Prostate Cancer Support Association of New Mexico

LIFELINE

PCSANM Quarterly **January 2013** **Volume 20, Issue 1**

Issue Highlights

Our website address
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New Meeting place as of January 19, 2013

This meeting will start our tenure at North Domingo Baca Multigenerational Center while the Bear Canyon Senior Center undergoes renovation. The Multigenerational Center is at 7521 Carmel NE , Albuquerque. The center is located two blocks north of Paseo del Norte on the west side of Wyoming.

WE MUST DO BETTER: A POSITION STATEMENT REGARDING PSA SCREENING by *Dean Foster, MD Medical Director*

From Prostate Cancer Research Institute Insights November 2012

Last May, the U.S. Preventative Services Task Force triggered a firestorm of debate when it recommended against the prostate-specific antigen (PSA) test as a screen for prostate cancer.
By discouraging PSA screening, they hope to diminish the harm caused by prostate cancer over-treatment. Unfortunately, they also risk delaying its diagnosis.

In her editorial responding to the controversy, Task Force chair Dr. Virginia Moyer summarized the committee's findings with this sentence: "We can do better." We at the Prostate Cancer Research Institute (PCRI), while disagreeing with the Task Force's "D" rating of PSA, do agree with Dr. Moyer's conclusion: We can, indeed, do better.

We can, for instance, do a better job of educating men on the optimal use of the PSA test. If men simply pause to think before rushing into a biopsy, they can:
1) Better determine the need for biopsy by determining the aggressiveness of the tumor with the PSA doubling time; and
2) Improve biopsy accuracy by locating the tumor beforehand with a multi-parametric MRI.

This is valuable information that improves biopsy outcomes and decreases the cost of care by improving the use of biopsy, the very things the USPS Task Force has asked us to do.
However, all this recent controversy gives people an excuse to ignore a disease that affects one in six men and causes the death of 28,000 every year. The subject of prostate cancer already makes men uncomfortable. The controversy over the PSA test gives them one more reason to avoid a well thought-out action plan for their prostate health and screening.

The PCRI encourages men to learn about PSA screening in consultation with their physician. When PSA screening detects elevated levels, be prepared for this consultation by using the PCRI Helpline and other educational programs before proceeding to biopsy and treatment.

PCRI supports Rep. Marsha Blackburn in her efforts to pass HR 5998, a bill that would help Dr. Moyer's team resolve controversies like this before they begin. The proposed bill would increase the accountability and oversight of the Task Force (to learn more about the bill and read the full text, visit http://www.opencongress.org/bill/112- h5998/show). You can take a position with us by sending me an e-mail at dfoster@pcri.org.

We at the PCRI encourage PSA use with wisdom, patience, education, healthy behaviors and careful health care choices. The PCRI stands in agreement with Dr. Moyer that together, we *must* do better.

FOUNDER Rae Shipp, established 1991

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In Memory of

Bob Henry

William C. (Bill) Myre

With Deep Sympathy and Regret, We List These Names

PC SUPPORT GROUP MEETINGS

Support Meetings are usually held on the first and third Saturday of each month at 12:30 PM. **As of January 19, 2013**, they will be held at the North Domingo Baca Multigenerational Center while the Bear Canyon Senior Center undergoes renovation, for at least several months. The Multigenerational Center is at 7521 Carmel NE , Albuquerque. The center is located two blocks north of Paseo del Norte on the west side of Wyoming. Please call ahead to verify time and dates. 254-7784 or (800) 278-7678; or check website or Facebook page.

PCSA *Lifeline*

A quarterly newsletter addressing issues of prostate cancer

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Jerry Cross

MEETINGS

Lou Reimer

DISCLAIMERS

The PCSA of New Mexico gives education, information and support, not medical advice. Please contact your physician for all your medical concerns.

Dr. Lindberg's Take
Northern New Mexico Cancer Care

Dr. Peter Lindberg
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Enzalutamide (Xtandi) has received FDA approval for the treatment of prostate cancer after taxotere chemotherapy has been tried. In the Phase 3 study of over 1,000 men survival increased by at least 4.8 months but in the portion of men who had a response, survival was considerably longer. I have given this drug to five of my patients in whom all previous medications including Zytiga or Abiraterone failed or stopped working. At least two of the men seem to be responding after one month of treatment while the others have not yet returned for their first follow-up visit. Enzalutamide, previously known as mdv-3100 blocks androgen, male hormone, attachment to the androgen receptors and androgen signaling within the prostate cancer cell. Adding Zytiga, which blocks testosterone PRODUCTION, to Enzalutamide is an appealing idea and studies have been started. However, besides the cost ($13,000 a month) we don't know if this would be safe or better than each drug alone. On November 13, Dr. Nicholas Vogelzang said there is very little pre-clinical data on safety, could possibly cause liver problems, and no proof yet of 1+1 =2 or even 1+1=1 or less. As I mentioned previously 6 Avodart given daily for three months before a radical prostatectomy is very effective at lowering Dihydrotestosterone levels in the cancer. COMPLETE androgen blockade?? This concept of total androgen blockade has been championed by Dr. Bob Leibowitz with his triple therapy, Lupron, Bicalutamide 150mg + Proscar since about 1994. We now have more potent drugs!

