

Prostate Cancer Support Association of New Mexico



Celebrating 26+
years of
supporting men

LIFELINE

PCSANM Quarterly

July 2018

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Support Meetings:

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 is at

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

Personal PSA Screening and Treatment Choices Among Expert Physicians

Published in **Urology** March 2018
Canadian Urological Association Journal

- This study looked at the practices of treating physicians with regard to prostate cancer screening and treatment. A total of 869 physicians, including urologists, radiation oncologists, and medical oncologists completed the survey. Overall, 90% of respondents supported past or future screening for themselves or relatives. Additionally, there was a clinically significant correlation between physician specialty and treatment selection.
- Based on these data, physicians treating prostate cancer are likely to recommend prostate cancer screenings for themselves and family members, acknowledging the associated risks and benefits.

Physicians who treat prostate cancer are aware of the controversies regarding PSA screening. In this survey of urologists, medical oncologists, and radiation oncologists, practitioners were asked if they would personally undergo PSA screening or recommend it to a family member. Of 869 respondents, 90% indicated that they have, or would, undergo screening. When asked about treatment of localized disease, urologists and radiation oncologists exhibited significant specialty-specific biases regarding treatment (Phi coefficient=0.61; $P = .001$).

While limited by reporting bias (unknown number of survey invitations) and not including the major urology and radiation oncology groups in America, these findings demonstrate that providers most familiar with the risks/benefits of prostate cancer screening would, in fact, pursue this option themselves. Treatment decisions were biased based on specialty.

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In Memory of

Harry Blakeslee

Richard Sellers

Lyle Ware

**With deep sympathy
and regret, we list
these names**

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Remembering Lyle Ware

Lyle A. Ware passed away February 25, 2018 in Albuquerque, NM. He was born in Iowa City, IA on June 15, 1936 to Dr. Stephen Ware and Anna Ware.

He was married to Carole Jean Morton in 1958. He is survived by his wife; children, Kurt, Eric and Kyla; brother, Phil; sister, Charlotte; and six grandchildren. He retired to NM in 1989.



He was a self-proclaimed amateur expert regarding prostate cancer and supported hundreds of men, helping them navigate the plethora of treatments and medicines to their best advantage. He wrote over 40 articles about prostate cancer that were published in Lifeline, a local support group's newsletter. From the Albuquerque Journal obituary, February 27, 2018.

Editor Notes: The first entry from Lyle that I could find in our Lifeline archives was a bibliography list in the Winter 1997-98 issue. His first article written was "The Patients Corner" in the Spring 1998 issue.

In the summer of 1998, PCSANM put out their first Buddy List in the Lifeline; it had 6 men on it, and Lyle was there.

He wrote the first **Beginner's Guide to Prostate Cancer**, which we give to all newly diagnosed men in our welcome packets, in Spring 1999.

Between 1998 and 2003, Lyle served as Lifeline editor or co-editor, Education Chairman, and/or Meeting Facilitator at one time.

He wrote a summary of the book "Invasion of the Prostate Snatchers" in the July 2012 Lifeline. He wrote "DES: my personal experience" in the October 2013 issue.

Lyle and this editor co-wrote "NM American Cancer Society Cancer Summit; Treating the person behind the Diagnosis" conference report in the October 2015 issue.

He advised and counseled many men during his 20 year involvement with this group. He will be missed. Our thoughts and prayers go out to his family.

The Newest Board Member Celia A. Cable

I became a caregiver in 2012 when the universe gave my husband, Gary, a prostate cancer diagnosis as a present for his 65th birthday.

Early on we happened upon the web site of the Prostate Cancer Association of New Mexico. They had and have a wealth of information, not only on their shelves, but especially in its membership. I learned alongside him about PSA levels, biopsies, Gleason scores, cancer cores, treatment centers, treatments, and medical specialties.

After traveling a most difficult journey of just over four and a half years, I was with him on his last day. I then began the difficult journey of widowhood. It was then that I remembered several ladies' comments that they would have welcomed a group separate from that of the patient to share understanding of the happenings in the doctor's office and at home.

