



Prostate Cancer Support Association of New Mexico

LIFELINE

Since 1991, supporting
those affected by
prostate cancer

Quarterly Newsletter
October 2026
Volume 33, Issue 4

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Support Group Meetings

Meetings are held at
Bear Canyon Senior Center,
4645 Pitt St. NE in Albuquerque,
from 12:30 p.m. to 2:45 p.m.
on the first and third Saturdays
of most months.

For meeting topics
and information:

<https://www.pcsanm.org/meetings/>

Please call 505-254-7784 or
email pchelp@pcsanm.org
with questions.

I Wish Someone Had Told Me

By Gerald Bowe, PCSANM Treasurer

Through PCSANM support group discussions and community conversations at health fairs and wellness events across New Mexico, we hear men reflect on what they wish they had known about life during and after prostate cancer treatment. One man described his experience like this: "I was hopeful that treatment was going to save my life. I just didn't understand how much it would change things in the process."

Others have shared similar reflections. Some wish they had been better prepared for urinary leakage or changes in bowel habits. Men receiving hormone therapy have talked about fatigue, hot flashes, weight and muscle changes, and changes in mood. Others say they were surprised by changes in sexual function. These experiences vary considerably from person to person and depend on the treatment received.

Perhaps the most difficult subject to bring up is sexual health. Men have shared they were reluctant to ask about erectile dysfunction, loss of libido, or changes in intimacy after treatment. Yet these concerns are common enough that the National Cancer Institute encourages men to discuss them openly with their healthcare team and ask what changes might occur, how long they might last, and what can be done to manage them.

Another message often heard is, "I wish I had asked more questions." Before making a treatment decision, you might want to ask your provider:

- What side effects are most common and less common with this treatment?
- Which side effects may be temporary, and which could last longer?
- How might treatment affect urination, bowel function, sexual health, energy, and emotions?
- What can I do to prevent or manage these problems?
- Who should I contact if a side effect becomes difficult to manage?

The support PCSANM provides can help people identify additional questions and concerns to discuss with their healthcare team, especially regarding clinical decisions and treatment. At PCSANM, men and their loved ones learn from others who have been there.

Sharing what we've learned along the way can help another man feel more prepared for the road ahead. That's at the center of why PCSANM exists.

PLEASE SUPPORT PCSANM

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PCSANM Lifeline

A quarterly newsletter addressing issues of prostate cancer

Published:

January April
July October

PUBLISHER

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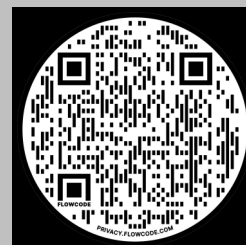
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FACEBOOK

MedPage Today: August 13, 2026

Study Questions How Prostate Cancer Focal Therapy Is Being Used — Half of procedures occurred in settings not supported by guidelines

Mike Bassett, Staff Writer, MedPage Today

<https://www.medpagetoday.com/hematologyoncology/prostatecancer/122603>

While the use of focal therapy for nonmetastatic prostate cancer is limited, half of procedures occurred in settings that are not supported by current guidelines, according to a retrospective study.

Among over 1.1 million men diagnosed with nonmetastatic prostate cancer from 2010 to 2023, 1.3% received focal therapy, and 51% of these patients had low-, high-, or very-high-risk disease, "settings in which routine use is not supported by contemporary guidelines," reported Quoc-Dien Trinh, MD, of the University of Pittsburgh School of Medicine, and colleagues in a research letter in [JAMA](#).

[Current guidelines](#) recommend that focal therapy—healthy tissue-sparing techniques that specifically target individual tumors within the prostate—be reserved for patients with intermediate-risk disease within clinical trials or prospective registries.

"For appropriately selected patients with intermediate-risk disease, focal therapy is an appealing treatment option because it aims to preserve quality of life while treating the cancer," Trinh said in a [press release](#). "But as promising new technologies become more widely available, it is important to understand which patients are most likely to benefit so that treatment decisions are guided by evidence and aligned with clinical guidelines."

In the case of patients with low-risk disease, the standard strategy is active surveillance. Therefore, focal therapy may represent overtreatment for these patients.

On the other hand, focal therapy lacks high-level evidence for high- and very-high-risk prostate cancer. Trinh and team noted that radiotherapy or surgery remain standard care for these patients, while focal therapy raises concerns about undertreatment, "given the need for durable oncologic control and lack of evidence supporting focal therapy."