In a recent education course Dr. Matthew Smith MD, Ph.D. Harvard Medical School states,"Over time conditions of incomplete androgen deprivation may select for cells that are exquisitely sensitive to very low levels of male hormones"
I believe that:

1. Not checking testosterone levels when giving Lupron (aim for less than 20)
2. Ignoring male adrenal hormones like DHEA and ANDROSTENEDIONE, as in using Lupron alone rather than combining with Bicalutamide
3. Ignoring the safety and effectiveness of drugs like Proscar and Avodart
4. Accepting a PSA level higher than 0.5 from treatment.
5. I believe all of the above 4 points leads to resistance that Dr. Smith describes.

Note that many prostate specialists say, "No data for Avodart – not evidence based" but two clinical series were reported in the peer reviewed journal "The Oncologist" and these experienced doctors believe Avodart treatment IS EFFECTIVE: Drs. Snuffy Meyers, Leibowitz, Strum, Lam, Scholz, and Lindberg.

A new approach to chemotherapy has been proven in Hodgkin's disease, Leukemia, and now Breast Cancer (current issue of New England Journal of Medicine) A very potent but toxic chemotherapy agent is linked to an antibody against a cancer cell marker, Her-2-neu in breast cancer. After the antibody attaches to the cancer cell, the chemotherapy drug is taken into the cancer and does its' work, but little if any of the chemo gets into normal tissue. PSMA is marker in prostate cancer. Initial studies with favorable results have already been reported but I suspect it will be at least 3 years for such treatment will be proven for prostate cancer.

C-11-choline Pet/CT now in use at The Mayo Clinic has received FDA approval. This scan can demonstrate cancer extent and location when psa rises when a radical prostatectomy or radiation therapy has failed. Most accurate results occur when psa is at least 2.0. Often bone scans, CT, and standard Pet are unable to show where the cancer is located, Journal of Urology Oct. 30, 2012.

A study of 5,995 medical records demonstrated a reduced risk of dying from prostate cancer in men treated for disease if they took aspirin; Not a prospective randomized trial. While suggestive of benefit, was not proven, Journal of Clinical Oncology 2012.

In men with low risk gleason 3+3 prostate cancer who are going to begin active surveillance , MRI of the prostate with the endorectal coil helps to predict which men are good candidates to be watched and those who will need immediate treatment after the repeat confirmatory biopsy. Experience and training of the radiologist in interpreting the MRI is crucial, Published Journal of Urology November 2012.

Viagra at 50 mg. daily starting 3 days before radiation and continuing for six months after radiation is completed, for a total of 8 months, helped to preserve sexual function in a randomized clinical trial. Med Page Today November 3, 2012

Int. Journal Oncol biol Physics October 2012. Dr. Anthony D'Amico from Harvard has also shown that men whose PSA is greater than 0.5 after completing hormone/radiation therapy do much worse and should be considered for some form of further therapy, perhaps a clinical trial.

When Treating Cancer Is Not an Option by Jane Brody

A version of this article appeared in print on 11/20/2012 in the New York Times

When my husband learned he had advanced lung cancer, he didn't even want to speak to an oncologist about chemotherapy. He saw no point in treatment that could not cure him and might make him feel worse.

Not so, though, for a majority of patients diagnosed with cancers of the lung or colon that have spread well beyond their original site and are currently not curable by any drugs in the medical armamentarium. Most patients with these so-called stage 4 cancers who choose to undergo chemotherapy seem to believe, incorrectly, that the drugs could render them cancer-free.

That is the finding of a recent national study of nearly 1,200 patients with advanced cancers of the lung or colon. Overall, 69 percent of those with stage 4 lung cancer and 81 percent of those with stage 4 colon cancer failed to understand "that chemotherapy was not at all likely to cure their cancer," Dr. Jane C. Weeks, an oncology researcher at the Dana-Farber Cancer Institute in Boston, and colleagues reported in The New England Journal of Medicine.

