http://www.lizpearson.com/)

**Editor’s Note:** Canada’s Food Guide to Healthy Eating is an excellent foundation to improving your diet. There is no magic pill, but according to Liz Pearson, Registered Dietitian, 10 foods “pack the biggest health and nutritional punch”.



### 1. Extra Virgin Olive Oil

It helps lower LDL (the ‘bad’ cholesterol), contains phenols that have strong antioxidant (anti-cancer) and anti-inflammatory effects (helps prevent heart disease). (Ed. Note: Olive oil loses some of its qualities when heated, thus it is best to use lightly as a dressing rather than as cooking oil)

### 2. Broccoli (& Kale)

Has anti-cancer compounds called indoles and isothiocyanates that block cancer in its initial stages. Notes:

raw or lightly steamed broccoli sprouts maintain more cancer-fighting qualities than boiled sprouts do

### 3. Spinach

Spinach has exceptional antioxidant (anti-cancer) qualities, as well as reducing your risk of diseases of the eyes, heart disease, Alzheimer’s disease, and birth defects. It is also very high in several minerals and vitamins.

### 4. Almonds

Almonds are very high in several vitamins and minerals including calcium, magnesium, potassium and vitamin E. They are also a source of protein, fibre and beneficial plant compounds that fight disease.

### 5. Pomegranate Juice

This juice is exceptionally high in polyphenols (anti-oxidants/anti-cancer) plant compounds. It also benefits the heart, immune system and the brain. It may also reduce risk of inflammatory disease such as arthritis. Because it is high in natural sugar, drink no more than half a cup a day.



### 6. Beans

Beans are packed with a variety of vitamins and proteins that build skin, bone, and hair. They help prevent birth defects, and lower the risk of kidney stones, diabetes and heart disease. Their antioxidant qualities help prevent cancers of the breast, colon and prostate.

### 7. Yogurt

We know yogurt is a great source of calcium. As well, some types contain good bacteria called probiotics (check the label). These may help defend against viruses, infections, allergies, asthma, irritable bowel disease (IBD), ulcers and colon cancer. Yogurt is a source of other essential nutrients. And, some research indicates that probiotics help to prevent cavities!

### 8. Blueberries

All berries have antioxidant qualities, but blueberries are best. They help fight 'free-radicals'; that is, they counter-attack factors that may cause heart disease, cancer and aging. They may help prevent Alzheimer's disease and brain damage from strokes.



## Low Iodine Diet Recipe Box

### Apple-cinnamon Compote With Toasted Oats

Fall's bounty is busting with a juicy variety of apples. This recipe also works well with other fruit such as peaches and nectarines.

1/3 cup rolled oats (not instant)  
 1/3 cup water  
 1/3 cup sugar  
 1 tablespoon fresh lemon juice  
 1/2 teaspoon ground cinnamon  
 4 apples, peeled, cored and sliced into 8 wedges each  
 [if using Royal Gala apples, no need to peel them]  
 1/3 cup raisins [optional]

Put oats in non-stick frying pan. Keep stirring oats on medium heat.  
 Dry roast until lightly golden brown. Approximately 5 minutes.

Combine water, sugar, lemon juice and cinnamon. Set pan over medium heat and simmer 5 minutes, stirring occasionally with a wire whisk. Add apple slices & raisins, cover and simmer 5 minutes, until apples are tender. Optional, drizzle with almond milk (homemade) & toasted almonds.

Put compote in individual bowls and sprinkle oats on top.



### New Recipes Added to the Thry'vors LID Recipe Index

Thry'vors LID recipe index now has over 300 recipes. To view LID recipes, go to:  
[www.groups.yahoo.com/group/thryvors/files](http://www.groups.yahoo.com/group/thryvors/files)

## Hope & Cope

With the collaboration of the Department of Endocrinology and the Head and Neck Surgery and Oncology Program, of the Jewish General Hospital (Montreal) Hope & Cope volunteers provide a unique program of information and support for individuals diagnosed with thyroid cancer.

### They offer:

- One-to-one support
- Links to other resources and support programs
- Help to navigate the medical system
- Help for patients and family to understand cancer by providing access to reading materials, internet sites and other relevant information.
- Help with preparation for treatments or follow-up schedule

Hope & Cope offers a wide variety of programs free of charge, both in their main office and at the Wellness Centre, a free-standing facility with a home-like environment located just two blocks away from the hospital.