My formal training was in education and business administration. My only qualification for caring for my husband was a loving heart. I hope to share everything I learned through experience with whomever welcomes it.

Patient Shortage for Cancer Trials Grows

Meir Rinde Apr 30, 2018

This very long article can be seen here:

<https://www.onclive.com/publications/oncology-live/2018/vol-19-no-9/patient-shortage-for-cancer-trials-grows>

At a time of rapid advancements in cancer biology and innovation, researchers are facing mounting challenges in finding enough patients to recruit for clinical trials. Although this has been difficult for many years, current trends in oncology drug development may be making the problem more acute.

The proliferation of targeted investigational drugs has both narrowed the pool of eligible patients and increased demand for them. In addition, trials are conducted more often at centrally located academic centers than at the community oncology offices where the vast majority of patients with cancer go for treatment. These factors make the study and approval of new drugs more expensive and time-consuming and leave many people who have treatment-resistant cancers without access to potentially life-saving therapies.

“Desperation Oncology’: When Patients Are Dying, Some Cancer Doctors Turn to Immunotherapy

Gina Kolata NY Times April 26, 2018

Dr. Oliver Sartor has a provocative question for patients who are running out of time. Most are dying of prostate cancer. They have tried every standard treatment, to no avail.

New immunotherapy drugs, which can work miracles against a few types of cancer, are not known to work for this kind.

Still, Dr. Sartor, assistant dean for oncology at Tulane Medical School, asks a diplomatic version of this: Do you want to try an immunotherapy drug before you die?

The chance such a drug will help is vanishingly small — but not zero. “Under rules of desperation oncology, you engage in a different kind of oncology than the rational guideline thought,” Dr. Sartor said. The promise of immunotherapy has drawn cancer specialists into a conundrum.

When the drugs work, a cancer may seem to melt away overnight. But little is known about which patients might benefit, and from which drugs. Some oncologists choose not to mention immunotherapy to dying patients, arguing that scientists first must gather rigorous evidence about the benefits and that treating patients experimentally outside a clinical trial is perilous business.

But others, like Dr. Sartor, are offering the drugs to some terminal patients as a roll of the dice. If the patient is dying and there’s a remote chance the drug will help, then why not?

“Immunotherapy is a particularly nuanced problem,” said Dr. Paul Helft, an ethicist and oncologist at Indiana University School of Medicine.

Cancer doctors are well aware of the pitfalls of treating patients before all the evidence is in. Many still shudder at the fiasco that unfolded in the 1980s and 1990s, when doctors started giving women with breast cancer extremely high doses of chemotherapy and radiation on the theory that more must be better.

The doctors did not systematically collect data; instead, they reported patient anecdotes claiming success.

Then a clinical trial found that this treatment was much worse than the conventional one — the cancers remained just as deadly when treated with high doses, and the regimen itself killed or maimed women.

Often, he and other doctors persuade a patient’s insurer to pay. If that fails, sometimes the maker will provide the drug free of charge. Immunotherapy drugs can have severe side effects that can even lead to death.

Once the immune system is activated, it may attack normal tissues as well as tumors. The result can be holes in the intestines, liver failure, nerve damage that can cause paralysis, serious rashes and eye problems, and problems with the pituitary, adrenal or thyroid glands.

Side effects can arise during treatment or after the treatment is finished. For most patients, though, there are no side effects or only minor ones. That makes giving an immunotherapy drug to a dying patient different from trying a harsh experimental chemotherapy or a treatment like intense radiation.

The problem is deciding ahead of time if an immunotherapy drug will help. Doctors check biomarkers, chemical signals like proteins that arise when the immune system is trying to attack. But they are not very reliable.

“A positive biomarker does not guarantee that a patient will benefit, and a negative biomarker does not mean a patient will not benefit,” said Dr. Richard Schilsky, senior vice president and chief medical officer of the American Society of Clinical Oncology. “You don’t have a solid biology to go on.”

It was this problem, described at a medical conference a couple of years ago, that led Dr. Sartor to begin offering immunotherapy to dying patients.

“I was thinking, ‘My God, these tests that are used to drive clinical decision making are not worth a damn,’” he said. “These are peoples’ lives here.”

