Prostate Cancer Support Association of New Mexico

LIFELINE

PCSANM Quarterly Newsletter July 2013 Volume 20, Issue 3

Issue Highlights

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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.

The Prostate Screening Guidelines Debate goes on.

Here are the latest guidelines from the American Urological Association. A very lengthy article and details can be seen here:

http://www.auanet.org/education/guidelines/prostate-cancer-detection.cfm

Guideline Statement 1: The Panel recommends against PSA screening in men under age 40 years. (*Recommendation;* Evidence Strength Grade C)
In this age group there is a low prevalence of clinically detectable prostate cancer, no evidence demonstrating benefit of screening and likely the same harms of screening as in other age groups.

Guideline Statement 2: The Panel does not recommend routine screening in men between ages 40 to 54 years at average risk. (*Recommendation;* Evidence Strength Grade C)
For men younger than age 55 years at higher risk (e.g. positive family history or African American race), decisions regarding prostate cancer screening should be individualized.

Guideline Statement 3: For men ages 55 to 69 years the Panel recognizes that the decision to undergo PSA screening involves weighing the benefits of preventing prostate cancer mortality in 1 man for every 1,000 men screened over a decade against the known potential harms associated with screening and treatment. For this reason, the Panel strongly recommends shared decision-making for men age 55 to 69 years that are considering PSA screening, and proceeding based on a mans values and preferences. (*Standard;* Evidence Strength Grade B)
The greatest benefit of screening appears to be in men ages 55 to 69 years.

Guideline Statement 4: To reduce the harms of screening, a routine screening interval of two years or more may be preferred over annual screening in those men who have participated in shared decision-making and decided on screening. As compared to annual screening, it is expected that screening intervals of two years preserve the majority of the benefits and reduce overdiagnosis and false positives. (*Option;* Evidence Strength Grade C)
Additionally, intervals for rescreening can be individualized by a baseline PSA level.

Guideline Statement 5: The Panel does not recommend routine PSA screening in men over age 70 years or any man with less than a 10 to 15 year life expectancy. (*Recommendation;* Evidence Strength Grade C)
Some men over age 70 years who are in excellent health may benefit from prostate cancer screening.

FOUNDER Rae Shipp, established 1991

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In Memory of

Vernon "Hank" Kerr

Andrew F. Rutkiewic

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

Dr. Peter Lindberg, MD
Northern New Mexico Cancer Care
Dr. Lindberg is accepting new patients
Call (505)662-3450 for an appointment

When hormonal therapy is indicated to treat prostate cancer, how should it be given? Options include 1. Blocking testosterone production by giving a lhrh agonist like lupron or trelstar or zoladex plus bicalutamide for only several weeks to block testosterone "flare", 2. Using an lhrh antagonist Firmagon which cause no temporary increase in testosterone, or 3. The very popular Orchiectomy to remove the testicles and thereby stop testosterone production.

Use of any of these treatments may be "ok" for men with far advanced prostate cancer psa of >100 and more than 5 bony mets. Disease at this late stage is already somewhat resistant to hormone treatment and adding a second drug may not help much.

Studies done in the 1990s showed only slight improvement when a single agent was combined with a "anti-androgen" such as bi calutamide. On this basis many, most?, urologists or oncologists give single agent therapy. They have applied these findings from men with far advanced disease to those men whose psa is rising quickly but do not yet have clear-cut bone or other metastatic disease. The c-11 choline scan or acetate Pet scan just recently used can find the site of the cancer when the above tests are "negative".

Since a significant portion of the DHT (diHydrotestosterone) inside the prostate cancer cell comes male adrenal hormones like DHEA, I believe it makes sense to do a maximum attack on the cancer with combined lupron(or Firmagon)+ a maximal dose of Casodex (bicalutamide) 150 mg. to kill cancer cells before they become resistant to hormone therapy.

