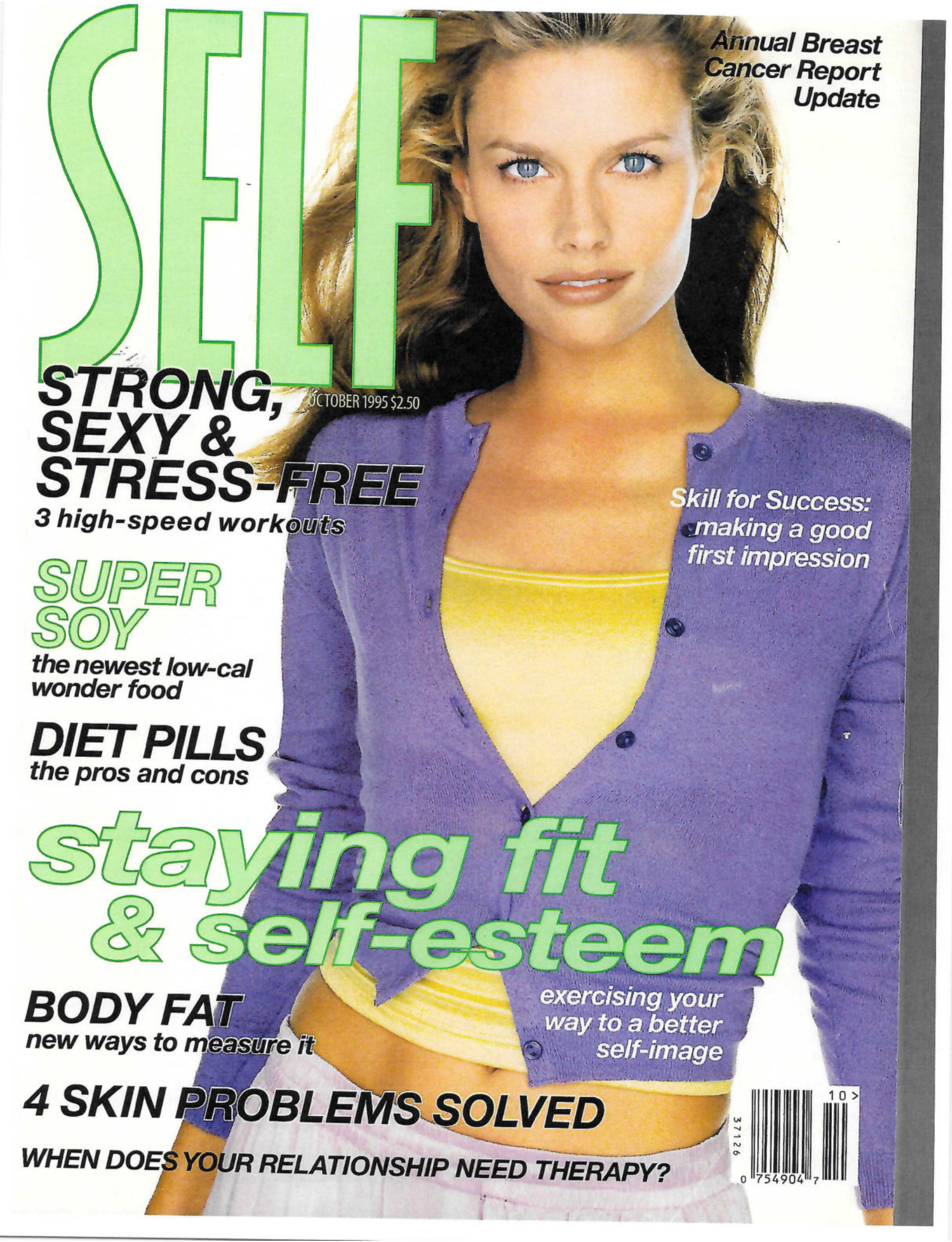
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staying fit & self-esteem
exercising your way to a better self-image
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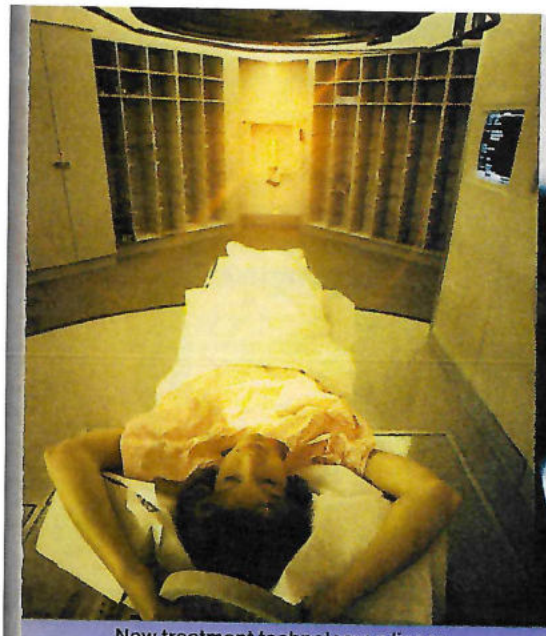
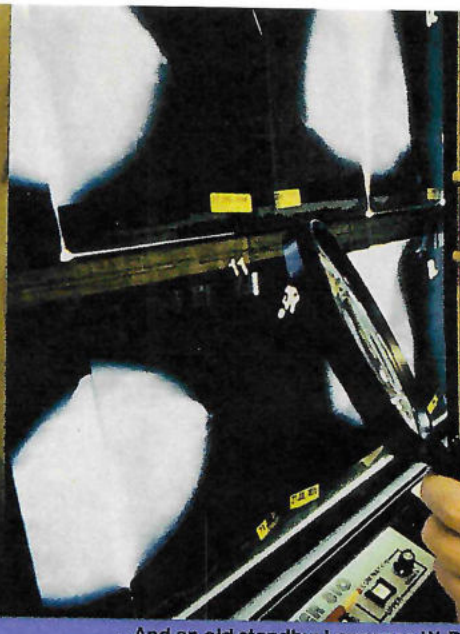


