

Prostate Cancer Support Association of New Mexico



Celebrating 25
years of
supporting men

LIFELINE

PCSANM Quarterly

July 2016

Volume 23, Issue 3

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Our website address

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Meeting Place:

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

Map: <http://binged.it/1baQodz>

Save the date for our next free conference
"Quality of Life after PCa Diagnosis"
Saturday, November, 5, 2016; 9AM-4:30 PM
Central United Methodist Church
201 University St NE, Albuquerque
University and Central, across from UNM

Tentative Schedule

Morning

9:00 – 9:15	Welcome, PCSA; Intro to Moderator, Joe Diaz, KOAT
9:15 – 10:00	Does PSA Testing Result in Overtreatment ? Dr. Schroeder (UNMCC Radiation)
10:00 - 10:45	Sexual side effects from PCa treatments Dr. Shah (UNM Urology)
10:45 – 11:00	Break
11:00 – 11:45	Erectile Dysfunction and Urinary Problem Solutions Dr. Grollman (Alb. Urology Associates Urology)
11:45 – 12:40	LUNCH

Afternoon

12:40-12:45	Intro to Moderator TBD
12:45 –1:30	Recovering Intimacy after PCa Treatment Dr. Mark Pugsley (Independent Psychologist)
1:30 -2:15	HIFU a New Treatment for Localized PCa Dr. Robert Pugach (Pacific Coast Urology-Urologist)
2:15-2:30	Break
2:30 –4:10	Breakout sessions -(2 cycles of 45 min each, plus 2 cycles of 5 min shift time) each session on a different topic Nutrition – Jan Esparza (Pres. Registered Dietitian) Physical Fitness – Don Hoover (RR Physical Therapy) Stress Management - TBD Sharing Session – PCSA Moderator
4:10	Thank you for attending - Closing remarks PCSA
4:30	Shut down/Clear the building

In addition to the above speakers and breakout sessions, there will be exhibitor tables with health information for attendees

FOUNDER Rae Shipp, established 1991, our 25th year

Board Members

Lou Reimer, Chairman	Charles Rowland, Treasurer
Dave Ball	Dave Hays
Gary Cable	Eli Maestas
Jerry Cross	Jan Marfyak
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PCSANM Lifeline

A quarterly newsletter addressing issues of prostate cancer

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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.

In Memory of

Andrew T. Clawson
Gerald Cooper
David Bruce Davis
Arnold Garcia
Tom Gallegos
Arnold M. Sargeant

With deep sympathy and regret, we list these names

Dr. Lindberg's Take

Dr. Lindberg is still on medical leave. He was due for surgery as this publication date approached.



All of Dr. Lindberg's Lifeline articles from 2007 and later are now posted on our website. We wish Dr. Lindberg and his family the best, and we wish him a full and rapid recovery.

PCSANM and Cancer Support Now Collaborate to help fill Community Services Void

As many of you might have heard by now, People Living Thru Cancer (PLTC) shut its doors on April 15. It had been around for 33 years, and leaves a void in the NM cancer support community. **That now makes PCSANM the oldest and largest support group in the state, we believe.**

Cancer Support Now has offered their support groups who wish to, the opportunity to affiliate with them. One of the main reasons facilitators want to be part of an organization that has a telephone contact line like theirs, is to have a way for new people to be referred into their groups. This would give them an organization in which to have a web presence and be on Facebook, have a newsletter to promote themselves in, a group to be a part of for conferences and other events, and to be able to have email communications with other survivor/caregiver groups.

We receive referrals from CSN this way several times a year. Cancer Support Now so far has nine support groups from PLTC who have agreed to affiliate with it. **PCSANM has been an affiliated organization with Cancer Support Now for several years.** We have advertised for each other's conferences, shared table displays at Health Fairs and other events, attended each other's meetings and picnics, and share links on our websites.