Commercial availability and recent reimbursement increases may have intensified patient and physician interest in focal therapy, which has emerged as an alternative to treating or removing the entire prostate for certain selected intermediate-risk patients, the authors explained.

In an [accompanying editorial](#), Daniel Spratt, MD, of Case Western Reserve University in Cleveland, and colleagues noted that "focal therapy should not be sold as an interchangeable middle option between radical prostatectomy and active surveillance."

The prospective trial evidence for focal therapy is limited to mostly 1- and 2-year outcomes from small single-group cohorts, they wrote, and the modalities used—including cryotherapy, high-intensity focused ultrasound, microwave, laser, waterjet, or ultrasound ablation—"each deserve evaluation on their own evidence."

"It is troubling when social and financial pressure bends clinical judgment toward experimental therapy given outside a trial," Spratt and colleagues wrote. "Investigators are wrong about their hypotheses all the time, and randomized trials are how they find out."

Trinh and colleagues used the National Cancer Database to identify 1,179,384 men ages 50 and older who were diagnosed with nonmetastatic prostate cancer between 2010 and 2023 and seen at U.S. centers with Commission on Cancer accreditation.

Of the 15,672 patients who received focal therapy, 49% had intermediate-risk disease, including 2,786 with favorable intermediate risk and 4,901 with unfavorable intermediate risk.

From 2010 to 2023, the rate of focal therapy did not significantly change in patients with low-risk disease (1.8% vs 2.2%, $P=0.46$ for trend).

Among those with favorable intermediate-risk disease, focal therapy rates significantly increased (2.1% to 2.9%), while decreases were seen in those with unfavorable intermediate risk (2.5% to 1.9%), high risk (2.1% to 0.9%), and very high risk (1.8% to 0.5%; all $P<0.001$ for trend).

The authors also determined that modality-specific patterns changed from 2010 to 2023, with cryotherapy use decreasing from 79.8% to 19.1%, while use of laser ablation increased from 14.6% to 45.8%, and high-intensity focused ultrasound grew from 5.6% to 35.1%.

In multivariable analysis, adjusted predicted probabilities of focal therapy were higher among older patients and those with low-risk disease, higher comorbidity burden, non-private insurance, treatment at community facilities, and treatment at higher-volume facilities.

The authors acknowledged that their study had limitations. For example, they observed that focal therapy performed outside Commission on Cancer-accredited centers is likely underrepresented, and that data on oncologic outcomes, toxicity, quality of life, retreatment, and costs were unavailable. In addition, they were unable to capture clinical factors influencing treatment selection, such as tumor multifocality, clinical trial or registry participation, and patient preference.

Weill Cornell Medicine: June 15, 2026

Experimental Treatment Directly Kills Prostate Tumor Cells While Reawakening Antitumor Immunity

Newsroom

<https://news.weill.cornell.edu/news/2026/06/experimental-treatment-directly-kills-prostate-tumor-cells-while-reawakening-antitumor>

Multiplex immunofluorescence image of a prostate tumor 10 days after treatment with prostate-targeted C' dots and immunotherapy showing extensive infiltration of immune cells throughout the tumor. Different colors represent distinct immune cell populations, including anti-tumor T cells, helper T cells, regulatory T cells, and macrophages. The image illustrates the coordinated immune response triggered within the tumor following treatment.

Credit: Bradbury Lab.

Prostate-targeted, engineered nanoparticles made of amorphous silica are effective in killing prostate tumors directly while enhancing anti-tumor immunity, according to a preclinical study led by investigators at Weill Cornell Medicine and the Cornell Duffield College of Engineering. The particles, derived from silicon dioxide, a common component of healthy foods or fossilized sedimentary structures from single-celled organisms, induced several complete remissions of aggressive tumors in mouse models, supporting the further investigation of their use in clinical trials.

Originally developed for medical imaging applications, these particles, known as ultrasmall fluorescent core-shell silica nanoparticles, or Cornell Prime dots (C' dots), have progressed into advanced-phase clinical trials for image-guided surgery and therapeutic applications. In recent years, the researchers have found that the C' dots on their own can exert therapeutic effects against cancerous cells, while sparing healthy cells. In the new [study](#), published June 15 in *Cancer Research*, a journal of the American Association for Cancer Research, the researchers evaluated the particles' effects on mouse models of aggressive prostate cancer. They showed that the particles make the tumor cells highly susceptible to a powerful self-destruct process, and simultaneously convert the normally inactive, "cold" prostate tumor immune microenvironment into a "hot" one featuring strong antitumor immune activity—which can dramatically enhance the effects of other immunotherapies.

