Prostate Cancer Support Association of New Mexico

Celebrating 25+ years of supporting men

LIFELINE

PCSANM Quarterly July 2017 Volume 24, Issue 3

Issue Highlights

Our website address
www.pcsanm.org
e-mail
pchelp@pcsanm.org

Meeting Place:

PCSANM is meeting at Bear Canyon Senior Center, 4645 Pitt St NE in Albuquerque. This is two blocks from Montgomery and Eubank; go north one block to Lagrima de Oro St, and east one block to Pitt, and left 50 yards to the Bear Canyon parking lot. We are in room 3, at the west end of the building. Meetings are usually the first and third Saturdays of the month; from 12:30-2:45 pm.

Map: **http://binged.it/1baQodz**

Risks of Serious Toxicities from Intermittent versus Continuous Androgen Deprivation Therapy for Advanced Prostate Cancer: A Population Based Study

May 2017

http://www.jurology.com/article/S0022-5347(16)31954-1/abstract?mc_cid=826ff9b0a5&mc_eid=5a1c3c3ce7

Purpose: Randomized trials have shown that intermittent androgen deprivation therapy for patients with advanced prostate cancer may improve sexual and physical functioning compared to continuous androgen deprivation therapy without compromising survival. To our knowledge it is unknown whether intermittent androgen deprivation therapy alters the risk of serious toxicities associated with continuous androgen deprivation therapy.

Materials and Methods: We performed a population based cohort study of 9,772 men 66 years old or older who were diagnosed with advanced prostate cancer from 2002 to 2011 and treated with androgen deprivation therapy. Intermittent androgen deprivation therapy was defined as a single 90-day interval between 2 androgen deprivation therapy sessions during which patients visited their physicians or underwent prostate specific antigen testing. Outcomes included acute myocardial infarction, stroke, heart failure, type 2 diabetes and fracture. We used Cox proportional hazard models to estimate the HRs of the comparative risk of serious toxicities between intermittent and continuous androgen deprivation therapy.

Results: A total of 2,113 (22%), 769 (9%) and 899 men (9%) had a new cardiovascular event, diabetes or fracture, respectively, within 5 years of starting androgen deprivation therapy. Compared to the continuous androgen deprivation therapy group, the intermittent therapy group was at lower risk for serious cardiovascular events (HR 0.64, 95% CI 0.53–0.77), particularly in reducing the risk of heart failure (HR 0.62, 95% CI 0.49–0.78) and fracture (HR 0.52, 95% CI 0.38–0.70, each p <0.0001).

Conclusions: Intermittent androgen deprivation therapy was associated with a lower risk of heart failure and fracture compared to continuous androgen deprivation therapy. This raises toxicity concerns for continuous relative to intermittent therapy and suggests that intermittent androgen deprivation therapy may represent a safer therapeutic choice in elderly men with advanced prostate cancer.

The corresponding author certifies that, when applicable, a statement(s) has been included in the manuscript documenting institutional review board, ethics committee or ethical review board study approval; principles of Helsinki Declaration were followed in lieu of formal ethics committee approval; institutional animal care and use committee approval; all human subjects provided written informed consent with guarantees of confidentiality; IRB approved protocol number; animal approved project number.

The Applied Research Program, NCI (National Cancer Institute); Office of Research, Development and Information, CMS (Centers for Medicare and Medicaid Services); Information Management Services, Inc.; and the SEER (Surveillance, Epidemiology and End Results Program) tumor registries were instrumental in the creation of the SEER-Medicare database.

FOUNDER Rae Shipp, established 1991, celebrating 25+ years of supporting men

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Jerry Cross **Lou Reimer**

Prostate Cancer Support Contacts Around the State

City	Contact	Phone
Clovis	Kim Adams	(575) 769-7365
Farmington	Fran Robinson	(505) 609-6089
Grants	Dorie Sandoval	(505) 285-3922
Los Alamos	Randy Morgan	505-672-3486
Las Cruces	John Sarbo or Ron Childress	(915) 503-1246 (575) 522-1083
Silver City	Herb Trejo	(575) 574-0225 C (575) 538-3522 H

In Memory of

Walt Hanson

Stephen J. Horner

Robert H. "Bob" Rogers

With deep sympathy and regret, we list these names

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PUBLISHER
The Prostate Cancer Support Association of New Mexico, Inc.
2533 Virginia St NE, Suite C
Albuquerque, NM 87110
(505) 254-7784
(505) 254-7786 Fax
In New Mexico, Call Toll Free
(800) 278-7678