When patients do not understand the limitations of such treatment, their consent to undergo it is not truly informed, the authors concluded.
This is not to say that chemotherapy is pointless when cancer is far advanced. Various drugs, some with limited toxicity, can be used as palliatives, perhaps shrinking tumors temporarily to relieve symptoms, slowing the cancer's growth and prolonging the lives of some patients.

But aggressive chemotherapy when death is but weeks or months in the offing can seriously compromise the quality of patients' remaining time and may delay their preparations for the end of life, to the detriment of both patients and their families.

"If you think chemotherapy will cure you, you're less open to end-of-life discussions," Dr. Weeks said in an interview.
When patients pursue chemotherapy under the false belief that they still have a chance for a cure, it often delays their transition to the comfort care of hospice. When patients spend only a few days or a week in hospice, caretakers don't have enough time to get to know them and their families and offer the physical, emotional and practical benefits hospice can provide.

Dr. Weeks said continued chemotherapy involves more trips to the hospital, blood draws and X-rays, whereas hospice attends to patients' symptoms and concerns, and encourages them to leave meaningful legacies. When my husband entered hospice after two miserable weeks in the hospital undergoing palliative radiation, he experienced such relief that he said cheerfully, though in jest, "What if I decide I want to live?" and then enjoyed a treasured last visit with two of his grandchildren.

'Optimistic Bias'

Communication is a two-way street; doctors and patients alike contribute to patients' failure to appreciate medicine's limited ability to treat advanced cancer.

In an editorial accompanying the journal report, Dr. Thomas J. Smith and Dr. Dan L. Longo pointed out that "people have an optimistic bias." Despite a grim prognosis, this bias prompts patients to believe treatment can cure them.

"Even with repeated discussions, about one-third of patients are not able to say they have a disease from which they will die in a year or so," Dr. Smith, an oncologist and director of palliative care at Johns Hopkins Sidney Kimmel Comprehensive Cancer Center, said in an interview.

"Our job is not to force them into acceptance but to encourage them to plan for the worst while hoping for the best," Dr. Smith said. "Such patients have better outcomes — less depression and less distress, and they're more likely to die comfortably at home."

Cultural and racial factors, and most likely religious beliefs, influence acceptance of the futility of continued treatment, Dr. Weeks said. In her study, nonwhite and Hispanic patients were more likely than whites to believe that chemotherapy could cure them. But surprisingly, patients' educational level, degree of disability and participation in decision-making were not associated with inaccurate beliefs about chemotherapy.

What can make a huge difference, Dr. Smith said, is how and how often doctors discuss options with patients and describe the potential of continued treatment. He and Dr. Longo suggested that practitioners master "the conversation known as 'ask, tell, ask,' which consists of asking patients what they want to know about their prognosis, telling them what they want to know, and then asking, 'What do you now understand about your situation?' "

Among the questions Dr. Smith said doctors should be asking are, "How much do you want to know about your cancer? What do you know about your cancer? Who would you like to include in discussions about your care? Would you like me to write down the important points? What is important to you? What are you hoping for? Who are your other doctors so that I can communicate with them?"

Continuing Discussion

Finally, he said, rather than asking the patient "do you have any questions?" the doctor should ask, "Now that we have discussed this, what is your understanding of your situation?" And rather than having this conversation only once, Dr. Smith said, "It should be repeated at every transition point."

He and Dr. Longo also recommend that oncologists state the patient's prognosis at the first visit, appoint someone in the office to discuss advance directives, schedule a hospice-information visit, and offer to discuss prognosis and coping at each transition.

Using this approach, practitioners in the US Oncology Network, a group of community-based oncology physicians, have doubled the time patients spend in hospice, decreased costs, alleviated patients' symptoms, reduced stress on caregivers and often lengthened survival, Dr. Smith said. Various studies have shown that cancer patients in hospice live weeks to months longer than comparable patients not in hospice care.

When doctors fail to give direct, clear information, Dr. Smith suggests that patients ask, "What is my prognosis, really? What are my options? Can I meet with the palliative care and hospice teams?" He noted, "This is the hardest conversation for doctors to have. A lot of doctors wait for someone to bring it up." If the patient does not, then a family member can initiate the needed discussion.

Aerobic Exercise Eases Breast and Prostate Cancer Fatigue

Kate Johnson Nov 14, 2012

Aerobic exercise can help relieve fatigue related to breast and prostate cancer, both during and after treatment, according to an updated review published online November 14 in the *Cochrane Database of Systematic Reviews*.

The findings suggest that aerobic exercise should "be considered as one component of a management strategy for fatigue that may include a range of other interventions and education," write review authors Fiona Cramp, PhD, and James Byron-Daniel, PhD, from the University of West England in Bristol, United Kingdom.
In the past, cancer patients were often encouraged to rest to manage their fatigue. Currently, this approach is considered counterproductive because "inactivity leads to muscle wasting and loss of cardio respiratory fitness, leading to increased fatigue," the authors write.

