Prostate Cancer Support Association of New Mexico

LIFELINE

PCSANM Quarterly Newsletter October 2013 Volume 20, Issue 4

Issue Highlights

Our website address
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New Meeting place as of January 19, 2013

This meeting will start our tenure at North Domingo Baca Multigenerational Center while the Bear Canyon Senior Center undergoes renovation. The Multigenerational Center is at 7521 Carmel NE , Albuquerque. The center is located two blocks north of Paseo del Norte on the west side of Wyoming.

National Coalition for Cancer Survivorship movement started in Albuquerque, NM

In 1983, 5 women started a cancer support organization in Albuquerque. In 1986, there was the three day long founding meeting of the National Coalition for Cancer Survivorship (NCCS) in Albuquerque. This meeting has been called the birth of the cancer surviving movement. Catherine Logan from Albuquerque became the first executive director. In 1990, they opened a second office in Washington DC, and moved later headquarters there in 1991. In July 1996, the National Cancer Institute established the NCI office of Cancer Survivorship to research and address the issues of the large and growing number of long term cancer survivors and their unique needs.

The NM Department of Health has a 14 page document on their website called "New Mexico's Pivotal Role in the Cancer Survival Movement".
To see the full story, you can download/read it here:

http://cancernm.org/pdf/NM_Role_in_Survivorship_Movmnt_history_2010.pdf

A host of other documents can be found at http://cancernm.org/publications.html

The National Comprehensive Cancer Network

Dr. Boris Naerev spoke of this site in his talk to our support group meeting August 3, 2013 You need to register at their site, it is free to see their work.

Patient guidelines book for Prostate Cancer is at
http://www.nccn.org/patients/patient_guidelines/prostate/index.html

NCCN Guidelines for Patients: an educational tool for patients and oncology professionals; the NCCN Guidelines® are the most comprehensive and most frequently updated clinical practice guidelines available. This information is invaluable not only to physicians, but also to the patients.
NCCN recognizes that patients benefit daily from utilization of the NCCN Guidelines and have created patient-friendly versions to provide state of the art cancer treatment information in easy-to-understand language.

FOUNDER Rae Shipp, established 1991

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In Memory of

John Driscoll

Harold G. Ferguson

Robert V. Peet

With Deep Sympathy and Regret, We List These Names

PC SUPPORT GROUP MEETINGS

Support Meetings are usually held on the first and third Saturday of each month at 12:30 PM. **As of January 19, 2013**, they will be held at the North Domingo Baca Multigenerational Center while the Bear Canyon Senior Center undergoes renovation, for at least several months. The Multigenerational Center is at 7521 Carmel NE , Albuquerque. The center is located two blocks north of Paseo del Norte on the west side of Wyoming. Please call ahead to verify time and dates. 254-7784 or (800) 278-7678; or check website or Facebook page.

PCSA *Lifeline*

A quarterly newsletter addressing issues of prostate cancer

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MEETINGS

Lou Reimer

DISCLAIMERS

The PCSA of New Mexico gives education, information and support, not medical advice. Please contact your physician for all your medical concerns.

Dr. Lindberg's Take

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

Dr. Lindberg is working on his presentation for the September 14 PCSANM Conference, so today we are running a repeat of the first monthly article he wrote for the PCSANM Lifeline, in October 2006, plus an addendum.

Prostate Cancer Reviewed by a Medical Oncologist

Men who have a high PSA and have had repeated prostate biopsies that were required because of rising PSA-especially a third biopsy after previous negatives-should consider having Dr. Duke Bahn do a color Doppler biopsy.

This thought has come up because I am now treating a patient with metastatic cancer who had three previous negative biopsies.

For low risk prostate cancer-Gleason score 6, PSA under 10 with no, or only a small lump on the prostate-perhaps all treatments will work. One should decide on the best treatment, based on the type of complications that might occur with each treatment. Surgery has the possibility of 10% urine control problems. Radiation causes rectal damage and bowel problems. However, all treatments can interfere with normal sexual functioning.

For more aggressive cancers-Gleason 4+3=7, 8, 9, or 10, with large tumors and high PSA, it becomes more important to choose external beam radiation plus at least 6 months of combined androgen blocks, i.e. Zoladex or Lupron + Casodex, for a cure.

Surgery in the high risk patient is less effective than radiation and hormones descried above. This statement is backed up by the work of Dr. Anthony D'Amico from the Harvard Medical School. The review had 7700 prostate cancer cases from 44 different centers. This review also showed combined androgen blockage of 6 months and radiation therapy in men of high risk (Gleason 7 and above) showed good outcomes.

Lupron alone plus radiation is not enough treatment for the best chance for a cure. Casodex or Flutomide should be added to Lupron or Zoladex when giving hormones along with radiation. It is a BIG mistake to just block testosterone alone because the adrenal gland also contributes male hormones that can feed prostate cancer. All the recent studies with radiation and hormones used at least 4 months combined- i.e. Lupron + Flutomide or Casodex-show a far better cure rate than just Lupron or Zoladex alone.