Office open Monday thru Thursday, 10 am-2 pm; or by appointment
Phone and email checked daily by Board Members

E-MAIL
pchelp@pcsanm.org

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LIFELINE EDITOR/ WEBMASTER/FACEBOOK

Jerry Cross

MEETINGS Lou Reimer

OFFICE ADMINISTRATIVE ASSISTANT

Ann Weinberg

Tentative Agenda of Topics, as speakers are confirmed, website will be updated

PROSTATE CANCER SUPPORT ASSOCIATION OF NEW MEXICO
Conference: What's next for PCa Diagnoses and Treatment?
Saturday, November 4, 2017
Sandia Preparatory School
532 Osuna Rd NE, Albuquerque, NM 87113

Morning -

- **8:30 Registration, Coffee, Exhibits, Sign up for lunch**

9:00 – 9:15 Welcome - PCSA –Steve Denning, Board Chairman
Intro to Morning Moderator
9:15 – 10:00 – History of Prostate Diagnosis and Treatment to date

10:00 - 10:15 – Break

- **10:15 – 11:00 - Current scanning tools**

11:00 – 11:45. - C-11 Scans and beyond

11:45- 12:45 Lunch Break On site, Food can be ordered day of the event

12:45 PCSA- Steve Denning, Board Chairman
Intro to Afternoon Moderator
1:00– 2:00 – Risk Assessment Panel 3-4 current testing reps 8- 10 min presentations each then questions from moderator &/or floor
ProstateNext – Ambrey Genetics
Prolaris – Myriad Genetics
GenomicDX – Genomic Genetics
4K test – GenPath

2:00 – 2:15 Break

2:15 – 3:50 Breakout, Sessions
Initial Treatments, Urology-
Initial Treatments, Radiology
Advanced PCa Treatments, Oncology-
3:50- 4:35 - What's next?
4:35- 4:45 Thank you for attending - Closing remarks
PCSA Steve Denning, Board Chairman
5:00 Shut down - Clear the building

Exhibitors (To be invited)

AccumetRx/Urology Group of New Mexico
Albuquerque Urology Associates
Bayer
Cancer Center at Presbyterian
Genomic Health
Janssen Biotech (Zytiga)
Medivation Inc. (Xtandi)
New Mexico Cancer Center
Santa Fe Radiology
UNM Cancer Center
American Cancer Society
Others

Does Proton Beam Therapy for Prostate Cancer Live Up to Its Promise?

From Health after Fifty **https://www.healthafter50.com/prostate/**

Men diagnosed with prostate cancer are faced with an array of prostate treatment options. Proton beam therapy—a form of external beam radiation therapy—is the latest choice now available in the United States. But it's a controversial option as well, with some critics suggesting that its popularity may be driven by advertising rather than by sound scientific evidence of benefit over other therapies.

Indeed, advertisements aimed directly at men with prostate cancer often promote proton beam therapy as a cutting-edge alternative treatment. While proton beams may sound like something out of science fiction, in reality, this therapy has been a part of cancer care for more than a half century, used to treat cancers of the brain, head and neck, spine, and eye.

Early on, much of that care was provided in research settings. But with the opening of the first hospital-based proton therapy center in 1990—and promising early results in men with prostate cancer—interest in proton beam therapy has taken off.

As of mid-2016, 20 medical centers in the United States were offering proton beam therapy, and 16 more facilities are under construction or in planning. In spite of the building boom, however, it may surprise you to learn that doctors are not yet sure whether proton beam therapy will live up to its promise—particularly when it comes to adverse effects.

Protons vs. photons

Proton beam therapy is a variation on conventional radiation therapy for prostate cancer. Conventional radiation therapy uses X-rays (also called photons) to destroy tumors. Proton beam therapy, as its name indicates, uses protons to irradiate, or kill, cancer cells. However, protons (positively charged atoms) have certain unique qualities that set them apart from X-rays. And those features allow doctors to target proton beams with greater precision.

Think of the difference between X-rays and protons this way: Imagine that an X-ray is a bullet that enters the body, strikes a tumor, and then exits the body through the other side. Throughout this process, the X-ray releases energy, damaging healthy and malignant tissue alike.

By contrast, doctors can calculate how deep in the body they want a proton beam to fire. That means a proton beam doesn't exit the body, so it delivers most of its energy in the tumor.

In theory, this pinpoint-targeting ability should make proton beam therapy less likely than conventional radiation treatments to damage healthy tissue in the vicinity of a tumor—damage that can result in side effects such as ED, incontinence, and serious gastrointestinal problems such as bleeding and ulcers.

