Prostate Cancer Support Association of New Mexico

LIFELINE

PCSANM Quarterly October 2014 Volume 21, Issue 4

Issue Highlights

November 1 Conference Flyer 1

Dr. Lindberg's Take 3

PSA test is Misused, Unreliable, Says the Antigen's Discoverer 4-5

November 1 Schedule 6

Six things not to say to men with PC 7

Editorial 8

Selenium, Vitamin E Bad 9

News You Can Use 10

NM Cancer Summit report 11

Message from the Chairman 12

Our website address
www.pcsanm.org

e-mail
pchelp@pcsanm.org

Meeting Place: As of January 4, 2014, PCSANM is meeting at our old meeting place at Bear Canyon Senior Center, 4645 Pitt St NE in Albuquerque. This is two blocks from Montgomery and Eubank; go north one block to Lagrima de Oro St, and east one block to Pitt, and left 50 yards to the Bear Canyon parking lot. We are in room 5, at the west end of the building. Remodeling has been completed to the facility. Meetings are usually the first and third Saturdays of the month; 12:30-2:45 pm.

The current list of speakers and timeline can be seen on page 6.

MEN, ARE YOU ONE OF THE SIX?

ONE out of every SIX men will be diagnosed with PROSTATE CANCER!

You and your significant other are invited to

A FREE 1 day conference

"EXPLORING THE OPTIONS"

presented by

The Prostate Cancer Support Association of New Mexico

Featuring **7 specialists** in prostate cancer diagnosis and treatment.

Prostate Cancer Support Association of New Mexico is hosting this conference to provide information to men and women in order to make the best decisions if faced with this disease.

- Learn what you need to know about this potentially deadly disease
- Learn about treatment options
- Learn about potential side effects of each treatment and how they can affect your quality of life (including failure of "Happy Parts")
- Ask questions of the Doctors

November 1, 2014
9:00am – 4:00pm
South Broadway Cultural Center
1025 South Broadway, Albuquerque NM

Prostate Cancer Support Association of New Mexico
Website www.pcsanm.org Email pchelp@pcsanm.org
2533 Virginia St NE, Suite C, Albuquerque, NM 87110
505-254-7784, Toll free 800-278-7678

FOUNDER Rae Shipp, established 1991

Board Members

Lou Reimer, Chairman **Charles Rowland, Treasurer**

Dave Ball

Gary Cable

Jerry Cross

Steve Denning

Eli Maestas

Jan Marfyak

Joe Piquet

PCSA Contacts Around the State

City	Contact	Phone
Clovis	Kim Adams	(575) 769-7365
Grants	Dorie Sandoval	(505)285-3922
Las Cruces	Bernard Ripper or Ron Childress	(575) 521-7942 (575) 522-1083
Silver City	David Schwantes or Walt Hanson	(575) 388-2331 (575) 388-1817
Socorro	George Austin	(575)835-1768

In Memory of

James Fletcher Brown

Gene Wood

With Deep Sympathy and Regret, We List These Names

Only about one/third of our members are signed up for email. If you were, you would get this newsletter sent in glorious color, and all websites listed would be hot linked so you could just click on them and go straight to the web pages. We only send about one email a week, one for meeting announcements, and the week of no meeting we send some news articles or web links. Just email the office at pchelp@pcsanm.org to get in the 21st Century.

PCSANM *Lifeline*

A quarterly newsletter addressing issues of prostate cancer
Months Published
January April
July October

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

Office open only Mondays and Thursdays, 10 am-2 pm; or by appointment
Phone and email checked daily by Board Members

E-MAIL
pchelp@pcsanm.org

VISIT OUR WEB SITES
http://www.pcsanm.org

www.Facebook.com/ProstateCancerSupportNM

LENDING LIBRARY
Free and Open to all

EDITOR/WEBMASTER/FACEBOOK
Jerry Cross, Dave Ball

MEETINGS
Lou Reimer

DISCLAIMER

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 is accepting new patients.

See below for new information.

With the assistance of my patients, new information about prostate cancer is pouring into my computer; journal scans, urology and oncology updates, UO -SCAN etc. Much of this involves animal and tissue studies with perhaps very early safety trials in humans making this information not applicable to men now. Also a large proportion of these findings will never pan out, but much practical advice can be found in these e-mail alerts that assist the best treatment for each individual patient. A recent major review concluded that very early treatment for men with a rising psa after surgery or radiation did not improve survival. True for the entire group of men but Walsh and Partin reported that the group with a psa doubling time of less than 6 months and whose cancer had returned within 2 years of surgery lived longer if given early hormone treatment. Triple hormone therapy with bicalutamide +lupron +avodart, maybe given on an intermittent schedule can be very effective for these men while the man with a 15 month Psa doubling can just be followed while he lives a normal life free from side effects of removing testosterone.