### These include:

- Coping Skills workshops
- Look Good, Feel Better
- Relaxation techniques
- Yoga
- Exercise
- Resource centre and library
- Nutrition and cooking demonstrations

For more information, contact:

Hope & Cope  
Thyroid Cancer Support Program - Room E-730.1  
3755 Côte Ste. Catherine Road  
Montreal, QC H3T 1E2

Tel: 514 340-8255 Email: [hgoodman@onco.jgh.mcgill.ca](mailto:hgoodman@onco.jgh.mcgill.ca)

Hope & Cope offers bilingual service.

If you live in the Montreal area, you may want to contact Hope & Cope to get on their mailing/emailing list so that they can let you know when they have special events in the future.

## 9. Whole Grains

They help fight heart disease, stroke, cancer and diabetes, and help you maintain a healthy body weight. Whole wheat contains a host of vitamins and minerals.

## 10. Salmon

Salmon is one of the best sources of Omega-3 fats which help prevent heart disease and stroke. These fats have anti-depression and anti-aging qualities as well. They preserve thinking skills and memory. Salmon also helps to cut your risk of breast, prostate and colon cancer. And it reduces symptoms of arthritis, IBD, asthma, allergies and eye disease



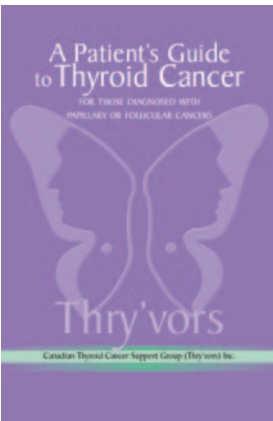
[www.thryvors.org](http://www.thryvors.org)

Thry'vors needs your help to make others aware of our support group. If you are willing to tell your doctor, clinic, cancer treatment centre, pharmacy, public library, employee services department, or any other organization about Thry'vors, please e-mail us at [thryvors@sympatico.ca](mailto:thryvors@sympatico.ca) and we will send you samples of our brochure, patient booklet and an order sheet to bring to your doctor/facility. Our members are our very best promoters!

*Offering information and support*



## NEW Thry'vors Publications



### **A Patient's Guide to Thyroid Cancer: For Those Diagnosed with Papillary or Follicular Cancers**

Our most popular booklet is bigger and better than ever. Includes new sections on hormone replacement, use of Thyrogen, and more. Available in PDF and HTML at [www.thryvors.org](http://www.thryvors.org). Also available in booklet form. To order multiple copies of the booklet, please use our order form at:

[www.thryvors.org/pdf/Order\\_Form\\_July\\_07.pdf](http://www.thryvors.org/pdf/Order_Form_July_07.pdf) or call 416-487-8267

### **Wally Patching Memorial Lectures 2007**

In 2004, the Board of Directors of the *Canadian Thyroid Cancer Support Group (Thry'vors) Inc.* announced the creation of the annual Wally Patching Memorial Lecture to honour one of our most vibrant and determined founding members and to help contribute to his vision of improved Canadian thyroid cancer patient information, support and access to qualified thyroid cancer specialists. This year we are very fortunate to have two presentations:

*Clearing up the Confusion and Improving Patient Compliance: The Thry'vors Low Iodine Diet* by Grace Wright, presented at the 2007 Annual Conference of the Cancer Patient Education Network (CPEN) in Montreal.

*Rob's Story: Lessons in Becoming an Informed Medullary Thyroid Cancer Survivor* by Jody Smith

The presentations may be viewed in the Resources Section of our website – [www.thryvors.org](http://www.thryvors.org) or are available by request in hard copy (contact Thry'vors at 416-487-8267 or email [thryvors@sympatico.ca](mailto:thryvors@sympatico.ca))

## Upcoming Events

### **Public Forums**

Sponsored by Genzyme Canada Inc. and Thry'vors

#### **1. Niagara Region**

**Topic:** *Niagara Region Patient Forum* – Sponsored by Genzyme Canada Inc. and Thry'vors

**Guest Speaker:** Dr. Meera Luthra, Endocrinologist and Assistant Professor of Medicine, St. Joseph's Hospital, Hamilton.

**Date & time:** Saturday, Sept 15, 2007 – 8:30am-12:00noon

**Location:** White Oaks Conference Centre  
253 Taylor Road, SS4, Niagara-on-the-Lake

If you are a thyroid cancer patient or family member, all welcome. Free Lecture.