But few prostate cancer patients receive conventional radiation treatments these days. Over the last decade or so, a more refined version of conventional radiation known as intensity-modulated radiation therapy (IMRT) has become by far the most common method for using X-rays to eradicate prostate tumors. IMRT uses computers to produce three-dimensional images of tumors. Doctors then use these images to irradiate a tumor from many different angles.

Like proton beam therapy, IMRT was designed to limit damage to healthy neighboring tissues. But is one method better than the other at accomplishing this?

How they stack up

Studies have shown that when it comes to eliminating tumors and treating prostate cancer, proton beam therapy works about as well as IMRT. However, relatively little research has been conducted comparing the safety profiles of proton beam therapy and IMRT. One recent study, reported in the *Journal of the American Medical Association (JAMA)*, is helping to provide much-needed clarity.

For the study, investigators analyzed Medicare claims data from nearly 13,000 men treated with radiation for nonmetastatic prostate cancer (that is, cancer that had not spread beyond the prostate) between 2000 and 2009. The men had been treated with conventional radiation, IMRT, or proton beam therapy.

The investigators reported that IMRT was associated with fewer adverse gastrointestinal effects and fewer hip fractures than conventional radiation, but more ED.

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Overall, there was no significant difference between proton beam therapy and IMRT—with one major exception. Men treated with IMRT were 34 percent less likely than those who had proton beam therapy to develop gastrointestinal problems after their treatments.

This seems to confirm results from an earlier study showing that men undergoing proton therapy had significantly higher rates of gastrointestinal bleeding and ulceration than those receiving other types of radiation.

Why pay more?

Proton beam therapy is significantly more expensive to perform than IMRT (though both are costly procedures). One study found that treating a prostate cancer patient in his 60s or 70s with proton beam therapy costs about $64,000, on average, compared with $39,000 for IMRT. (Medicare and health insurance plans usually cover either treatment, but some insurance companies no longer offer coverage for proton therapy.)

But the *JAMA* findings raise an important question: All else being equal, if proton beam therapy is more likely than IMRT to produce adverse gastrointestinal effects, why pay the additional cost? Patients aren't the only ones with a vested interest. Insurers (including Medicare) and hospital administrators have a stake as well.

Setting up a proton beam clinic requires a major investment of space and money. The massive machines that produce protons, known as cyclotrons, cost millions of dollars to build. While proton beam therapy has a role in treating many different forms of cancer, many hospitals that devote resources to these clinics assume that a good number of their patients will be men with prostate cancer. If that assumption is wrong, will they be able to recoup their costs? And if proton beam therapy offers no advantage over a less expensive prostate cancer therapy, why should insurers pay for it?

The only way to demonstrate which treatment is truly associated with a lower risk of side effects is to conduct a large head-to-head clinical trial. Fortunately, such a trial is underway.

Researchers are in the midst of a study that will eventually include more than 400 men with prostate cancer who will receive proton beam therapy or IMRT.

The research team will follow the men for several years and track whether they develop side effects, including bowel problems, urinary difficulties, or ED.

By the end of this important trial, which is expected to end in 2018, with data presented soon afterward, doctors should have a better idea about whether proton beam therapy and IMRT live up to the promise of protecting healthy tissue and preventing side effects. For now, however, there is no evidence to support claims that proton beam therapy provides improved cancer-free or quality-of-life outcomes when compared with less expensive alternatives like IMRT and surgery.

What to do in the meantime? "When patients ask about proton beam therapy, I tell them there is no good evidence that protons are any better than photons in curing prostate cancer," says Phuoc T. Tran, M.D., Ph.D., clinical director of radiation oncology and molecular radiation sciences at the Johns Hopkins Sidney Kimmel Comprehensive Cancer Center.

"I always tell patients that if you live near a proton center and your insurance covers the cost of treatment, sure, go for it," Trans says. "On the other hand, I would never recommend that a patient relocate to go to a proton center for prostate cancer treatment. It's simply not worth the effort or expense."

Benefits of participating in support groups may include:

Feeling less lonely, isolated or judged.

Gaining a sense of empowerment and control.

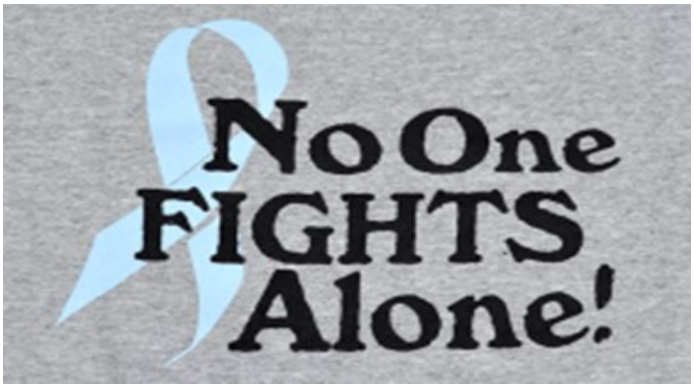
Improving your coping skills and sense of adjustment.

