Conference Summary Report

In 2020, IKCC hosted the 10th Global Kidney Cancer Summit – the only international conference for organisations representing patients with kidney cancer. It was also the first-ever virtual Summit due to the COVID-19 pandemic. More than 100 members of the worldwide kidney cancer community came together virtually over four days showing their commitment to improving the lives of people with kidney cancer.

As in previous years, the Summit offered updates on new developments in kidney cancer research and treatment, but also addressed the impact the global pandemic continues to have on our community of patients, caregivers and healthcare professionals.

Below is a description of each of the Summit's sessions. The bios for all presenters can be found using the link at the end of the document.

Day 1 – Thursday 29 October 2020

Keynote Address: Can Studies of the *VHL* Gene Get Us to Curative Combination Therapies for Kidney Cancer?
Moderator: Bryan Lewis (US)

Speaker: William G. Kaelin Jr., MD, 2019 Nobel Laureate in Medicine, Dana Farber Cancer Institute, Boston
Dr William Kaelin presented his Nobel Prize-winning research on the importance of oxygen in the *VHL* (Von-Hippel Lindau) gene and how this impacts the growth of kidney cancer tumours.

Von-Hippel Lindau (VHL) disease is inherited and can progress into kidney cancer. Mutations in the *VHL* gene (a type of protein) are also important in kidney cancer that is not inherited (i.e., sporadic kidney cancer). The *VHL* gene is important in the way cells respond to changes in oxygen, which is needed for the growth of tumours. When oxygen levels are low, the *VHL* gene interacts with a protein call hypoxia inducible factor (HIF) that turns on genes to allow survival of the tumour and the growth of new blood vessels. HIF is considered the 'master regulator' of this process.

Dr Kaelin described a series of experiments that identified how oxygen interacts with various genes in the body causing kidney tumours to grow. During his work, he identified new genes that could be targeted to treat kidney cancer. These include HIF-2alpha, a protein called PT-2399 that targets HIF-2alpha to activate it, and a protein called cyclin-dependent kinase (CDK) that is important for cell division. Substances that suppress or reduce the activity of another substance are called inhibitors. Inhibitors of HIF-2alpha, PT-2399 or CDK could starve the tumour of oxygen by suppressing the growth of new blood vessels (angiogenesis).

Some of these inhibitors have already entered clinical trials. MK-6482 is an oral inhibitor of HIF-2alpha. Data from a phase II study showed a response rate of nearly 40%. Further study is required to confirm the benefit of MK-6482 in randomised clinical trials and to understand its efficacy in advanced disease. Combination with immunotherapy drugs and boosting the immune system may improve effectiveness.

In conclusion, the *VHL* and HIF-2alpha pathway is very complex and there is not one single driver of tumour growth in kidney cancer. Studies of the *VHL* gene and HIF-2alpha inhibitors are ongoing to find combination therapies that may provide a cure for kidney cancer.

Impact of COVID-19 on the Kidney Cancer Community: Lessons learned and plans for the future
Moderator: Bryan Lewis (US)

Note: The summary of the COVID-19 session reflects the state of the pandemic at the time of the discussion, both globally and specifically in the countries or regions of the speakers.

Research Perspective: Dr William G. Kaelin Jr. (US)
In Boston, the research laboratories closed in late March for a month or two, followed by a phased return to work. Everyone was checked for COVID-19 symptoms before entering the labs. Some remained working from home and interacting virtually. Most clinical trials continued, and every effort was made to keep patients from harm. There has been a delay in starting new clinical trials.
Clinical trial recruitment declined, and patients were concerned about visiting the doctor with potential cancer symptoms. There was an impact on laboratory work and training and hiring. Billions of dollars have been diverted to COVID-19, causing a financial disaster in the labs; spending cuts and hiring freezes. This will affect young researchers. People have been discouraged from travelling to hospitals, which has delayed treatment. Telemedicine and Zoom conferences have been used instead. Manufacturers are making COVID-19 drugs before receiving regulatory approval to allow rapid distribution.