As mentioned in my last report, adding chemotherapy to hormone therapy in the patient who is just diagnosed with widespread prostate cancer having spread to bones and other organs improves survival, a plan advocated by my friend Robert Leibowitz for many, many years. At our American Society of Clinical Oncology June 2014 those men with a heavy tumor burden,, more than 5 cancers in the bone, were shown to live on average one year longer even though all the men studied had cancers sensitive to removing male hormones. This clinical trial randomizing men to hormones alone versus hormones and initial chemotherapy was started in 2001, taking 13 years to obtain the proof of benefit. So many other important question about correct treatment in prostate cancer have not been answered and seemingly take forever to know for certain best treatment, i.e., the art of medicine.

Dr. Anthony D'Amico, a "great" among prostate cancer scholars, recently discussed the problem of which therapy is best for men with High risk localized prostate cancer Psa >20 or a very large t-3 tumor or Gleason score of 8-10. Comparisons between therapy types can be very inaccurate. Older men tend to get radiation plus hormones and they may die early of other causes making fewer prostate cancer deaths so radiation may look better. Some centers such as John Hopkins may pick only the most favorable cases to take to surgery while at Mayo Clinic most of these men get surgery, it actually happened to one of the men in my practice. Mayo surgery model "get it out of there" vs Hopkins "we would never operate in a case like yours." Other factors include extent of tumor and tumor volume, maybe different tumor genetics, etc, interfere with comparisons. In Britain a large trial of surgery vs. radiation where men were just assigned to the treatment by the state controlled health system results will start to be reported in 2015-the Protect trial. But for now in 2014, which treatment to recommend??? In the early D'Amico trial of radiation alone vs. radiation +hormones for 6 months, at a 10 year follow-up 15% of the high risk group had died and Dr. D'Amico hypothesizes that using 3 years of hormones could reduce this death rate to 11%. Surgery alone is not curative in greater than 50% of high risk patients and therefore radiation is given to enhance the cure-rate.

Therefore a high risk individual as of October 2014 can be offered a radical prostatectomy either open or robotic with the likely chance of needing radiation or radiation plus hormones; radiation using IMRT with a dose to 76 cGy plus 18 months of hormonal therapy. In 33 men that I care for there have been only 3 failures plus 1 other failure in an individual who never took the prescribed bicalutamide. My numbers are small and follow-up short but there have been no failures after 4 years. For me all of the above argues for a second opinion, not just from urologists. A high risk cancer should be treated but studies show that treatment can be started as late as 2 months after diagnosis.

A July 2014 article in the Journal of Urology explored various options before a second biopsy of the prostate is recommended if the first biopsy was negative. Pca-3, and the prostate health index can help but the best test is a multi-parametric magnetic resonance imaging exam which predicted finding cancer if biopsy was done. A fusion of MRI with ultrasound biopsy is done at some centers, but not in New Mexico. Easily available if you are willing to travel to Ventura, California for a color-Doppler guided biopsy by Dr. Duke Bahn; this is very, very accurate and helpful in this situation.

I have moved my office and joined the group at New Mexico Cancer Center, phone 842-8171; Located at 4901 Lang Ave NE, Albuquerque NM, 87109. Second independent opinions for men with prostate cancer can often be very helpful.

PSA Test Is Misused, Unreliable, Says the Antigen's Discoverer

Eric J. Topol, MD, and Richard J. Ablin, PhD, DSc (Hon) August 08, 2014 This is a partial transcript of a 29 minute interview posted online at the website below.

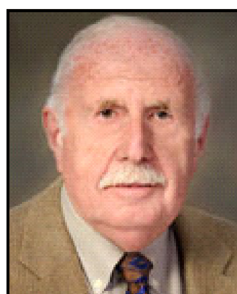
In this edition of Medscape One-on-One, host and Medscape Editor-in-Chief Eric J. Topol, MD, interviews Richard J. Ablin, PhD, DSc (Hon), who first discovered prostate-specific antigen (PSA) in 1970. At the time, Dr. Ablin and colleagues were trying to identify an antigen that was specific to prostate cancer. What Dr. Ablin identified instead was that PSA was present not only in malignant prostates but also in benign prostates. He did agree, however, that elevated levels of PSA might be useful in predicting a recurrence of prostate cancer in men who were thought to be in remission.
It was much to Dr. Ablin's dismay that more than 2 decades later, in the mid-1990s, the US Food and Drug Administration (FDA) approved the use of PSA not only to test for recurrence of cancer, but also as a possible predictor of cancer. Since then, Dr. Ablin maintains, the United States spends billions each year administering a preventive prostate cancer screening test to men, using PSA, which produces false positives in the majority of cases. In his interview with Dr. Topol, Dr. Ablin explains why physicians and patients should proceed with caution when using PSA as a marker for preventive screening.

http://www.medscape.com/viewarticle/828854?src=wnl_edit_specol&uac=209574DK

Editor: The transcript of the interview runs more pages than we can put in the newsletter, but I will highlight the seven topics covered. For each of the 7 sections, I have put just the first part of that discussion.

