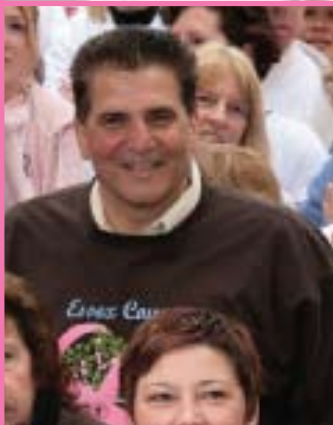




TEN
Thousand
Participants



\$2.1
Million
Raised



Winners Circle

First Place Finishers



Female
Lia Bella



Male
Doug Clark



Survivor
Shannon McGinn

And the Awards go to:

Second Place Finishers

Female - Susie McCabe

Male - Erik Donohue

Survivor - Mark Goldstein

Largest High School Team

Team Eileen

St. Vincent's Academy, Newark

Team Captain - Toni Piccolo

Top High School Team Fundraiser

Westfield High School

Team Captain - Hannah Rubin

Largest Community Team

Team DMC

Team Captain - Deborah M. Capko, M.D.

Top Community Team Fundraiser

Team DMC

Largest Corporate Team

Gibbons P.C.

Team Captain - Erin Davis

Top Corporate Team Fundraiser

Gibbons P.C.

Team Captain - Erin Davis

A Day of Hope for a World Without Breast Cancer



“Out of sight,” said Executive Director Deb Belfatto. “It was an extraordinary experience to see so many women, men and children from different backgrounds and cultures united in a single purpose – to save lives and end breast cancer forever. To date, 2.1 million dollars has been raised for research and critical breast health services for uninsured populations throughout northern New Jersey.”

Kudos to Race Chair, Robin Ventura; Race Vice-Chair, Lisa Rubin; Race Director, Nancy Alfano, and our outstanding Race Leadership Committee, committee members and volunteers for an overwhelmingly successful event. A special thank you, also, to our corporate sponsors, donors, partners and participants.

Race day at Essex County Branch Brook Park began at 5am when more than 250 volunteers arrived to set up for the morning's activities. Participants began flowing into the park as early as 7am. By 8:15 am, 10,000 runners and walkers gathered at the start line for the opening program. Kent Manahan, Senior Anchor for NJN News, and Steve Adubato, Emmy award-winning Anchor, Thirteen/WNET/PBS, shared the spotlight as Masters of Ceremonies. Religious leaders from the Catholic, Hindi, Jewish, Protestant and Muslim faiths offered a special blessing which was followed by a performance of “America the Beautiful” by vocalist, Samantha Dango, daughter of Affiliate staff member, Nancy Dango.

New Jersey Governor Jon S. Corzine addressed the audience, renewing his support for Susan G. Komen for the Cure and thanking the North Jersey Affiliate for its dedication to saving lives. The Governor ran the 5K – his first run since his accident last April. Thousands cheered as he crossed the finish line at 33:16.

Susan G. Komen for the Cure's Chief Operating Officer, Kimberly Simpson, offered special congratulations to the Affiliate and Race participants on the success of the inaugural event. Also celebrating the first North Jersey Race were New Jersey Senate President and former Governor Richard Codey, part of Team Codey with 110 members headed by his wife Mary Jo, a breast cancer survivor; Essex County Executive Joseph DiVincenzo; Newark Deputy Mayor Margarita Muñiz and Newark Councilman Donald Payne, Jr. Honorary Race Chair and Grammy award-winning artist Gloria Gaynor performed her number one hit “I Will Survive” during the Survivor Recognition Ceremony.

Children joined in the fun with face painting, sand art, Moon Bounce and “soccer skills and drills” conducted by players from the New Jersey Ironmen. Participants also enjoyed complimentary refreshments from ShopRite and visited the Health Exposition for nutrition and fitness information, literature and giveaways from national and local sponsors and businesses.

Race photos courtesy of

Andrea Mellen Photography • Lisa Klein • Mond Photography
Stephen Taylor Photography • The Image Maker

Newsletter Editors: Barbara Waters and Beverly Cohen

From the President of the Board, Lisa Ryan Burke...

June 1, 2008



As I look back over the past three years as Board President, the proudest day for me was Sunday, May 4, 2008. I stood at the top of the hill with Deb Belfatto in Essex County Branch Brook Park and turned around to see people coming. They kept coming. We had predicted a successful event but had not anticipated the thrilling image of everyone running and walking to the finish line to help find the cures. Ten thousand people participated because of the “passion, perseverance, patience and persistence” of each and every single person including our volunteers, staff, Board of Trustees and Medical Advisory Council.