"I was thinking, 'My God, these tests that are used to drive clinical decision making are not worth a damn,'" he said. "These are peoples' lives here.

We are playing with the highest of stakes." "For certain people it is like, bingo, you give the drug to them and they have a long-lasting and positive benefit," he added. "When our knowledge is not sufficient to inform our decisions, then we have an ethical conundrum."

Out of curiosity, Dr. Sartor emailed eight prominent prostate cancer specialists asking if they, too, offered immunotherapy drugs to patients on the off-chance the treatments would help.

Five said they offer it, with a variety of provisos, offering comments like, "If I was a patient, I want my doc to do everything." Dr. Daniel George, at Duke University, said he does not offer immunotherapy to every man who is dying of prostate cancer.

But, he said, "for those patients who want to do everything they possibly can, that's the group where we try checkpoint inhibitors," a type of immunotherapy.

To the others — the majority of his patients with metastatic prostate cancer — he does not mention immunotherapy. "We have to balance between hope and reality," he said. "The most difficult conversation we have with patients is when we have to tell them that more treatment is actually hurting them more than the cancer."

Dr. Daniel Petrylak, a prostate cancer specialist at Yale, said his inclination was to offer immunotherapy only to those rare patients whose tumors have a genetic marker indicating the immune system is trying to attack — already an approved indication for prostate cancer, he noted.

But this strategy gives him a rationale for trying the drugs on patients with other cancers. With the possibility of a dramatic and prolonged response, he said in an interview, "how can you ethically deny this to patients?"

At the Dana-Farber Cancer Institute in Boston, Dr. Christopher Sweeney said he petitions an insurance company to get an immunotherapy drug when the patient has a genetic marker predicting a possible

response — an indicator the drug might work even if there is as yet no clinical trial evidence that it will — and is strong enough to tolerate the treatment.

But if those conditions do not apply, as is usually the case, Dr. Sweeney only gives the drugs to patients if he can do so as part of a clinical trial, where something can be learned from their experience.

And if there is no clinical trial for the patient? "I basically say I don't have any approved therapies," Dr. Sweeney said. "Here's the truth — most patients don't benefit from these drugs.

He tells patients that just because he has no more drugs to give does not mean he has abandoned them. Supportive care can make patients more comfortable, even prolong their lives.

Dr. Sartor disagreed with the approach. "I would love for every patient to be on a clinical trial," he said. "But does that mean I shouldn't try because I don't have a trial?"

One of the first patients Dr. Sartor treated with immunotherapy was George Villere, a retired investment adviser who lived in New Orleans. Mr. Villere had bladder cancer and had tried chemotherapy.

It didn't work, so Dr. Sartor told Mr. Villere that he had run out of conventional options and asked if he wanted to try immunotherapy. At the time, the drugs had not been approved for bladder cancer.

Mr. Villere and his wife, Fran Villere, thought it over, asking themselves whether they would regret it if they did not try. "I thought we would," Mrs. Villere recalled in an interview. Their insurance agreed to pay, and Mr. Villere took the drug for several months.

Nonetheless, he died on November 15, 2016, at age 72. "He had no side effects," Mrs. Villere said. "But the drug didn't do a damn thing."

Then there is Clark Gordin, 67, who lives in Ocean Springs, Miss. He had metastatic prostate cancer, "a bad deck of cards," he said in an interview.

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The UNM Project HERO

12 week exercise and meditation study has ceased. They were not able to get enough participants for the June session, and the program has been moved to another state.

Cancer's Invasion Equation by Siddhartha Mukherjee

We can detect tumors earlier than ever before. Can we predict whether they are going to be dangerous?

We've tended to focus on the cancer, but its host tissue —“soil,” rather than “seed”— could help us predict the danger it poses.