The PLTC Library was recently turned over to Cancer Support Now. **On April 25, it was moved to the office of the Prostate Cancer Support Association of New Mexico, 2533 Virginia St NE, Suite C, 87110.** Map is at <http://goo.gl/maps/EUg9S>

For now, the office is open during PCSA office hours of 10 to 2 on Mondays and Thursdays, and by appointment. CSN hopes to get some volunteers to get the library staffed the other week days. If you have books checked out from the library, please return them to this new location. There is a mail slot, so some books could be returned when the office is closed.

The CSN library is more than four times larger than our library, and even has a whole row of books about Prostate Cancer, many of which we did not have. Please come by the office to make use of this great resource.

To see their Library catalogue, you can go to <https://www.librarything.com/catalog/CancerSupportNow>

To see the latest Cancer Support Now newsletter, with all their support groups, go to <http://www.cancersupportnow.org/pdfs/>

Cancer Support Now is hosting a Hope and Healing Honors event on Thursday, September 24, at the Indian Pueblo Cultural Center. People can nominate outstanding healthcare professionals, volunteers, and individuals who have shown kindness and compassion to those touched by cancer. There will be entertainment, food and drink, silent/live auction, and fellowship. Tickets are \$65.00 per person. If you want to attend, be a sponsor, donate an auction item, or just know more about the event, go to http://www.cancersupportnow.org/pdfs/hope_healing_honors.pdf

Test Case: Despite Debate, PSA Testing for Prostate Cancer Can Be a Life-Saving Measure by Deepak A. Kapoor

a board-certified urologist, is chairman and CEO of Integrated Medical Professionals in Melville, N.Y., and clinical associate professor of urology at the Icahn School of Medicine at Mount Sinai

From CURE magazine, Spring 2015

<http://www.curetoday.com/publications/cure/2015/spring2015/Test-Case>



The Nation's approach to prostate cancer is sometimes difficult to understand for those of us who treat this disease. For virtually every other human disease the focus is on early detection and treatment, but for prostate cancer, it seems there is an effort to convince Americans that this is no longer necessary. Most notably, the U.S. Preventive Services Task Force (USPSTF) has recommended against screening for prostate cancer, a position adopted by other national organizations and, more recently, by some insurance carriers.

The reality is much different and, unfortunately, much more frightening. Prostate cancer continues to be the most commonly diagnosed solid tumor in men — it's estimated that around 221,000 men will be diagnosed with the disease this year. Although it's true that prostate cancer may be slow-growing in some cases, it remains the second leading cause of cancer death in American men; nearly 28,000 will lose their lives to the disease this year alone.

So what's causing the confusion? As men age, the prostate gland undergoes cellular changes, sometimes including the development of cancer cells. Autopsy studies have revealed the presence of asymptomatic cancer cells in as many as 80 percent of 80-year-old men, yet most of these men die of causes other than prostate cancer. **Historically, we've had difficulty distinguishing men who are going to die *with* prostate cancer from those who are going to die of prostate cancer.**

Let's start by understanding how we detect prostate cancer. In addition to a prostate exam, screening involves a blood test for prostate-specific antigen (PSA), a protein that tends to be elevated in those who have prostate cancer. However, while the PSA is prostate specific, it is not prostate cancer specific; if levels are high, biopsies are needed to help confirm whether the disease is present. This is at the heart of the problem — while the PSA test itself is not dangerous, the USPSTF argues that, for the population overall, the risks of diagnosing and treating prostate cancer outweigh any potential survival benefits that result from early detection.

Is there any truth to this? As physicians, we weigh the risks of therapy against the risks of no treatment, but as prostate cancer therapies have become safer, less invasive and more effective, it has become easier to recommend treatment — particularly since, until recently, we lacked precise tools to specifically predict the aggressiveness of the cancer. This uncertainty may also cause patients to overlook untoward effects from treatment rather than face an uncertain probability of death from disease. As a consequence, some patients who may have been able to safely defer treatment have been treated immediately.

The good news is that we've made great strides in the past five years in our ability to predict the behavior of prostate cancer; improved staging techniques, along with genetic and molecular markers, now help determine which patients should receive immediate therapy and for whom intervention may be deferred.