These four words, “passion, perseverance, patience and persistence,” are ingrained in my head. When Deb Belfatto, Kathy Hubert McKenna and Lisa Koenigsberg started the Affiliate, the National Komen office informed them that the major fundraiser had to be something other than a race. They were disappointed but promised themselves that one day this Affiliate would have a Race for the Cure.® As President of the Board of Trustees, I was determined to make it happen. In 2007, we were granted our own Race for the Cure®.

We have more to do. We are still moving forward on our promise to a 10-year-old girl who lost her mother to breast cancer. The Pink Tie Ball® continues to be New Jersey’s premier fundraising gala in the battle against breast cancer. All Affiliate events have been a success, enabling us to put resources into the community and provide funds for research.

Now that my work is done, I know that your new Board President, Lois Greene, will take the Affiliate to the next level. I look back and I see that we have not yet reached the finish line. We have to keep going.

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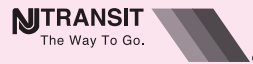
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Thank You to our 2008 Race Leadership Committee

Gloria Gaynor, Honorary Chair
Robin Bloink Ventura, Race Chair
Lisa Rubin, Race Vice-Chair
Lisa Ryan Burke, President, Board of Trustees
Deborah Q. Belfatto, Executive Director, Co-Founder
Nancy Alfano, Race Director

Angela Armstrong

Amy Barth

Nancy Basenese

Joseph Belfatto

Ivan Benjamin

Diane Carr

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Susan Shapiro

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Marisa Ventura

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Kathi Edelson Wolder

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ASK THE DOCS...

Linda R. Aboody, MD
Director of Radiology
Breast Imaging and Breast Intervention
Memorial Sloan-Kettering Cancer Center, Basking Ridge

My doctor wants me to have a screening mammogram. I have no family history and am concerned about radiation exposure. Would it be adequate for me to practice breast self examination and have my doctor examine me once a year or should I have the mammogram?

A: This is a common question and concern. Despite increasing awareness about breast cancer and the media attention it receives, studies still show that women have misconceptions about it. There are 200,000 new cases of breast cancer per year in the U.S., and women have a 1-in-8 lifetime risk. There are 40,000 breast cancer deaths in the U.S. each year. Breast cancer is the most common malignancy in women and the second leading cause of cancer death in women behind lung cancer. Unlike lung cancer, there is no “smoking gun” like the cigarette which can be causally related to it. A small number of cases, about three to ten percent, are associated with the BRCA1 and BRCA2 genes. Most cases, however, occur in women with no modifiable risk factors at all. Early detection is therefore the best way to reduce mortality from this disease.

The best way to approach this is to have regular physician examinations, to learn to perform breast self examination, and to have regular mammography. Mammography is the only approved screening test for breast cancer for

women of average risk. It has been shown in various large studies to reduce breast cancer deaths by approximately thirty percent. As your physician advises, screening should be annual and begin at age 40, unless risk factors are present which make it advisable to begin earlier. These include BRCA genetic mutation, family history, previous treatment of Hodgkins disease with mantle radiation, and previous biopsy showing high risk markers in the breast tissue. Your doctor can help you assess this risk and determine what guidelines are right for you. Keep in mind that mammograms can often see breast cancer before it can be felt and before it has had a chance to invade the surrounding tissue and spread to other parts of the body.

Radiation exposure from mammography is negligibly small, particularly after the age of 35 and with the advent of digital mammography. The risk of the examination approaches zero, and is less than the risk of other radiation exposures such as air travel or living in or visiting areas at higher altitudes than we readily accept.

I am 35 and my mother had breast cancer at age 41. I want to go for a mammogram at my local hospital but my friend told me that I need a digital mammogram because of my young age. How can I be sure that if I go locally I will get the kind of mammogram that I need and that the care will be of good quality?

You are very wise to ask about how to choose a facility for your care and about the types of mammographic examinations that are available.

The Mammography Quality Standards Act is a Federal law designed to ensure safe and reliable mammography. Facilities are checked for quality of equipment, radiation safety, and appropriate and updated credentials of staff and physicians annually. Women can ask about MQSA status and FDA approval of the facility when making their appointment. MQSA certificates should be posted in patient areas. The American College of Radiology also standardizes results with the BI-RADS system which mandates the assignment of categories to results and management recommendations for each patient in the radiology report.