This review, which involved 56 studies and 4068 patients, builds on a previous review from the same researchers (*Cochrane Database Syst Rev*. 2008;2:CD006145) by differentiating the specific effects of aerobic training from other forms of exercise, and points to benefits in breast and prostate but not hematologic malignancies.

"Further work is necessary to determine the most effective parameters of exercise for fatigue management, including multimodal exercise (combined aerobic and resistance), frequency and duration of each exercise session, and intensity of exercise," Drs. Cramp and Byron-Daniel write.

"It remains to be determined whether the type of cancer treatment alters the beneficial effects of exercise on cancer-related fatigue," they note. Future research should examine a broader range of cancer diagnoses, "including patients with advanced disease and those receiving palliative care," they add.

Effects of Exercise on Cancer Fatigue
Although 2 complementary reviews have examined the role of drugs (*Cochrane Database Syst Rev*. 2010;7:CD006704) and psychosocial interventions (*Cochrane Database Syst Rev*. 2009;1:CD006953) in modifying cancer-related fatigue, "there is currently no definitive stand on exercise for cancer-related fatigue from the American College of Sports Medicine, with minimal detail given on exercise prescription in those that do recommend it," they note.

The updated review involved 28 studies from the original review and 28 from an updated literature search, which provided data on 1461 patients who received an exercise intervention and 1187 control subjects.
Although the participants had various cancer diagnoses, many were from studies of breast cancer.

The exercise interventions occurred both during and after cancer treatment. The duration of the intervention ranged from 3 weeks to 1 year, and involved aerobic activity, resistance training, or flexibility exercises.
Delivery of the intervention varied widely, from home-based to supervised programs, and intensity varied from self-pacing to regimens that involved the monitoring of heart rate and oxygen uptake.

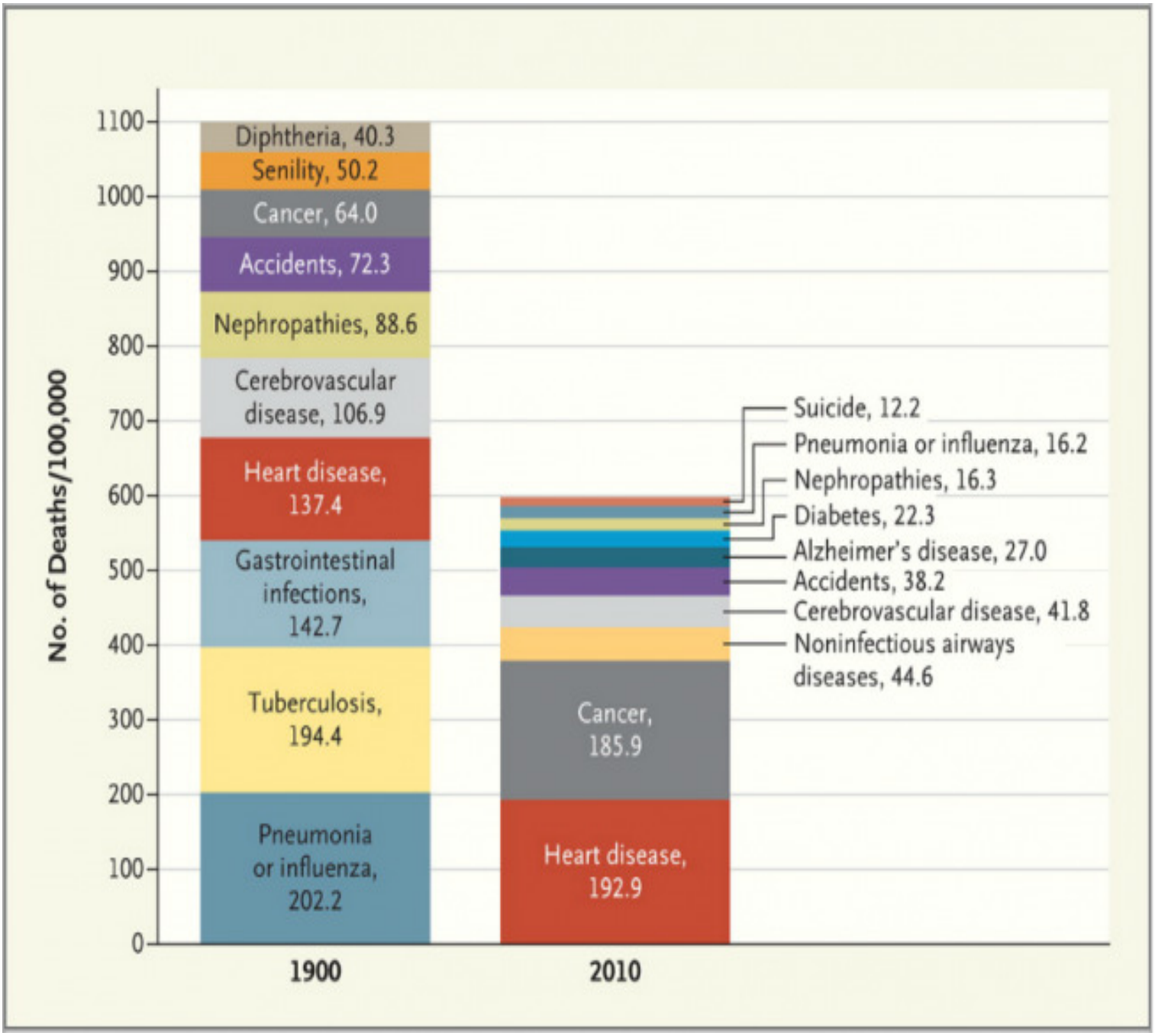
There was also a wide variation in the frequency and duration of exercise interventions. Some sessions were conducted daily and some just 2 times per week; some sessions lasted 10 minutes and others lasted 120 minutes.
For the outcome of fatigue, which was assessed using a wide range of outcome measures across studies, aerobic exercise such as walking and cycling had a statistically significant benefit over no exercise ($P = .03$).
The results of the review should not be considered in isolation, the authors note. A range of nonpharmacologic interventions can also be considered beneficial, they point out. "Interventions that may be delivered in conjunction with an exercise program include, but are not limited to, psychosocial therapies, stress management, nutrition therapy, and sleep therapy."