DHT can also be reduced through the use of finasteride or avodart. Avodart or Proscar blocks the enzyme that converts testosterone and other male hormones into DHT. As far as potency is concerned DHT is about 15 times stronger than testosterone in causing cancer cells to grow divide and spread(metastasize). I have used triple therapy® since 1997 and through the use of continued treatment with avodart made it possible for men to remain off hormones, have a return of testosterone to normal and still have excellent cancer control-live a normal life. I try to get the psa to 0, and do not consider 0.1 or 0.2 good enough to stop the hormone part of the treatment. Avodart as mentioned above does NOT lower testosterone only DHT. A few men on this treatment plan have gone for 9-10 years without needing further hormone treatment after just one 1 year cycle. But I believe most will need a second round of hormones at 24-30 months. I am currently treating a man who has been treated off and on with hormone agents for 15 years, still no mets in his bones.

A large 16 year study of men who had bone mets before starting any hormone treatment demonstrated better survival by an average of 8 months with continuous hormone treatment, most men who have more than a few mets, will require continuous hormonal therapy. If psa drops below 0.05 maybe could try intermittent therapy using avodart in the off treatment period. One other form of hormone therapy that I have used is peripheral androgen blockade with just Casodex 150mg+avodart +radiation to breast at the start to prevent breast soreness. This regime does NOT DECREASE testosterone. I am not able to get the psa to 0 with this therapy but it can be considered especially if previous experience with lupron has been very rough. Zytiga is often given when first line hormone treatment described above fails, but I have quite a few men who have had excellent prolonged cancer control with some form of estrogen.

Ethinyl estradiol is a compounded agent but now almost impossible to get. A drug called diethylstilbestrol can be substituted or maybe vivelle 0.1 mg patch about 14 patches per week on the skin. For those who are skeptical of avodart, the Redeem trial shows benefit in men on active surveillance of their cancer. Also in men who are having a rising psa after failing curative surgery or radiation or both, avodart prolongs the psa doubling time AND SLOWS the progression of the cancer- a European trial showed. Addenda: The reason for "triple therapy lupron+casodex 150mg. +avodart is to reduce all forms of male hormone inside the cancer cell.

New Test Improves Assessment of Prostate Cancer Risk, Study Says

By Andrew Pollack NY Times May 8, 2013

A new test can help distinguish aggressive prostate cancer from less threatening ones, potentially saving many men from unneeded operations for tumors that would never hurt them, researchers are reporting.

The test, developed by Genomic Health, could triple the number of men who could confidently monitor their tumors rather than undergo surgery or radiation treatments, according to the company and to researchers.

Results of a study assessing the test's performance will be presented Wednesday at the annual meeting of the American Urological Association in San Diego.

Many of the 240,000 cases of prostate cancer diagnosed each year in the United States are considered to pose a low risk of hurting or killing the man. But sometimes those assessments are wrong. So many men, reluctant to take the chance, undergo treatments that can cause impotence and incontinence.

"It's very hard to tell a surgeon 'I'd like to leave a cancer in place,' " said Dr. Jonathan Simons, president of the Prostate Cancer Foundation, a research and advocacy organization. "Having objective information is going to help a lot of patients make that decision."

Dr. Simons, who was not involved in the study, said the development of new genetic tests like the one from Genomic Health represented a "watershed," akin to going from pulse rate measurements to electrocardiograms in cardiology.

Still, some experts said it was too early to assess how accurate the test really was and whether it would make a difference in men's decisions. Insurers are going to want to know that before deciding to pay for the test, which will be available starting Wednesday at a list price of $3,820.

Even the senior investigator of the study, Dr. Peter R. Carroll, said he was not sure.

"Certainly for a group of men it will have an impact," Dr. Carroll, who is chairman of urology at the University of California, San Francisco, said in an interview. "The question is how many men and how many physicians."

The new test, which is called the Oncotype DX Prostate Cancer Test, is one of more than a dozen coming to market that use advanced genetic methods to help better manage prostate cancer. The most direct competitor to the Oncotype test is likely to be the Prolaris test, I introduced last year by Myriad Genetics.

But Genomic Health's test has attracted attention because of the company's track record. It already sells a similar test for breast cancer, also Oncotype DX, that is widely used to help women decide whether they can forgo chemotherapy after their tumor is surgically removed.