New treatment technology: a linear accelerating radiation machine...



...And an old standby: Lawrence W. Bassett, M.D., of the UCLA School of Medicine, uses a magnifying glass to examine mammograms.

Taxol, cu emother

We are on the verge of a revolution in treating breast cancer, but

the race against breast cancer

by Shannon Brownlee and Monika Guttman

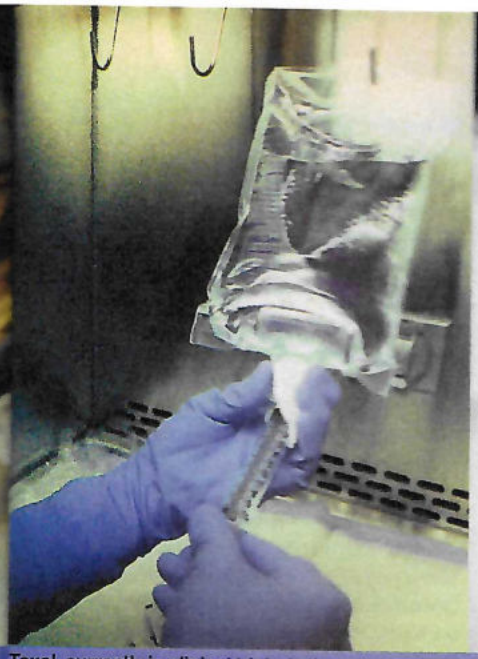
The news never made the front pages of any major newspapers, but it is cause for rejoicing, nonetheless. Last February, the *Journal of the National Cancer Institute* reported that the mortality rate for breast cancer dropped nearly 5 percent between 1989 and 1992, the largest decline since 1950. The numbers were even more dramatic for young women: Between 1987 and 1992, the mortality rate plummeted nearly 18 percent among white women younger than 40. But before you go dancing in the streets, consider this: The mortality rate among black women has gone up, and the sheer number of cases of breast cancer seems to be on the rise as well.

Twenty years ago, a woman's lifetime risk of breast cancer was one in 12. Now it's one in eight. That means in a roomful of 100 fresh-faced high school graduates, at least 12 will have battled breast cancer by the time 60 years have passed. By the turn of the century, cancer will supplant heart disease as the nation's leading killer.

Yet believe it or not, we are on the verge of a revolution in treating this frightening disease. Yes, yes, we've all heard that before, but for the first time since President Nixon declared war on cancer nearly 25 years ago, researchers have a clear picture of how a cancer cell becomes a tumor. They know how cells break free from a tumor and glide through the bloodstream to seed a new one in another part of the body. And they have a pretty good idea of how the female hormone estrogen makes breast cancer cells grow.

This is good news, indeed, because in the not too distant future, the knowledge gained in the laboratory will allow oncologists to tailor treatments to every individual woman's cancer, which is as unique to her as the nose on her face. "I think we're going to get this disease licked in my lifetime," says Susan M. Love, M.D., director of the Revlon/UCLA Breast Center in Los Angeles and one of the nation's

photographs by Ken Schles



Taxol, currently in clinical trials, is the only new chemotherapy drug developed in the past 10 years.