Update of Current Understanding
This review updates current understanding in this field, specifically pertaining to cancer trajectory, type of exercise, and particular cancers, said Margaret McNeely, PhD, an expert in cancer rehabilitation and exercise in an email to *Medscape Medical News*.

WHAT KILLS US: The Leading Causes Of Death From 1900-2010, deaths per 100,000

The New England Journal of Medicine takes a look at the leading causes of death in the U.S. from 1900 to 2010. From BusinessInsider.com
http://www.businessinsider.com/leading-causes-of-death-from-1900-2010-2012-6?op=1

The change is interesting, as is our ever-increasing longevity--something that scientists think may now reverse as a result of the global obesity epidemic.



What's going on? There are a couple of upcoming events which may occur, or have sign-up deadlines, before you receive the next Lifeline Newsletter in April. Since this is published once every three months, the fastest way to receive our news is to get on our email list. We only send out one meeting announcement or news bulletin per week. Promise! Just one fourth of those who get this mailed newsletter get emails from us. Please email to pchelp@pcsanm.org or call the office to be able to get the most current news. And be sure to check the website often www.pcsanm.org Thanks. Editor

PCSANM is affiliated with several national prostate cancer groups and other local cancer groups. We would like to tell you about some of them in upcoming issues.

One of the groups we are affiliated with is Cancer Support Now, Inc, in Albuquerque. Our Board members have taken two day peer facilitator training classes from them, two of us spoke at the last Long Term Cancer Survivorship Conference, and one of us sits on their Board.

Their second annual Long Term Cancer Survivorship Conference will be Saturday, April 6, 2013, 8 am-4 pm, at Central United Methodist Church, University near Copper, next to UNM.

The program tentatively looks like: a light breakfast, Keynote speaker, breakout sessions, at least 4 to choose from; then lunch, another Keynote speaker, breakout session, pick another one from 4 choices.

Topics they are looking at include: effect of chemo on cognitive functioning (chemo brain), caring for the caregiver, genetics panel/how BRCA testing works, a presentation from Hospice of NM, making a cancer care plan, and medical cannabis use for pain/nausea/appetite.

Registration cost is $20, which includes your light breakfast and lunch, and a years membership in CSN.

Maybe you don't need or care about any of these topics now, but might in the future.

Contact them for more info at 505-255-0405 or 1-855-955-3500 or at info@cancersupportnow.org

Take me out to the ball game.

We are looking to have a PCSANM group outing at the Albuquerque Isotopes baseball stadium at some point this spring/summer.

There would be a group rate for our tickets, and we would all sit together, and be recognized on the big screen. They would also let us have display tables in the concourse.