Some analysts say that with the breast cancer test facing intensified competition, the company's future growth could hinge on the prostate test, which could take time to gain acceptance. Genomic Health's stock closed Tuesday at $33.87, up 1 percent.

The test looks at the activity level of 17 genes in the biopsy sample and computes a score from 0 to 100 showing the risk that cancer is aggressive.

To see how well the test worked, testing was performed on archived biopsy samples from 412 patients who had what was considered low or intermediate-risk cancer but then underwent surgery.

In many such cases, the tumor, which can be closely studied after it is surgically removed, turns out to be more aggressive than thought based on the biopsy, which looks at only a tiny sample of the tumor.

The researchers found that the Oncotype test predicted such unfavorable pathology more accurately than existing methods, which depend mainly on the Gleason score based on how the biopsy sample looks under the microscope.

Genomic Health said that 26 percent of the samples were classified as very low risk by its test, compared to only 5 to 10 percent for the existing methods. In some cases, however, the new test showed the cancer to be more aggressive than the existing methods. (Continued)

Some experts not involved in the study were cautiously optimistic.

"They showed a pretty good correlation with the score and how it predicts things," said Dr. E. David Crawford, a professor of urology, surgery and radiation oncology at the University of Colorado. He has consulted for Myriad Genetics and said he might become a consultant to Genomic Health.

Dr. Stacy Loeb, assistant professor of urology at New York University, said, "I think it will help — they definitely showed it improves upon what we are using now." She said it was not clear, however, how the Genomic Health and Myriad tests compared to each other.

The 2013 Family Caregiver Resource Guide has just been put out by the Bernalillo County Department of Senior Affairs. It is available at some doctor offices and clinics, senior centers, and some major grocery stores. It is also available online here:

http://issuu.com/starlineprintingcompany/docs/the_2013_fcg_w-gatefold-new?mode=window&proSidebarEnabled=true&backgroundColor=%23222222

Editor: We could use the support of all our membership in many ways.

If you have any topics or speaker ideas for meetings and programs, please let us know.
Email to pchelp@pcsanm.org

If you have run across any good news items from newspapers, magazines, or internet, please let us know about it. We are always looking for new material to share in emails, or put on website, Facebook, or in the newsletter. If you would like to write an article for us, please do so and send it in.

Please sign up for our quarterly Lifeline newsletters to be emailed to you after they are published and mailed. Then you can share it with family, friends, and others. All the websites posted in the newsletter are hyperlinked, so you can just click on them to read original articles. And the pictures/graphs are in color!

We promise only one email meeting announcement or news email a week. Only about one/third of our membership has provided us email addresses.

Go to our website often for the most current info on office hours, meetings, and current news postings.
www.pcsanm.org

Look at, or get the younger members of your family, to LIKE our Facebook page. You do not have to be a Facebook member to see our page, you just can't comment.
https://www.facebook.com/ProstateCancerSupportNM

Come in to the office to visit, ask questions, borrow library books, and tell anyone you know who is newly Diagnosed about us.

Share our organization's info with work colleagues, your social groups, churches, etc. We are always willing to go out and make presentations to organizations, and exhibit at health fairs.

Attend our twice a month support group meetings from time to time. Programs are very good, and we all share good info with each other.

PCSANM was founded in 1991 by Rae Shipp, in an effort to learn about and share information with other NM Prostate Cancer survivors. He passed away in late 1997.

One of our Facebook friends is Samie Trimble, his granddaughter. She mentioned once to the Editor that she remembers folding and labeling the newsletters on the kitchen table at his house with his family. I asked her if she, and or her mother and grandmother would like to write something about their experiences back then, and give an update on what their family has done since. Samie is married to an Air Force sergeant, and lives at Dyess AFB, Texas. She has 2 daughters, Briley age 4, and Edie Rae, about 2. She is studying Education at Cisco Junior College, and is a composer/singer.

I was eight years old when my grandfather, Vonrae (Rae) Shipp passed away from Prostate Cancer. I didn't know him very well. I was too young and ornery at the time to understand what an important man he was to so many. I do know that Rae was a war veteran, a talented painter, and a family man. He also worked with The Bureau of Indian Affairs and did wonderful things to help Native Americans, designing homes and schools for them. Now that I'm older, I wish I had realized what a remarkable man he really was but I sure know now.