The USPSTF's recommendation that no one should be screened for prostate cancer — based on reviews by a committee that did not include a single physician with experience treating the disease — failed to appropriately consider the historically proven benefit of routine PSA screening. Since PSA testing was approved in 1986 by the U.S. Food and Drug Administration, the 10-year survival rate for prostate cancer in the U.S. has increased from less than 70 percent to over 99 percent. Our experience here is similar to that in other countries. The largest study ever performed on the subject, the European Randomised Study of Screening for Prostate Cancer, found that, after 13 years of follow-up, men screened for prostate cancer had a 21 percent decline in mortality when compared to unscreened men.

When the USPSTF issued its recommendation against PSA testing, urologists nationwide, myself included, warned about the possible public health repercussions that could ensue. Our fears have materialized, and much sooner than anticipated. **Continued on page 5**

Researchers just released findings showing that in the two years since the recommendation was issued, there has been a significant migration at time of diagnosis toward more advanced, higher-grade cancer. As these cancers are less treatable than those detected early, the study concluded that prostate cancer deaths could increase by 5 percent annually — the first increase in prostate cancer death rates in over 20 years.

Given this evidence supporting the value of PSA screening, I recommend that men talk to their doctors about their particular risk factors for prostate cancer and develop customized early detection programs that are appropriate in the context of their overall health and wellness. **The following represents a common-sense approach to prostate cancer testing, based on internationally accepted consensus guidelines:**

1. A baseline serum PSA level should be obtained in men in their 40s who have made an informed decision to pursue early prostate cancer detection.
2. Intervals for prostate cancer screening should:
 - be adapted to a patient's baseline PSA;
 - take into account an individual's prostate cancer risk factors (such as family history of prostate cancer and African-American descent); and
 - allow for the potentially short preclinical timeline of aggressive cancers.
3. PSA screening should be offered to men with a life expectancy of 10 or more years, without a pre-determined upper limit of age.

Most importantly, patients need to understand that undergoing prostate cancer screening does not obligate them to undergo further diagnostic testing or treatment, even if abnormalities are found. It simply provides a piece of information that assists in making sound health care decisions — which, ultimately, could prove life-saving.

New drugs for aggressive prostate cancer 'promising'

BBC News May 2, 2016

A new type of drug could benefit men with aggressive prostate cancer that is no longer responding to treatment, researchers from the Institute of Cancer Research have said.

In a study on mice, Hsp90 inhibitors were found to strip cancer cells of defenses against hormone treatments. This makes the drugs particularly promising for treating drug-resistant cancers, the research team said.

Prostate cancer is the most common cancer in men in the UK. About one in eight men will get prostate cancer at some point in their lives. It mainly affects men over the age of 50.

The cancer can sometimes be treated successfully with hormone treatments, which target androgen receptors linked to the growth of male hormones called androgens. But some prostate cancers don't work that way. Instead they create an abnormal form of androgen receptor which is not linked to the growth of hormones and therefore does not respond to standard hormone treatment.

This is the most common form of resistance in prostate cancer which leads to aggressive, difficult-to-treat cancers.

The latest research, published in the journal *Cancer Research*, found that a new class of drugs reduced production of both receptors. Professor Paul Workman, study author and chief executive of the Institute of Cancer Research, said it was an exciting discovery.

"We call Hsp90 inhibitors 'network drugs' because they tackle several of the signals that are hijacked in cancer all at once, across a network rather than just a single signaling pathway. "These drugs can hit cancer harder than those targeting only one protein, and look promising for preventing or overcoming drug resistance."

Prof Workman said the next step was to test the Hsp90 inhibitors in clinical trials on patients with aggressive, drug-resistant prostate cancer. Prof Johann de Bono, a professor of experimental cancer medicine at the Institute of Cancer Research, said: "These drugs are already in clinical trials for several types of cancer, and I am excited that our work suggests they could also benefit men with prostate cancer who have otherwise run out of treatment options."

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Regret after surgery for prostate cancer is widely understated

By Jill Margo Australian Financial Review
 May 3, 2016

<http://www.afr.com/lifestyle/health/mens-health/regret-after-surgery-for-prostate-cancer-is-widely-understated-20160502-gojrg3>

The reliability of studies depicting men's satisfaction with surgery for prostate cancer has been called into question.