This point of view is vigorously argued by Dr. Mack Roach, University of California, San Francisco, an expert authority on radiation therapy for prostate cancer

CURRENT ADDENDUM 8/29/2013 A recent update 18 year in the NEJM REVEALED NO DIFFERENCE IN SURVIVAL IN MEN WHO TOOK FINASTERIDE(PROSCAR) vs men on placebo in a prevention trial of prostate cancer. "If the increase in high grade prostate cancers was NOT a finasteride driven ARTIFACT of detection but rather reflected new high grade cancers induced by finasteride, some increase in mortality among men receiving finasteride should become obvious during long term follow-up." The current warning label on finasteride being given for enlarged prostate I believe is a BIG mistake.

Two studies show a benefit for dutasteride (avodart) a similar drug. In one study avodart was given to 150 men with low risk men with PCa who were being followed. Less progression of cancer that needed radiation or a radical. Also more negative follow up biopsies in the treated as compared to the placebo group of 150 men. A recent study published in the European Association Journal of Urology showed that dutasteride (avodart) delayed progression of psa in men with psa failure after local therapy. Also disease progression overall was delayed as compared to men treated with a placebo. I have used these drugs very successfully in treating men with prostate cancer. Also in published studies reported by Steve Strum and Mark Scholz and Bob Leibowitz. I am using avodart to maintain cures, a crucial part of my practice despite "no published phase three results." Fourteen years of experience. Of course other oncologists disagree and will not read or consider what I have been writing about. One medical oncologist refused to look at my last article. I recommend the city wide meeting Sept 14 at which I will be defending my use of TRIPLE®.

Editor: Now there seems to be a brewing fish oil/Omega 3 and PCa controversy

From Medical News Today
Written by Joseph Nordqvist July, 11, 2013
http://www.medicalnewstoday.com/articles/263179.php

Eating a lot of oily fish or consuming omega supplements may not be good for a man's health. New research reveals that males with high blood concentrations of omega-3 fatty acids are at a higher risk of developing prostate cancer.

The finding comes from a large prospective study published in the Journal of the National Cancer Institute.
A 71 percent increased risk of high-grade prostate cancer and a 43 percent increase for all prostate cancers were associated with high concentrations of EPA, DHA, and DPA.
These results are consistent with a 2011 study carried out by the same research team which found that high concentrations of DHA more than doubled the risk of high-grade prostate cancer.

The researchers were shocked to find that higher blood levels of omega-3 fatty acids, usually promoted as good for the heart, were associated with a higher risk of aggressive prostate cancer.
The consistency of these findings could mean that "these fatty acids are involved in prostate tumorigenesis and recommendations to increase long-chain omega-3 fatty acid intake, in particular through supplementation, should consider its potential risks."

For years, omega 3 fish oils have been recommended by health organizations to help reduce heart disease. The paper's senior author and member of the Fred Hutch Public Health Sciences Division, Alan Kristal, Dr. P.H, said: "we've shown once again that use of nutritional supplements may be harmful."

Theodore Brasky, Ph.D., a research assistant professor at The Ohio State University Comprehensive Cancer Center, added, "What's important is that we have been able to replicate our findings from 2011 and we have confirmed that marine omega-3 fatty acids play a role in prostate cancer occurrence.

It's important to note, however, that these results do not address the question of whether omega-3's play a detrimental role in prostate cancer prognosis."

Dr. Iain Frame, director of research at Prostate Cancer UK, says men reading about the results of this research should not panic about their omega-3 intake.
Dr. Frame says: "Omega 3, such as is found in oily fish, has been the focus of a large amount of research in recent years, the majority of which points to it having wide-ranging health benefits when eaten as part of a balanced diet..."
"Much larger and more complex studies will need to take place before we will fully understand how the risks of a diet high in Omega 3 balance against those benefits."

Dr. Frame adds: "Therefore, we would not encourage any man to change their diet as a result of this study, but to speak to their doctor if they have any concerns about prostate cancer."

Dr. Kristal's study compared the blood level concentrations of omega-3 fatty acids in 834 men who had been diagnosed with prostate cancer with samples from 1,393 men from the Selenium and Vitamin E Cancer Prevention Trial (SELECT).

The lowest risk group for developing prostate cancer had a 3.2 percent blood level concentration of omega-3 fatty acids, compared to 5.7 percent in the high risk group.
The results may come as a surprise to some, considering the number of positive health benefits that are associated with omega-3 fatty acids.

It remains uncertain why high concentrations of these fatty acids are associated with a heightened risk of prostate cancer.

Researchers say it is possible that omega-3 fatty acids are harmful because of they convert into compounds that can damage cells and DNA.

In conclusion, the finding suggests that high levels of omega-3 fatty acids can increase a man's risk of developing prostate cancer.

