Prostate Cancer Support Association of New Mexico

LIFELINE

PCSA Quarterly Newsletter

April 2010 Volume 17, Issue 2

Issue Highlights

We now have a new website address and e-mail so be sure to change us in your favorites and in your address book.
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TIDBITS

Reagan on Perspective
Government does not solve problems; it subsidizes them.
Ronald Reagan, 40th U.S. president

Finasteride Reduces Prostate Cancer Risks, But Which Men should Receive It?

By Roxanne Nelson
Medscape Medical News, Feb 2010

Finasteride (Proscar) reduced the risk for prostate cancer by nearly 25 % in the large Prostate Cancer Prevention Trial (PCPT), which was conducted in men 55 years and older.

Their analysis consisted of 9058 men, 1957 of whom were diagnosed with prostate cancer during the 7-year study period: 798 (18.3%) men were in the finasteride group and 1159 (24.7%) were in the placebo group. Demographic characteristics such as baseline PSA, age, race, and family history were similar in both groups.

The overall risk of being diagnosed with cancer was 21.6% and, in both groups, approximately half of all cancers were detected by a biopsy that followed an elevated PSA level and/or an abnormal digital rectal exam result.

But this finding begs the question of who to recommend the drug to, say the authors of a new analysis published online February 1 in the *Journal of Clinical Oncology*.

Despite the encouraging findings of the PCPT, the use of finasteride to prevent cancer in the community remains low and is not widely used, explained lead author Andrew Vickers, PhD, associate attending research methodologist at Memorial Sloan-Kettering Cancer Center in New York City.

"This suggests that, for the average man, the benefits of finasteride, in terms of reduced risk, do not outweigh the harms," he told *Medscape Oncology*.

The analysis conducted by Dr. Vickers and colleagues found that risk-group stratification for treatment with finasteride is "unlikely to be beneficial for preventing all prostate cancers detectable at biopsy." But if cancers found as a result of routine clinical care are used as an end point, then the optimal strategy would be to treat a subgroup of men at high risk rather than the whole at-risk population, they write.

The interpretation of these results, in relation to whether finasteride should be used as chemopreventive therapy for all men or for only those at higher risk, depends on the relative clinical significance of cancers found during the end-of-study biopsy, the authors explain.

Basically, clinicians should recommend finasteride to all men if they want to reduce the risk for any biopsy-detectable prostate cancer.

However, "clinicians who believe that it is unnecessary to prevent all cancers, but that preventing those readily detectable by screening is desirable, would be best off recommending finasteride only to a high-risk subgroup," they write.

(Continued on page 5)

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In Memory of

Morry Sheehan
Wayne Reynolds
Joe E. Chavez

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. We meet at the Bear Canyon Senior Center, located at 4645 Pitt NE (on Eubank go one block north from Montgomery - Right (East) on Lagrima De Oro - Left (North) on Pitt to Senior Center).

PCSA *Lifeline*

A quarterly newsletter addressing issues of prostate cancer

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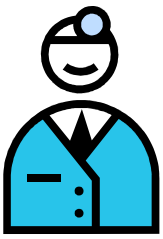

Dr. Lindberg's Report: 6 Bits of Good News, and A Little Bad From the AUA Meeting In San Francisco 3/6/10

Dr. Peter Lindberg

(1) At the recent prostate cancer symposium, the sipucel-t vaccine trial was reviewed. Patients lived significantly longer who received the freshly prepared (not frozen reconstituted product) treatment completed in a little over one month. There were minimal side effects, 15% had already failed taxotere chemotherapy. Most men had mild to no cancer symptoms before therapy. It is probable that the FDA will approve the vaccine and it will be available by the end of 2010.

(2) Carbazitaxel (who has ever heard of it???) is a next generation taxane, a "cousin of taxotere". In a large clinical trial, this drug, in combination with prednisone, was proven to improve survival significantly when given to patients who had failed taxotere (also known as docetaxol). This is the first proven second line therapy that reduces the death-hazard ratio by at least 30% (editorial comment - statistics are not my strong suit). The FDA may give approval in 2010.

(3) Avastin is an expensive intravenous "biologic" medication that blocks blood vessel growth and supply to cancers and is approved to treat breast, and colon cancer. A large phase 3 trial (with big numbers and half of the subjects do not get the drug) has been completed and results have been calculated according to my informed sources, Nancy Dawson and Tia Higano (University of Washington and both VIPs in prostate cancer academic circles). If this big trial shows clear-cut benefits in preventing death when the final results are reported at the American Society of Clinical Oncology meeting on June 10, this third drug may be approved for prostate cancer treatment. All three drugs reported having very tolerable side effects and look safe when considered in the context of what are probably fatal cancer (benefit vs. risk).