A recent meeting of urologists was told these studies are naive and should not be taken at face value.

According to leading urologist Claus Roehrborn, professor and chairman of the department of urology at the University of Texas, the studies underestimate the level of regret men feel afterwards.

He says standard questionnaires about "decisional regret" are superficial and fail to capture the complexity of men's response to the surgery and the distressing effects it can have on their lives.

He told the Urological Society of Australia and New Zealand's annual scientific meeting on the Gold Coast, in April, that these questionnaires need to be rethought.

His talk, which also covered the trend of overburdening of men with treatment options and expecting them to make an informed decision, became a talking point of the meeting.

A surgeon himself, he said researching the talk had taken him way beyond his comfort zone. Rather than presenting a packaged solution to these issues, he would just explore them and share some insights he'd gleaned.

DECISIONAL REGRET LIKE 'BUYER'S REMORSE'

Professor Roehrborn told The Australian Financial Review that decisional regret in medicine is similar to what is commonly called "buyers' remorse" or sometimes "post-purchase depression".

Despite the impact a radical prostatectomy can have on continence and potency, he says some studies have found decisional regret is as low as 4 per cent.

"How can this be?" he asks.

"A year after a radical prostatectomy, 15 per cent of men will still be leaking urine in some way, and of those who enjoyed full potency before the operation, only one in six will have resumed sexual activity."

Despite this, when men are asked if they regret the decision to have the surgery, most say it was a good decision. When asked if they feel the surgery may have harmed them, they say no.

To both the questions "Would you do it again?" and "Would you recommend it to others?" they answer yes.

"On the surface it looks like the world is in order," says Professor Roehrborn. "We do the treatments and the patients understand there are consequences, and in the end, they say it's all good and they made the right decision."

But the studies make no allowance for a particular form of mental stress that influences the responses.

COGNITIVE DISSONANCE

He says many of these men are experiencing "cognitive dissonance", which is the intolerable mental discomfort of holding two contradictory ideas in the mind at the same time.

The discrepancy can be unbearable and often leads them to rectify the dissonance by changing one of the two so they can better manage.

These men have had an irreversible operation that impacts their masculinity; they know they are suffering the consequences but they answer questionnaires in a way that ignores the suffering.

Professor Roehrborn describes this as a collision between beliefs and actions in which they typically create justifications to keep their world in order.

He says cognitive dissonance is easily illustrated with smokers who develop coping mechanisms to deal with the graphic images on cigarette packs.

They know smoking is bad but they justify it, saying they need it because it calms them, and as times are tough, it's the right decision to smoke.

Then they go further and create a plausible construct to support their actions. They may think up a conspiracy. Perhaps the harms of smoking have been overstated to encourage them to spend their money on expensive smoking cessation medication instead.

"These coping mechanisms can be so extreme that patients are quite incapable of differentiating between their beliefs and reality," says Professor Roehrborn.

"With prostate surgery, it would be extremely difficult for a man a year later to say 'Well, since I leak urine and can't have sex any more, I would never do that again'."

"It would be an admission that he made the made a wrong decision and this would collide with the dissonance concept."

"So nothing is said and urologists pat themselves on the back believing their patients have no regrets. But it's a hopeless oversimplification because it's just a reflection of men coping with cognitive dissonance."

Denial is a component of this. Denial is when a smoker denies smoking is that bad in his case. Cognitive dissonance is when he creates a construct to support this position.

WHY TAMPER WITH DEFENCES?

But when a man is already living with side-effects of prostate surgery, why tamper with his defences? Why strip him of his belief and force him to a frank admission of regret?

Professor Roehrborn says while there may be personal value in sustaining the belief, there's a deeper problem.

Men diagnosed with localised prostate cancer have several options, some of which don't cause serious side-effects. Were such men to read reports of 96 per cent satisfaction rate after surgery, they might feel that's a better choice, when it might not be.

Professor Roehrborn also has much to say about the trend of giving men with localised prostate cancer so many options it is almost overwhelming.