Part 2 on facing page

Editor: Here is an opposing viewpoint

from Prostate Cancer Research Institute website www.pcri.org By Jan Manarite, Senior Educational Facilitator

By now, most of us have seen these stories in the news - "Omega-3 Supplements Linked to Prostate Cancer" or "Omega 3s May Raise Prostate Cancer Risk"

As always, the news reports can give a partial picture, or state the scientific conclusion inaccurately. PCRI has some opposing responses from Dr Mark Moyad, Dr Anthony D'Amico, and Dr Snuffy Myers.
Here is the actual published study: Plasma Phospholipid Fatty Acids and Prostate Cancer Risk in the SELECT Trial

Harvard's Anthony D'Amico, MD, has been the most vocal in opposing the study's conclusions:
"All of these studies on associations, which is what this is, are hypothesis-generating
because they are looking back in time," said Dr. Anthony D'Amico, chief of radiation oncology at Brigham and Women's Hospital in Boston. "It's not a cause and effect." WebMD
"The study would have to account for other risk factors for prostate cancer before it could be considered definitive, he said. These include family history, age and race, among others, D'Amico explained". Medline Plus "The thing that concerns me the most is that you can find almost anything associated with aggressive prostate cancer....The scientific strength is weak at best."

Mark Moyad, MD recently wrote:

"This was a fishy and oily study of some blood levels from participants of the SELECT trial. Remember that trial which cost well over 100 million dollars to learn vitamin E can increase the risk of prostate cancer and selenium has no impact on prostate cancer?! So, in a further effort to spend money in a wise fashion (note the sarcasm) researchers found slightly higher omega-3 levels in some men with more aggressive disease, and this was overtly construed as a cause and effect and the Researchers did not even know the sources (diet, supplements, other...) of omega-3 from these men.

There were also a lower percentage of aggressive prostate cancer cases with greater alcohol intake and tobacco use.

So, what I learned from this study is that I should drink more, start smoking and smoke a lot and stay away from fish and fish oil pills (sarcasm injection again). In reality, there is only 1 thing that should be noted from this study, which is over 86% of the men with high grade disease were overweight or obese (highest percentage among all comparative groups of the study), which reflects the ongoing U.S. and global obesity epidemic.

It is such a pain in the gluteus maximus to lose weight or maintain a healthy weight that any distractions from this goal should ignored unless the evidence is unusually consistent and strong. Medical research is usually like a courtroom folks-the weight (no pun intended) of the evidence usually determines the verdict.

We need to cast our net of attention in other healthier distractions and remember heart healthy=prostate healthy. Excess weight and waist sizes increase the risk of aggressive prostate cancer, other cancers, cardiovascular disease and just dying at a much younger age compared to the rest of the population. Eating fish is heart and prostate healthy, but we do not know if fish oil supplements really have any impact on prostate cancer right now and this study does not sway the verdict in either direction.

Oh and why are fish so smart? It is because they travel in schools! And, what did the fish say when it hit the wall? Dam! Have a great day folks and now I have to sign off because I need to work out and then I am going out with my wife to eat some sushi!"

EDITOR: As always, PCSANM says you should be sure to consult your physician or other medical provider for advice on any medical or nutritional matters.

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The Cancer Center at PRESBYTERIAN

Phone (505)559-6100

From Medscape Today News http://www.medscape.com/viewarticle/770892?src=emailthis

Adult Cancer Survivors Discuss Follow-up in Primary Care 'Not What I Want, But Maybe What I Need'

ByShawna V. Hudson, PhD, Suzanne M. Miller, PhD, Jennifer Hemler, MA, Jeanne M. Ferrante, MD, Jennifer Lyle, MA, Kevin C. Oeffinger, MD, Robert S. DiPaola, MD,
Annals of Family Medicine, 2012-09-01

Abstract Background Nearly one-third of office visits for cancer are handled by primary care physicians. Yet, few studies examine patient perspectives on these physicians' roles in their cancer follow-up care or their care preferences.

More than one-half of individuals with a diagnosis of cancer are expected to survive for more than 5 years. For cancerous breast and prostate tumors, 5-year survival exceeds 90%.[1] Cancer sur-active cancer treatment. Survivors' follow-up management entails more than routine surveillance for recurrence of cancer.[2,3] It also requires proactive care, which includes systematic planning for cancer prevention and patient-centered surveillance based on the survivor's personal risk, cancer therapy, genetic predispositions, lifestyle behaviors, and other comorbid health conditions.[2,4,5]

Methods We explored survivor preferences through qualitative, semistructured, in-depth interviews drawing on patients recruited from 2 National Cancer Institute–designated comprehensive cancer centers and 6 community hospitals. We recruited a purposive sample of early-stage breast and prostate cancer survivors aged 47 to 80 years, stratified by age, race, and length of time from and location of cancer treatment. Survivors were at least 2 years beyond completion of their active cancer treatment.