UCLA's radiology team studies mammograms, looking for the tiny shadow that indicates the possibility of a tumor.

...ncer, but we're not there yet. Here's what you need to know now.

foremost experts on breast cancer.

Until then, information is the most powerful tool a woman has. "A cancer diagnosis is not an emergency," Dr. Love says. "The first thing the patient should do is take a deep breath. Then she should take time to educate herself and find out what the options are." She will need to learn a whole new vocabulary if she is to understand what her doctors are talking about. And if she is to make the best decisions about her own illness, she needs to know that mastectomy is not inevitable, but chemotherapy and/or radiation probably are. And she should be aware that some treatments, which are often still experimental, may be more dangerous to her life than her disease—bone-marrow transplants, for example.

Most of all, she needs to remember that breast cancer is not a death sentence and that more than half of all women who develop it will live at least 15 years after their diagnosis. This in spite of the fact that there have been few advancements in treatment over the past two decades. However bright the future looks, much of the good news right now has to do with refining old therapies, gaining a clearer understanding of how the disease progresses and better informing patients. Here's where we stand in treating breast cancer today.

SURGERY AND RADIATION

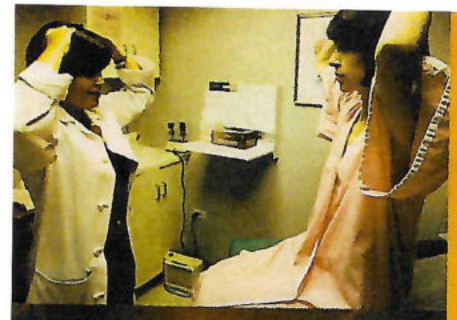
Cancer is civil war. While normal cells obey the body's rules regulating their growth and reproduction, cancer cells reproduce willy-nilly. "Cancer cells are not some evil enemy that invades the body," says Love. "They are your own cells; they just don't work right." For the most part, our bodies are able to keep these wayward cells in check, killing them at the first sign of rebellious behavior. In fact, many researchers now believe that we successfully fight off little cancerous cells every day.

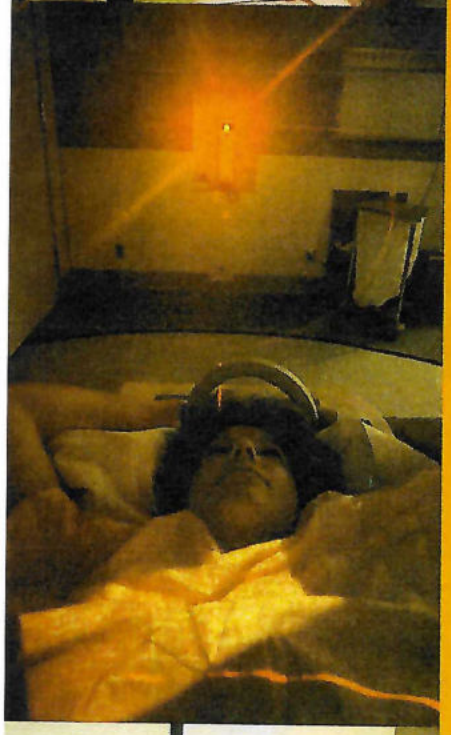
This new understanding has led oncologists to think of breast cancer as two diseases requiring two very different treatments. The first is the tumor in the breast; the second develops when tiny cells leave the original tumor, slip into the blood or lymphatic system and spread to other places in the body. If the immune system fails to catch and kill these fugitive tumor makers, they can set up shop in other organs, such as the lungs or liver, and begin growing another breast tumor, only it's not in the breast. At this point the cancer is said to have metastasized, and from a treatment point of view, it can be thought of as a different disease. Surgery and radiation are effective against the cancer in the breast, while chemotherapy and hormone treatments are aimed at the disease in the rest of the body.

The most dramatic change in the treatment of breast cancer in the past 20 years is that mastectomy is no longer considered the safest course.

The most dramatic change in the treatment of breast cancer in the past 20 years is that mastectomy, which is a massive surgical intervention that removes the entire breast and often part of the underlying chest muscle as well, is no longer considered the safest course. Experts are unanimous in their opinion: The chances of survival are no greater after a mastectomy than after the less invasive lumpectomy, in which just the tumor is removed and the breast is left intact. "There are good reasons to choose mastectomy," says Larry Norton, M.D., chief of breast cancer medicine at Memorial Sloan-Kettering Cancer Center in New York City, "but increasing your chances of a cure is not one of those reasons." Yet only 30 percent of women get lumpectomies nationwide; in the South, a whopping 90 percent of breast-cancer patients choose to have their breasts removed.