Talking openly and honestly about your feelings.

Reducing distress, depression, anxiety or fatigue

And

Connecting with new people who may be experiencing similar things as you



Prostate Cancer Treatment: When to Wait

by H Ballentine Carter, MD from Health after Fifty

https://www.healthafter50.com/prostate/article/prostate-cancer-treatment-when-to-wait

There is an ongoing debate in medicine about whether to treat prostate cancer that is very-low risk to low risk. For men older than 75, who are more likely to die of other causes, the decision is fairly straightforward. But some experts believe that most other men—even if they have low-risk disease—should be treated to eliminate any chance of future cancer progression and possible metastasis.

However, now that large clinical trials have demonstrated the lack of benefit in treating older men with favorable-risk cancer, a growing number of doctors—myself included—believe that a man diagnosed with low-risk cancer over the age of 65 to 70, or any man with serious health issues, should seriously consider surveillance as one option.

During active surveillance, a digital rectal examination, [prostate-specific antigen (PSA) test], and periodic biopsies are used regularly to monitor prostate cancer progression. If these tests ever indicate that cancer is progressing, treatment—surgery or radiation therapy—may be warranted.

A common cancer

Prostate cancer is a very prevalent cancer. Doctors know that most men over age 70 harbor some cancerous cells in the prostate. Because the PSA test is not specific for prostate cancer, many of these malignancies are uncovered when a prostate biopsy is performed for a PSA elevation that is unrelated to cancer. I call this serendipity. We also know from countless studies and autopsy reports that most of these small cancers will not cause harm during the lifetime of the patient.

It has been estimated that from 30 percent to 50 percent of prostate cancers detected today with PSA testing would not have been discovered during the patients' lifetime if a biopsy had not been performed. Treating these cancers cannot prolong life but only reduce its quality. If we treat every man that we find to have prostate cancer, overtreatment rates will continue to be unacceptable.

An alternative approach is to recognize that carefully selected men can be monitored, and if their cancer changes, treatment can be undertaken at that time. That is the thinking behind active surveillance as it is practiced at Johns Hopkins and other urology centers around the world. This approach is gaining more interest in the medical community because of the realization that prostate cancer is being overtreated.

Cancer fears

Prostate cancer has a long, protracted course in most men. Today, in the United States, with widespread PSA screening of men who are free of any noticeable symptoms, prostate cancer is being detected at an extremely early stage in the natural course of the disease.

When compared to men whose cancers are detected the old fashioned way, without PSA screening, most of the cancers discovered today by PSA are of low to moderate risk and unlikely to result in death from prostate cancer in 10 to 15 years if left untreated among men over the age of 65—especially those with other health problems, such as hypertension and cardiovascular disease.

Still, in the absence of definitive tests that can guarantee a man that his cancer will not progress, most men today—even those whose age gives them a life expectancy of less than 15 years—want a solution to their cancer problem. Fearful that cancer will take their lives, they head off to the hospital or radiation center to undergo treatment for their prostate cancer—even though the risks of treatment far surpass the risks posed by the cancer.

It's the fear factor at work. Everyone fears cancer, and no one wants to die from it, so most men will take a pass on active surveillance. They want the cancer out (surgery) or stopped in its tracks (radiation).

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Benefits of active surveillance:
• The side effects of surgery or radiation therapy can be avoided.

• Small, indolent cancers do not receive needless treatment.

• Quality of life is retained.

Potential disadvantages:
• Increased anxiety due to living with untreated prostate cancer.

• The need for frequent testing, including digital rectal exam, PSA, and biopsy.

• The uncertain possibility that the cancer will progress or metastasize before treatment can begin and the window for cure will be lost.

• If treatment is eventually needed, the cancer might be more difficult to treat later on.

What patients ask
To follow are answers to questions that I regularly get from patients recently diagnosed with prostate cancer who want to know about active surveillance and whether it is a course of action that they should consider.

Q. Who should consider active surveillance for prostate cancer?

A. Active surveillance is an acceptable alternative for carefully selected older men (typically 65 and older) who want to monitor their cancer rather than undergo immediate surgery or radiation. Even though these men have curable disease, they understand that it does not have to be cured right now. Instead they take an alternate course of active surveillance and regular testing, deciding to live with an uncertain future while still maintaining a high quality of life, free from any side effects of cancer surgery or radiation.