Your question about the different types of mammography is a more complex one. There are two types of techniques that can be used to perform a mammogram. These are called film screen and digital mammography, respectively. Film screen is the traditionally used method which is in widespread use, and accounts for most of the mammography which is done in the U.S. and in the world. The newer digital mammogram is like a digital photograph. It uses different technology and has the advantages of allowing manipulation of the images, faster acquisition, electronic consultation with radiologists at other facilities, image storage and archiving, and lower x-ray dose. This all comes at higher cost and not all facilities offer digital mammography. This should not be a great concern since several studies

show no clear advantage of screening with digital mammography vs. film screen in the general population. However, some subgroups including younger women (under 50 in the pre- or perimenopausal age group) and women with dense breasts do benefit from digital imaging because of the higher contrast it offers.

Overall, the most important factors in obtaining good mammography are the high quality of the facility and expertise of the professionals working there. It would not be advisable to hesitate to have a mammogram because of the lack of availability of digital mammography.

I just had my first mammogram and they called me back because they said they needed more pictures of my right breast. They asked me to come for a diagnostic mammogram, which I thought I already had. I am confused. What does all this mean?

A: There are two types of mammograms, each performed for a different purpose. The one you had originally is called a “screening mammogram,” which consists of four views, two of each breast. This is done annually after age 40 in average risk individuals to screen for cancer. Its purpose is to find anything that could be abnormal that needs further evaluation. A small percentage of women need to be called back to evaluate a finding on the screening mammogram to see if it could be significant. This second mammogram is called a “diagnostic mammogram” whose purpose is to work out whether the area seen on the initial screening mammogram is something that needs further investigation, such as with a biopsy. Diagnostic mammography is also performed if a woman has symptoms, either a lump, discharge or other complaint

or abnormality found on physical examination. Diagnostic mammography may include angled, magnified or focused views of a given area. An ultrasound is sometimes performed if a mass is found or if a lump can be felt.

My friend's breast cancer was not detected on her mammogram, but was found by ultrasound. I want to have ultrasound or an MRI in addition to mammography to make sure nothing is missed. Can I request these, or ask my doctor to order them?

A: Mammography is the only approved screening test for breast cancer for women of average risk. It is unchallenged in its ability to see small calcifications as small as grains of sand within ducts, which can be an early sign of breast cancer. It has been shown conclusively in several large studies to reduce mortality from breast cancer by at least thirty percent. However, it may miss up to ten to fifteen percent of breast cancers on average, depending on breast density and other factors.

Ultrasound is a very powerful and important tool in the diagnosis of breast cancer. It is an important problem solver in the setting of a lump that can be felt or in the evaluation of a mammographic mass. It can tell a cyst from a solid mass, and it can guide biopsy or aspiration of cysts. However, there are difficulties with the use of ultrasound for screening. It cannot assess the whole breast, since the sound waves come in very thin sheets. Furthermore, it is very dependent on the skill of the person performing it. The radiologist is the best person to decide whether an ultrasound is needed in a given situation. The overuse of ultrasound can lead to too many false positive examinations, leading to unnecessary anxiety, cost and scarring.

A new study, which is being published in JAMA, the Journal of the American Medical Association, shows a fifty percent increase in cancer detection for a selected population screened with ultrasound. The difficulty with this practice is the very high biopsy rate that results from it, and the relative lack of availability of high quality ultrasound screening. For both these reasons, ultrasound screening will remain controversial, but new data will now support some efficacy.

MRI is probably the most exciting recent development in breast imaging. It is an extremely powerful tool and one of the fastest growing areas in all of medical imaging. However, it is also a monster to be tamed. It can screen the whole breast and has a very high sensitivity for invasive breast cancer. It can find very small or other lesions not seen by mammography or ultrasound. It may miss some DCIS, an early form of breast cancer which is confined to the ducts. There are many false positive MRI examinations in which abnormalities in the breast are found that turn out not to be cancer, and this makes screening with breast MRI less attractive for average risk patients.

MRI is best used in situations where the probability of finding breast cancer is very high. This is most important in situations where there is a known newly diagnosed cancer, and MRI is used to evaluate the extent of disease in the same breast and to make certain there is no abnormality in the opposite breast. MRI can be helpful to the surgeon to determine if a lumpectomy can be safely done. It is also valuable when tumor recurrence at a lumpectomy site is suspected. MRI is commonly used to assess the progress of women who are being treated with chemotherapy to shrink tumors before surgical intervention. MRI may be useful when the mammogram and ultrasound are inconclusive. It is always done when there are lymph nodes with cancer in the axilla, or armpit, and the primary tumor cannot be found.