Infectious Disease Specialist: Dr Roy F Chemaly (US)
Dr Roy Chemaly from MD Anderson Cancer Centre in Texas summarised what we know about severe acute respiratory coronavirus (SARS-Cov-2), the virus that causes coronavirus disease-19 (COVID-19). SARS-Cov-2 is an RNA virus that started in bats or pangolins and transferred to humans. It has an incubation period of up to 14 days and is transmitted in respiratory droplets. Some people appear asymptomatic. Currently, there is no immunity. SARS-Cov-2 is similar to common illnesses such as flu and respiratory syncytial virus (RSV). Contact tracing and isolation are critical to control the spread of the virus.
Deadly features include decrease in white blood cells, (similar to HIV), inflammation, silent hypoxia (low oxygen without shortness of breath) and cytokine storm, which can all cause death. Risk-factors include certain comorbidities, smoking, immunosuppression therapy, age, race (Hispanic/Asian), cancer and pregnancy. SARS-Cov-2 is here to stay. Masking and social distancing will continue beyond 2021 and into 2022 until there is a vaccine or herd immunity.

Patient Perspective: Jay Bitkower (US)
Jay and his wife, Ellen, contracted COVID-19 in March on the same day. Jay is clinically vulnerable, being 80 years old, and diagnosed with non-metastatic kidney cancer in 2001. Ellen has Hashimoto's disease: an autoimmune disorder. Symptoms were cough and fever for 3 weeks, fatigue, and loss of smell and taste. Ellen went to hospital with viral pneumonia. Ellen was transferred out of ICU and discharged on day 15.
Jay had significant fatigue and shortness of breath for 2 months. His chest x-ray was normal, and he had an increase in creatinine. He joined a COVID-19 study and still had antibodies several months later. Both are still socially distancing. Jay's advice was to wear a mask, social distance, and be considerate.

Clinical Perspective: Prof. Tom Powles (UK)
Professor Tom Powles from Barts Cancer Centre in London described the pandemic in the UK. Initially, there was a lot of uncertainty around patients and safety in hospitals. As the pandemic increased, the NHS became unsafe and patients were afraid to visit hospital for immunotherapy treatment or surgery. Initiation of new treatment was interrupted. The number of new patients dropped significantly. Biopsies were disrupted and have not yet caught up. During April, there was a switch to oral therapy and a big drop in patients starting therapy. There was no COVID-19 testing, lack of personal protective equipment (PPE), and lack of knowledge. The infection risk in the community for patients was high, but hospital risk lowered as screening and self-isolation started. Younger people are at very low risk, causing social unrest and economic hardship for these people. Another enforced lock down and a second wave might be more dangerous than the first.

Haemotology, immunotherapy and hormone treatments are essentially safe, but there is still a debate around chemotherapy. Knowledge, PPE, testing and screening are improving. The backlog needs to be addressed, especially surgery as hospital infections recede. Patient testing is important. Diagnosis and surgery went back to normal during July. However, face-to-face contact needs to be minimised. We are ready for a second wave, since we know a lot more about the pandemic and how to keep patients safe. Patients may need to shield to prevent spread to other people. Immune combinations should continue to be the standard of care.

Summary and lessons learnt

- Patients are safer in hospital than in the community as a result of the precautions taken in hospitals to prevent the spread of the disease. Examples include COVID-free hubs, testing, social distancing and PPE.
- There are different practices and guidelines between countries and within countries. At the start of the pandemic, guidelines couldn't keep up with changes in practice. Some hospitals have acute assessment units for COVID-19 patients to isolate them from other patients. Hospitals need to be kept safe with infection control procedures and patients should be receiving as close to standard care as possible.
- Governments have introduced restrictions to prevent transmission of the virus, such as the use of masks, social distancing, hand hygiene and eating outside of restaurants.
- Precautions need to be followed for many months.
- The number of cancer patients coming into hospitals for treatment has dropped considerably. Hospitals need to keep diagnostic pathways safe and running and there needs to be a balance between COVID-19 and cancer care.
- Younger people are at very low risk from COVID-19. Collective responsibility of communities to prevent the spread of the virus and enforced lockdowns to protect the vulnerable is causing social unrest and economic hardship for people whose risk is very low.
- Cancer services need to change to address the backlog of cancer patients. Patients are presenting with more advanced disease. Patients will miss treatment or not live as long as they are now.
- We have learned a lot about the virus and how we can mitigate future pandemics. Protection against the virus is important. Community spirit for tackling the virus has been very humbling and the vulnerability of humanity has been exposed. A vaccine is needed to prevent a third and possibly a fourth wave of COVID-19 infection.