Increasing numbers of studies document the importance of primary care clinicians (eg, family physicians, internists, physician assistants, nurse practitioners, and, in some cases, gynecologists) in increasing cancer survivors' screening for recurrence[6,7] and in providing comprehensive extended follow-up care.[8–13] Approximately 70% of cancer survivors have comorbid conditions that require a comprehensive approach to their medical care.[14,15] Of the 36.6 million annual physician office visits made for cancer care, nearly one-third (32%) are made to primary care physicians.[2] The American Society of Clinical Oncology projects a medical oncologist shortage by 2020 that will necessitate a multifaceted strategy to meet future cancer follow-up care demands.[16] These data suggest that primary care physicians may increasingly provide the main medical home (ie, usual source of care) for survivors who have completed treatment.[2,17]

Results Sixty-two patients were invited to participate in the study; 24 breast cancer and 18 prostate cancer survivors completed interviews for a participation rate of 67% (). Individuals who chose not to participate were comparable to respondents in terms of race and age, although men were significantly more likely to refuse participation than women (70% vs 30%, P = .05).
Forty-two survivors participated in the study. Most participants expressed strong preferences to receive follow-up care from their cancer specialists (52%). They described the following barriers to the primary care physician's engagement in follow-up care: (1) lack of cancer expertise, (2) limited or no involvement with original cancer care,
Only one-third of participants (38%) believed there was a role for primary care in cancer follow-up care and suggested the following opportunities: (1) performing routine cancer-screening tests, (2) supplementing cancer and cancer-related specialist care, and (3) providing follow-up medical care when "enough time has passed" or the survivors felt that they could reintegrate into the noncancer population.

Conclusion Survivors have concerns about seeing their primary care physician for cancer-related follow-up care. Research interventions to address these issues are necessary to enhance the quality of care received by cancer survivors. This article is very lengthy, with 5 pages of tables, and another 5 pages of text. But we wanted to give you a taste of it.

Androgen deprivation therapy and risk of acute kidney injury in patients with prostate cancer.

Lapi F, Azoulay L, Niazi MT, Yin H, Benayoun S, Suissa S

From JAMA, 2013 Jul 17;310(3):289-96. doi: 10.1001/jama.2013.8638.
Source: Centre for Clinical Epidemiology, Lady Davis Institute, Jewish General Hospital, Montreal, Quebec, Canada.

IMPORTANCE: The use of androgen deprivation therapy (ADT) in the treatment of advanced prostate cancer has been shown to delay the clinical progression of the disease. However, the testosterone suppression associated with this therapy may lead to a hypogonadal condition that can have detrimental effects on renal function, thus raising the hypothesis that ADT-induced hypogonadism could potentially lead to acute kidney injury (AKI).

OBJECTIVE: To determine whether the use of ADT is associated with an increased risk of AKI in patients newly diagnosed with prostate cancer.
DESIGN AND SETTING: A nested case-control analysis using medical information extracted from the UK Clinical Practice Research Datalink linked to the Hospital Episodes Statistics database.
PARTICIPANTS: Men newly diagnosed with nonmetastatic prostate cancer between January 1, 1997, and December 31, 2008, were selected and followed up until December 31, 2009. Cases were patients with incident AKI during follow-up who were randomly matched with up to 20 controls on age, calendar year of prostate cancer diagnosis, and duration of follow-up.
MAIN OUTCOMES AND MEASURES: Conditional logistic regression was used to estimate odds ratios (ORs) with 95% CIs of AKI associated with the use of ADT. ADT was categorized into 1 of 6 mutually exclusive groups: gonadotropin-releasing hormone agonists, oral antiandrogens, combined androgen blockade, bilateral orchiectomy, estrogens, and combination of the above. RESULTS A total of 10,250 patients met the study inclusion criteria. During a mean follow-up of 4.1 (SD, 2.9) years, 232 incident cases of AKI were identified (rate, 5.5/1000 person-years). Overall, current use of any ADT was associated with an increased risk of AKI when compared with never use (OR, 2.48 [95% CI, 1.61-3.82]), generating a rate difference of 4.43/1000 persons per year (95% CI, 1.54-7.33). This association was mainly driven by a combined androgen blockade consisting of gonadotropin-releasing hormone agonists with oral antiandrogens (OR, 4.50 [95% CI, 2.61-7.78]), estrogens (OR, 4.00 [95% CI, 1.06-15.03]), other combination therapies (OR, 4.04 [95% CI, 1.88-8.69]), and gonadotropin-releasing hormone agonists (OR, 1.93 [95% CI, 1.20-3.10]).

(continued) CONCLUSIONS AND RELEVANCE: In a cohort of patients with newly diagnosed nonmetastatic prostate cancer, the use of ADT was significantly associated with an increased risk of AKI. These findings require replication in other well-designed studies as well as further investigation of their clinical importance.

Patient Advocate Foundation Launches Financial Assistance Program for Patients Battling Prostate Cancer

LIVESTRONG Foundation and Movember Grant Funding to Help Cover Expenses Associated with Radiation Therapy

From Tom Mims, NM Department of Health

Hampton, VA. As of August 15th, prostate cancer patients now have access to financial support in the form of $1,000 grants that contribute towards the co-pay expenses associated with prescribed radiation therapy during treatment. Nationally recognized case management organization Patient Advocate Foundation (PAF) has partnered with Movember and the LIVESTRONG Foundation to launch the Radiation Co-Payment Small Grant Financial Aid Fund, ensuring prostate cancer patients across the nation have access to monetary support that can bring needed relief to their budget.