"Choice is good, but too much can lead to paralysis. The human mind can only wrap around a limited number of choices and make intelligent decisions."

With prostate cancer, he says, when men are faced with many options they often tend not to make a choice. The range of options raises the possibility

that there may be a perfect fit and if they could only find it, they'd be happy with the decision and have no regrets

As their expectations that this is possible escalate, so does their difficulty in making a choice. It can be a time of anxiety and uncertainty.

Professor Roehrborn says many consult him for a second opinion and the conversation usually goes as follows:

Patient: "I've been told about all these options and their consequences."

Roehrborn: "So what have you decided?"

Patient: "I haven't. I'm here to ask what you think."

LAUNDRY LIST OF TREATMENT OPTIONS

He says the patient's doctor has usually given him a laundry list of treatment options and told him to go home and think about these options and make a decision.

"I believe the doctor has only done half the job. Of course patients need to participate in decision making, but it can go too far."

Once doctors were patriarchal and made the decisions. Now the pendulum has over-swung and they've given patients the autonomy for decision making.

"They're saying 'We will explain the options but you must decide.' Some won't even help with the decision – which is not in accordance with the Hippocratic Oath."

He says the latest thinking is that doctors should give patients the right to transfer the autonomy back. A man may be fully capable in all other regards, but may not feel capable of making a decision about his prostate cancer.

Professor Roehrborn believes full autonomy for patients is an impossibility because some of the decisions and their ramifications are too complicated. The fact that many men turn to unreliable sources of information, such as friends and the internet, doesn't help.

**The May 15, 2016
NY Times Magazine
Health issue was focused
on cancer articles.
To see it, click [HERE](#)**

Urine Test Accurately Identifies Tumor Grade in Prostate Cancer

Megan Garlapow, PhD
Oncology Nurse Advisor

April 20, 2016

<http://www.oncologynurseadvisor.com/urine-test-accurately-identifies-tumor-grade-in-prostate-cancer/printarticle/490940/>

A new test using urine analysis can increase prostate cancer detection.

A new urine assay that can detect genetic changes correlated with prostate cancer correctly identified cancer grade in 92% of men with elevated prostate-specific antigen (PSA) levels that had high-grade cancers.¹

Despite its common use, the PSA blood test cannot distinguish between low-grade cancer and high-grade cancer. Low-grade cancer can be monitored and does not need active treatment whereas high-grade cancer requires surgery and radiation therapy. Elevated PSA levels are values higher than 4 ng/mL.

The United States Preventive Services Task Force (USPSTF) recommends against PSA-based screening as PSA blood tests generate a large number of false positives. Only approximately 25% of men with elevated PSA levels have prostate cancer.

This study, published in *JAMA Oncology*, compared a urine-based gene expression assay with biopsy results from 499 patients whose PSA levels were between 2 ng/mL and 20 ng/mL to train the assay for deriving prognostic scores. Next, researchers validated derived prognostic scores in urine samples from 1064 patients from 22 community practice and academic urology clinics in the United States.

Samples were from participants who did not have indolent prostate cancer, were 50 years or older, and were scheduled for an initial or repeat prostate needle biopsy due to digital rectal examination results and/or PSA levels (limit range, 2.0 to 20.0 ng/mL).

At a derived prognostic score of 15.6, researchers correctly identified the cancer grade as high in more than 90% of men with prostate cancer. In addition, the assay correctly identified the cancer grade as low in 91% of men with the disease. A score above 15.6 predicted high-grade cancer, and a score below 15.6 predicted low-grade cancer.

In 66% of men with low-grade cancer, however, the test incorrectly predicted high-grade cancer. In clinical practice, use of this test would have saved 27% of men from undergoing unnecessary prostate biopsies.

"The test has the potential to be a significant improvement over PSA alone in distinguishing between low- and high-grade prostate cancer, especially in the PSA gray-zone patient," said James McKiernan, MD, the John K. Lattimer Professor and chair of urology at Columbia University Medical Center and urologist-in-chief at New York-Presbyterian/Columbia, New York City, and first author of the study.