Day 2 – Saturday 7 November 2020

19th International Kidney Cancer Symposium

Kidney Cancer Association (US) was very kind in extending an invitation to IKCC affiliates to join their annual International Kidney Cancer Symposium free of charge. During the symposium, IKCC affiliates joined patient-centred panel discussions about diagnosis, treatment, side effects and living beyond kidney cancer. There was also a session about treating kidney cancer patients during the COVID-19 pandemic and shared treatment decision-making.
Visit www.kidneycancer.org/virtual-patient-symposium/ to watch recordings of the presentations.

Day 3 – Thursday 19 November 2020

Research Update: A 360 Review of Renal Cancer Clinical Trials and Research
Moderator: Dr Michael Jewett (CA)

Clinical trials current and ongoing: Dr Craig Gedye (AU)
Dr Craig Gedye from the University of Newcastle spoke about current clinical trials in kidney cancer. He defined the commonly used primary outcomes of cancer trials, which include the odds of cancer shrinkage (response rate), treatment time until the drug stops working and tumours start growing again (progression-free survival, PFS), and overall survival time (OS). Immunotherapies were the first systemic treatments for kidney cancer (interferon, interleukin (IL)-2) in the 1990s. Interferon and IL-2 showed little benefit and were very toxic. Targeted therapies that blocked blood supply to the tumour (sunitinib, pazopanib) improved survival by about 13 months and could be used in sequence.

Immunotherapy is now undergoing a renaissance with new treatments, called checkpoint inhibitors, that unleash the immune system to attack the cancer cells (e.g., nivolumab, ipilimumab). These work well in some people, but not all. The new drugs are now being combined but with increased toxicity. This needs to be considered in assessing net benefit. There are many combinations of drugs, which can be very confusing for patients. Some combinations (pembrolizumab plus axitinib) can improve survival for up to 50 months, but are very toxic. There are multiple first-line treatments for kidney cancer at present, but the question remains, which is best for the individual patient? We need to consider survival benefits versus side effects and quality of life. More clinical trials are needed to answer these questions.

Horizon Scanning: Dr Eric Jonasch (US)
Dr Eric Jonasch from MD Anderson Cancer Center in Texas gave an overview of future research for kidney cancer treatments. Researchers need to understand the interaction between malignant tumour cells and blood vessels, hot and cold tumours and T cells. Clinical trials need to consider new endpoints, such as response rates. There are new treatments being tested, such as HIF 2alpha inhibitor (MK6482), which targets the VHL/VEGF pathway to suppress blood vessel formation. Others include T cells to target human endogenous retrovirus (HERV), PSMA in the blood vessels of kidney cancer cells, CAR-T for kidney cancer, and low dose radiation combined with immunotherapy.

Work on biomarkers could result in new treatments, (e.g., *VHL* mutations, *PBRM1*, *BAP1*, *SETD2*) and liquid biopsies looking for tumour DNA or proteins in the blood could be used to measure tumour response. There are new dynamic imaging techniques, such as AraG PET scans to detect T cells in the body. However, we need to understand how cancer works and get better at targeting cancer cells.

Patient Perspective: Alison Fielding (UK)
Alison Fielding, patient advocate and member of the National Cancer Research Institute (NCRI) Bladder and Renal Cancer group gave a summary of the patient perspective in research. Research needs to be based on patient needs. She talked about side-effect management, diet and exercise, quality of life, mental health, and survival being top priorities. She mentioned patient and public involvement (PPI) in funding bids for clinical trials, up-front engagement, and PPI improving clinical trial design and management. Future trials would benefit from shared decision-making with patients.

Often quality of life data is missing or inadequate, but are key to real-life decisions of patients. The effectiveness of the drug needs to be balanced against risks and quality of life. Most trials exclude patients with certain co-morbidities, rare subtypes or brain/bone metastases. Researchers need to consider how to include these in multi-arm trials. PPI can help with plain language summaries and patient information. Patients should be included as co-authors on publications and have their input acknowledged. Challenges include COVID-19-free hospitals, fear of infection, loss of talent and research opportunities. However, meetings conducted virtually result in less travel, conference access for patients, faster and easier PPI. People with access to technology can engage and there is more of an opportunity to ensure patient involvement. COVID-19 has shaken up the market to help patients in the future.