Eligible men include those who have been diagnosed and are in active radiation treatment for prostate cancer with an annual income of $60,000 or less. Qualified patients may use the one-time grant of $1,000 to cover their out-of-pocket expenses associated with radiation therapy, helping to reduce the financial burden associated with treatment. On average, Medicare patients receiving up to nine weeks of radiation treatments have an out-of-pocket responsibility ranging from $1,054 to over $3,300, depending on the specific radiation treatment prescribed. Patients who receive proton beam therapy radiation treatments can see almost double that amount in out-of-pocket costs allowed within their 20% copayment.

Patient Advocate Foundation's professional staff is available to assist applicants and distribute funds through the toll-free financial assistance line at (855) 824-7941. Live financial counselors are available Monday – Thursday 8:30 a.m.-5 p.m. and Friday 8:30 a.m. - 4 p.m. Eastern time to assist patients through the grant application process.

Radiation Therapy After Radical Prostatectomy

Ramesh Gopal MD, PhD
Assistant Professor of Radiation Oncology
Medical Director MD Anderson Radiation
Treatment Center at Presbyterian Healthcare Services
Albuquerque, New Mexico

In 2012, an estimated 241,740 men were diagnosed with prostate cancer (American Cancer Society, 2012). The most common primary treatment for localized disease is radical prostatectomy (Miller 2006). In approximately two-thirds of men, prostatectomy constitutes a cure, but within 10 years up to one-third of patients have recurrent disease (Amling 2000; Chun 2006; Han 2001; Bianco 2005). Recurrence after prostatectomy is thought to result from residual subclinical disease in the operative site that later manifests as a rising prostate-specific antigen (PSA) level, a local tumor recurrence, or metastatic disease, or from occult metastatic disease that was present at the time of the prostatectomy. The risk of recurrence is greater in men with positive surgical margins, seminal vesicle invasion (SVI), extraprostatic extension (EPE), and higher Gleason scores (e.g., Stephenson 2006; Swindler 2005; Hawkins 1995; Kupelian 1997; Epstein 1993; Zietman 1994; Lee 2004; Ohori 1995; Lowe 1997; Pound 1999; Catalona 1994).

We are, therefore, frequently confronted with two situations when prostatectomy is the primary prostate cancer treatment. First, in patients revealed to have adverse pathological features at prostatectomy we have to decide whether adjuvant radiation therapy should be considered to prevent a possible future recurrence. Second, in the post-prostatectomy patient who later presents with a detectable PSA level, appropriate salvage therapies should be considered.

Recently, the American Society for Radiation Oncology (ASTRO) and the Prostate Guideline Panel of the American Urological Association Education and Research, Inc. formed a committee to create guidelines for these situations. Membership of the committee included urologists, radiation oncologists, and a medical oncologist, with specific expertise in prostate cancer. The mission of the committee was to develop recommendations that are analysis-based or consensus-based for optimal clinical practices in the diagnosis and treatment of prostate cancer.
This guideline reviews the evidence for use of radiotherapy (RT) in the adjuvant and salvage contexts and provides a clinical framework for the use of radiotherapy after prostatectomy. The complete text of the guideline can be found here: http://www.redjournal.org/webfiles/images/journals/rob/RAP%20Full%20Text%20Guideline%202nd%20Revision051613.pdf

Adjuvant radiotherapy
Adjuvant radiotherapy (ART) is the administration of radiotherapy to post-prostatectomy patients at a higher risk of recurrence because of adverse pathological features, prior to evidence of disease recurrence (i.e., with an undetectable PSA).

The highest-quality evidence that addresses the use of radiotherapy after prostatectomy is provided by three randomized controlled trials (RCTs) that have examined the effect of radiotherapy delivered primarily in an adjuvant context. The majority of patients in the RT arms of these three trials were treated with 60 Gy – a dose somewhat lower than currently used.

These RCTs (SWOG 8794, EORTC 22911, and ARO 96-02) documented significant improvements in biochemical recurrence-free survival (bRFS) among patients with seminal vesicle invasion, positive surgical margins, and/or extraprostatic extension with the use of adjuvant RT in comparison with observation only post-prostatectomy (Thompson 2006; Bolla 2012; Wiegel 2009).

The Panel, therefore, emphasizes that ART should be offered to all patients at high risk of recurrence because of adverse pathological features. This should occur in the context of a thorough discussion of the potential benefits and risks/burdens associated with ART. The panel recognized that adjuvant treatment results in overtreatment of many patients who would never have had a recurrence.

Salvage Radiation Therapy
Salvage radiotherapy (SRT) is the administration of radiotherapy to the prostatic bed and possibly to the surrounding tissues, including lymph nodes, in the patient with a PSA recurrence after surgery but no evidence of distant metastatic disease. Biochemical (PSA) recurrence after surgery is defined as a detectable PSA level > 0.2 ng/mL with a second confirmatory level > 0.2 ng/mL.

There is no evidence that addresses the timing of the first PSA test post-prostatectomy to determine a patient's disease status. In the Panel's clinical experience the first PSA generally should be obtained 2 to 3 mos post-RP. Adjuvant radiotherapy is usually administered within 4-6 months following radical prostatectomy. Generally, radiotherapy is initiated after the return of acceptable urinary control. As sexual function can require 1-2 years before a full return of function is observed, return of erections is not a requirement before initiation of adjuvant radiation.