"It could reduce hundreds of thousands of invasive biopsies each year. Given the pain and risks associated with performing a prostate biopsy, that's not a trivial thing."

This is the only urine-based experiment that does not need a rectal digital examination before collection. Furthermore, the test is easy to integrate into the clinical setting.

Grants from Exosome Diagnostics supported this study.

REFERENCE

1. McKiernan J, Donovan MJ, O'Neill V, et al. A novel urine exosome gene expression assay predicts high-grade prostate cancer at initial biopsy [published online ahead of print March 31, 2016]. *JAMA Oncol*. doi:10.1001/jamaoncol.2016.0097.

We recently found out about some other cancer support groups, specific to location in NM. Since we have many members in the Santa Fe area, here is the Cancer Foundation for New Mexico:

<http://cffnm.org/>

Also the Los Alamos Council on Cancer:

<http://www.losalamoscounciloncancer.org/Pages/default.aspx>

Shorter, intensive radiation can be recommended in early Prostate Cancer

From Science Daily, April 4, 2016

Publishing April 4 in the *Journal of Clinical Oncology*, the research team compared the shortened radiation therapy schedule of about 5.5 weeks to the standard 8-week regimen to determine if rates of cure were similar. Both treatment schedules were similar in terms of controlling cancer, but doctors reported slightly more mild side effects in patients getting the shorter radiation schedule.

"This study has implications for public policy," said the study's principal investigator, W. Robert Lee, M.D., a professor in the Department of Radiation Oncology at Duke. "Because the shorter regimen has advantages such as greater patient convenience and lower costs, it's important to establishing whether we can cure as many patients with the shorter regimen. Our study provides that information for the first time."

Lee and colleagues, working as part of NRG Oncology, a non-profit cancer research organization, enrolled about 1,100 men whose prostate cancer was diagnosed early, before it had spread. Roughly half the patients were randomly assigned to receive the typical regimen of 41 treatments; the other half received the higher dose over just 28 treatments.

At five years, disease-free survival was no different between the two groups, with 85.3 percent of men in the traditional group being cancer-free, compared to 86.3 percent of men in the shorter regimen group.

Overall survival at five years was also no different, at 93.2 percent and 92.5 percent respectively. The researchers also asked patients to describe their own experiences of side-effects, but these data have yet to be analyzed.

Mild gastrointestinal and genitourinary toxicity as reported by doctors was observed more frequently in patients getting the higher daily dose, shorter frequency radiation, but no differences were observed in more severe side effects, which were rare (less than 5 percent) with either regimen. The researchers also asked patients to describe their own experiences of side-effects, but these data have yet to be analyzed.

"An estimated 220,000 men are expected to be newly diagnosed with prostate cancer each year in the United States, and the majority will have early-stage disease at low risk for recurrence," Lee said. "These findings should help guide clinical decisions, and doctors should be comfortable recommending a shorter radiotherapy course as an alternative to the conventional schedule."

PCSANM Needs Your Help Now

Have you or someone you know been helped by the Prostate Cancer Support Association of New Mexico? Did you know that PCSANM is an entirely volunteer run organization? And did you know that many of our volunteers are prostate cancer survivors themselves who have a desire to provide support to others facing the same issues?

Now is your chance to join us in helping to reduce the anxiety associated with a prostate cancer diagnosis and providing men and their relations with up-to-date information about diagnosis and treatment options.

PCSANM has immediate openings on its board of directors as well as other volunteer opportunities. Do you have computer skills? Do you like talking to people? Do you have media or management experience? We have needs in all these areas and more. No matter your level of knowledge or amount of time you can commit we need you.

Call PCSANM at 505-254-7784 or email us at pchelp@pcsanm.org to find out how you can help us.

Expert Sorts Through New Tests for Prostate Cancer Detection

by Laura Panjwani

Cure Magazine Online March 30, 2016

<http://www.curetoday.com/articles/expert-sorts-through-new-tests-for-prostate-cancer-detection>

Although prostate-specific antigen (PSA) screenings can be helpful in prostate cancer detection, the results are not always straightforward when used alone, says Stacy Loeb, MD, assistant professor of Urology and Population Health at NYU Langone Medical Center.