(4) Now, for the bad news. I expected arbiterone to be available this year but now it looks like late 2011 at the earliest. Also, mdv3100 might be unavailable until 2013 or 2014. These drugs are hormone-type treatments that are very powerful when first-line hormones Lupron, Eligard, Casodex, Zoladex, etc. fail. At this time, oral estrogen, ketoconazole, and estrogen patches are my second line treatment and these new drugs will add to our hormonal therapy greatly and allow a lot more time before we are forced to offer chemotherapy. Plus, maybe if it is taken early enough, it will really prolong disease control (not cure). Dr. Clark Haskins and his oncology partners now are offering mdv3100 to men who have failed chemotherapy and who have not been on much ketoconazole (ie keto was stopped for side effects). I believe the group will be split at 2/3 getting the mdv3100 and 1/3 getting a sugar pill. We are testing whether this new pill can prolong life compared to a placebo is this situation. Dr. Haskins can be reached at 505-842-8171 in Albuquerque. So maybe some good news here.

(5) News - If hormone therapy is needed, Dr. Matthew Smith from Harvard offered data at the San Francisco meeting that shows no cardiac reason to hold off on hormonal therapy, if needed. Data does show, however, that hormonal therapy for prostate cancer does bring on type 2 diabetes. Avoid this situation by watching your diet and your weight and, of course, EXERCISE. Nevertheless, the data does not show a large increase in heart disease.

(6) ALSO concerning the PSA testing. The first PSA should be done at age 40. Men under 50 should have a biopsy done if their PSA is more than 1.5. Dr. Eric Klein, Chief of Urology at Cleveland Clinic, recommends a biopsy when a PSA is over 1.5 and the man's age is 45 or under. Finally, be certain that, if you are diagnosed with prostate cancer, to find out if it really needs treatment. Get a second pathology opinion by Bostwick Labs in Richmond, Virginia or at Johns Hopkins with Dr. Epstein. If your Gleason score is 6 or less, PSA is low, and there is no lump, ask for ki-67 pathology testing. A second opinion from a radiation oncologist would also be advised.

Live long and prosper as Dr. Spock from Star Trek and Dr. Lindberg from Out There would say.

Transition From Pure Laparoscopic to Robotic-Assisted Radical Prostatectomy: A Single Surgeon Institutional Evolution—Abstract

Dept of Urology, Kimmel Cancer Center
UroToday February 2010

To review a single surgeon experience of transitioning to a robotic-assisted laparoscopic prostatectomy program (RALP) with prior pure laparoscopic radical prostatectomy (LRP) experience.

A retrospective review of surgical results from a single surgeon performing LRP transitioning to RALP was performed. Two hundred five patients undergoing RALP by a single, fellowship-trained, urologic oncologist were analyzed and compared with 45 patients undergoing LRP by the same surgeon. Operative, pathologic, and functional outcomes were evaluated. Validated questionnaires, including the International Prostate Symptom Score (IPSS) and International Index of Erectile Function (IIEF), were utilized for assessing urinary and sexual parameters.

Preoperative parameters (age, PSA, Gleason score) were similar in both RALP and LRP groups. Operative time (190 vs. 299 minutes), estimated blood loss (253 vs. 299 ml), and length of stay (1.6 vs. 2.6 days) were reduced in RALP vs. LRP. Although not statistically significant, there was a trend toward fewer transfusions with RALP (2.0% vs. 4.4%) as well as a lower positive margin rate in organ-confined (pT2) disease (9.8%, RALP vs. 20%, LRP). Continence at 12 months was 94% following RALP as opposed to 82% after LRP. In preoperatively potent men undergoing bilateral nerve sparing procedures, RALP conferred 81% potency at 12 months as opposed to only 62% following LRP.

Tidbits

IBD 8 February 2010

Andrews On Drive

Perseverance is failing 19 times and succeeding the 20th. - **Julie Andrews**, *actress*

Glasgow On Selectivity

All change is not growth, as all movement is not forward. - **Ellen Glasgow**, *novelist*

Overweight? It's Your MOVE!

health trends
Vol 15 Iss 1

If you're overweight or obese, you're at increased risk for health problems, including heart disease, diabetes, some cancers, sleep apnea and gallstones. To help you achieve and maintain a healthy lifestyle, the VA offers a program called MOVE!, which stands for Managing Obesity/ Overweight for Veterans Everywhere.