Surgical Advances Summary: Exploring cytoreductive surgery, biopsy, small renal masses and oligometastatic disease

Moderator: Dr Michael Jewett (CA)

Role of renal tumour biopsy in 2020: Dr Antonio Finelli (CA)

Using a case study, Dr Antonio Finelli from the University of Toronto explained the role of kidney biopsy. He addressed the question of indications to biopsy small renal masses, and how the results from the biopsy might change treatment. Without tumour tissue, surgeons are 80% confident that the tumour is malignant. However, tissue type and grade are harder to estimate. Major complications occur in <0.1% of biopsies, and seeding and bleeding is very rare. Biopsies are 90% accurate and grading compares to those who had surgery (agreement >90%).

Most benign tumours do not require treatment but are often removed in the absence of a biopsy to make the diagnosis. Surgery can be associated with complications (1% mortality within 30 days), so why not avoid surgery (resources, admission rates, morbidity) by conducting a biopsy? Kidney cancer is a heterogeneous disease that requires personalised treatment. Even some malignant tumours grow slowly and may not need removal (e.g., papillary 1). Dr Finelli concluded by suggesting biopsy for most patients – it is accurate, safe, avoids over-treatment, and is the first step to personalised care.

Current management of small renal masses: Dr Ricardo Leão (PT)

Dr Ricardo Leão is from Portugal but trained at the University of Toronto and is associated with the Portugese Association of Kidney Cancer Patients. He described the current management of small renal masses. Small renal masses are kidney tumours measuring less than 4cm in size. Detection is increasing but mortality rate has been constant over the last 40 years. They are heterogenous, ranging from benign (15-25%) to malignant and aggressive. It is important to differentiate between them. Larger, fast-growing masses tend to be more aggressive; smaller, slow-growing masses are usually benign, but not in all cases.

CT imaging can identify tumour subtypes but is not 100% accurate. Biopsy is the only means to reliably identify histology. Biopsy is safe with <1% complications and high diagnostic rates >90% with histology. The management of small renal masses is controversial, since there are no prognostic biomarkers. Treatment includes initial active surveillance, nephrectomy, or ablation. Complications of surgery or ablation include reduced renal function, bleeding, damage of nearby structures, flank bulge etc. There is no difference in cancer specific survival between patients who have active surveillance compared to surgery/ablation. Patient preference is accounted for – patients with significant co-morbidities and limited life expectancy might have active surveillance, younger and fitter patients might opt for surgery/ablation.

In the future, biomarkers are needed for diagnosis of small renal masses, and biopsy has a role because of the heterogenous nature of small renal masses. Active surveillance is appropriate in the right patients, and high-grade tumours will need to be removed.

Role for surgery in advanced disease: Prof. Axel Bex (UK)

In his presentation, professor Axel Bex from the Royal Free Hospital in London discussed whether there is a role for surgery to remove the primary tumour and/or metastasis in patients where the cancer has already spread. He discussed the results from two clinical trials: SURTIME (3 months of sunitinib followed by nephrectomy) and CARMENA (sunitinib alone, only nephrectomy if tumour bled) to determine whether it is necessary to remove the primary tumour. In CARMENA there was a survival benefit if the nephrectomy was performed immediately. The SURTIME trial showed there may be a survival benefit if patients start on drug therapy and they have a nephrectomy if their cancer responds to treatment.

Treatments have changed since these trials and current treatments are now more powerful than sunitinib. Up to 30% patients treated with immunotherapy had their primary tumour in place and had better outcomes than those in SURTIME and CARMINA. The aim is to shrink the primary tumour with drug treatment first, then have a nephrectomy after a response to drug treatment. This treatment strategy may be beneficial for patients with a small number of metastases where removal of metastases may improve survival, but this has not been tested

yet. It could spare exposure to side effects from drug treatments. This needs to be balanced against potential side effects of surgery and discussed with the patient.

A panel discussion followed the presentations with Dr Stênio de Cássio Zequi (BR), Dr Roman Sosnowski (PL), Dr Francisco Rodríguez-Covarrubias (MX), Dr Seok-Soo Byun (KR), Ms Christine Collins (CA), Dr Antonio Finelli (CA),

Special Announcement: The Cecile and Ken Youner IKCC Scholarship
Moderator: Dr Michael Jewett (CA), Eris Jonasch (US)

Dr Michael Jewett and Dr Eric Jonasch (Chair and Vice-Chair of the Medical Advisory Board) awarded Dr Adriano Beserra the Cecile and Ken Youner IKCC Scholarship**.** Dr Beserra is from the A.C. Camargo Cancer Centre, São Paulo, Brazil. He was recognised for his work on developing patient-derived xenografts for renal cell carcinoma as an experimental model to study new kidney cancer treatment. Many congratulations to Dr Adriano Beserra for being awarded this prestigious scholarship to enable him to continue with this vital piece of research.