For about 30 percent of women, mastectomy is the only reasonable choice: for example, a woman who has very small breasts and a large tumor. And new evidence suggests that for women





under 40, there is a slightly higher risk of recurrence with lumpectomy. But for many women, the concerns about which procedure to choose have more to do with lifestyle and attitudes. A lumpectomy requires a full course of radiation treatment immediately following surgery to kill any cancer cells that may have been left behind in the breast, which means daily visits to a clinic for at least five weeks. If the clinic is a great distance away, these trips could be difficult. And scheduling could be a problem. Nancy Reagan decided to undergo a mastectomy because radiation treatments would have taken too much time.

In 1984, the public spent $4 billion—nearly half the entire National Institutes of Health research budget—on unproven cancer cures.

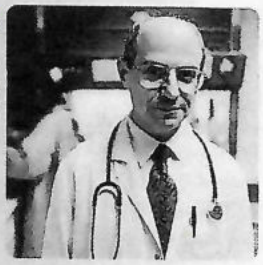
In too many cases, however, women choose the more invasive procedure out of fear and ignorance. "Some women are terrified of radiation and need to understand what it is really all about," says Carol Fred, a clinical social worker at UCLA's Rhonda Fleming Mann Resource Center for Women With Cancer in Los Angeles. "It's not Hiroshima. You're not going to glow in the dark; you're not going to contaminate your partner." The machine that administers the treatment aims radioactive particles at a very specific and limited area of the body. After a lumpectomy, that means the breast from which the tumor was removed. The purpose is to destroy cells that are growing and reproducing rapidly, and in the breast those would, for the most part, be cancer cells. The treatments make most women tired and can sometimes leave the skin feeling sunburned, but after the machine has been turned off, the breast is not radioactive.

HORMONE TREATMENTS AND TAMOXIFEN

Once the tumor in the breast has been removed, the biggest challenge for oncologists is deciding whether or not they should go after any cancer cells that may have escaped the breast. The principal tool for making that decision is a biopsy of the lymph nodes under the arm. During lumpectomy or mastectomy, the surgeon removes a dozen or so of these nodes so they can be examined under the microscope for evidence of cancerous cells. The term *node negative* means a pathologist has found no evidence of metastatic cells in the lymph nodes, and the oncologist can probably treat the cancer as a single disease isolated in the breast. Half of the women who are diagnosed with breast cancer today are node negative, thanks, at least in part, to improved mammography. *Node positive* means cancerous cells have left the main tumor, and they may be circulating through the body. In general, doctors believe the greater the number of positive lymph nodes a woman has, the more likely it is that her cancer has spread.

Seventy percent of the women whose tumors are smaller than two centimeters in diameter (about three quarters of an inch) and who are node negative will be cured. That's a lot better than even a decade ago. Unfortunately, the 30 percent of women on the other side of those hopeful statistics, women who also have small tumors and negative nodes, are still dying because their cancer has already metastasized. Some of these cases are missed in biopsies of the lymph nodes because the tests used by pathologists aren't perfect; there may be too few cells to be detected. But some of

Larry Norton, M.D.,
chief of breast cancer medicine at Memorial Sloan-Kettering Cancer Center, New York



Dr. Norton, whose research focuses on refining chemotherapy regimens, was instrumental in designing Memorial Sloan-Kettering's Evelyn H. Lauder Breast Center, one of the most advanced in the U.S. At many hospitals, the facilities for diagnosing and treating breast cancer—the surgical suites, the pathology labs, the mammography machines—are spread out, forcing patients to traipse from floor to floor and from building to building. At the Lauder Center everything is under one roof.

Left, top to bottom: **A breast self-exam is still the technique by which many women discover their lumps. But there have been advances in radiation technology, in the ability of cancer specialists to confer over long distances via videoconferencing, and in mammography.**

Susan M. Love, M.D.,
director of the Revlon/UCLA Breast Center, Los Angeles

The big lie, says Dr. Love, is that mammography and breast self-exam can catch the majority of cancers early enough to cure them. Truth is, these screening techniques expose the growing mass of scarlike tissue around the tumor, not the tumor itself, and that tissue isn't always obvious when the tumor is still small. Love wants to develop a way to detect the earliest signs of breast cancer, before it becomes a full-blown tumor. She is currently testing a fiber-optic device called a ductoscope that can be inserted through the nipple and would allow her to map the intricate system of ducts inside the breast where cancer gets its start.

these patients have tumors that don't behave as traditionally expected. Oncologists used to think that cancer progressed through regular, predictable stages. The theory was that it began as a small tumor that remained localized in the breast until it reached a certain size. Then it would begin to shed cells into the rest of the body.