The documentary film, produced by Ken Burns, entitled “Cancer: The Emperor of All Maladies”, was based on the 2010 Pulitzer prize -winning book “The Emperor of All Maladies: A Biography of Cancer”, written by Siddhartha Mukherjee, MD, PhD. Mukherjee has published three books, including “The Emperor of All Maladies,” for which he won a Pulitzer Prize, and, most recently, “The Gene: An Intimate History.” The 3 part series was shown in late March 2015 on PBS

From Annals of Medicine September 11, 2017 issue

This article appears in the print edition of the September 11, 2017, issue, of **The New Yorker Magazine** with the headline “**The Invasion Equation.**”

It runs over 30 pages, so we can't print it here, but you can read it at:

<https://www.newyorker.com/magazine/2017/09/11/cancers-invasion-equation>

Does Vasectomy Increase Prostate Cancer Risk?

UC Berkeley, School of Public Health
Health and Wellness Alerts April 18, 2018

A large 2017 study says no. Over the past 25 years, however, research has produced conflicting results about this potential risk, for which there is no established biological rationale. For instance, a large 2014 Harvard study of health professionals found a small increased risk in men with vasectomies (often decades after the procedure), but a large 2016 study from the American Cancer Society did not.

The new study followed nearly 85,000 European men (15 percent with vasectomies) for 15 years and found no link between the procedure and overall, high-grade, or advanced-stage prostate cancer. All three studies were published in the Journal of Clinical Oncology.

What factors have been shown to increase the risk of prostate cancer?

Increasing age.

Family history. Having a brother or father with prostate cancer more than doubles your risk (brother more so than father). Your risk is even higher if several of your relatives have had the cancer, especially if they were young when it was found.

Race. Black men are 60 percent more likely to develop it than white men, and more than twice as likely to die from it.

Genes. Men who inherit certain genetic mutations (notably of the BRCA gene, best known for increasing the risk of breast and ovarian cancer) have elevated rates of prostate cancer.

Continued from page 5

Dr. Sartor tried conventional treatments, but they didn't work for Mr. Gordin. Finally, the doctor suggested immunotherapy. Mr. Gordin's insurer refused. But then the lab that had analyzed his tumor discovered it had made a mistake.

There was a chance Mr. Gordin might respond to immunotherapy, because he had a rare mutation. So his insurer agreed to pay. \$15.99.

Immediately after taking the drugs, Mr. Gordin's PSA level — an indicator of the cancer's presence — went down to nearly zero. "Makes my heart nearly stop every time I think about it," Dr. Sartor said. "Life sometimes hangs on a thin thread."

A new program from PCSANM

The Prostate Cancer Support Association of New Mexico (PCSANM) is launching a program to help men who have never had a PSA test or haven't had one in a long time to get the test for free.

The Prostate Cancer Support Association of New Mexico believes men should have at least a baseline PSA score for reference, starting at age 50 for most men, and age 40 for high risk men; African Americans and men with a family history of prostate cancer. Prostate cancer strikes about one in seven men during their lifetimes and about one in six for African Americans.

This new program is designed for men who haven't had a recent PSA test, for reasons such as but not limited to no doctor or health care, no insurance, show troubling symptoms, or need reassurance. It is not designed for our current PCSANM members. It is not designed for men who get regular checkups and blood work. A gentleman is entitled to one FREE lifetime use of this program.

Continued next column

Continued from prior column

We will only ask you for your name and dob, address, email, and phone number for our tracking. No one from our group will call you (except to remind you to use the voucher after a month), email or write you. User may give us their info to get on our mailing/notices list if they wish before or after testing, or if they want to receive our materials. All our services, including 1 on 1 consults, buddy list, library, meetings, etc are free support services by fellow Prostate Cancer survivors, and unpaid peer facilitators for the group.

To receive this free PSA blood test, you must come to our office at 2533 Virginia St NE, Suite C, Albuquerque, NM 87110, just NW of Wyoming and Menaul to pick up a voucher. Our office is open Monday thru Thursday, 10 am to 2 pm.

When you present this voucher to the specified Any Lab Test Now facility, at 2305 San Pedro NE, Suite D1, Albuquerque, NM 87110, they will draw blood, and you can choose how you want to get your results: fax, mail, email, pickup yourself. Tests before 4 pm get results in one day, tests after 4 pm take 2 days. Their office is open Monday thru Friday, 9 am to 5 pm. PCSANM will have no knowledge of your results.