Eric J. Topol, MD left

Richard J. Ablin, PhD, DSc (Hon) right



1 The Discovery of Prostate-Specific Antigen

Eric J. Topol, MD: This is Eric Topol here for Medscape One-on-One, with Richard Ablin at the University of Arizona. Dr. Ablin has recently coauthored a book titled ***The Great Prostate Hoax*** (Macmillan, 2014).[1] This is a very interesting opportunity to speak with the discoverer of PSA. Welcome, Dr. Ablin.

Richard J. Ablin, PhD: Thanks very much. Having followed your work, this is a treat for me. I hope that in the course of our conversation, people and families will understand what they should know about prostate cancer moving forward, so thank you for this opportunity.

Dr. Topol: Let's talk about your background. You were at Lake Forest College, and then at SUNY in Buffalo. You worked at the well-known cancer center at Roswell Park. You were in Chicago at Cook County for a while, and now you are at the University of Arizona.

Let's go back to 1970, around the time that you first came across what is now called PSA. What were your thoughts about it at that time?

2 A Harbinger of Prostate Cancer Recurrence

Dr. Topol: Immunotherapy is one of the newest dimensions of cancer. That was your early work where you observed the PSA, but at that point did you think it was specific for cancer?

Dr. Ablin: To my dismay and disappointment, the tissue-specific antigen that I found -- PSA -- was the same protein found in the normal (benign) as well as the malignant prostate. It wasn't what I was looking for. We didn't have monoclonal antibodies in 1970, but with available techniques, we could see a spike in the area where PSA would have occurred, from a molecular standpoint. After treatment, if we followed this level, we saw a reduction of that peak. That was the forerunner of the test approved by the FDA in 1986 -- the PSA test that was the harbinger of the recurrence of the disease.

3 The Calamity of Mass Off-Label PSA Screening

Dr. Topol: In 1994 (8 years later), the FDA approved the PSA test for routine use in men aged 50 years and older. That is what the company was initially after. What created the big problem?

Dr. Ablin: The calamity was that right after its approval in 1986, people started to use the PSA test off-label. The only company that was permitted to produce the test kit was Hybritech, but several other biotech companies began producing it shortly after the approval. A tsunami began in the urology community when clinicians started to use the PSA test off-label between 1986 and 1994. This was a crime, because they were using a test that was approved as a harbinger of the recurrence of the disease for the detection of prostate cancer 8 years before it was approved for that indication.

Furthermore, it should have never been approved for that purpose, because at the advisory committee hearing in 1993 (before the 1994 approval), many members of the committee opposed it. For example, Alexander Baumgarten made the statement that because of the results that Bill Catalona was presenting, it was like Pontius Pilate; you won't be able to wash the blood (the guilt) off your hands because of the 78% false-positive rate.

How is a test with a 78% false-positive rate approved? Eric J. Topol, MD
Dr. Topol: How is a test with a 78% false-positive rate approved? As you wrote in the book, the PSA is wrong 80% of the time.

(Next page)

Dr. Ablin: Through the Freedom of Information Act, we obtained the transcripts of the 1985 and the 1993 meetings. A portion of the transcripts are reprinted in the book. The meeting had a circus atmosphere. Prostate cancer patient support groups were there. Lobbyists were there. Bill Catalona was saying that every few minutes, a man is dying of prostate cancer. The irony is that even Dr. Catalona said that the PSA test doesn't detect prostate cancer. It is a measure of risk. By his own admission, it wasn't a test for prostate cancer, but to determine the risk of developing prostate cancer. There was chaos.

4 Fear and Money Keep PSA in Use

Dr. Topol: It seems outlandish, and you cover this in the book. We then go from 1994, when the FDA approves the PSA for mass screening, to today. I was presenting at the American Urological Association (AUA) in May 2013, the day after the professional society said that we should no longer use the PSA routinely.[2] Why did it go on for almost 20 years?

Dr. Ablin: Fear and money, because other than melanoma, prostate cancer is the most prominent cancer in men. It went on because of the continual proselytizing of fear and the money that was being generated by the screenings.