"We're very encouraged by these results; a treatment that directly induces tumor-cell death while transforming the immune microenvironment, as this does, would represent a new clinical paradigm," said study senior author [Dr. Michelle Bradbury](#), the Endowed Professor of Imaging Research in Radiology and director of the [Molecular Imaging Innovations Institute](#) at Weill Cornell Medicine and a neuroradiologist at New York-Presbyterian/Weill Cornell Medical Center.

The study was part of a long-term collaboration between Dr. Bradbury's laboratory and the laboratory of co-corresponding author [Dr. Ulrich Wiesner](#), the Spencer T. Olin Professor of Engineering in the Department of Materials Science and Engineering and a professor in the Department of Design Tech in the College of Architecture, Art, and Planning. It was funded in part by the Parker Institute for Cancer Immunotherapy at Weill Cornell Medicine.

As detailed in the study, the unusual effects of the C' dots include pushing prostate tumor cells toward a self-destruct mode called "ferroptosis," in which the overwhelming oxidation of molecules in the cells, especially the fat-related molecules that make up cell membranes, leads to the degradation of those membranes. Precisely how the particles trigger ferroptosis remains unclear, but the researchers have found evidence that the particles, originally designed as carriers for imaging agents, often pick up positively charged iron ions in the bloodstream, and transport those reactive cargoes inside tumor cells—where they ultimately can help catalyze runaway oxidation.

The C' dots had numerous immunological impacts, including the conversion of T cells, macrophages and other immune cells in the tumor vicinity from inert or actively immunosuppressive modes to robust antitumor activity. These results led to C' dots sensitizing tumors to clinically approved anticancer immunotherapies. The experiments also revealed extensive growth-inhibiting metabolic disruptions in different cell populations within the tumor microenvironment.

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The silica particles were specifically targeted to prostate tumor cells by a molecule that homes in on a prostate cell surface protein called PSMA, but even in non-prostate tissues where the particles were briefly concentrated, such as the spleen, there was no sign of toxicity.

“It seems unreal—how is it possible that rather than a single pathway we see all these effects happening simultaneously and only in tumors and not in healthy tissues?” Dr. Wiesner said. “I have to wonder whether ultrasmall silica’s very early and ubiquitous presence in the environment and foods like leafy greens or cereal grains has given it a connection to biology that we’re only beginning to glimpse.”

The most striking results came when the researchers conducted survival experiments in mice with aggressive prostate cancer. The C’ dots on their own, and immunotherapies on their own, moderately extended survival compared to no treatment. But the combination of silica particles with an immunotherapy called immune checkpoint blockade synergistically resulted in complete or near-complete remissions and indefinite survival in four out of ten mice treated this way. Adding a third treatment called CSF-1R blockade, which targets tumor-associated macrophages, yielded five out of ten complete remissions.

“We think there’s nothing else out there that has such a strong and durable tumor growth suppressing effect,” Dr. Bradbury said.

“One of the most intriguing aspects of this work is the convergence of direct tumor cell killing with broad immune remodeling,” said study co-author [Dr. Jedd Wolchok](#), the Meyer Director of the [Sandra and Edward Meyer Cancer Center](#), professor of medicine at Weill Cornell Medicine, director of the [Parker Institute for Cancer Immunotherapy at Weill Cornell Medicine Meyer Cancer Center](#) and an oncologist at New York-Presbyterian/Weill Cornell Medical Center.

“By creating conditions that support a more effective antitumor immune response, these particles may help unlock the full potential of immunotherapy in prostate cancer, where durable responses have historically been difficult to achieve.”

Dr. Bradbury and her colleagues also recognized the contributions of the study’s co-first authors, Drs. Nabil Siddiqui, Li Zhang, and Gabriel DeLeon, who led many of the biological, mechanistic, and translational studies, as well as the graduate students in Dr. Wiesner’s laboratory, Nada Naguib and Rachel Lee, whose precision synthesis and characterization of particle batches made the work possible. “This study reflects years of collaborative effort across multiple laboratories and would not have been possible without the dedication, creativity and perseverance of this tremendous research team that helped drive the science forward,” she said.

The researchers are continuing to explore these ultrasmall core-shell silica particles as a new class of anticancer therapeutics that can simultaneously modulate inflammatory, immune and metabolic pathways, with the ultimate goal of evaluating their safety and efficacy in clinical trials.