I remember turning up my nose at his funny smelling green drink and the handful of big bulky vitamins that he took every day. Rae lived for 12 years after his diagnosis with Prostate Cancer. Within my family now, nutrition is very important. My husband and I try to eat well, juice raw fruits and vegetables, and take vitamins and supplements. We're raising our children to understand the importance of nutrient-filled foods. Grandpa was really on to something with his research and knowledge of nutrition and exercise. His will power astounds me and I look back and know that there were feats overcome in my own life that must have something to do with being his granddaughter. I can only hope. I have two children now. The oldest is 4 and her name is Briley Renee. The youngest is named Edith VonRae, after him and my grandmother. Both of my grandparents are people that have made this world a better place and I am proud to be apart of that.

When I was a little girl, I would go with my mother and fold hundreds of pamphlets and newsletters for the men in the group. By then, the number had grown to over five hundred members. My grandfather was a beacon of hope to so many men and their families. I am so glad that the group is still growing strong and that men are getting the support they need through such unimaginably hard times in their lives. My grandfather never gave up hope and he fought as hard as he could for others while he himself was going through it. His energy and positivity was such an inspiration for so many. I hope that the group continues to help many people for years to come.

When my grandfather passed away, there were over three hundred fifty people at his funeral. I tried to squeak out "You Are My Sunshine" through the tears. I didn't understand just how loved and respected he was until I stood on stage and saw the enormity of people standing, packed in the church, to honor him. After the service, I was lying on my grandmother's lap in the limo, holding a single red rose and looking out the window. As we drove away, I looked up into the sky. The clouds looked like a staircase and I could see him turn around at the top and wave to me. I was in shock of what I saw and unsure if it was real or if I had lost it but I felt such happiness and serenity come over me. I'll never forget that, such an odd but beautiful moment in life where you feel as if you're so small and so unknowing.

I wish the very best to each and every man and their family going through Prostate Cancer. I know that my grandfather would be proud all of the members. Rae was as example of what one person can do, despite having cancer, and he believed in everyone joining together to help each other. The people around you are what get you through. Never stop hoping, learning, fighting.

All of my love and faith to you all,
Samantha Trimble

Rae Shipp's daughter is Lisa Hansen. She works at Albuquerque Health Partners in the Orthopedics Department. Samie got her to write this about him.

I would like to share with you a few words about my late father and founder of the Prostate Cancer Support Association of New Mexico, Vonrae (Rae) Shipp. I'm sure some of you remember him. He started the group in 1991 after he was diagnosed with prostate cancer in 1985, and learned that there was not very much information for men to study, nor was there very much support to those who were newly diagnosed with PC. The group began with two or three men meeting in our house and learning together all they could about PC. It was not long before more men learned about the meetings and joined in. They held support group/educational meetings with doctors and other professionals and soon formed a close family of men and their families. There were many people who brought their education and energy to the group and helped to make it a success in helping others. Dad's sharing included a holistic approach in developing a positive and spiritual belief, appropriate exercise and nutrition, information regarding types of medical and surgical treatments and alternative methods of treatment.

My mother, Virginia Shipp, has been an instrumental member of the group as she supported, encouraged and loved my dad very much and was always there to help him and others in any way possible. She still keeps in touch with some of the PCSA members. The group moved from our home to an office, and then to a bigger office. The cost for these facilities was never thought about twice by my dad, as it became his mission to be available to help anyone who needed his support, day or night. The group started receiving donations and even state funding at one point. Dad greeted each person with an uplifting smile and a hug. He told me once that when he met men who were just learning they had PC, they seemed to come into the office "on their chin", so sad, depressed and searching for help and comfort.

When my dad was first diagnosed with PC, he was shocked and depressed but soon decided that he had a lot to learn and a lot to do and that a positive attitude was so important. He became so positive and uplifted in helping others that we had to wonder what in the world would he be doing next. He started eating a macrobiotic diet and walking miles each day, sometimes he would even walk backwards! One day I came home to find him jumping on a trampoline in the living room. His love and energy touched everyone around him and it was hard to be sad when you were near him. Dad chose hormone treatment as well as radiation, and he LIVED with PC for twelve years, feeling great almost all of that time. He was an inspiration to so many of us and he is truly missed.