**For information and registration:** [info@thyroidupdate.ca](mailto:info@thyroidupdate.ca)

#### **2. Calgary Area**

**Topic:** *An Overview of the Treatment and Follow-Up Of The Thyroid Cancer Patient: Addressing Your Questions And Concerns*, Sponsored by Genzyme Canada Inc. and Thry'vors

**Guest Speaker:** Dr Christopher J. Symonds MD, FRCPC, Clinical Assistant Professor of Medicine, Division of Endocrinology, University of Calgary, and, a Thyroid Cancer Patient (TBA) *"Living With Thyroid Cancer"*

**Date & time:** September 19, 2007 5:30pm-9:00pm

**Location:** Calgary Foothills Medical Centre Auditorium, 1403 29th Street NW, Calgary, Alberta. \*Park in Lot 1, enter main entrance, take elevators/stairs down to ground level, follow signs for the event. If you are a thyroid cancer patient or family member, all welcome. Free Lecture.

**For information and registration:** [info@thyroidupdate.ca](mailto:info@thyroidupdate.ca)

#### **3. Montreal Area**

**Topic:** *Thyroid Cancer - Diagnosis, Management and You* - Sponsored by Hope & Cope and Genzyme Canada Inc.

**Guest Speakers:** Dr. Michael Tamilia (endocrinologist), Dr. Tina Kader (endocrinologist) and Dr. Chris Rush (nuclear medicine) will speak on topics such as: Introduction and Epidemiology; Diagnosis and Follow-up of Thyroid Cancer and Treatment of Thyroid Cancer. Susan Raymer, member of Thry'vors, will speak about A Patient's Perspective. The event will be moderated by Dr. Martin Black.

**Date and time:** Thursday September 20 – 5:30pm-7:00pm

**Location:** Wellness Centre, 4635 Cote St. Catherine (corner Lavoie), Montreal

**For information call:** 519-340-8255

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**US Thyroid Cancer Survivors' Association - 10th International Thyroid Cancer Survivors' Conference**

**Date:** October 19-21, 2007  
**Location:** San Francisco, California, Sofitel San Francisco Bay Hotel, 223 Twin Dolphin Drive, Redwood City, CA 94065  
**Topics:** • Learn from experts and share experiences with others coping with thyroid cancer • More than 80 sessions: The latest research, advances in treatment and follow-up, insurance and employment issues, and coping skills for well-being • Featuring leading physicians and other specialists. More than 50 speakers  
**For more Information:** [www.thyca.org/conf2007.htm](http://www.thyca.org/conf2007.htm) or call toll free - 1-877-588-7904

**Thyroid Foundation of Canada Events:**

**1. Kingston Chapter**

**Topic:** Discussion led by Loblaws' DRUGstore Pharmacist Bozica Popovic, B.Sc.Pharm. and representatives of Kingston Chapter  
**Date and time:** 4th Sunday of each month, 3:00-4:00 pm  
**Location:** Loblaws upstairs Kingston Centre, 1100 Princess St.. Bring your questions. Thyroid literature available. Free, no registration required. All welcome -  
**To confirm the seminar date and time call DRUGStore @ 613-530-3414 or Margaret @ 613-545-2327**

**2. London Chapter**

**Public Education Meeting - September 2007**  
**Topic:** 'Parathyroid'. Presented by: Dr. Terri Paul, Endocrinologist, St. Joseph's Health Centre  
**Date and time:** SEPTEMBER 18 - 7:30 PM - 9:00 PM  
**Location:** Central London Public Library (Galleria), 1st Floor, Stevenson & Hunt Meeting Room, 251 Dundas Street, London. All Welcome! Open to the Public! Free Admission. **To confirm the seminar date and time call (519) 649-5478.**

**Public Education Meeting - November 2007**  
**Topic:** 'Hypothyroidism' Presented by: Dr. Merrill Edmonds, Chapter Medical Advisor & Endocrinologist, St. Joseph's Health Centre  
**Date and time:** November 20 - 7:30 PM - 9:00 PM  
**Location:** Central London Public Library (Galleria), 1st Floor, Stevenson & Hunt Meeting Room, 251 Dundas St., London. All Welcome! Open to the Public! Free Admission  
**To confirm the seminar date and time call (519) 649-5478.**

**Tell us what you think**

Your comments and suggestions are welcome.

Editor: Rhonda McMahon

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**Like you, we have been touched by thyroid cancer. We are a non-profit organization and we are all volunteers. If you would like to donate or to become a volunteer please visit [Thryvors.org](http://Thryvors.org).**

**Donation cheques can be made payable to:** Canadian Thyroid Cancer Support Group (Thry'vors) Inc.

**Mail to:** Canadian Thyroid Cancer Support Group (Thry'vors) Inc.  
PO Box 23007, 550 Eglinton Ave. West  
Toronto, ON M5N 3A8