If you want to come back to our office to find out more information, we are glad to help. We strongly encourage you to share your results with any medical personnel you do see.

A PSA test is a simple blood draw that measures the level of a protein called prostate-specific antigen (PSA), which is manufactured by the prostate. Doctors use the test to help detect cancer, but it does not provide a definite diagnosis.

Finally, if you don't fit into this target group, but know someone who does – family member, coworker, or friend, for example – let them know about it.

PCSANM depends on a NM Department of Health grant and member donations for its livelihood. We gladly accept any donations through the year, and especially IRA Directed Distributions. We thank all who have supported us over the years. We also depend on manpower to get things done; we can always use members to sit at our table at health fairs or other community events. Contact the office to see how you can help.

How to Find an Expert Radiation Oncologist: Please Read This Before You Get Any Treatment

By Janet Farrar Worthington

October 2017

from PCF.org

Medical care is uneven. Even if hospitals offer the same treatment, by no means does this mean that this treatment is interchangeable. Do yourself a huge favor and do your due diligence: Make sure you are getting treatment at an excellent center, from an expert radiation oncologist and team.

Patient volume matters. First, says Johns Hopkins radiation oncologist Phuoc Tran, M.D., Ph.D., look at the numbers. (In fact, he recently co-authored an editorial on a study correlating patient volume with improved outcomes in radiation treatment for prostate cancer and other forms of cancer.) “Find out how many cases of prostate cancer they have managed,” he says. “The more, the better.” Ask how many patients with prostate cancer the center treats each day. Radiation therapy, done properly, is technically difficult; precision is essential. “For the most part, your best bet is to look for a high-volume center that treats a lot of men with prostate cancer – at least 30 to 40 patients a day – with IG-IMRT.”

How do you find a high-volume center? Here are two websites, one from the National Cancer Institute, <http://www.cancer.gov/research/nci-role/cancer-centers/find-and-one-from-the-National-Comprehensive-Cancer-Network>, https://www.nccn.org/patients/about/member_institutions/qualities.aspx

Look for a center where different specialties work together. The very best centers offer a multidisciplinary approach – this means that you get expert opinions from a pathologist, medical oncologist, radiation oncologist, and urologist. Adam Dicker, M.D., Ph.D., Chairman of Radiation Oncology at the Sidney Kimmel Cancer Center at Thomas Jefferson University, describes it this way: “We’ve been doing this for over 20 years; the patient stays in the same room, and doctors from different disciplines go in and out. We think that provides the ultimate service to a patient.” This teamwork promotes a more thoughtful and thorough approach to treatment decision-making.

Ask your doctor about his or her success rate. The best cancer doctors, in any specialty, follow their patients for many years. How many patients have remained cancer-free? What percentage have had long-term side effects?

Ask to talk to some patients. Many doctors have a list of their patients who are willing to talk to other patients and share their experiences. If your doctor doesn’t provide such a list, look for prostate cancer support groups and talk to men who have undergone radiation therapy from this doctor.

Keep your antennae up. It should raise a red flag, says Tran, if your doctor seems hesitant for you to get a second opinion, or “seems overly concerned with getting you to start treatment fairly quickly without addressing all your concerns.” Remember, your cancer took years to grow. You can afford to take a few weeks to find the right doctor to treat it. Also, be leery if a doctor is pushing a specific treatment; it may be that the hospital just spent millions on a new machine and needs to pay for it.

Don’t trust reviews on the internet. They are unreliable, in large part because it’s not clear exactly who is writing them.

Don’t trust hype, either. Hospital websites and ads can promise a lot of things. Whether they can actually deliver them is a different matter.

https://www.pcf.org/c/how-to-find-an-expert-radiation-oncologist/?utm_source=NewsPulse&utm_medium=email&utm_campaign=APR18NP

Save the Date:

**The Prostate Cancer Support Association of New Mexico’s
FREE Annual Conference,
“Living and Thriving with
Prostate Cancer”
is scheduled for Saturday,
November 10, 2018, from
9:00 am to 4:45 pm at
Sandia Prep School.
Please plan on attending.**

MRI matches standard biopsy at detecting significant prostate cancers

Neil Osterweil March 27, 2018 From the **New England Journal of Medicine**

Men who dread the prospect of multicore prostate biopsies can take heart in the news that multiparametric MRI with or without targeted biopsy was noninferior to transrectal ultrasound at detecting clinically significant cancers, results of a multicenter randomized trial indicate.