Our family would like to thank all of the PCSA Board members, volunteers and everyone who works so hard in keeping dad's mission of support and education going strong.

Best wishes and hope to all who are fighting prostate cancer.
Lisa Hansen

At the May 18 PCSANM support meeting, Dr. Lindberg referred to 3 news articles about research studies. Here are links to them and /or summaries.

AUA Offers Evidence-Based Guide For Sequencing CRPC Therapies castration-resistant prostate cancer (CRPC)
http://www.ncbi.nlm.nih.gov/pubmed/23123372

Operational characteristics of (11)c-choline positron emission tomography/computerized tomography for prostate cancer with biochemical recurrence after initial treatment.
http://www.ncbi.nlm.nih.gov/pubmed/23123372

Dutasteride treatment over 2 years delays prostate-specific antigen progression in patients with biochemical failure after radical therapy for prostate cancer: Results from the randomised, placebo-controlled Avodart after radical therapy for prostate cancer study (ARTS)
http://www.ncbi.nlm.nih.gov/pubmed/23176897

Prostate Cancer: 'Change in Mindset' Needed

Gerald Chodak, MD for Medscape April 15, 2013

I want to talk again about prostate cancer screening and treatment and the controversies surrounding the US Preventive Services Task Force (USPSTF) guidelines.

An interesting and well-done article by Scardino and Vickers, published in *[AUA News]* in March, and a report by Dr. Ian Thompson at the Genitourinary Cancers Symposium raised the question of whether it is time to rethink how we manage this disease. The enthusiasm for screening has clearly resulted in overdiagnosis and overtreatment. While it may reduce mortality to some extent, the USPSTF concluded that the harms of overscreening outweigh the benefits, and they recommended against screening.

Many people are obviously upset by that recommendation, thinking that by abandoning screening we will now shift back to a higher mortality. So the question being raised by these smart individuals is, can we find an approach that modifies what we have been doing and shifts us back to a favorable outcome with more benefits than harms?

Drs. Scardino and Vickers make the following suggestions. First, clearly for men with low-risk disease, we are overdiagnosing and overtreating that problem. Men over age 70 are not benefiting from treatment of low-risk disease and should be offered active surveillance. Second, we need to stop screening men who have little chance of benefiting: those with a life expectancy less than 10 years, and particularly older men. Nearly half of men over age 75 are undergoing routine screening. That clearly needs to change. For men under age 60 with a prostate specific antigen (PSA) < 1 ng/mL, the likelihood of dying from the disease during the remainder of their life is very low, and so limited screening in that group is warranted.

It makes sense to reduce the number of biopsies being performed because most men do not have prostate cancer. If you select a cutoff of 3 ng/mL and a patient has a level exceeding that, repeating the PSA within a few months before proceeding to a biopsy makes sense, because roughly 4 out of 10 men will have a drop in their PSA level back to < 3 ng/mL. Also, using the PSA velocity is not a reliable way to recommend biopsies in men with a PSA < 3 ng/mL, as it leads to a greater chance of finding low-risk cancers.

Finally, we come to the issue of active surveillance. Clearly for men over age 65 with low-risk disease, the chance of benefiting from treatment seems to be small. We need to be more cautious about counseling these men that their chance of benefiting will not be outweighed by their chance of being harmed by therapy.

These recommendations are clearly good ones and could shift the paradigm or the results back to a more favorable outcome. However, how are we going to make sure that it actually occurs for patients? We have hospitals, doctors who own their radiation equipment, others who are invested in the robotic device, who will be faced with pressure to continue to use those therapies even in men unlikely to derive much benefit. What will persuade those people to shift away from aggressive therapy to more conservative management?

Patients themselves will need a reeducation process, because they hear the diagnosis of cancer and the thought of not getting rid of it in some fashion is going to be difficult to accept, particularly when they are counseled by doctors who are biased in favor of aggressive therapy over conservative management.