Now in case this happens without enough notice for the next Newsletter, and you don't get our weekly emails or check our website, www.pcsanm.org , you can get yourself, family, and friends on a tentative interest/sign up list by emailing pchelp@pcsanm.org or calling the office to let us know you are interested.

Give us your name, fastest way to contact you, how many tickets you might like, and preference on when you would like to go: evening, Sunday afternoon, or weekday businessmen's special. And if you want to do just a seat or the picnic lunch option.

Once an announcement is made, we would need to collect money asap to purchase tickets: pre-paying would be necessary, so we don't get stuck with leftover tickets.

GO ISOTOPES! GO PCSANM!

Meet some more of your PCSANM Board Members and Officers

Louis Reimer (Lou) has served on the Prostate Cancer Support Association Board of Directors for the past three years and was elected as Chairman in July 2012. In addition, Lou has been, and continues to perform the duties of Programs Chairman.

Lou is a scientist/engineer and holds a B.S. in geology degree from Rensselaer Polytechnic Institute and a M.S. in geological engineering from Colorado School of Mines. His career has covered the American West and several foreign assignments. His career has created an insatiable curiosity for how nature works. In the latter 17 years of his career he was performing environmental cleanup programs in Southern California. He is a trained hazardous waste emergency responder. To conduct these programs he was trained in physiology and the effects that various contaminants had on the human body. This work has made him aware of reactions by the human body to contaminants including those that are cancer causing. In addition to his studies at university, Lou has taken courses provided by his employers on project management for engineers, personnel management, decision making, various technical courses in his field, and health/ safety courses.

Lou was diagnosed at age 63 in 2002 with prostate cancer. He underwent 19 months of androgen deprivation therapy and has had no further signs of the cancer. During his initial treatment, he was located in Orange County in Southern California and was introduced to the local prostate cancer support group. He was amazed at the work they did in helping both the newly the diagnosed and survivors through both one-on-one support and educational programs. He moved to Las Vegas, NV where he joined another support group whose focus was mainly educational. He has brought these experiences to the Prostate Cancer Support Association of New Mexico. He began sharing ideas gleaned from his earlier experiences, and was asked to join the Board of Directors, where he eventually became Programs Chairman. He believes that education is key for the individual to be able to survive the disease. To gain a greater knowledge of this disease Lou has attended three conferences put on by the Prostate Cancer Research Institute in California. At these conferences, he has had the opportunity to hear lectures by some of the leaders in the medical profession that diagnose and treat prostate cancer; such as Dr. Patrick Walsh (surgery, Johns Hopkins), Dr. Steven Strum (medical oncologist, private practice), and Dr. Eugene Kwon (Radiation oncologist, Mayo Clinic) and a long list of others. At the conferences' break-out sessions Lou has been able to query the experts directly and has had his questions answered and has been become more knowledgeable about the disease and it's treatment.

To facilitate service for the people getting support from the Prostate Cancer Support Association, Lou has taken training as a cancer peer support Facilitator and in HIPPA compliance.

Lou is grateful for the unqualified support from Carol, his wife of 51 years. She assisted him throughout his career and especially during his battle with prostate cancer. Carol is the mother of his two children Beth (49), a physicians assistant in Denver Co, and Baird (42), general manager of a plastics plant in Fontana, Ca.

CAPT Marian L Bruce USN/RET I'm a native New Mexican born in Portales in 1937.After two years as a student at Eastern New Mexico University I joined the Navy as a Naval Aviation Cadet receiving my commission and wings as a Naval Aviator. I served in several squadrons, staffs and ship over a 26 year period. I retired after serving 6 years in the Washington DC area on the staffs of the Bureau of Naval Personnel and Chief of Naval Operations having a sub-specialty in manpower and personnel.

Upon retirement I attended University of New Mexico earning a BBA and MBA in Human Resources Management. After which I worked 7 years as Human Resources Manager for a company in Albuquerque.

In 1997 at the age of 60 I was diagnosed with prostate cancer. The diagnoses was as a result of a family doctor who recognized the rate of growth of PSA could indicate the possibility of cancer.

I contacted Prostate Cancer Support Association of New Mexico and was given expert information about treatments. After months of study and doctors visits I decided to treat with Brachytherapy in Scottsdale AZ because of the record of the doctor who performed the procedure.

I became a PCSA board member in 1998 subsequently serving 5 years as chairman and I remain on the board as Treasurer.

I am married to Dusty and we have two children and have a wonderful grandson who lives in Albuquerque. My greatest pleasure is fishing with him at every opportunity.