Q. Who are the ideal candidates for active surveillance for prostate cancer?

A. There is disagreement among physicians about who are the ideal candidates for surveillance. However, to ensure maximum safety, at Johns Hopkins we recommend this approach mostly for men who have a very-low-risk cancer and are, in general, older than 65. Johns Hopkins pathologist Dr. Jonathan Epstein originally classified very-low-risk prostate cancers as small (less than 0.5cc) and low grade (Gleason score 6 or less) and likely to be present if they have the following features:

• Stage T1c

- PSA density (PSA divided by prostate volume) is below 0.15
- No more than two cores with cancer
- No core with more than 50 percent cancer involvement

Many experts are recommending an MRI (magnetic resonance imaging) of the prostate as an additional means of insuring that no larger more aggressive cancer was missed on a prostate biopsy prior to entering surveillance. However, the value of this is yet to be proven.

A low-risk prostate cancer is defined as:

- Stage T1c or T2a
- A PSA less than10.0 ng/ml
- A Gleason score of 6 or less

Together, very-low-risk and low-risk prostate cancer are referred to as favorable-risk prostate cancer.

I believe that the safest candidates for active surveillance are men with very-low-risk disease—unless an individual's life expectancy is limited by other health issues, in which case a man's higher-risk disease may also do well with surveillance. But for a man over age 65 who wishes to avoid treatment, studies show that harm is not likely over 15 years without treatment if favorable-risk prostate cancer is present.

In my practice, men with very-low-risk prostate cancer and a life expectancy of less than 20 years are ideal candidates for surveillance. Those with low-risk prostate cancer who have a life expectancy over 15 years can consider surveillance as one option, while men with a life expectancy below 15 years should consider surveillance as a leading option.

Likewise, surveillance should be the recommended strategy for any man in poor health with favorable-risk prostate cancer and a life expectancy of less than 10 years.

Q. What factors should be considered before deciding on active surveillance for low- risk prostate cancer?

A. If you are considering active surveillance, you should first review all other options carefully and understand their benefits and drawbacks. Understand, too, that active surveillance entails close monitoring by a physician on a regular basis. In the Johns Hopkins program, we monitor men with regular PSA measurements and a digital rectal exam twice yearly, as well as an annual or eighteen-month prostate biopsy up until the age of 75.

It goes without saying that if you decide to be monitored, you must stick to the recommended surveillance schedule. Just as important, active surveillance also requires that a man be able to live with the idea that he has cancer and will require long-term testing.

Expert Discusses Biomarker Development in Prostate Cancer

SHANNON CONNELLY April 28, 2017 www.curetoday.com

The field of prostate cancer has been transitioning with the identification of novel biomarkers. However, physicians are now facing a new challenge: which one is best appropriate for their patients?

Leonard Gomella, M.D., recommends that healthcare providers familiarize themselves with how each biomarker should be used and then decide which one to use — a more individualized approach in clinical practice.

In an interview with *CURE*, during the 10th Annual Interdisciplinary Prostate Cancer Congress, Gomella, professor and chair, Department of Urology, and director, Kimmel Cancer Center Network, Thomas Jefferson University, discusses the future of biomarkers in prostate cancer.

Can you give an overview of your talk on biomarkers in prostate cancer?

Gomella: Biomarkers in prostate cancer is a very rapidly evolving field. We're seeing new markers for prostate cancer almost on a weekly or monthly basis. Right now, biomarkers for prostate cancer fall into two general categories: biomarkers that are used for the biopsy and initial diagnosis of prostate cancer, and biomarkers that are used after the diagnosis of prostate cancer.

In the first case, we primarily have new blood and urine tests that are out there to help us decide who may or may not have prostate cancer and who may or may not need a biopsy. In the latter case, after we make a diagnosis we have genomic tissue markers that allow us to be more clear on what the best treatment might be for a patient, either active surveillance or active therapies, such as radical prostatectomy or radiation therapy. And lastly, for patients who have had radical prostatectomy, we have biomarkers to help us decide if those with adverse pathology need more treatment, such as radiation.

Right now in prostate cancer, a lot of it revolves around what we call the somatic markers in the tumor to help us guide treatment. We have a whole different class of biomarkers now, both genomic and basic tests, such as the SelectMDx, 4Kscore test, the PHI (Prostate Health Index) test and other blood and urine tests, to help us with the decision for the initial biopsy.

With so many new biomarkers available, what are the challenges?