Most oncologists now understand that size is not the critical factor: Some very large tumors remain confined entirely in the breast, while many small tumors shed their potentially deadly cells. One of the reasons size isn't always a good predictor, says Harry D. Bear, M.D., Ph.D., director of the Breast Health Center at the Massey Cancer Center in Richmond, is that cancers develop their own private blood supplies, and even small tumors can shed

Lacking newer, better drugs, oncologists are turning to higher doses of those they do have. But the human body can tolerate only so much of these powerful drugs.

cells directly into the bloodstream. Because the blood supply bypasses the lymph nodes, the cancer cells that have escaped may not show up in biopsies, so patients whose cancers have, in fact, metastasized are classified node negative.

What oncologists would desperately like to find is a method of distinguishing between patients whose node-negative status truly indicates that the cancer has not left their breasts and those whose node-negative status means the tumors have, in fact, spread but have done so without leaving traces in the lymph nodes. "We have two choices," says Jeffrey Abrams, M.D., a clinical oncologist who oversees large-scale trials conducted through the National Cancer Institute (NCI). "Either we treat everybody with chemotherapy, including women who have negative nodes, or we try to develop strategies for predicting which of the 25 to 30 percent of node-negative women have tumors that have metastasized." Nobody is happy with the first choice, because the women whose negative nodes genuinely indicate that the cancer has not spread are subjected to chemotherapy when they don't need it, and chemotherapy is not only unpleasant, it also carries its own risks to a woman's health.

There are a couple of new techniques being tested that will expose metastatic cells much more effectively. For example, Impath Inc., a biotechnology company in New York City, uses microscopic Y-shaped proteins called monoclonal antibodies to search for cancerous cells in lymph tissue. Even when a pathologist can't see cancer cells in a woman's lymph nodes, antibodies can, says Anu Saad, Ph.D., the company's CEO.

A better place to search for metastasis is in the bone marrow, where cancer cells go before finding a new home in another part of the body. One day, Dr. Saad predicts, surgeons will routinely extract a sample of bone marrow during a woman's surgery, and pathologists will use antibodies to screen it for metastatic cells.

Regardless of how they get it, once oncologists have evidence that a woman's cancer has spread beyond the breast, they have two weapons at their disposal: hormone treatments and chemotherapy. Hormone treatments work because some breast-cancer cells thrive on the female hormone estrogen, which is produced by the ovaries. Depriving the cancer of this nourishment slows its growth. The most direct way to cut off the estrogen supply, of course, is to remove the ovaries and plunge a woman into instant menopause, but this kind of hormone treatment is seldom used these days. Now there's tamoxifen, a drug that interferes with a breast cell's ability to use estrogen.

Tamoxifen is a peculiar drug. Taken as a pill once or twice a day, it blocks estrogen uptake in breast cells, while it can actually mimic the hormone in the bones, liver and uterus. It sometimes causes side effects, including nausea and depression, and it may increase a woman's chances of developing uterine cancer, but oncologists believe the drug's benefits so outweigh its side effects that they have begun to use it to treat some cancer patients who are node negative—and as a preventive measure in some women who don't yet have cancer. The NCI has launched a large-scale clinical trial involving 16,000 women who have never had breast cancer but are at increased risk—because of a family history of the disease, perhaps, or simply because of their age—to see if the drug can protect them.

Unfortunately, all breast-cancer cells don't respond to estrogen, which means tamoxifen isn't useful in all breast-cancer cases. Unlike the node-negative problem, however, oncologists have a diagnostic tool—known as the estrogen-receptor test—that allows them to know which women will not benefit *(continued)*

Carol Fred,
Clinical Social Worker, Rhonda Fleming Mann Resource Center for Women With Cancer, UCLA, Los Angeles

The Rhonda Fleming Mann Center was one of the first facilities in the country to offer psychological support services to women with cancer. Fred, a full-time counselor at the center, says the most difficult psychological aspect of the disease for most women is the uncertainty about their futures, even for those with the best prognosis. "The reality is, breast cancer can recur," she says. "Diagnosis and treatment are just the beginning. Life after breast cancer needs to be the focus of one's life."

from tamoxifen. For those patients, the oncologist must turn to chemotherapy.