"Patients and doctors believe that lives have been saved by the PSA test. This is offset by all of the men who have developed urinary incontinence or who have lost sexual function -- all of the travesties that have occurred Eric J. Topol, MD

For example, in 1989, which was 5 years before the test was approved by the FDA for detection, Schering-Plough paid $1.2 million to a marketing firm during September, which is Prostate Cancer Awareness Month, to promote PSA screening. Primary care physicians were brainwashed that they needed to do a PSA test. If you don't do a PSA test and a man is subsequently diagnosed with prostate cancer, you could be sued.

5 As Costly as the Human Genome Project

Dr. Ablin: I will give you an example of why I call this a public health disaster, as you wrote in your book, ***The Creative Destruction of Medicine*** (Basic Books, 2013).[4] Our healthcare system is broken. The latest statistics show that the annual budget for the National Cancer Institute is about $5.1 billion; of that, approximately $300 million goes for urologic research. But every year, we spend $3 billion on PSA screening in asymptomatic men, using a test that can't do what it's purported to do.

Every year, we spend $3 billion on PSA screening … using a test that can't do what it's purported to do. Richard J. Ablin, PhD

Dr. Topol: Even though the recommendations have changed by the US Preventive Services Task Force[5] and AUA,[2] there doesn't seem to be any decline in the use of PSA screening. Has it changed?

6 Spawning an Industry for Drugs and Diapers

Dr. Ablin: Third, we can't tell the difference between latent cancer or nonclinical cancer and aggressive cancer. I make the analogy in the book of a rabbit and a turtle and an open box. The turtle crawls around the box and goes nowhere. That's the nonaggressive, indolent cancer. The rabbit, representing the aggressive cancer, can jump out of the box and metastasize anytime. The problem is, we can't tell the difference between a rabbit and a turtle.

The most important crux is that prostate cancer is an age-related disease. If you get, for example, 100 men -- black or white -- between the ages of 60 and 69 years and do biopsies, you will find that 65% of these men have prostate cancer because it's age-related.

Dr. Topol: But rarely is it aggressive. In the future, is it possible that we will identify a marker that will help sort out whether someone has an aggressive type of prostate cancer that warrants the big-gun treatments?

Dr. Ablin: Going back to when I started working on this in 1967, up to the present time, no one has found a cancer-specific antigen for the prostate. As we talk today, there are 11 -- and probably more -- tests out there that have been proposed as a replacement for the PSA. These tests are awaiting validation and clinical trials. I have reviewed these tests. So far, it's questionable as to whether any of them right now will fulfill what we are looking for.

Dr. Topol: They are not likely, at least imminently, to get us out of this bind of not being able to partition the serious types of prostate cancer from the innocent types. Is that right?

Dr. Ablin: One problem is that people are still using the PSA test. They go from PSA, to ultrasonography, to biopsy. It's a cash cow.

7 Book Reaction: Silence

Dr. Topol: Have you suffered any repercussions from the book? Have there been any lawsuits or any retaliatory-type tactics?

Dr. Ablin: No. In fact, there has been silence. Several articles have come out. I've had several interviews with the local papers.

Dr. Topol: You had a nice review in *The Economist*.[6] That's pretty widely read.

Dr. Ablin: That was the poorest review that we received, because it was anonymous, and whoever wrote it said that I made hyperbolic claims. Every single statement in this book is supported by a reference.

Dr. Topol: As you look back on the past 5 decades of PSA and what you have learned, do you think that it was a conspiracy, that it was intentional, or that it was unwittingly done trying to help men to try to prevent the sequelae of a horrible cancer? What do you really think?

I believe that the use of the PSA test for screening asymptomatic men was strictly for money -- a lot of money. Richard J. Ablin, PhD

Dr. Ablin: My opinion is that the driver of this, beyond the use of the PSA test as a harbinger of the recurrence of the disease, is money. There are some highly intelligent people in the industry. No one has ever refuted my 4 cruxes, so I believe that the use of the PSA test for screening asymptomatic men was strictly for money -- a lot of money. A company wanted to develop a blockbuster drug, some form of immunotherapy, which they talked about in the early days back in San Diego. Many people could see that this test couldn't do what it was purported to do.

Go to website mentioned above to see the entire interview and comments.

You've got a few months between diagnosis and doing something about it. Get busy. Forget about your lawn, your cousin's house, and all your sister's problems. You just became your #1 priority. But don't forget about your partner - you'll need their support more than you can ever know. It is best to go through this experience with a loved one for support, help and understanding. From EnglishAlf, HealingWell.com Forum

Financial Support for this newsletter edition provided by:

The Cancer Center
PRESBYTERIAN

Phone 505-559-6100

Did you know the USA put out a 33 Cent Prostate Cancer Awareness stamp in 1999? Time for them to do it again?