With all the biomarkers, the challenge is which is the best one. There are so many out there, and I think it's up to the individual provider to start to work with one or two of the biomarkers and decide if they work well in his or her hands. There are not a lot of comparative trials out there right now with the different biomarkers, either the standard blood and urine test, or the newer genomic assays on the tumor. We don't have head-to-head comparisons, but the ones that are approved by the Food and Drug Administration (FDA), such as the PHI test, which is approved for the screening of the initial determination if someone needs a biopsy, doctors just have to start using them and decide which one works best.

Since there are not a lot of clinical trials ongoing in this area, what do you envision for the future of biomarkers in prostate cancer?

The future of biomarkers is going to be tough in the absence of clinical trials. There are a few centers that are doing some head-to-head comparisons. The FDA has the burden on them right now to approve these markers, and once they get approved, it's going to be in your hands to decide which one works the best. Absent of these clinical trials, I think it's going to be very challenging going forward as more biomarkers become available.

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Let's face it, we've had many biomarkers over the last 10 to 15 years that have come and gone because, although they got FDA approval, when they got out to the real world of patient care, the providers did not find that they helped in their decision making. Each new biomarker is going to have to stand on its own and I think once they get FDA approval, the marketplace is going to decide if it's a good test, or 'you know what, when I use this it doesn't help me that much' — it's like flipping a coin. So again, each biomarker is going to have to stand on its own. The papers are all based on clinical trials and very defined populations, so once they get out into the day-to-day practice of urology and screening and diagnosis of prostate cancer, that's where they will either live or die.

How can urologists best decide which biomarkers to use?

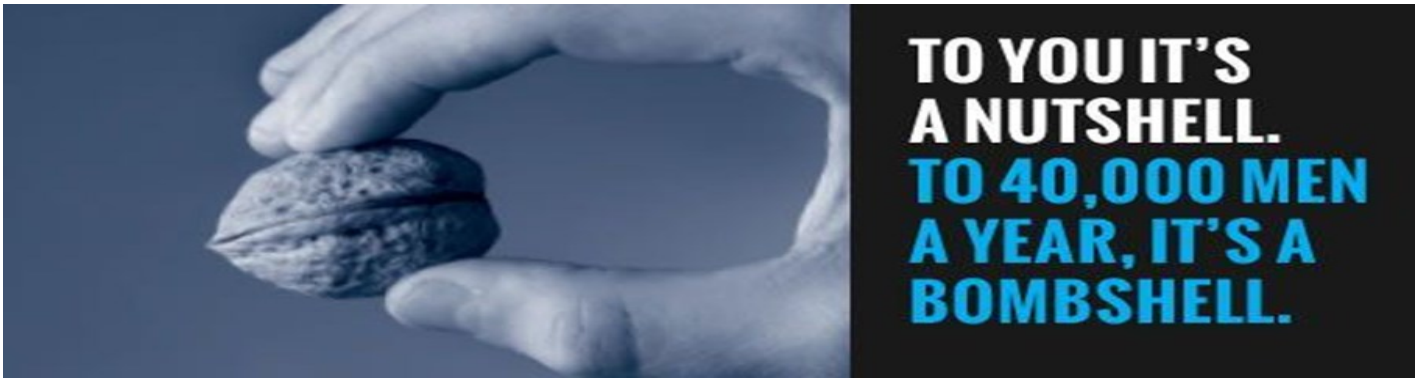
You have to first look at what the biomarker is approved for. Some biomarkers are approved for that initial yes or no decision making for biopsy. Other biomarkers are approved after the diagnosis is made for deciding whether you follow this patient with a less aggressive approach, such as active surveillance, or if they need some type of active treatment. The decision making has to be put in the context of what you're doing with the individual patient. The important thing is that any provider, whether it be a urologist, radiation oncologist, or medical oncologist, should be familiar with the different assays that are out there and understand that it's not one-size-fits-all. They often have very narrow FDA labels for how they should be used.

Meet the newest Board Member: Rod Geer

Rod Geer, PCSANM's newest board member first strolled into the office last February. He'd just been diagnosed with prostate cancer. Thus began Rod's PCa journey, which included multiple visits to three doctors, one in California, over the next several months of 2016. And there were regular visits to the PCSANM office to chat and check out books. He also spoke to many helpful men who populate our Buddy List.

Da Vinci robotic surgery occurred in late June 2016. About a year out now things are upbeat. A runner, Rod completed his first post-Prostate half marathon recently in "Post-Prostate-Personal-Best" time. Rod's working life has been primarily in public relations. A short stint in the '70s at the University of New Mexico was followed by more than 30 years at Sandia National Laboratories.