CHEMOTHERAPY

Chemotherapy drugs kill cells that are dividing rapidly, which is precisely what cancer cells do best. The drugs don't have much effect on cells that are just sitting there. Unfortunately, many normal cells are dividing rapidly too—the cells lining the gut, for example, and cells in the bone marrow and those in hair follicles. This is why chemo causes such a wacky variety of unpleasant side effects, including baldness and nausea. For reasons that are not known, chemotherapy works better in younger women.

If you have to undergo chemotherapy you want the stuff to work, and there are two new formulations that appear to be more effective than the usual regimen. The standard combination of chemotherapy drugs is called CMF, for cyclophosphamide methotrexate fluorouracil. Doctors sometimes replace the methotrexate with Adriamycin (CAF), which may be particularly effective against metastatic breast cancer. One national study found that four rounds of treatment with CAF were as good as six rounds with CMF, but more studies are needed to verify that conclusion. In the meantime, young women in particular should be aware that Adriamycin can be toxic to the heart and can cause irreversible cardiac damage.

The only new chemotherapy drug is Taxol, a compound that has provoked considerable excitement among oncologists. Clinical trials are now under way to test its effectiveness in treating breast cancer. But Taxol is no wonder drug; it appears to work about as well as Adriamycin, though with fewer side effects. Sadly, the excitement is due mostly to the fact that there hasn't been a new chemotherapy drug in years. "We definitely need more and better drugs," says Thomas J. Smith, M.D., chairman of the health research committee of the American Society for Clinical Oncology.

Lacking newer, better drugs, oncologists are turning to higher and higher doses of those they do have. But the human body can tolerate only so much of these powerful compounds. Chemo destroys many healthy cells along with the cancer cells, and when the dose is upped, the destruction also goes up. Bone marrow, which is the source of very specialized, life-sustaining blood cells, is particularly vulnerable. Chemotherapy wipes out the red blood cells, which carry oxygen; white blood cells, which fight infection; and platelets, which help in clotting the blood. Without them, the body is defenseless against infection and injury. Bigger doses of chemo might wipe out metastatic cancer, but they could also kill the patient.

BONE-MARROW TRANSPLANT

In an effort to increase the dosage of chemo without killing the patient, some doctors have turned to bone-marrow transplant (BMT), a controversial, painful and exceedingly expensive treatment. Basically, BMT works like this: First the doctor removes some of the patient's own bone marrow and stores it away in the freezer. Then the patient is blasted with very high doses of chemo, so high they kill every dividing cell in the body, including most, if not all, of the bone marrow. When that's over, the doctor injects the previously extracted bone marrow back into the patient in an attempt to rebuild her immune system.

When doctors first began experimenting with BMT about five years ago, 20 percent of patients died not from their cancer but from the treatment. It took about six weeks for the bone marrow to reconstitute and replenish the body's supply of red and white blood cells and platelets. During that time, the woman was vulnerable to even the slightest infection and had to be isolated in a hospital for six weeks.

Nowadays, BMT is far less dangerous and less expensive. Oncologists have learned to use the body's own growth factors, which act like fertilizer for cells, to help reconstitute blood cells and speed recovery. The new biotech drug Neupogen is a manufactured version of one of these growth factors. Because it fuels the growth of immune cells in the bone marrow, BMT patients who are treated with it can leave the hospital after only two weeks. As a result of these new techniques, the risk of dying from BMT has fallen to around 10 percent, and the cost has gone from $200,000 or more to as little as $40,000. And those statistics could get even better. Researchers are experimenting with extracting specialized bone-marrow cells (called stem cells) directly from the blood, which is a lot simpler—not to mention less painful—than taking marrow from bone.

Still, nobody knows for sure whether or not BMT helps women live longer than standard chemotherapy. Two major trials now under way will randomly assign women to BMT plus standard therapies or to standard therapies alone. But recruiting enough women for these studies is proving difficult, says Christy Russell, M.D., associate director of the Norris Breast Cancer Center at the University of Southern California. "A lot of women have heard of BMT and want it," she says. "Instead of referring their patients into the trials, physicians will try to get them a bone-marrow transplant somewhere. I think it's appropriate to criticize those doctors who are getting into more aggressive therapies outside of clinical trials. We don't learn anything about the therapies, and that's a waste."

Until such trials are completed, BMT will continue to be lumped with all the other experimental, unproven, alternative therapies. And a fair number of patients will continue to use these treatments without knowing if they do any good or not. In 1990, an American Cancer Society study revealed that 9 percent of cancer patients seek out some form of alternative therapy, involving diets, vitamins, herbs, even shark cartilage and laetrile. In 1984, the public spent $4 billion—nearly half the entire National Institutes of Health research budget—on unproven cancer cures.