Evidence regarding the efficacy of SRT in the post-RP patient is available in the form of a large literature composed of observational studies. However, only a few studies compared post-RP patients with PSA or local recurrence who received SRT to patients with PSA or local recurrence post-RP who did not receive further therapy (e.g., Boorjian 2009; Trock 2008). Generally, these studies indicate that SRT improves outcomes compared to RP only patients but the benefits may be specific to certain risk groups (see Discussion under Guideline Statement 7).

One of the most pressing clinical questions regarding the care of the post-RP patient is whether it is better to administer RT before evidence of recurrence – RT as adjuvant therapy – or to wait until recurrence manifests and

then administer RT as salvage therapy. It is acknowledged that the use of ART may involve irradiation of some patients who never would have had recurrent cancer, thus exposing them unnecessarily to the risks, toxicity, and quality of life impact of RT. Waiting to administer RT as a salvage therapy limits its use to patients with recurrence but, particularly in patients with high-risk disease, could be less effective and could allow the progression to metastatic disease.

The Panel concluded that it is not possible from the available evidence to address the question of the superiority of ART vs. SRT. Currently, two RCTs are actively accruing patients to address this important question – the RADICALS trial and the RAVES trial.

The Panel Provided 9 Guideline Statements

Guideline Statement 1
Patients who are being considered for management of localized prostate cancer with radical prostatectomy should be informed of the potential for adverse pathologic findings that portend a higher risk of cancer recurrence and that these findings suggest a potential benefit of additional therapy after surgery.

Guideline Statement 2
Patients with adverse pathologic findings including seminal vesicle invasion, positive surgical margins, and extraprostatic extension should be informed that adjuvant radiotherapy, compared to radical prostatectomy only, reduces the risk of biochemical (PSA) recurrence, local recurrence, and clinical progression of cancer. They should also be informed that the impact of adjuvant radiotherapy on subsequent metastases and overall survival is less clear: one of two randomized controlled trials that addressed these outcomes indicated a benefit but the other trial did not.

Guideline Statement 3
Physicians should offer adjuvant radiotherapy to patients with adverse pathologic findings at prostatectomy including seminal vesicle invasion, positive surgical margins, or extraprostatic extension because of demonstrated reductions in biochemical recurrence, local recurrence, and clinical progression.

Guideline Statement 4
Patients should be informed that the development of a PSA recurrence after surgery is associated with a higher risk of development of metastatic prostate cancer or death from the disease. Congruent with this clinical principle, physicians should regularly monitor PSA after radical prostatectomy to enable early administration of salvage therapies if appropriate.

Early PSA rise was associated with more rapid development of metastases. Specifically, men who developed a rise in their PSA value within 2 years of surgery developed metastases more rapidly - usually within five years. Men who developed a rise in their PSA values more than two years post-surgery, however, developed metastases later, many more than ten to fifteen years later. Patients should be informed of the relationship between PSA recurrence post-surgery and the probability of metastatic recurrence of prostate cancer.

Guideline Statement 5
Clinicians should define biochemical recurrence as a detectable or rising PSA value after surgery that is ≥ 0.2 ng/ml with a second confirmatory level ≥ 0.2 ng/ml.

Guideline Statement 6
A restaging evaluation in the patient with a PSA recurrence may be considered. It was recognized that the likelihood of a positive bone scan or pelvic CT was low at low PSA values.

Guideline Statement 7
Physicians should offer salvage radiotherapy to patients with PSA or local recurrence after radical prostatectomy when there is no evidence of distant metastatic disease.

Two of the RCTs included a subgroup of patients who had detectable PSA levels post-RP – patients that could be categorized as salvage patients. Subgroup analyses of these patients suggest a benefit of RT. In SWOG 8794, RT significantly reduced metastatic recurrence rates among patients with detectable PSA post-RP (Thompson 2009). In EORTC 22911, RT significantly reduced rates of biochemical failure among patients with detectable PSA post-RP.

Guideline Statement 8
Patients should be informed that the effectiveness of radiotherapy for PSA recurrence is greatest when given at lower levels of PSA. The relevance of pre-SRT PSA level was confirmed by a recent systematic review of 41 selected SRT studies (King 2012). These authors reported that PSA level before SRT was significantly associated with relapse-free survival with an average 2.6% loss of relapse-free survival for each 0.1 ng/ml PSA increment at the time of SRT. In addition, a meta-regression performed on a selected group of 25 SRT studies indicated that pre-RT PSA levels were significantly associated with 5-year progression-free survival levels such that progression-free survival rates dropped by 18.1% for every 1 ng/ml increase in pre-RT PSA (Ohri 2012). Therefore, patients should be advised that if recurrence is detected without evidence of distant metastases, then radiotherapy should be administered at the earliest sign of PSA recurrence and, ideally, before PSA rises to 1.0 ng/ml.

Guideline Statement 9
Patients should be informed of the possible short-term and long-term urinary, bowel, and sexual side effects of radiotherapy as well as of the potential benefits of controlling disease recurrence.

Editor Note: There are almost 2 pages of References to go along with this article. They will be posted on the PCSANM website page with the October Newsletter articles.