MRI is now recommended by the American Cancer Society for annual screening in women for whom the lifetime risk of breast cancer exceeds twenty to twenty-five percent, such as for people with the BRCA1 and BRCA2 genes, or who have had radiation to the chest for Hodgkin's disease. At Memorial Sloan-Kettering Cancer Center we are a bit more aggressive about whom we screen with MRI and have sometimes included people with previous breast cancer or people with high-risk markers on previous biopsies, though the data on this is not yet conclusive. Screening for "dense, difficult-to-examine-breasts" in women who are not at high risk is not an accepted practice at this time, and might lead to too many false positive examinations to make it worthwhile. However, guidelines for MRI are evolving and changing rapidly, and more radiologists are gaining experience with it. It is certainly powerful and has become an integral part of breast imaging practice.

My mammogram showed an abnormality and the radiologist has recommended a core biopsy; I am concerned and want it all removed. I would prefer to have surgery. Can you tell me if it's safe to have a core biopsy, and what it entails?

A: Ninety-five percent of all diagnostic breast biopsies are now done by radiologists rather than surgeons. The object of these biopsies is to determine whether an area found on mammography, ultrasound or MRI is cancer or not. There are many ways this can be done, ranging from a fine-needle-aspiration biopsy, done with the same kind of skinny needle used to draw blood, to larger biopsies called core biopsies done with a thicker needle, often with a vacuum attached, to help obtain a

better sample. Biopsies can be guided by ultrasound, mammography or MRI. Mammographically guided biopsies, called stereotactic core biopsies, are often done for calcifications or other areas best seen on the mammogram. Most masses or lumps can easily be biopsied using ultrasound, if they are visible by that modality. Abnormalities seen only on MRI can be biopsied using MRI for guidance with the same needle with the vacuum attached that is used for stereotactic core biopsies. For all these biopsies, only local anesthesia is necessary, and a diagnosis can be achieved without surgery or general anesthesia. In cases of positive biopsies where cancer cells are found, surgery can usually be planned so that definitive treatment can be achieved by one operation, rather than more than one, as had often been necessary in the past. If the biopsy does not show cancer, then surgery is not needed. In experienced and caring hands, these biopsies are safe and comfortable, and represent the state of the art for breast cancer diagnosis.



**three steps
can save
your life**

1. monthly breast self-examination
2. clinical breast examination
3. annual screening mammography

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Deborah M. Capko, MD, FACS
Attending surgeon,
Hackensack University Medical Center
The Valley Hospital. Member, North
Jersey Affiliate Medical Advisory
Council.

What type of surgical options do I have after being diagnosed with early breast cancer? I have been reading on the internet about lymphedema and am very concerned about this.

Breast cancer treatment has changed significantly over the last decade. Due to the rise in women getting their screening mammograms, most breast cancers are found in the earliest stages (Ductal Carcinoma in Situ, DCIS, stage 1 or stage 2). At least seventy percent of women diagnosed with breast cancer are candidates for lumpectomy, also known as breast conservation surgery. Removal of a lymph node under the arm is often part of the staging procedure for breast cancer. Standard of care is the sentinel node biopsy procedure. A radio-isotope and/or a blue dye is injected into the breast prior to the surgery allowing the surgeon to remove one to two lymph nodes under the arm to determine if the cancer has spread. A full auxiliary node dissection often does not need to be done and lymphedema, swelling of the arm after a node dissection or auxiliary radiation, rarely occurs.

Do I absolutely need radiation therapy?

Standard of care for women opting for lumpectomy has been to add adjuvant radiation to decrease the risk of recurrence. Many large, well-designed

multi-institutional studies have strongly supported the addition of radiation. The questions arising include: Are there some women who do not “need” radiation and are there other methods to deliver the radiation? One study from the Brigham and Women’s Hospital concludes that a specific subset of women over the age of seventy may not receive the benefits of post-operative radiation and can consider eliminating radiation. A newer technique still being studied is partial breast irradiation. In one method, a temporary balloon catheter is placed in the breast and radiation can be delivered over a five-day period instead of the usual six and one-half weeks. The preliminary results are promising and the studies continue to update their results.

Will I need chemotherapy?