“PSA is not like a pregnancy test; it’s not black and white where you either see the pink line or you don’t,” she says. “Since a PSA elevation is nonspecific, it can be increased because the prostate is growing, there’s a tumor growing or there is an infection.”

Fortunately, several new tests are on the market that, often times in conjunction with PSA, can give oncologists and urologists more insight into prostate cancer risk. These include the Prostate Health Index, 4Kscore, PCA3, and ConfirmMDx.

“Since we don’t really know the cause of increased PSA in many cases, the purpose of these tests is to help sort out, through various ways, if it is due to a significant prostate cancer or just something else,” explains Loeb.

In an interview with *CURE*, Loeb discusses how these tests work, what their benefits are, and what urological specialists need to know in order to best utilize them.

How has the use of prostate biopsy evolved in recent years?

Loeb: Historically, one PSA threshold was used to decide if a biopsy was necessary. Back in the early 1990s, the FDA approved PSA screening with a threshold of four. That means that levels above four were considered abnormal, so it didn’t matter if you were 50 years old or 80 years old, or if you were known to have a big prostate or any other factors. Basically, if it was above four, irrespective of any other issues, then you were referred for a biopsy. Actually, because the randomized studies of PSA screening were designed in the early 1990s, one PSA cutoff was used to decide on biopsy for everyone.

Since then, it has become clear that PSA really cannot be dichotomized like that. It’s actually a spectrum. Therefore, as the level gets higher, the risk increases continuously and makes it hard to draw a line in the sand.

We have learned a lot since the early 1990s on how to use PSA better, and there are new markers available that are more specific to help us make better decisions regarding biopsy.

What are some of those new markers?

There are two blood tests called the Prostate Health Index and the 4Kscore. They are actually very similar to each other. They perform similarly and are both based on PSA. They use differ-

forms of PSA combined together, which jointly do a better job than just looking at total PSA. Both of these tests are recommended as options in the 2015 NCCN Guidelines.

If a man has a PSA that’s above three, and you’re trying to decide whether he should proceed with biopsy, both of these tests can be used to help make that decision. This is because the Prostate Health Index and the 4Kscore are specific to clinically significant disease. If these tests are high, that means that this man has a higher risk of having significant prostate cancer.

There are also other types of markers, including PCA3. This is a urine test and is also FDA approved, but only for men who already had a prostate biopsy that was negative and we have to decide if they need another biopsy. This is also commercially available; it was FDA approved in 2012.

The problem is that there is conflicting data on whether it actually predicts significant prostate cancer. The other two tests that I spoke on earlier—the Prostate Health Index and the 4Kscore—are consistently, across all studies, associated with aggressive disease. Whereas, with PCA3, some studies show a relationship and some don’t. It’s important that we focus on markers that will actually help us in this quagmire of trying to find the important cancers and not unearth indolent cancers.

There is also a tissue test called ConfirmMDx. This is also for men who had a negative biopsy. Unlike the other tissue tests on the market, which look at tumor tissue, this is actually looking at a negative biopsy. It examines benign tissue and asks the question, “Are there suspicious changes in the benign tissue that suggest that there’s a tumor somewhere lurking that was missed on the biopsy?”

If they are there, then that would suggest the need to re-biopsy and it would show us where we need to be looking. All of these tests are commercially available. It’s great that we have some more testing options because so many men are in the position of trying to decide if they should have a biopsy or they have already had one or more negative biopsies and are trying to decide if they should get another one.

Are there challenges in terms of accessibility of these newer tests or a lack of knowledge on how to use them?

Definitely. I think it’s a major challenge because there’s just been such an expansion of the number of tests on the market.

There is confusion among physicians and patients on which test should be used in which setting. Some of the tests can be difficult to obtain in certain areas, but that’s also why it’s nice that there are multiple options available. If it is difficult to obtain one of these tests in your region, hopefully one of the others are available.

Continued on page 11

A good example of this is MRI. We do a lot of prostate MRIs at NYU. We have a very longstanding program for this, and I think MRI is one of the most important tools in our armamentarium for prostate cancer nowadays. However, it's still at the beginning in many places, and there are many people who tell me that they don't have a lot of experience with it or have radiologists who are experienced with it.