Drs. Michelle Bradbury and Ulrich Wiesner are inventors on patents related to the technology described in this study.

This study was funded by the Department of Defense (PC220534); the National Cancer Institute, part of the National Institutes of Health, through grant numbers R01CA253658, R01CA243085, U54CA199081 and the Cancer Center Support Grant (P30 CA008748); and Cycle for Survival/Parker Institute funding.

MedPage Today: August 19, 2026

Dramatic Increase in Active Surveillance Use for Prostate Cancer

— Soared past 90% in VA system for low-risk disease, to 61% for favorable intermediate-risk disease

Charles Bankhead, Senior Editor, MedPage Today

<https://www.medpagetoday.com/hematologyoncology/prostatecancer/122679>

Use of active surveillance for low- and favorable intermediate-risk prostate cancer more than tripled since 2005, according to a large study of veterans.

In 2005 active surveillance accounted for 27% of men with low-risk prostate cancer in the Veterans Affairs Healthcare System (VAHCS). By 2024 the proportion had increased to 93%. Among men with favorable intermediate-risk prostate cancer, use of active surveillance increased from 14% to 61%.

Across individual VA facilities, overall surveillance rates ranged from 23% to 93%. For grade group (GG) 1 prostate cancers diagnosed from 2015-2024, active surveillance accounted for 60% to 100% of patients, except for a single outlier facility with 26%.

Rates of active surveillance/watchful waiting in the VAHCS exceeded those reported from studies of community-based clinical practices, reported Matthew R. Cooperberg, MD, MPH, of the University of California San Francisco (UCSF), and colleagues in [JAMA](#).

"Prostate cancer screening saves thousands of lives by finding aggressive cancers early, but it also detects many slow-growing cancers that do not spread, and should not be treated except in rare occasions," Cooperberg said in a [press release](#). "Many experts are recommending that we not even call these 'cancers.'"

The findings reflect a paradigm shift in the approach to managing low-risk prostate cancer, according to the authors of an [accompanying editorial](#).

"These are not marginal shifts. They represent a wholesale change in what guideline-concordant care looks like," wrote Daniel E. Spratt, MD, of University Hospitals Seidman Cancer Center in Cleveland, and colleagues. "Randomized trials, mature prospective cohorts with long-term follow-up, unified guideline support, and patient advocacy all converged to reverse a pattern of overtreatment that has been witnessed over the past years."

"Clinicians came to recognize that patient anxiety, so often invoked to justify intervention, is something they can address directly rather than a reason to expose a patient to the harms of treatment he does not need," they wrote.

"Here the evidence, and the VA institutions, created the pressure to do the right thing, and they held that line against the potential financial incentives pervasive in other environments."

Prostate cancer specialists have agreed that active surveillance is the preferred mode of management for low-risk and many intermediate-risk prostate cancers, as defined by GG and prostate-specific antigen (PSA), Cooperberg and colleagues noted in their introduction. Active surveillance "is essential" to achieve a favorable benefit/risk ratio for early detection.

Such tumors have minimal potential to progress to aggressive or metastatic disease, they continued. Despite support for active surveillance across multiple major clinical guidelines, studies have suggested that use of active surveillance for National Comprehensive Cancer Network (NCCN)-defined low-risk prostate cancer remains suboptimal. To provide comparator data, the investigators examined the incidence and quality of active surveillance as practiced in the VAHCS, the nation's largest integrated healthcare system.

The study included all men with NCCN low- and favorable intermediate-risk prostate cancer diagnosed from 2005-2024 within the VAHCS. Patient management was classified as active surveillance or watchful waiting (implying monitoring without curative intent) if a patient did not receive treatment within 15 months of a diagnostic biopsy and had at least one PSA value ≥ 1 ng/mL during the timeframe, or if they had a confirmatory biopsy within 3 to 15 months after a diagnostic biopsy and before any active treatment.

A search of the VAHCS database identified 73,042 eligible patients, of whom 38,130 initially entered active surveillance/watchful waiting. Overall, use of active surveillance more than tripled during the study period and more than quadrupled in the subgroup of patients with favorable intermediate-risk disease.

See In a subset, page 7

MedPage Today: May 31, 2026

Dramatic Increase in Active Surveillance Use for Prostate Cancer

Charles Bankhead, Senior Editor MedPage Today

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In a subset analysis that considered the reason for intermediate-risk assignment, use of active surveillance increased from 11% to 55% for patients with PSA <10 ng/mL and GG2 in less than 50% of biopsy cores. The rate increased from 27% to 88% in patients with GG1 and PSA 10-20 ng/mL.