The November 1, 2014 Conference Schedule

MAIN TOPIC	SUBTOPIC	TIME	SPEAKERS	AFFILIATION
Intro	Welcome Learn about PCa	9:00	Lou Reimer	PCSA
Decision Tools	PSA, DRE, etc	9:30	Dr. Arthur Caire	Santa Fe Urology
Decision Tools Imaging Center	Scans	10:10	Dr. Fabio Almeida	Arizona Molecular
		10:50	Break	
Define Disease Stage and Risk	Definitions	11:05	Dr. Mark Scholz	Prostate Oncology Specialists Marina del Ray CA
Local Disease- Low Risk	Active Surveillance			
		12:00	Lunch Break	
Local Disease/ Intermediate Associates –High Risk	Surgery Options	1:00	Dr. Andrew Grollman	Albuquerque Urology
	Radiation options	1:40	Dr. Tom Schroeder	UNM Cancer Center
	Hormone options	2:20	Dr. Peter Lindberg,	New Mexico Cancer Center
		2:50	Break	
Advanced Disease Overview		3:05	Dr. Jose Avitia	New Mexico Cancer Center
Wrap-up		4:00	PCSA	

HUMOR: An Important Statistic

The published statistics on prostate cancer show that single men are diagnosed much less frequently than married men. On the other hand, married men who are diagnosed with prostate cancer live longer than single men with the disease. The conclusion that can be drawn from this is that men should stay single, but should get married if diagnosed with prostate cancer.

Financial Support for this newsletter edition provided by:

Six Things Not To Say to Men with PC

By RickRed52 May 15, 2014 UsToo Prostate Cancer Support Community

http://www.inspire.com/groups/us-too-prostate-cancer/discussion/six-things-not-to-say-to-men-with-pc/?ref=as&asat=165622005

In this online thread, the UsToo writer was asking men with prostate cancer (and their partners) to add to this list of foolish and/or unhelpful responses to receiving the news that you have prostate cancer. Additionally, they explain why these comments are not helpful so those who are lacking in sensitivity or wisdom can learn the reasons why these comments hurt rather than help. Finally they asked their members to comment on other unhelpful comments made to them. Interesting reading.

1. That's too bad, my father, (Uncle Cousin, etc) died from prostate cancer.

2. At least you have a "good" cancer-

3. Telling people how they should feel based on your assessment of the situation is a very bad idea. Listening without passing judgment is the way to be helpful. After surgery I was depressed about the quality of life changes brought about by prostate surgery. When I shared that with a friend she said "Why do you think you need emotional support? You've been cured of cancer and you should feel grateful."

4. Blame the man with cancer for his disease Blaming someone for their disease AFTER a diagnosis is not in the least bit helpful.

5. I'll pray for you. There's nothing inherently wrong with that response. As a Christian I appreciate and place a high value on people praying for me. Yet I've experienced this used as a way to shut down discussion. If someone offers to pray with you without you asking for prayer, and/or without the person asking if there is something specific they can pray for, the odds are this offer though genuine, might serve a dual purpose of preventing you from saying anything specific that would make the person who is volunteering to pray for you feel uncomfortable, fearful or anxious. So don't offer to pray for someone unless you know in advance those coping with prostate cancer place a value on prayer and you ask if there is something specific you can pray for. Keep in mind it's possible the person with cancer is angry with God or had their faith shaken in some way. Be sensitive about this possibility before you ask to pray.

What is the worst or best thing someone said to you about your diagnosis?
Please share with us by sending message to office at pchelp@pcsanm.org

Editorial: Why aren't more members of our group using more of our free services, and helping us get the word out to the thousands of men in New Mexico who don't even know we exist?

By J Cross

I was diagnosed with PCa, and joined this "club" just over 3 years ago, and was then asked to join the Board and take over duties as Lifeline Editor/Webmaster/ Facebook Admin just under 3 years ago, when the office went from a paid staff to your Board Members volunteering to provide office hours and man the other duties of the organization. Since then we have increased the number of Lifeline newsletters we print each Quarter by 200, increased the size of the newsletter from 8 to 12 pages, and started a new host site and layout for the PCSANM Website.

My point today is to find out why so many of our free services are so underutilized. You have 9 Board members working hard for you, and we could use some feedback to get more involvement and serve you better.

Membership: We have 750 individual members in our group, plus about 200 professionals, agencies, clinics that we contact with. But according to the NM Department of Health, 1500 cases of PCa are diagnosed each year in NM. We could have gained 4500 members just in the last 3 years. Where are they? Half would be expected in the rural parts of the state, where it is hard for them to hear about us. But in the Metro area, we don't see much growth. We have only added 14 new members to our group this year. We need everyone's help to get the word out. And we are very much underrepresented in the African-American community, who are more affected by PCa than other ethnic groups.