Day 4 – Monday 30 November 2020

Changing Side-Effect Management in the Era of Immunotherapy
Moderator: Dr Rachel Giles (NL)

Clinical Perspective: Dr Ravindran Kanesvaran (SG)
Dr Ravindran Kanesvaran from the National Cancer Centre in Singapore gave an overview of immune-related adverse events. Immunotherapy (or immune checkpoint inhibitors) has revolutionised cancer treatment. It boosts the immune system via antigen-presenting cells which activate T cells in the lymph nodes. The side effects from these drugs are very different to other treatments. Early recognition of side effects and treatment is important. Immune-related side effects can affect any organ system and start at various times after administration. They can also affect hormones. Skin and gastrointestinal side effects are most common and start within the first 2-3 months. Myocarditis and hepatic failure are fatal immune-related events, which increase with immunotherapy combinations.

Patients continue to benefit when they come off treatment but still have side effects up to 4 months after stopping. Treat side effects with oral steroids, continue with immunotherapy, especially for high-grade patients. Consult immunologist specialists for severe immune-related side effects, such as pneumonitis and colitis. A multi-disciplinary team may be required. Infusion-related side effects include allergies, headache, chills, anaphylaxis etc. Infusion needs to be done in a specialist unit with resusication available. It is important to educate patients to look out for immune-related side effects. Rechallenge with immunotherapy can be dangerous if the patient experienced a severe or life-threatening side effect.

Nurse Perspective: Nikki Hunter (UK)
Nikki Hunter, Clinical Nurse Specialist at the Royal Marsden in London, talked about the management of immune-related side effects from the nurse perspective. Patients need to be prepared for immunotherapy with good education. She emphasised the importance of timely, accurate information about potential side effects, suggesting Macmillan Cancer Support and the ESMO patient information booklet (which IKCC co-authored; https://www.esmo.org/for-patients/patient-guides/immunotherapy-side-effects) as sources of information. Patients need time to discuss treatment side effects with their families before returning to have treatment. They need to understand the unpredictability and uncertainty of response to treatment – this requires good communication with their health team.

A patient information leaflet is used to share information, along with pre-therapy patient seminars. Patients keep side-effect diaries and use cancer treatment record books, immunotherapy alert cards and the Bristol stool chart app for assessment of diarrhoea. They are also given skin toxicity packs and advised to use hypo-allogenic shower gels/soaps and E45 cream. There are telephone clinics to check for side effects. Patients need to know who to call, keep records, and be assured they can continue on treatment if they act promptly to resolve the side effects. They must not self-medicate. Most side effects are mild if caught early. Patients need to be aware of their own body and what is normal for them. A healthy and varied diet and limiting alcohol are important, as are supplements and exercise to maintain muscle mass.

Carer Perspective: Ellen Menzies (AU)

Ellen's husband, Angus, was diagnosed with kidney cancer in June 2011. Angus had always been in good health and his diagnosis came out of the blue. He had a nephrectomy, followed by 2 years of relatively normal life. A scan at 2 years found brain metastases. He was given TKIs and had nausea, vomiting, diarrhoea and fatigue. He couldn't plan his life and each medication posed new challenges.

Anti-nausea medication did not work, and he was told to skip a dose to calm the diarrhoea. The abdominal pain turned out to be diverticulitis. Other side effects included fatigue, dry mouth, mouth sores, white hair – all of which limited his life. Axitinib was the worse for diarrhoea. He was on cabozantinib for 2 years and had nausea and fatigue. All this took its toll on him and his family. Angus was then put on pembrolizumab, with very few side effects, but no tumour response. He also tried nivolumab, but immunotherapy was not working. This resulted in extreme anxiety and global amnesia due to stress.

Ellen's lessons learned are to approach each side effect as a necessary evil – find pragmatic solutions, consult with other patients who have been through the same treatment, but remember meditation, mindfulness, counselling, support systems, and unconditional love can help lighten the burden.