As a new board member, Rod is focusing on outreach. Questions? Reach him at 505-203-5122.



Shorter Length of Sleep Associated With Increased Risk of Death from Prostate Cancer

KATIE KOSKO April 3, 2017

http://www.curetoday.com/articles/ shorter-length-of-sleep-associated-with-increased-risk-of-death-from-prostate-cancer

Men under the age of 65 who get fewer than seven hours of sleep each night have a greater risk of dying of prostate cancer, according to a new study presented April 3 at the American Association for Cancer Research Annual Meeting, taking place April 1-5 in Washington, D.C.

Researchers from the American Cancer Society in Atlanta examined data from two large, long-term cohort studies, Cancer Prevention Study-I (CPS-I) and Cancer Prevention Study-II (CPS-II), and determined that shorter sleep duration was associated with an increased risk of death from the disease in men under age 65 years.

In the CPS-I study, 407,649 men were followed from 1950 through 1972 and 416,040 men from the CPS-II study were followed from 1982 through 2012. All men were cancer-free when the studies began. However, 1,546 men in CPS-I and 8,704 men in CPS-II died of prostate cancer during the follow-up periods.

Sleep-related behaviors such as sleep duration, shift work and insomnia were self-reported by study participants.

Examining the deaths from prostate cancer more closely, researchers found that during the first eight years of follow-up, men younger than 65 who got three to five hours of sleep a night had a 55 percent greater risk of dying of prostate cancer than men who got seven hours. In addition, men who got six hours of sleep a night had a 29 percent higher risk than those who got seven hours. Men who were 65 or older showed no difference in the risk of death from prostate cancer, no matter how much sleep they got.

"While these results are intriguing, and contribute to a growing body of evidence that circadian rhythm-related factors might play a role in prostate carcinogenesis, more research is needed to better understand the biologic mechanisms," Susan M. Gapstur, Ph.D., M.P.H., vice president of epidemiology at the American Cancer Society and lead author on the study, said in a statement. "If confirmed in other studies, these findings would contribute to evidence suggesting the importance of obtaining adequate sleep for better health."

Gapstur explained that sleep deprivation and the associated presence of light at night, such as the use of electronics like cell phones and televisions, can inhibit the production of melatonin — a hormone that affects sleep cycles. She added that producing low amounts of melatonin can cause increased genetic mutations, greater oxidative damage, reduced DNA repair and immune suppression. Also, less sleep may contribute to the dysregulation of genes involved in tumor suppression.

Regarding sleep duration and death from prostate cancer in older men, Gapstur said the reasons remain unclear. However, she feels it may be related to the natural decline in nocturnal melatonin levels with age, possibly reducing the relative impact of sleep deprivation.

The authors noted two limitations of the study: self-reporting of data and the fact that data were collected only once, at the start of the study.