We have an opportunity to make things better, but it will require a change in the mindset of many doctors and many patients. Ultimately, that may lead to a very important paradigm shift in managing this disease so that we can achieve a greater benefit over harm.

COMING OUT by Robert Wood

Gotcha! No, this is not about sexuality. However, it is every bit as important to us survivors. I'm writing about bowel and bladder implications following prostate cancer treatment. I have noticed in my reading and talking to survivors about side effects of our treatment options that bowel issues are not a common topic, I don't believe we are being honest with the questionnaires. We will talk about incontinence and sexual problems but bowel issues, for the most part, are kept to ourselves. Because of this and my personal experience, I am suspect of the statistics we see about how many of us have one or more of those problems. My suspicions are confirmed by physicians' comments about seeing differences in men's bladder and bowel conditions about 10 years post-treatment. I had radiation in '04 and bowel and bladder problems started in 2012. Nothing really serious, but bothersome and unpleasant at times.

I discussed the bowel problem with my primary care physician and finding it was time for my 10-year colonoscopy, he recommended I take my concerns to the gastroenterologist performing my colonoscopy. I met with the gastro doctor prior to the colonoscopy to review my concerns. He replied that my condition was not uncommon among men my age, 77, and medical history. He suggested an over-the-counter treatment, which has provided total relief. In five short words, "I am a happy pooper!" My bladder issue was cleared up with a simple cystoscopic exam.

My purpose in this short, with somewhat potty humor, message is to encourage my fellow survivors to do two things to improve and maintain a happy and productive quality of life: first, take a cancer related health issue to a specialist and discuss your concerns; second, do not avoid a colonoscopy! It has the potential to save your life. Colon cancer is very treatable in the early stages. We all know that our PSA test was a potential indicator, not a positive diagnosis of prostate cancer; however a colonoscopy is a reliable examination to detect the presence of colon cancer or conditions that should be monitored.

As I often stressed in our Saturday meetings, I encourage each of you to be proactive in your personal health care. And, to the women readers: "Ladies, encourage, nag if necessary, your men to take their health issues to a specialist and to get a colonoscopy."
Good health to all.

Aggressive Prostate Cancer Risk Higher in Men with Diabetes **From Johns Hopkins Health Alerts**

Diabetes has been shown to be significantly associated with an increased risk of high-grade aggressive prostate cancer (Gleason score 8 to 10). New research shows that the increased risk is present regardless of which type of diabetes a man has.

As reported in the *International Journal of Radiation Oncology Biology Physics* (Volume 82, page e463), investigators analyzed data from 15,330 men diagnosed with prostate cancer between 1991 and 2010. They found that men with type 1 or type 2 diabetes were significantly more likely to have a Gleason score of 8 to 10 than to have a score of 7 or lower.

In some men, examination of prostate tissue after radical prostatectomy shows a higher Gleason score than was predicted by their biopsy. The study findings, if they are validated in future research, mean that men with diabetes and a Gleason score of 7 or lower may warrant a more exhaustive initial workup to rule out the presence of hidden higher grade disease.