Some of these therapies carry their own risks or interfere with standard treatment, while others probably won't hurt and may even help. For example, 20 years ago, if a woman had confessed that she was treating her illness by watching funny movies or imagining that her immune system was a Pac-Man chewing up her tumor, people would have thought she was crazy. These days, many doctors are encouraging their patients to combine such mind-body techniques with standard therapy. Studies have also shown that women who eat low-fat diets are protected from breast cancer, and many doctors believe that even after a patient has been diagnosed, eating less fat certainly won't hurt her chances of recovery. The national Women's Intervention Nutrition Study (WINS) is currently enrolling patients to test whether diet has any impact on recurrence of breast cancer.

Alternative therapies, whether offered by a witch doctor or a bone-marrow specialist, will remain unproven without clinical trials to test their worth. "The real tragedy, aside from not enough dollars to support all cancer research, is that only 2 percent of breast-cancer patients enter a clinical trial," Dr. Bear says. "We could make progress much more rapidly if we had more women going into trials." Obviously, cancer treatment is far from perfect. It is still a matter of "slash, burn, poison," as Love puts it, and many doctors are hoping that more research will uncover not only better treatments, but also ways to prevent the disease from happening in the first place. Until then, a woman's best defense is regular mammograms and knowing all her options.

SHANNON BROWNLEE *is a senior editor at* U.S. News & World Report. MONIKA GUTTMAN *is a freelance writer living in Los Angeles.*

(continued on page 205)

STYLIST, LIZ GESSNER

breastcancer
(continued)

time. They accomplish this by using a sort of miniature bilge pump to empty the drug out of the cell as fast as it comes in. Researchers have now isolated this little pump, called the multiple-drug resistance receptor, or MDR, and they are developing drugs that can disable it. Other researchers are removing cancer-fighting cells of the immune system, called T cells, from the blood of patients. Huge numbers of these cells are then grown outside the body in a lab and reinjected back into the patient to act as reinforcements against a tumor.

Among the most promising of future treatments are monoclonal antibodies, which are versions of the tiny Y-shaped proteins the immune system employs to fight off disease. Monoclonals were dubbed "magic bullets" when a means of manufacturing them was first discovered in 1975. It was an appropriate sobriquet because monoclonals can be programmed to home in on particular targets in the body. Some seek out microbes, such as viruses; others can be made to latch onto the surface of cancer cells.

These antibodies don't do the actual killing, however. They are paired up with another molecule that does the dirty work. In the fight against breast cancer, researchers have devised three main strategies for employing monoclonals. One is to pair an antibody that will find the cancer cell with a toxin that will deliver a debilitating wallop to it. The second is to pair the monoclonal with a cancer-killing drug, such as doxorubicin, or a radioactive molecule. Several biotech companies are currently testing this strategy. Finally, there are antibodies being developed that will give the immune system a swift kick in the pants. New Jersey–based Medarex has created a monoclonal that hooks up with a certain type of immune cell inside the body and hauls it off to find cancer cells. Then the immune cell engulfs the cancer and kills it.

For all the promise of monoclonals, nobody expects them to be the final answer to cancer. Instead they will probably be used to augment chemotherapy. The New York–based biotech firm ImClone Systems is testing antibodies that actually sensitize breast-cancer cells to the effects of chemotherapy while doing some damage to the cells on their own. When injected, these antibodies zip through the bloodstream and glom onto little structures called growth factor receptors, which stud the outside of many breast-cancer cells. The cancer cell can't grow as fast when these growth factor receptors are knocked out of commission, giving a chemotherapy drug a chance to come in and finish the cell off.

Most of these treatments won't be widely available until the end of this century. But they are making the future look a lot more promising than the present. □

beautydetails

Editors' choice Page 54 Here's where to find these must-have items: *Aphrodisia Naturals' PMS Aromaceutical Oil* is available at Bed Bath & Beyond and specialty stores nationwide. *Nivea's Light Creme* is available at food, drug and mass-merchandise stores nationwide. *Yves Saint Laurent's Rouge Pur Lipstick in 007 Red* is available at Saks Fifth Avenue, Bloomingdale's, Neiman Marcus and other major department stores nationwide. *Conair's Curl 'n Carry* is available at CVS Drugs, Drug Emporium and Venture Stores. *Kiss My Face's Cold & Flu Bath* is available at health-food stores nationwide, or call 800-262-KISS.