The MOVE! program has been tailored to meet the individual needs of each Veteran, and provides guidance on nutrition and physical activity. Your MOVE! healthcare team at your local VA medical center will provide you with lots of support and follow-up.

Tucson residents, Dorothy Stump and her husband John, are Veterans who have experienced the benefits of participating in the MOVE! program. Dorothy served as a nurse in the U.S. Army and John is a Marine Corps Veteran. "We were overweight," says Dorothy, "and our primary care physician at the Southern Arizona Health Care System recommended the MOVE! program. It was great advice, and we've each lost about 60 pounds."

When asked how difficult it was, she replied, "It wasn't that hard. There are really good guidelines and we got lots of support which made it easy. It was a great experience and we have a much better and more active lifestyle now."

Surgeons Now Won't Miss A Beat

IBD
14 December 2009

New robotic technology can predict the heart's movement as it beats, enabling surgical tools to move in concert with each beat, says a report in the *International Journal of Robotics Research*. This means a surgeon can perform a procedure as if the heart weren't moving. The advance may provide big benefits for millions of people who need less-invasive heart surgeries, where stopping the beating would cause unnecessary risk. It's the first successful attempt to effectively isolate movements of the heart and lungs during surgery.

(Continued from Page 1)

Finasteride

Balancing Benefit and Harms

The primary adverse effect associated with finasteride is decreased sexual function, the authors explain. Even though this effect is generally mild, the reduction in libido can be experienced immediately. Conversely, men at higher risk have a greater potential benefit from finasteride. Therefore, note the authors, a strategy that focuses on high-risk men might tip the balance between the benefits and harms of finasteride in favor of treatment.

Osteoporosis: Vitamin D is Key

USA Weekend

Experts estimate that 10 million Americans—8 million women and 2 million men—already have osteoporosis, and nearly 34 million have low bone mass that puts them at risk of bone loss. New research from Johns Hopkins demonstrates that vitamin D, a supplement recommended by doctors to prevent and treat osteoporosis, delivers an extra benefit: A study of 1,010 men showed that adequate levels of vitamin D not only helps prevent and treat osteoporosis but also may help prevent heart disease. Both men and women can increase their vitamin D levels by eating fatty fish (salmon, tuna, mackerel) and vitamin D-fortified dairy products, taking vitamin D supplements, and briefly exposing skin to sunlight strong enough to enable the body to make vitamin D. A blood test to check your vitamin D level should show that your is more than 30 nanograms per milliliter.

Testosterone does not cause aggression, contrary to popular wisdom, a study by the Univ. of London Royal Holloway found. The study examined 120 people who were given a dose of 0.5 mg. of testosterone or a placebo. The group receiving testosterone acted no differently than those who received placebos. It is not testosterone but the myth surrounding the hormone, the researchers said.

Scanner Pinpoints Prostate Cancer

Newsmax Health
28 January 2010

U.S. researchers have found a way to pinpoint where in the prostate a tumor may be hiding by using an imaging technique that measures the chemical composition of tissues.

Although the research is in its early stages, the finding may lead to a better way for doctors to diagnose prostate cancer.

A team at Massachusetts General Hospital in Boston used magnetic resonance spectroscopy, which analyzes the biochemistry rather than the structure of tissues.

"It detects tumors that cannot be found with other imaging approaches and may give us information that can help determine the best course of treatment," said Leo Cheng of Mass General, whose study appears in the journal Science Translational Medicine.

Blood tests that screen for prostate-specific antigen or PSA can suggest cancer, but benign growths can generate excess PSA, too. Currently doctors have no imaging test that can confirm the size of location of tumors within the prostate, or tell how aggressive they might be.

Prostate biopsies are done "blind" and can easily miss a tumor.

CT to Reduce Radiation Exposure

by IBD
1 March 2010

A new CT scan technology could cut patients' radiation exposure up to 90% compared with regular CT scans, a Columbia University study found. With regular CT scanning, numerous X-ray beams and a set of X-ray detectors rotate around the patient. The new technology can, for example, image the heart in a single rotation within a single heartbeat. By imaging the entire heart in one picture, the X-ray tube is left on briefly - as little as 0.35 second.

Astaire on Behavior

The hardest job kids face today is learning good manners without seeing any.
Fred Astaire, dancer

Adams on Education

Let us tenderly and kindly cherish, therefore, the means of knowledge. Let us dare to read, think, speak, and write.
John Adams, 2nd U.S. president

Be Cautious About Giving Info to Census Workers from the BBB

by Susan Johnson

With the U.S. Census process beginning, the Better Business Bureau (BBB) advises people to be cooperative, but cautious, so as not to become a victim of fraud or identity theft. The first phase of the 2010 U.S. Census is under way as workers have begun verifying the addresses of households across the country.