Posted in Prostate Disorders on March 13, 2013

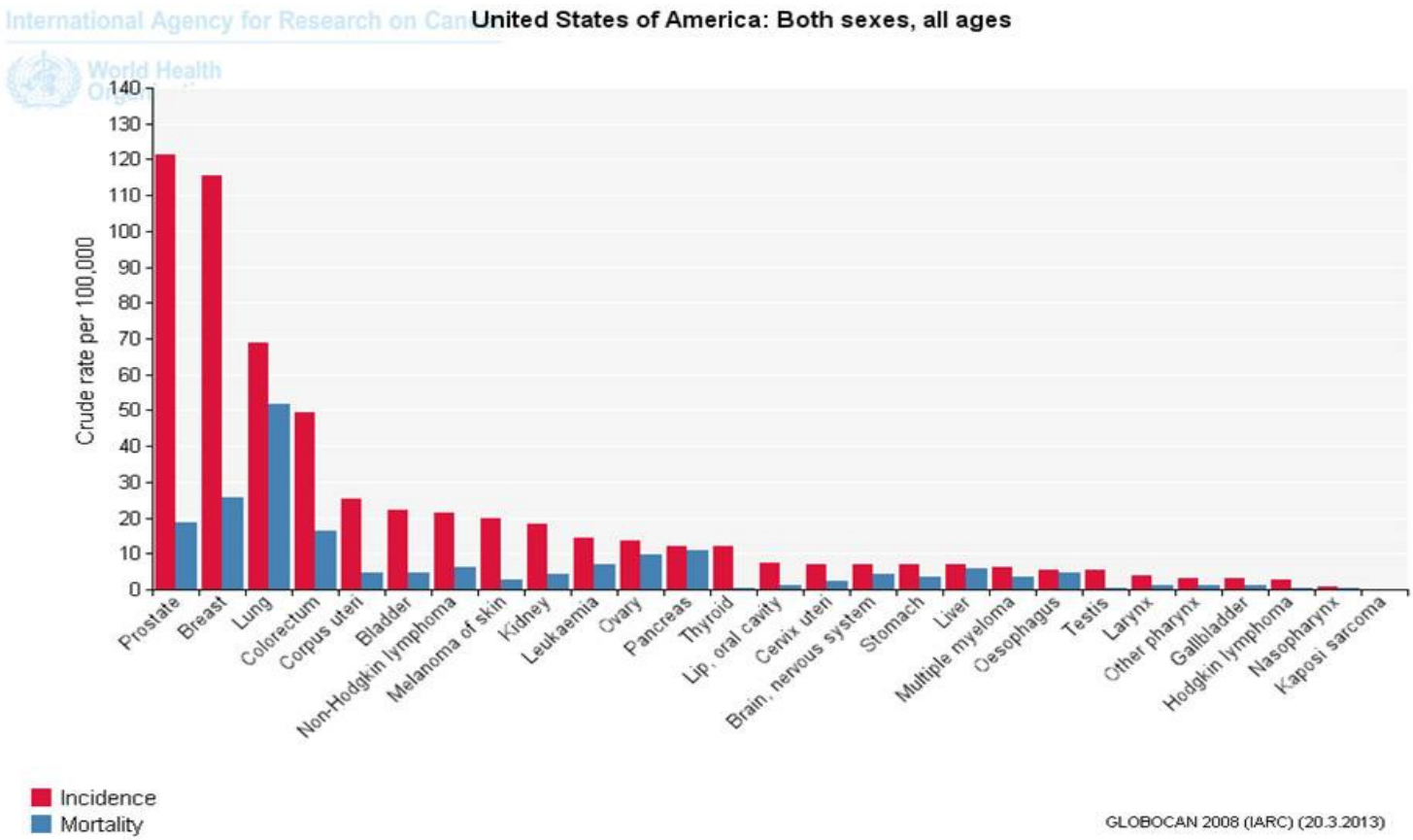
Research on Exercise and Prostate Cancer Survival
From Johns Hopkins Health Alerts

According to a study published in the *Journal of Clinical Oncology* (Volume 71, page 3889), vigorous physical activity may lower the risk of death from prostate cancer.

Investigators examined data from 2,705 men with prostate cancer who took part in the Health Professionals Follow-Up Study and were followed for 18 years. During the study, the men reported how much physical activity they performed each week, including cycling, running, walking and other exercises.
Any type of regular exercise improved overall prostate cancer survival, regardless of intensity. However, men with prostate cancer who walked at least 90 minutes per week at a normal or brisk pace were 46 percent less likely to die of any cause than were men who walked less than 90 minutes per week at a slow pace.
What's more, men who reported taking part in vigorous activity -- at least three hours of intensive exercise each week -- had a significantly lower risk of dying of prostate cancer. Compared with men who exercised an hour a week or less, vigorous exercisers were 61 percent less likely to die of prostate cancer.

Take-away message. Exercise has well-known heart benefits, and these findings add to the mounting body of evidence that it's good for the prostate, too. If you haven't been exercising, start slowly and build up to a more vigorous level of activity.
Posted in Prostate Disorders on January 24, 2013

Here is an interesting graph on types of cancer incidence and mortality in the USA. On left line is incidence, Right line is mortality. Statistics are from 2008.