Carbon-11-Acetate PET/CT Imaging for Prostate Cancer: Ongoing Open Clinical Trials at Arizona Molecular Imaging Center

Fabio Almeida, MD
PCRI Weekly
Volume 3, Issue 2, June 28, 2012

Dr. Almeida spoke at our October 20, 2012 Support Group Meeting about this topic

In patients with prostate cancer, recurrence after treatment is unfortunately frequent, occurring within 10 years in 20–50% of patients after radical prostatectomy (RP), and in 30–40% of patients after external-beam radiation therapy (EBRT).

Tumor recurrence is commonly assessed by a progressive increase of serum prostate-specific antigen (PSA) that typically precedes the clinically detectable recurrence. After RP, a PSA level >0.2ng/mL, confirmed by two consecutive measures, can be associated with either residual or recurrent disease. After radiation therapy (RT), a PSA value of 2ng/mL above the nadir represents persistent or recurrent disease.

Management of recurrent prostate cancer depends strongly on whether recurrence is confined to the prostatic bed (local failure), to the regional lymph nodes in the pelvis or if distant spread has occurred. Although a trend of increasing PSA has been proposed as a way of predicting a local recurrence versus a distant recurrence, only imaging procedures are capable of discriminating between these scenarios.

Several imaging methods, including computed tomography (CT), magnetic resonance imaging (MRI) and bone scans are currently used, but none of these are very effective at detecting recurrences early enough to help select patients for salvage therapy with a curative intent.

Positron emission tomography integrated with CT, which combines the most advanced performance for both techniques, has become one of the primary tools in the restaging of cancer patients. The PET tracer 18F-FDG (fluorodeoxyglucose) is widely used for a variety of cancers, but has limitations in imaging prostate cancer. Although 18F-FDG may accumulate in aggressive and undifferentiated tumors, most prostate cancers often present with poor uptake of 18F-FDG, probably because of the high incidence of well-differentiated tumors. Furthermore, 18F-FDG is secreted into the urinary system, often interfering with pelvic pathologic findings and therefore significantly limiting its usefulness.

Among the different PET tracers that have been specifically evaluated for prostate cancer imaging, Carbon-11-Acetate (C11-Acetate) is demonstrating utility for detecting recurrent prostate cancer. Acetate is an essential component of phospholipids of the cell membrane. Cell proliferation and up-regulation of fatty-acid synthase are two mechanisms suggested for the increased uptake of this tracer in prostate cancer.

Due to recent changes in FDA regulation regarding new radiopharmaceuticals such as C11 agents, access to C11-Acetate now requires participation in an approved clinical study. The Arizona Molecular Imaging Center has worked with the FDA to open an approved Phase II clinical investigation, and is pleased to offer Carbon-11-Acetate PET/CT imaging studies for localizing recurrent prostate cancer.

Because this type of scan requires an on-site cyclotron, we are one of the few sites in the country capable of doing these studies. Currently, we are the only FDA-approved private site for C11-Acetate. Our center is also equipped with state-of-the-art PET/CT imaging, which provides an extra advantage in the detection of small lesions. Our C11-Acetate study requires only a single intravenous injection of the tracer. The imaging procedure can be completed in about 20 minutes.

Preliminary results from studies with C11-Acetate PET/CT imaging in our clinical trials have been very encouraging, and are demonstrating a direct benefit to many patients that would not be achievable with any other standard imaging technique.

Figure 1 shows an example of a positive imaging study. In over 110 patients studied thus far, the detection rate of recurrent or metastatic disease has been 85%. When separated into various PSA levels, the detection rate has been 73% for PSA 0.4 – 1.0ng/mL, 89% for 1.0 – 2.0ng/mL and 93% for > 2.0ng/mL. Most patients are still in early follow-up. However, in several patients with initial follow-up after additional therapy (radiation therapy directed toward the recurrence or metastasis), there has been a significant decrease in PSA, confirming the accuracy of the C11-Acetate imaging. There will be much more to come as we proceed with our study.

A second trial is also now open at our center for evaluating the changes in treatment decisions made based on C11- Acetate PET/CT findings. This additional study is designed for those with newly diagnosed prostate cancer to assist with initial treatment decisions, or as part of monitoring prior to other treatment.