Probably the greatest breakthroughs have been in better chemotherapies and targeted treatments. We have learned a lot about breast cancer in the last ten years. First, all breast cancers are not the same and we now know that size is not the deciding factor. Each breast cancer has its own biologic or genetic/molecular makeup and this is most important in determining treatment and outcome. The Oncotype DX breast assay is a new test that assesses the likelihood of recurrence using genetic and molecular traits and this can translate into who may best benefit from chemotherapy and who may not. Herceptin and Tykerb are examples of targeted chemotherapies, blocking specific receptors in some breast cancers resulting in reduced cell growth. We have chemotherapies for women with recurrent or advanced diseases and are now turning breast cancer into a chronic disease, like diabetes. We are constantly finding new clues and refining our treatment of breast cancer.

Is there anything I can do to decrease my risk of developing breast cancer?

For years, we have been listing the risk factors that we cannot do anything about:

- age (breast cancer risk increases with age)
- age at 1st menstrual period
- age at 1st pregnancy
- number of relatives with breast cancer
- age at menopause

Many recent studies have pointed to diet and exercise and their relationship to breast cancer development. It is a fact that breast cancer rates in countries with diets low in saturated/total fats are lower. The NCI (National Cancer Institute) has shown that post menopausal women with forty percent calories from fat were eleven percent more likely to develop breast cancer than women receiving twenty percent calories from fat. Women who exercise are less likely to develop breast cancer. Regular exercise boosts the immune system, prevents excess pounds, and lowers estrogen and insulin levels, all of which may play a role in breast cancer cell growth. A study at the University of Southern California showed that if a woman exercised as little as 1.3 hours a week, her breast cancer risk was decreased by twenty percent. Finally, obese women are more likely to develop and die from breast cancer. If women were more than twenty pounds over their ideal weight when they were 18, their risk is forty percent higher than women with no weight gain. A ten-year study at Harvard showed premenopausal women with 1300 mgs. calcium and 500i.u.’s vitamin D decreased their risk by one-third and the odds of invasive breast cancer by sixty-nine percent. Consistent evidence continues to amass concerning alcohol intake – greater than 1 drink per day increased risk twenty percent and

more than 2 drinks per day over 5 years had an eighty-two percent greater chance of developing breast cancer. Healthy diets low in saturated fats and a regular exercise program beginning in the teenage years can decrease breast cancer risk over a lifetime.

I have heard a lot of talk about high risk. What exactly is high risk? Who should be in a high-risk program and/or be considered for genetic testing. What can be done if the gene test is positive?

Breast cancer is the most commonly diagnosed cancer in women and the risk increases as women age. Many families have family members with breast cancer but that does not necessarily mean “high risk.” There are several models that can be used to calculate risk, most which use some combination of number of family members and their age at diagnosis. The breast cancer gene, BRCA 1 and 2, is found in only three to five percent of people with breast cancer. Many comprehensive breast centers have high-risk programs with genetic counselors who assess genetic risk for breast cancer. If the risk is ten percent or higher, testing is usually considered. For women who test positive, they may have as high as eighty-seven percent lifetime risk of developing breast cancer. Some women choose to be followed with surveillance including breast MRI, and others choose to take medication including Tamoxifen or Raloxifene to lower risk. With the excellent cosmetic results from breast reconstruction, many women are opting for bilateral prophylactic mastectomy with immediate breast reconstruction.

Komen Champions for the Cure™

Hala Modellmog Calls for Congress to Launch Cancer Crusade

Susan G. Komen for the Cure® CEO Hala Modellmog testified on May 8th 2008 before a special hearing of the Senate Committee on Health, Education, Labor and Pensions on the need for comprehensive legislation to address the nation's cancer crisis. Modellmog, along with a select few advocates including Elizabeth Edwards and Lance Armstrong, told the assembled Senators that the cancer community is united in the belief that comprehensive action is needed now.

A six-year cancer survivor, Modellmog also stressed to the Senators the importance of early detection and the need to develop systems for all cancers that can detect their presence earlier than we can currently imagine. She painted a vision of a future where scientists have discovered the critical biomarkers that enable doctors to detect cancer in a person's body with a simple blood test, and where personalized treatments have been developed so effectively that cancer can be fought with limited side effects by a patient-friendly injection or pill. She highlighted disparities in access to care and mortality rates and pointed out that as science surges, the gap in access will only widen without a comprehensive approach to cancer care. She then challenged Congress to help achieve that vision and pledged the support of Komen and the cancer fighting community.