Until people become more experienced using MRI, it's very helpful to have some objective marker tests available that are not dependent on the level of experience. Also, they can be ordered from anywhere, as long as you can obtain a blood test or a urine sample.

What does the urology community need to know about these tests?

They need to understand what is the state of the evidence on each of these tests and the role that each test has in our clinical decision-making process. Is the test used to help with the initial biopsy decision, to help with the repeat biopsy decision, or designed for men who already have prostate cancer to help predict prognosis and make management decisions?

Some tests span more than one of these decision points and others do not. Because there are so many, much education is needed so that the right patient can receive the right testing options that may really help them.

The ultimate goal is to have an improvement in patient care by taking advantage of the fact that we do have more specific options available to provide more information and make better decisions.

A BETTER PROSTATE CANCER TEST?

FEATURED May 10 IN THE WALL STREET JOURNAL – HEALTH

From Prostate Snatchers Blog <http://prostatesnatchers.blogspot.com/>

Distinguishing aggressive disease from slow-growing tumors means more patients can forgo treatment. Several new prostate-cancer tests aim to reduce needless biopsies and unnecessary treatments by sorting out harmless from aggressive tumors.

30 MILLION U.S. men will have a PSA test. 6 MILLION of them will be found to have elevated PSA levels. 1 MILLION of them will undergo a prostate biopsy. 180,000 men who have biopsies will be diagnosed with prostate cancer. Another 180,000 men will have prostate cancer the biopsy missed. 100,000 men with prostate cancer will have low-risk tumors that are unlikely to spread or cause symptoms. 60,000 men with low-risk cancers will undergo surgery or radiation anyway, probably unnecessarily.

mpMRI vs BIOPSY.

Mark Scholz, a prostate oncology specialist in Marina del Rey, Calif., maintains that an mpMRI can yield much of the same information as a biopsy and far less invasively. Low-risk prostate cancers barely register, he says, adding, "When patients find out they have a choice between 12 harpoon sticks to the prostate through the rectum or an MRI, they are on board big time."

Joel Copeland, 62 years old, has been monitoring his PSA closely for a decade; his two brothers were diagnosed with prostate cancer. He opted for an MRI instead of a biopsy when his PSA bounced up in 2013. "I don't like needles, but that's not the point," Mr. Copeland says. "The point is, biopsies can cause infection and miss cancers."

We would like your help on a new website feature on our News You Can Use page, under the helpful Hints from Members tab <http://www.pcsanm.org/wp-admin/post.php?post=509&action=edit>

We want to start a new feature on this page where members can give suggestions and helpful hints, to share with other survivors, regarding their treatment. As always, remember we are not doctors, but sharing as survivors from our own experiences. You should always check with your own Doctor about advice provided, your mileage may vary.

You can submit hints by emailing the office pchelp@pcsanm.org attention Webmaster, or post on the comments link on the main page of this website www.pcsanm.org

PCSANM *Lifeline* Newsletter

July 2016

Celebrating 25 years of supporting men

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Chairman's Message, July 2016

As I prepare this Chairman's Corner, I near the end of my second term as your chairman. When I started as Chairman, I wrote in this column that my vision for PCSANM is much the same as I believe our founder had. He believed that PCSANM would be a comprehensive organization for educating and communicating prostate cancer information to the newly diagnosed, to our Members, and the public throughout Albuquerque and the State of New Mexico. We will continue to conduct one-on-one counseling for the newly diagnosed and share our personal experiences with this disease.

This vision has not changed during my four years in office. Our organization has maintained its membership, advanced the electronic presence of our group on the web and held 3 more annual conferences. We are participating in many more health fairs than before. All of these accomplishments have not happened on their own and the Board and members who have pitched in to help out are owed a big thank you for all they have done. Our membership needs to step forward to continue to make PCSANM the premier prostate cancer support organization in New Mexico.

I wish all our members good health and well being.



Lou Reimer, Chairman of the Board