The rate of clinically significant cancers detected in men with clinical suspicion of prostate cancer who were randomly assigned to undergo MRI was 38%, compared with 26% ($P = .005$) for men assigned to standard transrectal ultrasound guided biopsy with 10 or 12 biopsy cores, reported Veeru Kasivisvanathan, MRCS, of University College London, and colleagues in the PRECISION trial (Prostate Evaluation for Clinically Important Disease: Sampling Using Image-guidance or Not?).

Significantly fewer men assigned to MRI-targeted biopsy were diagnosed with clinically insignificant cancers, suggesting that MRI could help to reduce the number of invasive biopsies and the associated pain, discomfort, and infection risks, the investigators stated in the *New England Journal of Medicine*.

“MRI, with or without targeted biopsy, led to fewer men undergoing biopsy, more clinically significant cancers being identified, less overdetected of clinically insignificant cancer, and fewer biopsy cores being obtained than did standard transrectal ultrasonography-guided biopsy,” they wrote.

Multiparametric MRI combines several different imaging modalities, including standard T1- and T2-weighted scans with dynamic contrast-enhanced and/or diffusion-weighted imaging to provide a wealth of information to aid in diagnosis. The technique has been shown in single-center studies to be similar or superior to ultrasound guided biopsy at detecting clinically significant cancers and minimizing detection of cancers that turn out to be clinically insignificant, the investigators said.

To add to the body of evidence, investigators from 25 centers in 11 countries randomized a total of 500 men with clinical suspicion of prostate cancer and no history of prostate biopsy to undergo either MRI plus targeted biopsy (not 10- or 12-core biopsy) if the scans indicated suspicion of malignancy, or standard transrectal ultrasound-guided biopsy with 10 or 12 core samples.

The investigators defined clinically significant cancer as the presence of a single biopsy core indicating disease of Gleason score 3 plus 4 (Gleason sum of 7), or greater. Of the 252 men assigned to MRI, 71 (28%) had results that did not suggest prostate cancer, and these men did not undergo biopsy.

As noted before, MRI was noninferior to standard ultrasound-guided biopsy. In the MRI group, 95 men (38%) were determined to have clinically significant tumors, compared with 64 of 248 men (26%) in the standard biopsy group.

Getting down into the statistical weeds, the lower boundary of the 95% confidence interval for the difference was greater than -5%, showing that MRI with or without targeted biopsy was noninferior to standard transrectal ultrasonography-guided biopsy for the detection of clinically significant cancers. In fact, the 95% confidence interval for the 12-point difference between the two techniques (95% confidence interval, 4-20) showed that MRI was superior to standard biopsy, the authors stated.

There were no health-related quality of life differences at either 24 hours or 30 days after the procedure, and immediate postintervention discomfort and pain were also similar between the groups. However, patient-reported complications were lower in patients assigned to MRI, including blood in urine (30% vs. 63% for standard biopsy), blood in semen (32% vs. 60%), procedural-site pain (13% vs. 23%), rectal bleeding (14% vs. 22%), and erectile dysfunction (11% vs. 16%).

“We found that a diagnostic pathway including risk assessment with MRI before biopsy and MRI-targeted biopsy in the presence of a lesion suggestive of cancer was superior to the diagnostic pathway of standard transrectal ultrasonography-guided biopsy,” Dr. Kasivisvanathan and his associates concluded.

The study was supported by awards to Dr. Kasivisvanathan from the U.K. National Institute for Health Research and by the European Association of Urology Research Foundation. He reported no other significant conflicts of interest to disclose.

<https://www.mdedge.com/oncologypractice/article/161806/genitourinary-cancer/mri-matches-standard-biopsy-detecting>

Experts have new advice on prostate cancer screening. Here's why they put it back on the table.