Meetings: We have 26 meetings a year, with excellent speakers and good discussions and sharing, but meetings average 15-30 in attendance. Of 500 members who live in the Albuq/SF to Belen area, I don't think I have ever seen more that 50 different faces at a meeting over the 3 years. If you live in the area, why don't we ever see you? What could we do to get more of you here once in a while?

Newsletters: We always are looking for news articles for the Lifeline, or even to post on the Website or Facebook page. Is this your only source of information? Let us know what else you are learning about PCa from other sources.

If you move, or don't need to receive Lifeline any more, please let us know. It costs 4 times as much for the Post Office to return your newsletter to us when you move as it does to mail it out.

Website: I get a report every week from our web page host, and the number of people who look at our website is dismaying. Less than 20 people a week look at it and most do not even look past the home page. There is posted on the Website: the last 4 issues of our newsletter, Meeting schedules, lots of info at News you can Use page. We are trying to put meeting highlights, with websites mentioned by speakers, and copies of the handouts on it more.

Facebook page: On this aspect, we do even worse. Only 60 people total like our page, visits are way less than that, and I suspect many of those are mine, because I post several news articles a day on this page. You do NOT have to be registered at Facebook to see our page, just click on the link on our website, newsletter, or office emails and you can read our page without any trouble, you just can't post or reply.

Office and Library: Last fall we moved to a new office, and frankly, we are lonely. Come by and see us, chat or ask questions, or look at our library of books or DVD's to check out. We have fewer than 40 books checked out and hundreds more on the shelves. Don't you want to know about new developments in the field?

Emails: If you move or change servers, please let the office know. Every week we get 15 or more bounce-backs of meeting announcements. We try to call to get current info, but many people have phone number changes/ disconnected.

If you don't receive our maximum of 1 email a week, please consider signing up. It's fast and easy, you get the newsletter in color, know when and where the meetings are, and get news items

Referrals: The Board members go to health fairs, conferences, and other events to get the word out. We need you to help share our info, printed materials, or business cards with people you meet. Share our email newsletter with family friends, and colleagues. Help us reach out to the many men we are not serving in NM, and make yourself more informed on your PCa. Please talk to your church, work, fraternal, or social groups about us. Come by the office and pick up some bookmarks or other handouts.

You came to us once before to get information and support. I must assume that none of us get cured, just remission or dormancy, and we need to look at our future education about PCa. New developments are coming all the time that you should know about.

Selenium, vitamin E supplements can increase risk of prostate cancer in some men

February 21, 2014 Fred Hutchinson Cancer Research Center suggested by Joe Piquet

A multi-center study led by Fred Hutchinson Cancer Research Center has found that high-dose supplementation with both the trace element selenium and vitamin E increase the risk of high-grade prostate cancer. But importantly, this risk depends upon a man's selenium status before taking the supplements.

These findings, published in Journal of the National Cancer Institute, are based on data from the Selenium and Vitamin E Cancer Prevention Trial, or SELECT, a rigorously executed, randomized and placebo-controlled trial conducted by the SWOG cancer research cooperative group that involved more than 35,000 men. The study sought to determine whether taking high-dose vitamin E (400 IU/day) and/or selenium (200 mcg/day) supplements could protect men from prostate cancer.

The trial, which began in 2001 and was designed to last 12 years, stopped early, in 2008, because it found no protective effect from selenium and there was a suggestion that vitamin E increased risk. While use of the study supplements stopped, men were still followed and after an additional two years the men who took vitamin E had a statistically significant 17 percent increased risk of prostate cancer.

Selenium supplementation increased cancer in men with high selenium status at baseline.

When the study started, there was some evidence that selenium supplementation would not benefit men who already had an adequate intake of the nutrient. For that reason, researchers measured the concentration of selenium in participants' toenails and planned to test whether selenium supplementation would benefit only the subset of men with low selenium status at baseline. Instead, they found that taking selenium supplements increased the risk of high-grade cancer by 91 percent among men with high selenium status at baseline. When selenium supplements were taken by men who had high selenium status to begin with, the levels of selenium became toxic.

Taking vitamin E increased cancer risk in men with low selenium status at baseline.

The study also found that only a subgroup of men was at increased risk of prostate cancer from taking vitamin E. Among men with low selenium status at baseline, vitamin E supplementation increased their total risk of prostate cancer by 63 percent and increased the risk of high-grade cancer by 111 percent. This explained one of the original SELECT findings, which was that only men who received vitamin E plus a placebo pill, and not those who received both vitamin E and selenium, had an increased prostate cancer risk. Selenium, whether from dietary sources or supplements, protected men from the harmful effects of vitamin E.