Five ways to wear a lipstick Page 66 Some more intense lipstick shades to try: Clarins' Lipstick in Burgundy, Max Factor International 2-in-1 Moisture Rich Lipstick in Bordeaux, Avon's Maximum Color Creamy Matte Lipstick in Cherry Ice, Black Radiance Cosmetics' Moisturizing Lip Color in Kente Diva, Estée Lauder's Double Matte Moisturizing Lipcolor in Rare Wine, Christian Dior's Haute Couleur Lipstick in Bold Claret #974, Elizabeth Arden's Luxury Lipstick in Lacquer Red, Lancôme's Rouge Absolu in Rouge Ombré, Cover Girl's Continuous Self-Renewing Color Lipstick in Rum Raisin, Maybelline's Revitalizing Matte Lip Color in Matte Raisin, L'Oréal's Colour Supreme Lipcolour in Sangria and Prescriptives' Extraordinary Lipstick in Mod Velour.

Beauty's secret weapon: toners Page 180 **For very dry or older skin** *Arbonne's Freshener* gently removes impurities without irritating or drying (to order, call 800-ARBONNE); *Bath & Body Works' Honey Water Toner's* alcohol-free formulation is mild and soothing; *St. Ives' Swiss Formula Soothing Mint and Aloe Purifying Facial Toner* removes impurities and dirt from pores; *Hydron's Best Defense Botanical Toner* is an exhilarating freshener (to order, call 800-345-1515); *Swisscare for Givenchy's Gentle Toning Lotion* is mild enough for use around eyes.

For normal to dry skin *BeneFit's Alpha Smooth* softens and smooths with gentle AHAs (to order, call 800-781-2336); *Shiseido's Pureness Balancing Lotion* adds moisture without clogging pores; *Murad's Phytelene Peach Toner* readies the skin for moisturization (to order, call 800-33-MURAD); *Orlane's Revitalizing Toning Lotion* refreshes skin without drying; *Christine Valmy's Valora II Toning Lotion* extracts surface impurities (to order, call 800-526-5057); *Carita Paris' Tonique Soin de Fleurs* is floral-based and alcohol-free to refresh normal skin (available exclusively at Saks Fifth Avenue); *Black Opal's Purifying Astringent* is alcohol-free and is designed to clear remaining traces of makeup and oil from African American skin.

For sensitive skin *H_2O Plus' Alcohol-Free Toner* removes the dull film from skin's outer layer; *Beauty Logics' Gentle Balance Daily Purifying Toner* controls oil production and cleans and tightens pores (to order, call 800-848-2929).

For oily skin *Yves Rocher's Pure Système Gentle Skin Clarifier* tones and refreshes with grapefruit extract (to order, call 800-321-3434); *Paul Mitchell Skincare's Facial Fresh* adds alcohol-free moisture that won't clog oily pores (available at salons); *The Body Shop's Cucumber Water* contains mild natural astringents to fight oil; *E. E. Dickinson's All-Natural Witch Hazel Formula* absorbs oil without burning or irritating.

For acne-prone skin *Physicians Formula's Oil Control Conditioning Skin Toner* absorbs surface oils and helps heal blemishes; *BeautiControl's Clarifying Mallow Tonic* kills acne-causing bacteria with benzalkonium, an ingredient previously available only by prescription (to order, call 800-BEAUTI-1); *Repêchage's Herbal Astringent* absorbs oil and stimulates skin (to order, call 800-284-5044); *Andrea's Sensation Clarifying Toner Gel* comes in a premeasured, single-use tube and contains an intense alpha-hydroxy-acid cleanser; *Alpha Hydrox's Toner-Astringent* contains glycolic acid to remove surface layer of dead cells (to order, call 800-55-ALPHA).

For one-step toning and cleansing *Mariana Chicet's Apple Milk Cleanser and Toner* is made from all-natural ingredients, mild enough for sensitive skin (to order, call 800-995-4490).

Stores for "Hair Flair" (September issue, page 60) are listed below:

Barrettes *Clockwise from left:* Felissimo, $22 (to order, call 800-565-6785); Colette Malouf, $22 (available at Henri Bendel, Nordstrom and Neiman Marcus); Felissimo, $22; Riviera, $3 (available at Macy's and Bloomingdale's); Colette Malouf, $22.

Combs Both from Riviera: *left,* $8; *right,* $6.

Hair sticks *Left to right:* Riviera, $8; Felissimo, $35 per pair; Colette Malouf Clear Stick Pin, $22; Kara Varian Baker, $165 (available at Harry B's, Nashville; Nordstrom, San Francisco; Fred Segal/Ron Herman, L.A.); Colette Malouf, $22.