For information about participating in these clinical trials, please visit the following links on the ClinicalTrials.gov website:

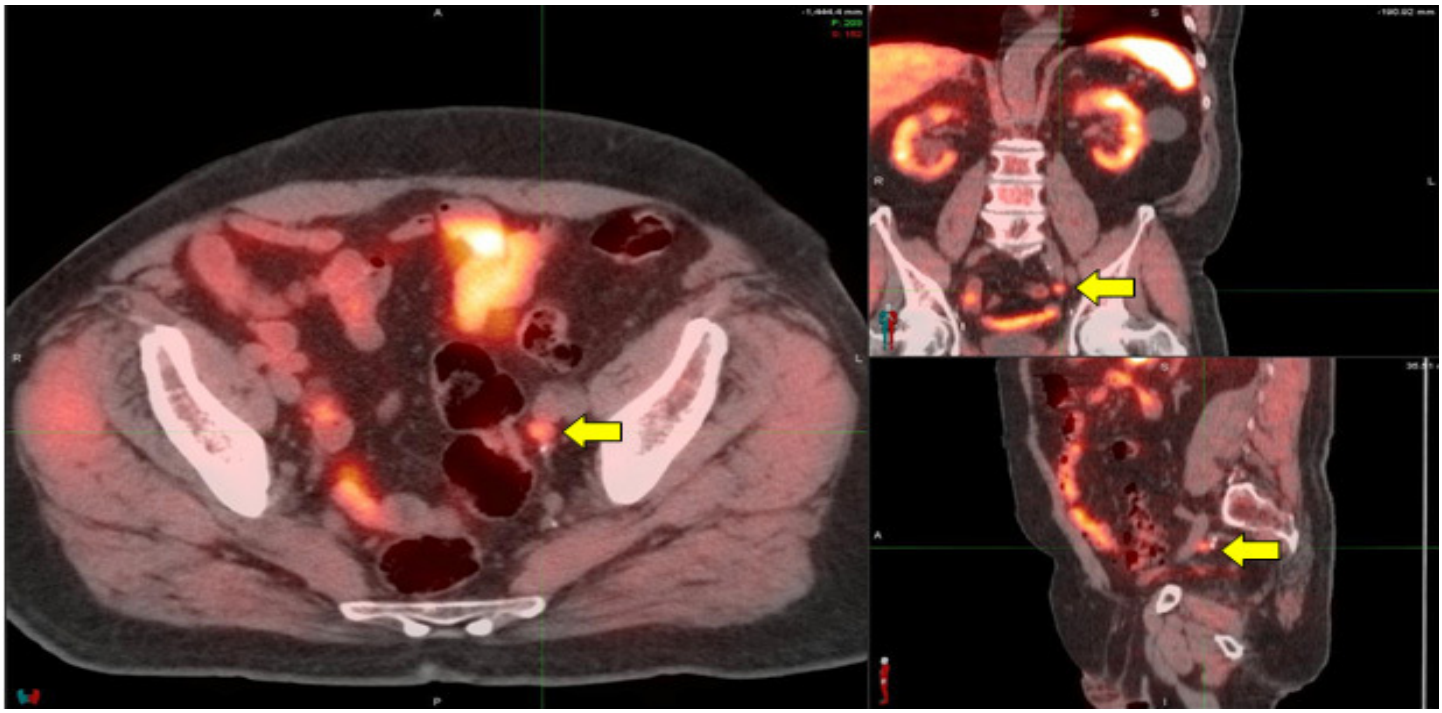
http://clinicaltrials.gov/ct2/show/record/NCT01304485

http://clinicaltrials.gov/ct2/show/record/NCT01530269

or call Dr. Fabio Almeida directly at 602.331.1771.

FIGURE 1

Gentleman with prostatectomy 10 years previously. External beam radiation 1 year previously for a rising PSA. The PSA continued to increase up to 6.9 ng/mL. The 3 dimensional Carbon-11 Acetate PET/CT images show a small metabolic lymph node in the left pelvis (yellow arrow). This would not have been diagnosed on CT alone based on its small size. Other areas of 'red' seen on the images are of normal Carbon Acetate in the intestines, kidneys, liver and spleen. No other lesions were seen. The left pelvis node was treated with IMRT and the PSA then decreased to 0.9 ng/mL, confirming involvement of the identified node.



PCSA *Lifeline* Newsletter
January 2013
Prostate Cancer Support Association
of New Mexico, Inc.
909 Virginia NE, Suite #109
Albuquerque, NM 87108

Chairman's Message, January 2013

I hope everyone has had a good holiday season. The Prostate Cancer Support Association wishes all our members well for 2013.

In the last year, the Prostate Cancer Support Association has helped 39 prostate cancer patients in-person, and 712 through telephone conversations. In addition, 103 people seeking information about prostate cancer were walk-ins at our office. In the New Year we are hoping to help more individuals with their journey through the diagnosis and treatment of this disease.

The Board of Directors takes our commitment seriously for educating New Mexico residents about prostate cancer and the options for treatment. We are working on the expansion of our services to underserved communities throughout the state while maintaining our current efforts. I ask for your support in any way you can help with "getting the word out".

I wish all our readers good health and good fortune in the New Year.

Lou Reimer
Chairman of the Board