"Many people think that dietary supplements are helpful or at the least innocuous. This is not true," said corresponding and first author Alan Kristal, D.Ph., a faculty member in the Public Health Sciences Division of Fred Hutch. "We know from several other studies that some high-dose dietary supplements -- that is, supplements that provide far more than the daily recommended intakes of micronutrients -- increase cancer risk. We knew this based on randomized, controlled, double-blinded studies for folate and beta carotene, and now we know it for vitamin E and selenium."

The data for the current analysis compared the effect of selenium and vitamin E, taken either alone or combined, on prostate cancer risk among 1,739 men who were diagnosed with prostate cancer and, for comparison purposes, a random sample of 3,117 men without prostate cancer who were matched to the cases by race and age.

The bottom line: The study showed no benefits to any men from either selenium or vitamin E supplements, and for significant proportions of men in the study these supplements were harmful.

"These supplements are popular -- especially vitamin E -- although so far no large, well-designed and well-conducted study has shown any benefits for preventing major chronic disease," Kristal said.

No known benefits -- only risks

"Men using these supplements should stop, period. Neither selenium nor vitamin E supplementation confers any known benefits -- only risks," he continued. "While there appear to be no risks from taking a standard multivitamin, the effects of high-dose single supplements are unpredictable, complex and often harmful. Taking a broad view of the recent scientific studies there is an emerging consistency about how we think about optimal intake of micronutrients. There are optimal levels, and these are often the levels obtained from a healthful diet, but either below or above the levels there are risks."

Dietary Guidelines That May Help Prevent Prostate Cancer

(Not proven but good advice anyway)

Lower fat in your diet to 10% of total calories consumed
Eat fish (non-fried) 2-3 servings/wk, (Consider taking fish oil or flax seed oil)
Avoid charred red meats (anthroglycines)
Increase your Omega 3 intake
Avoid hydrogenated fats (saturated fats) as much as possible and always avoid partially- hydrogenated oils(trans-fats)
Keep your fiber intake >30 grams daily, consume a diversity of low-cost fruits and vegetables that are high in fiber. Stay away from high-calorie fruits.
Take Vitamin D 1000 I.U.s/day as calcium citrate (do not take it at bedtime)
Consider taking POMx to lower LDL levels
Exercise 30-60 minutes per day to raise HDL levels. Exercise should include resistance and aerobic training.
Take baby Aspirin (81 mg per day)
Take a Statin - see your FP, GP or internist to check your progress..

Arnold Palmer: "Just get your regular check-ups and PSAs and, if you're diagnosed, do everything you can to eradicate the disease. I think we are fortunate to have the best doctors in the world in this country. If you're not satisfied with the diagnosis and prognosis, then get another couple of opinions. But, in the final analysis, you need to do what it takes to get rid of the cancer and get on with your life."

Robert Goulet: "I'm a prostate cancer survivor. When you or the person you love is diagnosed with cancer, the first thought is of the end, and that is our destiny, but I'm here to talk about the value of living with cancer. It's not an easy battle, but we need to believe life goes on even in the face of cancer, and life can become more full because of cancer."

Gen. H. Norman Schwarzkopf: "I was diagnosed with prostate cancer in March of 1994. I survived, but since then over 175,000 American men didn't. The good news is that this war can be won with a combination of early detection, treatment and a commitment to ongoing research."

VOLUNTEER OPPORTUNITY

Our PCSANM members have a chance to assist in supporting the following volunteering opportunity:
It entails assisting at the Radiation Oncology/Gamma Knife, Lovelace Radiation Oncology Associates on a monthly basis on Tuesdays from approx. 8 to 3, or even half day in the AM. The facility is located on Jefferson Lane, just north of the woman's hospital near San Mateo and Montgomery. The frequency will depend on how many volunteers we get.

On Tuesdays, Dr. Anthony sees all of his patients after their radiation treatments. We would like to have a volunteer walk the patients from the treatment machines to the exam rooms. The patients usually have family members waiting in the waiting room who also like to see the Dr. with the patient. Once the patient and family members are roomed the volunteer would find the nurse and/or physician and tell them which patient is in the room waiting to be seen. The majority of our patients are mobile however we do have an occasional patient in a wheelchair. Dr. Anthony currently sees about 25 patients on Tuesdays. It would probably work best to assign a morning and afternoon shift. A volunteer from 8am-12pm and have another volunteer come in from 1pm-4pm.
About half of the time would be spent on your feet and half the time sitting or conversing with patients and staff. The group has a very welcoming and friendly culture. The low stress environment and rewarding nature is perfect for anyone who enjoys helping people.
Please contact our office or David Ball (604-4835) if this is something you would be interested in.