Melissa Healy May 8, 2018

<http://www.latimes.com/science/sciencenow/la-sci-sn-prostate-cancer-psa-20180508-story.html>

In a shift that puts early detection of prostate cancer back on the agenda of middle-aged men and their doctors, a federal panel of experts is recommending that men ages 55 to 69 weigh the potential harms and benefits of prostate cancer screening and judge whether getting tested feels right to them.

A recommendation issued Tuesday, May 8, 2018 by the U.S. Preventive Services Task Force judged the "net benefits" of screening these men for prostate cancer to be small. But the panel said the prostate-specific antigen, or PSA, test should be offered to them "based on professional judgment and patient preferences."

For men 70 and older, the task force stuck with an earlier recommendation against routine prostate cancer screening.

The new guidance for men in late middle age is an unusual reversal of advice the panel offered in 2012. At that time, the task force suggested that for most men at any age, getting screened for prostate cancer just wasn't worth the risks — including anxiety, infection, erectile dysfunction and incontinence — of the unnecessary treatment that too often came with it.

Since then, the ledger of risks and benefits has changed on both sides.

As large studies have followed men for longer periods of time, researchers have seen that the PSA test can save lives — at least a few more lives than earlier believed — when used to screen men in their late 50s and 60s.

In a European clinical trial, periodic testing was initially found to prevent seven deaths for every 10,000 men screened. But with four years of additional follow-up, researchers have discovered the number of lives saved per 10,000 men screened is closer to 13. And mathematical models suggest that number will likely rise further as the men in the trial get older.

The increase "is not a big number," said Dr. Alex H. Krist, vice chairman of the task force, an independent group that operates under the auspices of the federal Agency for Healthcare Research and Quality. But the new data gave his panel "a little bit more confidence that fewer men would die" when more were screened before age 70.

In 2012, 90% of men who had their diagnosis confirmed with a biopsy were quickly ushered into surgery or treated with radiation, despite growing evidence that many of these cancers would never become dangerous.

Now, no more than 60% of such men proceed directly to treatment. The rest begin a process of "active surveillance" in which surgery or radiation is used only if the cancer progresses.

Meanwhile, urologists are using genetic testing, more precisely targeted biopsy procedures and improved imaging techniques to identify the more aggressive prostate tumors that warrant quick action.

Despite efforts to improve prostate cancer treatment, surgery and radiation therapy still exacts a high toll on patients: two out of three men will experience long-term erectile dysfunction, and about 20% of those who undergo radical prostatectomy will experience urinary incontinence.

But as more men "watch and wait," fewer men are exposed to the negative effects of treatment that might never have been necessary in the first place. "That has changed the math of risks and benefits for screening," said Dr. David Penson, who chairs the Department of Urologic Surgery at Vanderbilt University in Nashville and was not involved in the new task force recommendation. "Take that small benefit and then reduce the harms of screening, and suddenly, the equation looks quite different."

In the United States, a man's risk of being diagnosed with prostate cancer at some point in his life is 13%, but his risk of dying of the disease is just 2.5%. Without screening, many men would never even know they had the disease, which can grow slowly for years. One-third of men who died in their 70s of other causes were found to have had prostate cancer.

For men between 55 and 69, the evolution of both knowledge and medical practice have made the question of whether to get the PSA test a potentially complex judgment call.

"This is what's called a preference-sensitive decision," said Ruth Etzioni, a biostatistician at Seattle's Fred Hutchinson Cancer Research Center who crunched the numbers from two of the largest clinical trials on

prostate cancer screening but was not directly involved in setting the new guidelines. "It means the benefits and harms of the decision are going to be different for different people. Screening might be a good decision for you, but your friend may come up with a different decision."

Race would likely be a factor in those deliberations: African American men are nearly twice as likely to die of prostate cancer as white men.

A family history of prostate cancer, and of cancers called adenocarcinomas (which include breast, ovarian, pancreatic and colorectal cancer), also might nudge a man toward regular screening. Smoking, too, is linked to a higher risk of death from prostate cancer.

The task force cautioned, however, that there is insufficient evidence on the role of race and family medical history to draft separate recommendations for subgroups.