Kennedy-Hutchison Bill to Reignite War on Cancer

Senators Edward Kennedy (D-MA) and Kay Bailey Hutchison (R-TX) are developing bi partisan comprehensive cancer legislation that will reignite the war on cancer. The forthcoming legislation calls for:

- A greater investment in research

- More emphasis on early detection
- Improving access to cancer care for underserved populations

The Kennedy-Hutchison bill is currently being drafted and is expected to be introduced in the Senate this summer. Susan G. Komen for the Cure® and many other organizations from the cancer-fighting community have come together in support of this comprehensive cancer approach.

To learn more, visit: IVotefortheCure.org

Genetic Information Non-Discrimination Act (GINA)

Passed by Congress and signed by President Bush, Genetic Information Non-Discrimination Act was signed into law on May 21st 2008. GINA protects Americans against discrimination by health insurers and employers based on their genetic information.

It is a known fact that testing for a specific mutation commonly associated with breast cancer can lead to early detection and treatment.

“The passage of GINA is an important step that presents a great opportunity to promote personalized medicine and the use of genetic information in healthcare,” said Diane Balma, Komen Vice President of Strategic Relationships. “This will lead to better research and development for new targeted drugs and treatments, which will save lives.”

Voters Speak Up

With the presidential campaign in high gear, a new survey shows six in ten voters support raising taxes to ensure all women have access to high-quality breast cancer screening and treatment. The survey, commissioned by the new Komen public policy offshoot, the Susan G. Komen for the Cure Advocacy Alliance, was conducted by KRC research. The following are survey highlights:

- A majority of voters, 62%, believe breast cancer is the most critical health problem facing women today;
- More than 90% of voters want the federal government to pay more attention and secure more resources for research, screening and treatment;
- Half of voters feel that presidential candidates are not giving enough time to the discussion of healthcare, an election issue that both men and women cite as a top priority;
- Voters recognize there are disparities in access to quality breast care; seven in ten think income level impacts quality of care while five in ten say ethnicity is also a factor;
- For nearly 40% of voters, less emphasis on funding for breast cancer research and community programs could negatively impact their support for a presidential candidate.

Some Key Facts About Cancer

- 40 % of Americans will be diagnosed with cancer at some point in their lives.
- 1.4 million new cases of cancer will be diagnosed this year alone.
- The National Institutes of Health (NIH) estimates the annual costs of cancer to be \$219 billion; today, the federal government invests about \$5 billion in cancer research each year (about \$850 million on breast cancer).

2008 Volunteer Recognition Awards

There is nothing stronger than the heart of a volunteer. With it beats the spirit of service, generosity and compassion, ... and the health and well-being of our community, our country and our world.

— Kobi Yamada



Lisa Ryan Burke
Ruth Siksnius Volunteer Of the Year Angel Award



(1st row, l-r): Lexis Nexis representatives Mary Ann Hromoko, Betty Hromoko and Hazel Connor, *Cure Award*; Roberta Morton, *Support Award*; Jackie Bertolini, *Courage Award*; Jennie Silecchia and Lori Gaier, *Promise of One Award*. (2nd row, l-r): Barbara Dalton, *Hope Award*; Mike Kriak and Bisi Bamiaboje, *Real Men Wear Pink Award*. Absent from photo, Kathleen Pellicane, *A Promise Kept Award*. *The Spirit of Komen Award* was presented posthumously to Roseanne Crickellas, a dedicated volunteer of the Affiliate for many years and one who truly exemplified the spirit of volunteerism.

Photos courtesy of At Home Studios

Upcoming Events

September 29 – October 31

Style for the Cure
The Mall at Short Hills

October 1 – October 31

Tie a Ribbon™

October 1 – 31

Passionately Pink
for the Cure™

BMW Ultimate Drive®

October 7 Prestige BMW, Ramsey
October 8 Paul Miller BMW, Wayne
October 18 BMW of Roxbury, Roxbury
October 21 Morristown BMW, Morristown

Save the Date
Pink Tie Party

Saturday, October 25, 2008

6pm
New Jersey Performing Arts Center
One Center Street
Newark, New Jersey

Medical Honoree
Deborah M. Capko, MD FACS
Hackensack University Medical Center
The Valley Hospital

Corporate Honoree
sanofi-aventis
John Harrington
Vice President and Head of Oncology

Individual Honorees
Affiliate Board Presidents Emeritus
Amy G. Margolis
Andrea B. Karsian
Lisa Ryan Burke



SAVE THE DATE
April 26th, 2009

Susan G. Komen North Jersey Race for the Cure[®]

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