NM Cancer Summit: Treating the Person Beyond the Disease August 7, 2014

By Lyle Ware and Jerry Cross

Lyle Ware and his wife, Carole, and this Editor, recently attended the local American Cancer Society's first Cancer Action Network Summit, which focused on Palliative care. We were both were very impressed by the presentation and the goals of implementing this into our health care system. This is a compilation of our thoughts.

Palliative Care essentially is a patient centered, team approach, dealing with: pain, symptom management, treatment, stress, aimed at Quality Of Life (QOL) for the patient and the patient's loved ones.
Palliative Care is often confused with Hospice Care, which is a Medicare insurance program that focuses on: pain management, End Of Life care and bereavement care with patient and family centered goals.

The first annual New Mexico Cancer Summit was an exploration of palliative care, including: Why palliative care achieves better patient experience, improved quality of life for patients, better quality of care, and lowered health care costs; How palliative care honors patient choice about treatment goals and helps bring the family into the care process; How palliative care is appropriate *any age* and *any stage* of illness; What kinds of legislative strategies and health care system change promote access to palliative care.

Speakers were Congresswoman Michelle Lujan Grisham of Albuquerque, a cosponsor of two federal bills that will expand access to palliative care; Dr. Esme Finlay, Assistant Professor in the Department of Internal Medicine at the UNM School of Medicine with board certifications in palliative medicine, medical oncology and internal medicine; Dr. Lisa Marr, Associate Professor and Section Chief, Palliative Medicine, at the UNM School of Medicine; Dr. Nancy Guinn, Medical Director, Presbyterian Home and Transition Services; And Congressman Ben Ray Lujan.
Both members of Congress related stories about their family members who passed away from cancer, and are helping to sponsor a Palliative Care Bill in Congress.

The PowerPoint presentations have not yet been put up on their website yet; but go to http://acscan.org/action/nm to join their network for $10, or check back later to see the presentations. When they are up I will put a link to them on our webpage.

Palliative Care can be given to a patient **whether in Hospice or not.** There is a randomized prospective study reported in the New England Journal of Medicine, [NEJM 363; 8, 733-742] comparing early palliative care to aggressive medical treatment for terminal small cell lung cancer. The patients with palliative care lived **longer** and had better **QOL** than the aggressively treated patients. [11.6 months vs. 8.9 months - a 2.7 month survival advantage. To date, no trial of palliative care has demonstrated harm.
Both of these care approaches are a win: win for patient and the system. The patient gets better QOL and it **costs less.** Both of these are encouraged and implemented by the Affordable Health Care Act. In the last two years of life 32% of Medicare is spent. Of that, 78% is spent in the last month.

Both UNMH and Presbyterian Health Care have palliative care available (Lovelace Gentiva has services at the Gibson facility, and maybe the VA has services) here in Albuquerque.

Hospice is a package of services, not a place. It may be provided in the home, hospital, nursing home, or inpatient hospice facility KEY POINT: Palliative care is ALWAYS a part of Hospice, BUT Hospice is Not Always a part of Palliative care. **While we cannot add days to life, we can add life to our days**.

PCSA *Lifeline* Newsletter
October 2014

Prostate Cancer Support Association
of New Mexico, Inc.
2533 Virginia St. NE, Suite C
Albuquerque, NM 87110

NON-PROFIT
ORGANIZATION
US Postage
PAID
Albuquerque, NM
Permit #856

RETURN
SERVICE
REQUESTED

Chairman's Message, October 2014

As part of our efforts to increase awareness of prostate cancer, PCSANM will be presenting our third free conference on prostate cancer on November 1, 2014. I believe this will be the best conference we have presented to date. The conference title is "Exploring the Options" and is designed to guide the patient through the prostate cancer journey from initial diagnosis and, if necessary, to metastasized prostate cancer. During the conference the prostate cancer patient will be shown tools and information they can use to analyze their particular situation and come to a decision about the optimal treatment for themselves. For those of us who are somewhere along this journey, we can see where we might improve our treatment or look to what the next step might be.

Making presentations are some familiar expert doctors from New Mexico: Doctors Caire, Schroeder, Lindberg, Grollman and Avitia. We have two visiting experts; Doctor Scholz from Los Angeles, and Doctor Almeida from Phoenix. In addition to the presentations there will be free literature from support groups, providers and pharmaceutical companies. This conference is open to the public and I ask you to promote it to your friends and neighbors.

Our annual Christmas Party lunch meeting will be held on December 20 and, in addition to our sharing in fellowship, I will be giving our annual summary of activities.

I wish all our members good health and well being.

Lou Reimer, Chairman of the Board