The big question is - How do you tell the difference between a U.S. census worker and a con artist?
BBB offers the following advice:

- If a U.S. Census worker knocks on your door, they will have a badge, a handheld device, a Census Bureau canvas bag, and a confidentiality notice. Ask to see their identification and their badge before answering their questions. However, you should never invite anyone you don't know into your home no matter how cold it may be. Get a coat so you can stand outside with them during the questions.
- Census workers are currently only knocking on doors to verify address information. Do not give your social Security number, credit card or banking information to anyone, even if they claim they need it for the U.S, Census.

REMEMBER, NO MATTER WHAT THEY ASK, YOU REALLY ONLY NEED TO TELL THEM HOW MANY PEOPLE LIVE AT YOUR ADDRESS.

- While the Census Bureau might ask for basic financial information, such as salary range, YOU DON'T HAVE TO ANSWER ANYTHING AT ALL ABOUT YOUR FINANCIAL SITUATION. The Census Bureau will not ask for Social Security, bank account, or credit card numbers, nor will employees solicit donations. Any one asking for that information is not with the Census Bureau.
- Eventually, Census workers may contact you by telephone, U.S. mail, or in person at home. However, the Census Bureau will not contact you by e-mail, so be on the lookout for e-mail scams impersonating the Census. Never click on a link or open any attachments in an e-mail that are supposedly from the U.S. Census Bureau.

Degas on Expression
Art is not what you see, but what you make others see.
Edgar Degas, artist

Cancer-Related Communication, Relationship Intimacy, and Psychological Distress Among Couples Coping with Localized Prostate Cancer - Abstract

Fox Chase Cancer Center
UroToday 30 December 2009

The present study evaluated intimacy as a mechanism for the effects of relationship-enhancing (self-disclosure, mutual constructive communication) and relationship-compromising communication (holding back, mutual avoidance, and demand-withdraw communication) on couples' psychological distress.

Seventy-five men diagnosed with localized prostate cancer in the past year and their partners completed surveys about communication, intimacy, and distress.

Multi-level models with the couple as a unit of analyses indicated that the association between mutual constructive communication, mutual avoidance, and patient demand-partner withdraw and distress could be accounted for by their influence on relationship intimacy. Intimacy did not mediate associations between self-disclosure, holding back, and partner demand-patient withdraw communication and distress.
These findings indicate that the way in which couples talk about cancer-related concerns as well as the degree to which one or both partners avoid talking about cancer-related concerns can either facilitate or reduce relationship intimacy, and that it is largely by this mechanism that these three communication strategies impact psychological distress.

Relationship intimacy and how patients and partners communicate to achieve this intimacy is important for the psychological adjustment of early stage prostate cancer survivors and their partners.

Breast Cancer Gene

Cancer Genetics Network 2009 Newsletter
(Journal of Genetic Counseling)

A recent study by researchers at Fox Chase Cancer Center in Philadelphia found that men with BRCA mutations are unaware of their cancer risks. BRCA+ men have the same chance (50%) as women of passing the mutation to their children. These men are at an increased risk for melanoma, prostate, pancreatic , and male breast cancer. If men have many family members with breast or ovarian cancer (diagnosed before age 40), they should talk to their physician and possibly consider genetic counseling.

Tumor Percent Involvement Predicts Prostate Specific Antigen Recurrence After Radical Prostatectomy Only In Men With A Smaller Prostate - Abstract

Division of Urologic Surgery and Duke Prostate Center
UroToday 4 February 2010

We determined the predictive power of tumor percent involvement on prostate specific antigen recurrence in patients when stratified by prostate weight.

Data on 3,057 patients who underwent radical prostatectomy between 1988 and 2008 was retrieved from our institutional prostate cancer database. Patients with data on tumor percent involvement, prostate volume and prostate specific antigen recurrence were included in analysis. Patients were divided into 3 groups based on prostate volume less than 35, 35 to 45, and greater than 45 cc. The variables tumor percent involvement, age at surgery, race, prostate specific antigen, pathological Gleason Score, positive surgical margins, extraprostatic extension, seminal vesicle invasion and surgery year were analyzed using the chi-square and Mann-Whitney tests to determine individual effects on prostate specific antigen recurrence. Tumor percent involvement and prostate specific antigen were evaluated as continuous variables. Significant variables on univariate analysis were included in multivariate Cox regression analysis to compare their effects on prostate specific antigen recurrence.