DES - AN ALTERNATIVE HORMONAL DEPRIVATION FOR PROSTATE CANCER
MY PERSONAL EXPERIENCE Lyle A. Ware July 2013

I want to propose something other than drugs like Lupron® when treating Prostate Cancer (PC). I have tried almost everything other than chemo and surgery, including one type of Hormone Deprivation Therapy (HDT) called TAB® (Lupron®, Casodex® and Proscar®, Registered by Dr. Bob Leibowtiz). I have been using synthetic estrogen (DES, DiEthylStilbestrol) along with Avodart®. In my opinion this is much better than other types of HDT. The side effects are less and, the results are just as good, if not better.

For prostate cancer, an important thing to track is your PSA Doubling Time (DT). Many doctors believe that a shorter DT indicates the cancer is more aggressive.
Make a simple line graph of PSA versus time, and see when the line was at a certain number. Then compare to how long it takes to double. That is your doubling time. If it is over two years, that is good. Mine was 22 months when first diagnosed in 1996. In 2009, it was under 5 months. In 2011 it was every month!

In the fall of 1996, my PSA was 17.1. I thought that it was a mistake. Checking with a different lab, it was 16.0. A prostate biopsy revealed five of six cores with cancer and a Gleason Sum of 3+3=6. I was treated with six months of TAB, then 25 external beam radiation treatments and radioactive Iodine seed implants. My PSA went below 0.1 and stayed there for over six years. In April of 2004, it rose to 0.31 and kept going up. DAMMIT!

By August, 2009, my PSA was almost 4 ng/ml - DT was five months. I started TAB® which brought my PSA down to <0.04 in 11 months. Then I started estrogen (Estrodiol) gel patches and got PSA to 0.008 in four more months. In January 2011, I stopped the estrogen patches. Before starting the estrogen, I had my breasts treated with electron beam radiation - hoping to avoid breast enlargement - it did not work very well - the area under my nipples got very tender and enlarged.

In November of 2011, my PSA was 0.39 and I tried High DoseTestosterone Replacement Therapy (HDTRT) for five months. I wanted to see if very high testosterone levels would slow the doubling rate of PSA. It did not - DT was still about one month. However, my testosterone quickly rose to over 2000 ng/dL and my PSA rose to 8.47. My strength and stamina increased greatly along with my red blood cells. One month after stopping HDTRT, my PSA dropped to 5.8. Six weeks later, in July, 2012, my PSA was up to 9.7. I needed to resume some kind of treatment.

Instead of Estrodiol Gel patches, Dr. Natalie Marshal at NM Cancer Center, suggested 1.0 mg per day oral capsule of DES and aspirin as an anti-coagulant instead of Coumadin. Dr. Peter Lindberg said that Dr. Nicholis Vogelzang (Las Vegas, NV) has had good results with using aspirin instead of Coumadin. If I have blood clotting problems, I will need to use Coumadin. Symptoms of clotting are: Breathlessness, chest pain, fainting, and leg pain. Dr. Lindberg also said that Dr. Steven Strum uses Coumadin along with DES as does Dr. Charles (Snuffy) Meyers. Snuffy says that DES is the best tolerated hormone deprivation.

In July 2012, I started taking one mg of DES along with two 81 mg aspirin and one 0.5 mg Avodart and one 5 mg finasteride (generic Proscar®) per day. In less than four months my PSA dropped to 0.1 - a hundredfold decrease. In July 2013, after thirteen months of DES, my PSA is less than 0.02, Testosterone is 13 and DHT is <5.

In April of 2013, I learned that Avodart had a half-life of five weeks! So I am only taking one per week, and my DHT has not risen. Also, I have stopped taking finasteride because it only inhibits five alpha reductase type 2, whereas Avodart protects against type 1 and 2. Allegedly, there is a type 3, and no inhibitor for it so far.

Note that when I used TAB, it took over ten months to drop my PSA one hundredfold, with DES, it took less than four months. Also note that, PSA DT was much shorter before I started DES.

Good things about DES: It takes the place of Lupron® by lowering testosterone. It takes the place of anti-androgens like Casodex® which block the androgen receptors in the prostate cells. It promotes apoptosis (programed cell death; Ref. ***Induction of Apoptosis by Diethylstilbestrol in Hormone Insensitive Prostate Cancer Cells*;** Cary N. Robertson, et. al. Journal of the National Cancer Institute, Vol. 88. No. 13 July 3, 1996). I have had much fewer side effects than when I used Lupron, especially hot flushes. It is cheap. I am getting 90 one mg custom compounded capsules for $45. That is a three month supply. [Avella Specialty Pharmacy, Phoenix, AZ. 1.877.546.5779] A three month Lupron® shot costs Medicare about $2200.

Not so good things about DES: As with any type of HDT, you lose strength and stamina because of anemia plus all the usual side effects. When Lupron was approved, it was compared to 3 mg of DES and there were about 6% cardiovascular events versus about 12% for DES. Lower doses of DES like I am using and drugs like: blood pressure meds, diuretics, and blood thinners all reduce these side effects.