A New Study for Prostate Cancer Survivors and Fighters

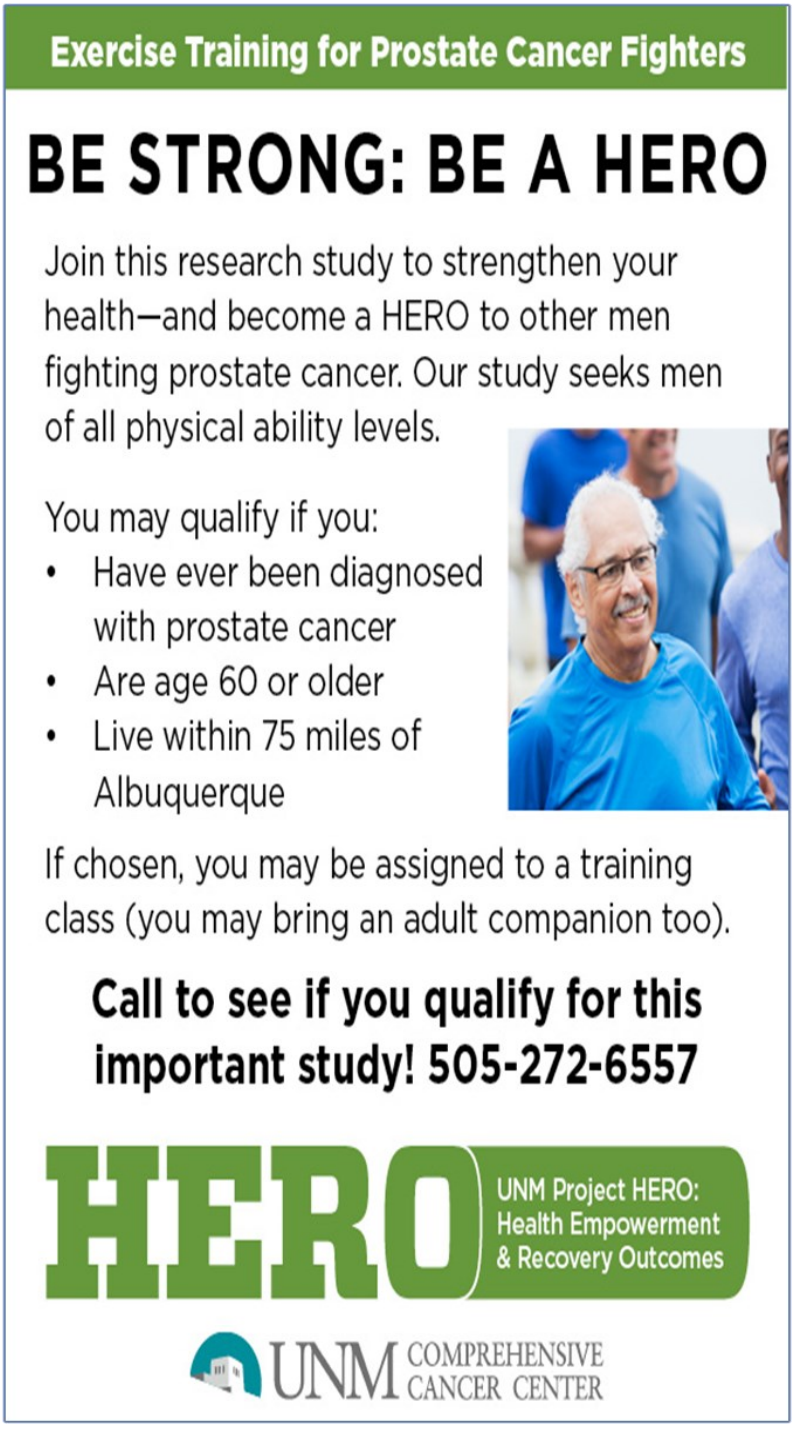
Researchers at the UNM Comprehensive Cancer Center are recruiting participants for a new study to improve health for prostate cancer fighters and survivors.

Approximately 20% of all cancer survivors are men who have been diagnosed with prostate cancer.

Project HERO (Health Empowerment and Recovery Outcomes) is trying to learn how different mind and body exercise programs affect how men with prostate cancer recover and thrive.

The study involves 12 week sessions starting in August after screening and some tests, and follow-up for a year. Several stipends are paid. Quarterly sessions will start every 3 months

You may be eligible if you have been diagnosed with prostate cancer, are age 60 or older, and live within 75 miles of Albuquerque. For more Information and to see if you are eligible to participate, please contact the UNM HERO team at 505-272-6557.



There is a more detailed flyer on our website at:

http://www.pcsanm.org/wp-content/uploads/2015/09/HERO-Brochure-4_25_17_Gotham.pdf

PCSANM *Lifeline* Newsletter
July 2017

Celebrating 25+ years of supporting men
Prostate Cancer Support Association
of New Mexico, Inc.
2533 Virginia St. NE, Suite C
Albuquerque, NM 87110

Chairman's Report July 2017

The big news last quarter was the reversal by the US Preventative Services Taskforce of its discouragement of regular screening for prostate cancer in order to stem the tide of overtreatment. While we agree that at one time overtreatment was a problem, in recent years open dialogue, the development of non-invasive screening techniques and the acceptance "watchful waiting" has balanced the scales and made regular screening vital again. We do disagree that the recommended age for beginning screening should be 45 and not 55 in order to catch more virulent forms that seem to affect younger men. Along with the newer treatments available we believe this will save more lives. We are submitting a comment to this effect on the new recommendations to the USPSTF and we encourage our members to do the same.

This has also been a good quarter for PCSANM as we step up our plans to increase our outreach efforts. Our office administrator, Ann Weinberg, has been incredibly effective at organizing our efforts, making phone calls and scheduling opportunities for us to make appearances where we can spread the word about prostate cancer screening and our support services. But we won't be able to reach the State without more help. Most of our efforts have been conducted by our board members but now we would like to expand these efforts without the commitment of board membership. If you've been helped by PCSANM in the past would you consider volunteering a little of your time manning a table at a health fair, organizing an event or making a presentation to a group? You'll be surprised at the number of men and women you'll meet who have questions about prostate cancer. Together we really do make a difference.

Chairman of the Board PCSANM