Tumor percent involvement significantly predicted prostate specific antigen recurrence in men with a small prostate ($p=0.006$) but not in those with a prostate of greater than 35 cc. Black race was a marginally significant predictor of prostate specific antigen recurrence in men with a medium prostate ($p=0.055$). Age at surgery was a predictor of prostate specific antigen recurrence in men with a larger prostate ($p=0.003$). Prostate specific antigen, positive surgical margins, seminal vesicle invasion and pathological Gleason score 7 or greater predicted prostate specific antigen recurrence in men with all prostate sizes.

In men with a prostate of less than 35 cc tumor percent involvement is an important variable when assessing the risk of prostate specific antigen recurrence. Tumor percent involvement and prostate volume should be considered when counseling patients and determining who may benefit from heightened surveillance after radical prostatectomy.

Catherine II (the Great), empress of Russia
I praise loudly. I blame softly.

An Update Of The Gleason Grading System - Abstract

Johns Hopkins School of Medicine
UroToday 4 January 2010

An update is provided of the Gleason grading system, which has evolved significantly since its initial description.

A search was performed using the MEDLINE ® database and referenced lists of relevant studies to obtain articles concerning changes to the Gleason grading system.

Since the introduction of the Gleason grading system more than 40 years ago many aspects of prostate cancer have changed, including prostate specific antigen testing, transrectal ultrasound guided prostate needle biopsy with greater sampling, immunohistochemistry for basal cells that changed the classification of prostate cancer and new prostate cancer variants. The system was updated at a 2005 consensus conference of international experts in urological pathology, under the auspices of the International Society of Urological Pathology. Gleason score 2-4 should rarely if ever be diagnosed on needle biopsy, certain patterns (ie poorly formed glands) originally considered Gleason pattern 3 are now considered Gleason pattern 4 and all cribriform cancer should be graded pattern 4. The grading of variants and subtypes of acinar adenocarcinoma of the prostate, including cancer with vacuoles, foamy gland carcinoma, ductal adenocarcinoma, pseudohyperplastic carcinoma and small cell carcinoma have also been modified. Other recent issues include reporting secondary patterns of lower and higher grades when present to a limited extent, and commenting on tertiary grade patterns which differ depending on whether the specimen is from needle biopsy or radical prostatectomy. Whereas there is little debate on the definition of tertiary pattern on needle biopsy, this issue is controversial in radical prostatectomy specimens. Although tertiary Gleason patterns are typically added to pathology reports, they are routinely omitted in practice since there is no simple way to incorporate them in predictive nomograms/tables, research studies and patient counseling. Thus, a modified radical prostatectomy Gleason scoring system was recently proposed to incorporate tertiary Gleason patterns in an intuitive fashion. For needle biopsy with different cores showing different grades, the current recommendation is to report the grades of each core separately, whereby the highest grade tumor is selected as the grade of the entire case to determine treatment, regardless of the percent involvement. After the 2005 consensus conference, several studies confirmed the superiority of the modified Gleason system as well as its impact on urological practice.

PCSA *Lifeline* Newsletter
April 2010
Prostate Cancer Support Association
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Chairman's Corner

In an article published in the Opinion section of the New York Times newspaper, March 9, 2010, Dr. Richard J. Ablin wrote that money is being wasted in early screening for prostate cancer. Dr. Ablin is the discoverer of PSA. The discovery was made in 1970 and approved by the FDA in 1994, according to the Times.

My cancer was found as a result of routine PSA screening during my annual physical. After the second increase in PSA level a biopsy was done and cancer discovered. That started me on my search for a treatment protocol that met my life plans. I insisted my son, age 47, be screened and he too was found to have PC and has been successfully treated, non-surgically.

I want to make an analogy between PC and blood pressure. As part of most visits to our doctors our blood pressure (BP) is tested and recorded. When our doctor notices an increase in our BP he will monitor that condition carefully and may prescribe a BP medicine to control a life-threatening condition. Simply put, blood pressure measurements and PSA values are used by our physicians to monitor our health. Why should one be declared unimportant or not cost effective and not the other?

As advocates of good prostate health, we at PCSANM suggest that men have their PSA tested on a regular basis, keep a personal record of each test. In the event that it increases too rapidly the man and his doctor can use that record to make an informed decision for treatment. I personally consider monitoring our health conditions to be smart and the best preventative medicine available.

Do not be surprised if our health insurers begin to restrict payment for PSA screening using this and similar reports as their rationale for cutting costs.

The Times article can be found at:
www.nytimes.com/2010/03/10/opinion/10Ablin.html

Good Health to All,

Robert Wood, Chairman, PCSANM