Save the Date: Saturday, September 14, 2013

PANEL DISCUSSION ON ADVANCED/RECURRENT PROSTATE CANCER

As part of its educational program, the Prostate Cancer Support Association of New Mexico will be hosting a panel discussion on advanced and recurrent prostate cancer on Saturday, September 14, 2013 at Sandia Preparatory School's McCall Family Theater. The program is still in the development stage, but will cover a wide range of topics. Doctors will present talks on:

· How to develop a post local treatment monitoring plan with your doctor:
· What local treatments are available for recurrent prostate cancer;
· How to identify where the cancer is;
· Systemic treatment with hormone therapy;
· Chemotherapy;
· New therapies and combination therapies.

The final part of the session will be a panel discussion by the attending doctors responding to questions submitted by attendees.

Once prostate cancer is treated as a local disease, the patient needs to be aware of the symptoms that may signal a return of the cancer (recurrence).

When the cancer is initially diagnosed as having had escaped from the prostate capsule, it is said to be an advanced cancer. Treatments are similar for both recurrent and advanced cancer.

The doors will open at 8:45 AM and the program will be wrapped up by 4:15 PM. A one hour break between 11:30 AM to 12:30 PM is planned so that attendees can go for lunch.

Sandia Preparatory School is at 532 Osuna Rd. NE, in Albuquerque. There is no fee for the conference.

5-ARIs and the Progression of Prostate Cancer From Johns Hopkins Health Alerts

In this health alert, Johns Hopkins experts answer the question, "Will dutasteride prevent my prostate cancer from getting worse?"

A 2012 study conducted at Brady Urological Institute at Johns Hopkins found that it's very unlikely that 5-alpha reductase inhibitors (5-ARIs) -- a class of drugs that includes dutasteride and finasteride (Proscar) -- can prevent the progression of prostate cancer.

The study included 587 men with low-risk prostate cancer who had participated in an active surveillance program. Forty-seven of the men were taking a 5-ARI for lower urinary tract symptoms (LUTS). After roughly two years, these men experienced dramatically lower prostate-specific antigen (PSA) scores and a substantial reduction in prostate size -- both expected outcomes since 5-ARIs lower PSA scores and help shrink the prostate. But tissue samples from at least two annual biopsies found no significant difference in the growth or grade of prostate cancer in men taking 5-ARIs.

Another reason not to take these medications to prevent prostate cancer progression: In 2011 the U.S. Food and Drug Administration warned that 5-ARI use was associated with an increased risk of being diagnosed with high-grade prostate cancer.

Doctors are not recommending that you stop taking 5-ARIs if you have lower urinary tract symptoms. The absolute risk of advanced prostate cancer is low. **Still, because 5-ARIs artificially lower PSA levels your doctor will need to adjust your PSA results up.**

Posted in Prostate Disorders on May 1, 2013

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Chairman's Message, July 2013

I hope this edition of Lifeline finds everyone in great spirits and enjoying the outdoors and great climate here in New Mexico.

Prostate cancer diagnosis is undergoing a sea change with new guidelines regarding PSA testing, local treatment, metastatic treatment, and castration resistant prostate cancer treatment being published almost what seems daily. We have seen guidelines from various expert groups that recommend no PSA testing, or testing only those between the ages of 50 and 74, or testing those over 40. After getting tested, what to do? Active surveillance, local treatments of surgery, radiation or a systemic treatment like hormone therapy. Confusing??? You bet.!! Now we have a plethora of new drugs for the treatment of advanced prostate cancer - Provenge, Zytiga (Abiraterone), Xtandi (MVD-3100), and a newly approved radiologic drug, Xofigo. These are in addition to existing chemo treatment drugs, such as Docetaxel, Taxotere, Ketoconazole, Cabazitaxel and others. How can a patient become educated in these treatments and work with his doctor to achieve optimal results?

PCSA is trying to become a clearing house for this information and we try to sort through it so we may share that info with those to whom who we provide guidance. The ultimate choice regarding what to do still remains with the patient and his doctor

In Good Health, Lou Reimer, Chairman