I hope that all of you readers know that you don't have to go through surgery and, or, radiation, and then have your cancer come back to use this therapy. For the past 50 years, DES has been used safely in many countries to treat PC as a ***first line defense***.
Hormonal deprivation is recommended in this book: ***Invasion of the Prostate Snatchers: No More Unnecessary Biopsies, Radical Treatment or Loss of Sexual Potency*** - by Mark Scholz M.D. and Ralph Blum; Hardcover (Aug. 24, 2010) $17 at **Amazon.com**

I hope that you have found this personal narrative helpful and will consider the use of DES if your PC does recur, ***or*** if you want to use it as a first treatment, of course consult with your doctor. Lyle A. Ware

Reel Recovery Fishing Retreat for men Cancer Survivors, by Jerry Cross

I recently had the privilege to travel to Cow Creek Ranch, http://cowcreekranch.com/ , 1 hour north of Pecos, for a 2 night fly fishing retreat sponsored by Reel Recovery, www.reelrecovery.org Reel Recovery is a national non-profit organization that conducts free fly-fishing retreats for men recovering from all forms of cancer.

Reel Recovery was founded in 2003, with one retreat, and now has 24 retreats this year in 12 states. The one I attended was the 144th in their history. At my retreat, July 31-August 2, we had three sessions of fishing over the day and a half, totaling about 9 hours of fishing time. We also had 6 Courageous Conversations events, facilitated by Stan Golub, where we talked and listened, and supported each other. We had 12 men, I was the only one from Albuquerque. Three others were PCa survivors from Santa Fe, none of them had heard of our group. I did share handouts with all.

After a quick casting lesson, when it came time for fishing, they had over a dozen fishing volunteers who went out with us as our own fishing "butlers" They drove us to spots on the stream or on one of a dozen ponds at the ranch, changed all our flies, unstuck our hooks, showed us what to do, guided and instructed us, and shared their skills and equipment with us. We had a different guide for each fishing session.

Their Program Goals are: To provide a safe, reflective environment for the participants to discuss their disease and recovery with other men with shared experiences, thereby providing support and information to help them in their recovery;
To provide expert fly-fishing instruction that enables the participants to learn a new skill, form a healing connection with nature, and participate in a sport they can continue throughout their recovery and lifetime; and
To provide participants information about cancer-related resources, both in the local community and nationally, to facilitate networking and enhanced management of their recovery

Though only a few days in duration, a Reel Recovery retreat can be a life-changing event for men battling cancer. The program blends outdoor activity with directed conversations to create a unique environment conducive to relaxed, open interactions. Retreats are offered at no cost to the participants and are led by professional psychosocial facilitators and expert fly-fishing instructors. A maximum of twelve men are invited to participate, to ensure the quality of the instruction and to create a powerful small-group dynamic. The program is designed to be both experiential and reflective, to develop group camaraderie as well as individual skills, and to build bonds of friendship that provide a reservoir of personal hope.

Lodging, food, drinks and snacks, use of facilities and fishing gear were all provided free. We did have to buy a fishing license. And they gave us a box of flies, a fly fishing book, and many other things. Funding come from donations and grants, the largest donor is the John Wayne Cancer Foundation, http://johnwayne.org/

Applications are taken on-line in the spring, and if you get a chance to attend one of these, please make an effort. I had a wonderful time, learned a lot, met some great people, and had some fun. And that's from a person who had a life-long dislike for fishing.

Coming soon:
Prime Time 50+ Expo

Be sure to attend the Albuquerque Prime Time 50+ Expo on Wednesday, October 9, 2013, at the Albuquerque Embassy Suites, Lomas and I-25, from 8:30 to 3:00 pm. PCSANM will have a display there. Lovelace Medicare Plan is a main sponsor. Stryker Orthopaedics is a silver sponsor and they will be providing one of our speakers. The continental breakfast is made possible by Sandia Hearing Aids and they will also provide free hearing tests. Isleta Resort and Casino is providing carry bags with a few surprise goodies inside, and the Department of Senior Affairs will provide transportation from local senior centers. There will be mobile mammography van, glaucoma and diabetic retinopathy testing, heel scans for bone density and osteoarthritis testing, hearing testing and even a dentist for dental screenings.

PCSA *Lifeline* Newsletter
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Prostate Cancer Support Association
Of New Mexico, Inc.
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Chairman's Message, October 2013

I hope this newsletter finds our readers in good health and spirits.

I am writing this chairman's corner well before the October newsletter's publication date. At this time your support association is preparing for two major events: the advanced/recurrent prostate cancer conference on September 14 and the annual PSA draw on October 5. Your board and other volunteers have been working very hard to bring these events to you and I hope you were able to take advantage of the learning and testing these events provided for you.

Our association has two major missions. The first and most critical mission is to provide support for the newly diagnosed. The second mission is to educate our members, and the general public, about prostate cancer and treatment options. We appreciate your donations of time and money to help achieve these missions. We continue to work to bring our regular support meetings and events like the conference and PSA draw, to you, and the people of New Mexico.

I wish all our members well.

Lou

Lou Reimer
Chairman of the Board