A multivariable analysis showed that the odds for active surveillance increased with age (OR 1.43 per decade, 95% CI 1.39-1.47, $P<0.001$) and more recent year of diagnosis (OR 1.21 per year, 95% CI 1.21-1.22, $P<0.001$). Factors associated with decreased odds for active surveillance were Black or African American race (OR 0.95 vs white, 95% CI 0.90-0.99, $P<0.001$), Hispanic or Latino ethnicity (OR 0.85 vs non-Hispanic, 95% CI 0.76-0.95, $P=0.003$), GG2 versus GG1 (OR 0.13, 95% CI 0.12-0.13, $P<0.001$), Area Deprivation Index score (OR 0.97 per quartile, 95% CI 0.95-0.99), and greater percent of positive-result biopsy cores (OR 0.88 per decile, 95% CI 0.87-0.89, $P<0.001$).

Although the study was carried out in a large integrated healthcare system, adherence to key components of disease monitoring can make active surveillance feasible for clinical practice environments with more limited resources than the VAHCS, said co-author Grace Lee, MD, also of UCSF.

"With the caveat that active surveillance can be personalized to each patient depending on their specific risk factors, PSA generally should not be obtained more than every 6 months (which can be performed in local/rural labs) and MRI/biopsy no more frequently performed than once per year," Lee told *MedPage Today*. "If patients have repeat negative biopsies, MRI/biopsy can be spaced out even further. Given this, it is very feasible to manage patients under active surveillance even with limited healthcare resources. Another critical part of active surveillance is ensuring a confirmatory biopsy (after initial diagnostic biopsy) is performed generally within 6-12 months of the initial diagnostic biopsy."

Information and Support: Essential Tools for Living with Prostate Cancer

A prostate cancer diagnosis can feel overwhelming, but there are many groups that exist to help. Information and support are two of the most important tools available to patients and their families. The more informed you are about your diagnosis, treatment options, side effects, and ongoing care, the better prepared you are to make decisions and advocate for the best possible outcomes.

PCSANM exists to provide local, personalized, face-to-face support from men who have walked the same path. Sharing experiences, asking questions, and connecting with others who understand can make a tremendous difference during every stage of your experience.

In addition to the support available through PCSANM, several national organizations offer valuable educational resources:

- **Prostate Cancer Research Institute (PCRI)** – PCRI offers an extensive YouTube library covering nearly every aspect of prostate cancer. New videos are added regularly, and topics are easy to search. (<https://www.pcri.org> and <https://www.youtube.com/@ThePCRI>)

- **Active Surveillance Patients International (ASPI)** – ASPI provides webinars and educational programs focused on men considering or pursuing active surveillance. (<https://aspatients.org>)

- **Prostate Cancer Foundation (PCF)** – PCF offers excellent free patient guides for localized, advanced, and recurrent prostate cancer, along with webinars featuring leading experts. (<https://www.pcf.org>)

We encourage every man diagnosed with prostate cancer—and every caregiver—to seek out reliable information and support. Learn about your disease, ask questions, attend support meetings, and take advantage of the many educational resources available. An informed patient is better equipped to work with his medical team, make confident decisions, and pursue the treatment approach that best fits his individual situation, optimizing both treatment results and quality of life.



**Prostate Cancer
Support Association**
of New Mexico

PCSANM Lifeline Newsletter
**Celebrating 35 years of supporting individuals with
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A Message From the Treasurer

October 2026

Dear Readers,

As Treasurer of PCSANM, I'm reminded every day how much our organization depends on the generosity of people who believe in our mission. Like many nonprofits, we've seen donations decline—and recent national giving trends help put that challenge in perspective.

According to Give.org, individual donors provided about 80% of all charitable giving between 1986 and 1990. By 2025, that share had declined to 64%, with individual giving increasingly concentrated among a smaller number of wealthier donors. At the same time, charitable giving has not kept pace with overall economic growth, and individual giving as a share of disposable income has fallen from a peak of 2.4% to 1.7% in 2025.

Through October 31, PCSANM is holding a \$10,000 matching gift campaign, giving your contribution an opportunity to have twice the impact. If PCSANM's work has touched your life, or if you simply want to ensure that others get the support they need, please consider making a donation. Your gift matters, and together, we can sustain our work.

Warm regards,

Gerald V. Bowe
Treasurer, Board of Directors