Knowing the Right Treatment for the Right Patient and the Right Time: Balancing the Options

Moderator: Dr Rachel Giles (NL)

Clinical Perspective: Prof. James Larkin (UK)

Professor James Larkin from the Royal Marsden Hospital in London spoke about first-line treatment for metastatic kidney cancer patients. Most metastatic patients are treated with immunotherapy in the first line, although active surveillance is still an option. Reimbursement and availability remain issues in a lot of countries. Patients with autoimmune conditions or organ transplants should not have immunotherapy. The ipilimumab/nivolumab combination is only given to patients with intermediate or poor risk disease, the other combinations can be given to all patients with metastases. Side effects of combinations need to be considered, especially with ipilimumab/nivolumab, which has more immune-related side effects. In general, we need more data on how these therapies influence non-clear cell kidney cancer, and if side effects might be different.

Clinical trial end points include response to treatment, treatment-free survival, safety and quality of life. Long-term survival is not yet known for kidney cancer because the data are not available (52% survival at 4 years for ipilimumab/nivolumab, only 2 years of data for pembrolizumab/axitinib). For patients with favourable disease risk, sunitinib is recommended. However, pembrolizumab/axitinib and avelumab/axitinib are superior to sunitinib for intermediate or poor risk patients. If treatment is discontinued after 2 years, the benefit is just as good and gives patients time off treatment with good quality of life without side effects. Side effects can affect any part of the body. Ipilimumab/nivolumab has a higher risk of side effects.

In conclusion, options need to be discussed and considered case-by-case, together with side effects and co-existing medical problems. While the data are most mature for ipilimumab/nivolumab, it pertains to intermediate/poor risk patients only. Most patients who have immunotherapy in the first line go on to have a TKI such as lenvatinib plus everolimus or cabozantinib as second line therapies, but these are typically case-by-case decisions.

Clinical Perspective: Dr Daniel Heng (CA)
Dr Danny Heng from the University of Calgary in Canada defined metastatic disease and the lines of treatment. Metastases can be surgically removed after cytoreductive nephrectomy, and this is decided on a case-by-case basis. Every patient is different and treatment patterns differ. There is very little evidence for the effectiveness of 3rd /4th line treatment. Patients tend to use a drug they have not tried before. These later lines of treatment are most likely not reimbursed, and the patient might need to pay for it. Not all patients have multiple lines of treatment – 100% have first-line, 51% have 2nd line, 24% have 3rd line, and 8% have 4th line. The best treatment is used first and often the patient is too ill, or doesn't want further treatment, or the tumour shrinks before 3rd or 4th line treatment can be given.

There are clinical trials in the 3rd and 4th line, e.g., tivozanib versus sorafenib which gave little benefit. There is also data that demonstrates activity in the 3rd and 4th line and clinical trials of new agents, such as HIF 2alpha inhibitors, glutaminase inhibitors, and immunotherapy re-challenge. There are also a number of different drug sequencies that could be tried, e.g., ipilimumab/nivolumab – pazopanib – sunitinib – cabozantinib – lenvatinib/everolimus etc. Stop treatment if the patient is too ill, the side effects outweigh the benefits, or if the patient does not want treatment – this is a collaborative decision with healthcare professionals. We need a biomarker to decide which treatment to use and more studies in 3rd and 4th line to find the most effective sequence.

Patient Perspective: Adilson Dias Lopes (BR)
The patient perspective was provided by Adilson Dias Lopes from Brazil. Mr Lopez was 42 when diagnosed with a 6.5cm tumour in his right kidney. The entire kidney was removed by radical nephrectomy. At the time, there was no effective treatment for advanced kidney cancer. His surgery was scheduled quickly, and a biopsy confirmed stage I kidney cancer with 90% chance of surviving 5 years. He didn't need any further treatment and was followed for 5 years. He was very anxious and nervous when having CT/MRI scans for fear of remission or metastases. He should have seen a psychotherapist for his anxiety. He has been in good health since and is now used to the situation. He takes care of his health and his life is normal with one kidney. As time goes by, he thinks less about the disease.

Mr Lopes' advice is to trust the doctors and science, stick to your faith, get support from family, try to keep working to keep your mind off the situation, protect your mental health, and get support if you need it. Don't look at the Internet – it can be scary. With information, you can make better decisions and the right decisions.

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