"My typical prostate cancer consultation used to be 30 minutes," said Dr. Inderbir S. Gill, chairman of USC's Department of Urology. "Now it's become a one-hour, 15-minute consult, and we're not finished. That's the price of our evolving knowledge."

This is still the most common solid cancer in men, and it's treatable," he said.

But some men are skeptical of screening's value, and others are anxious that any possible threat to their health should be reckoned with head-on. Some have family histories of cancer, and others have so many health issues that a long-term threat like prostate cancer takes a back seat to more immediate concerns.

"The key thing is talking to the man before you draw his blood," Saigal said. Such nuanced discussions take time, and in modern medicine, time is in short supply. "We're moving into an era in which personalized medicine and shared decision making is going to come to the forefront. The data is too complex, and people are too complex, for one model to fit everyone."

Dr. Christopher Saigal, the vice chair of urology at UCLA's Geffen School of Medicine who studies how doctors and patients make decisions about prostate cancer treatment.

Saigal, who was not involved in the task force's deliberations, said he remains convinced that for most men in the designated age group, PSA screening is a sensible choice.

"Don't ask the question if you're not sure what you'll want to do with the result," said Dr. Christopher Saigal, the vice chair of urology at UCLA's Geffen School of Medicine who studies how doctors and patients make decisions about prostate cancer treatment.

The new task force recommendations are in line with those of the American Urological Assn., which specify that men ages 55 to 69 with a life expectancy of more than 10 to 15 years be informed of screening's benefits and harms. The AUA notes that successive screening tests should be performed at least two years apart.

USC's Gill praised the new recommendations. But he added that the task force was not wrong in issuing its earlier, more skeptical views on prostate screening.

"This group very rightly said in 2008 and 2012, 'You urologists are hurting far more patients than you're helping, and the whole rigamarole starts when you take the PSA,'" Gil said.

"They have certainly stirred soul-searching in the urological community. They have certainly prodded urologists into acknowledging that yes, not every prostate cancer needs to be treated. They have done a great service.

The graphic is titled "USPSTF Prostate Cancer Screening Recommendation" in white text on a dark red background. Below the title, there are two columns. The left column is for the years "2008 - 2016" and features a large red "D/I" with the text "Discourage the use of this service" below it. The right column is for the year "2018" and features a large yellow "C" with the text "Offer or provide this service for selected patients (55 - 69), depending on individual circumstances" below it. At the bottom of the graphic, it says "Join ZERO in the fight for every man to have access to early detection!" in bold black text. Below that is the "ZERO" logo, where the "O" is a red circle, followed by "THE END OF PROSTATE CANCER" in small text and "ZEROCANCER.ORG" in red text.

PCSANM *Lifeline* Newsletter

July 2018

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Chairman's Message

July 2018

There's been a lot of activity and excitement around the office these days and it's been invigorating. It seems like something new is happening every time I go in to the office. To begin with our Outreach Committee is putting together some new ideas about how we can reach more men in our State with the message of how we can help men make better decisions about their prostate health. We are also looking into a major overhaul of our website to make it interactive and more relevant to people searching for answers or information. Our next conference planning is well under way and we are planning to promote it much more aggressively than in the past which should boost attendance. And we are making presentations to professional groups about our services so they are more inclined to refer people to us.

What's stimulating much of this activity is our wonderful Program Manager, Ann Weinberg, She has been taking classes in marketing and promotion and it is making a difference in our outreach. She has been lining us up with opportunities to speak and scheduling us for numerous health fairs. And she has taken the facilitator training like the rest of us and will be helping us hone our consultation skills. And I think she has been responsible for drawing in some new dedicated volunteers to help us. But we can use more. If we are successful in reaching more men in need we are going to need more help with everything from maintaining our library to making presentations, from maintaining our website to keeping our books, from consulting with newly diagnosed men to manning our phones after hours. If you have time and an interest in making a difference in the lives of those who've been affected by prostate cancer, I'm sure we can find a perfect place for you. Give Ann a call Monday through Thursday between 10AM and 2PM and let us know what you like to do. We'll get you plugged into a great group of people, and this includes women, too.



Chairman of the Board, PCSANM