Prostate Cancer Support Association of New Mexico

# LIFELINE

Celebrating 27 years of supporting men

PCSANM Quarterly
January 2019
Volume 26, Issue 1

## Issue Highlights



**Our website address**
**www.pcsanm.org**

**E-mail us at**
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**Support Meetings:**

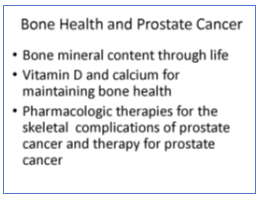
PCSANM meets at Bear Canyon Senior Center, 4645 Pitt St NE in Albuquerque. This is two blocks from Montgomery and Eubank; go north one block to Lagrima de Oro St, and east one block to Pitt, and left 50 yards to the Bear Canyon parking lot. We are in room 3, at the west end of the building. Meetings are usually the first and third Saturdays of the month; from 12:30-2:45 pm. Map is at **http://binged.it/1baQodz**

## 2018 PCSANM **Living and Thriving with Prostate Cancer** Conference Presentations

Just hit control and click on the presentation picture to go to it. Email or online versions only.

Nutrition and Wellness by Jan Esparza


Bone Health in PCa by Dr. Ken Smith




Sexual issues after PCa Treatment by Molly Adler


Travel Medical Conditions by Judy Fuller


Paying for Medical Treatment by Stephanie Michnovicz, Tonia Bateman, and Darlene Duran-Mondragon


There no slides available from Dr. Fabio Almeida's presentation "Being Alert for Potential PCa Recurrence", but he has dozens of articles and other information on his websites, Phoenix Molecular Imaging at **http://www.phxmi.com** and at his site **http://www.drfabio.com**

All presentations are posted as pdf's, so no one can change anything. The actual narrated slide shows, as filmed on November 10, will be available on the DVD sets, which can be purchased for $25.00, or borrowed from the PCSA Library when they are finished.

**FOUNDER : Rae Shipp, established 1991, celebrating 27 years of supporting men**

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## *In Memory of*

**Hyman Eisenberg**

**William "Bill" Little**

**Eric Lanphere**

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

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## PCSANM *Lifeline*

**A quarterly newsletter addressing issues of prostate cancer**

**Months Published**
**January April**
**July October**

**PUBLISHER**
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**Albuquerque, NM 87110**

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# Treatment for Prostate Cancer

**From WebMD.com 2018**

**https://www.webmd.com/prostate-cancer/guide/prostate-cancer-treatments#1**

There's no one prostate cancer treatment that's right for every man, but you've got plenty of options. Your doctor will consider many things when he recommends one for you, including:

The size of your tumor and how far it has spread, called the stage of your disease

How quickly the tumor is likely to grow

Your age and how healthy you are

Your personal preferences

## What Options Are Available?

**Watchful waiting** or **active surveillance.** Your doctor might suggest waiting to see if your tumor will grow or spread before you treat it. Most prostate cancer grows slowly, and some doctors think it's better not to treat it unless it changes or causes symptoms. In watchful waiting, your doctor will closely track how the disease makes you feel. With active surveillance, you'll also get regular tests to check on the cancer.

**Surgery.** This usually involves removing all or part of the prostate. The kind of operation you get depends on the size of the tumor and where it is.

**Radiation.** This treatment uses high-energy waves or particles to kill cancer cells and shrink tumors. There are a few types doctors can use for cancer that's only in the prostate, and others for when it spreads to other parts of the body.

**Proton Beam Radiation.** This is a special kind of radiation therapy that uses very small particles to attack and kill cancer cells that haven't spread.

**Hormone therapy.** Some of the hormones your body makes can fuel the growth of prostate cancer cells. This type of therapy lowers levels of those hormones or stops the cells from using them.

**Chemotherapy.** Drugs that you take by mouth or through an IV travel through the body, attacking and killing cancer cells and shrinking tumors. You might get chemo if the disease has spread outside your prostate and hormone therapy isn't working for you.

**Immunotherapy.** This treatment works with your immune system to fight the disease. It's used to treat advanced prostate cancer.

**Bisphosphonate therapy.** If the disease reaches your bones, these drugs can ease pain and prevent fractures.

Your doctor will usually start with one treatment at a time. But in some cases, you might get a few treatments at once. Talk to your doctor about the course that's best for you.

Scientists also are studying other types of treatment in clinical trials. They test new therapies to see if they're safe and if they work. Some of the ones researchers continue to look into include:

**Cryotherapy** or **cryosurgery.** They treat cancer located only in the prostate. Doctors use probes that give off extreme cold to freeze the tumor's cells.

**High-intensity focused ultrasound.** The opposite of cryotherapy, this treatment uses a probe that gives off high heat, which kills cancer.

Ask your doctor if you might benefit from joining one of these trials.

**Continued on page 9**

# What's New in Prostate Cancer: Five Takeaways

May 1, 2018 by Susan Keown / Fred Hutch News Service

https://www.fredhutch.org/en/news/center-news/2018/05/prostate-cancer-news.html

Expert panelists from the Fred Hutch/University of Washington Cancer Consortium discuss the latest in prostate cancer with audience members at the 7th annual IPCR symposium. From left to right: Drs. Marian Neuhouser, Heather Cheng, Jonathan Wright, Niels Johnsen and Ruth Etzioni. Photo by Quinn Russell Brown for Fred Hutch

In 2018, doctors know more than ever before about prostate cancer, with more effective treatments coming on line, knowledge about risk factors growing, and other improvements happening fast. Prostate cancer is becoming less common and less deadly.

In short, said Fred Hutchinson Cancer Research Center expert Dr. Pete Nelson, "There are many reasons for optimism."
In front of a full auditorium at Fred Hutch, Nelson kicked off the seventh annual community symposium of the Institute for Prostate Cancer Research. IPCR is a joint effort of Fred Hutch and its consortium partners, UW Medicine and Seattle Cancer Care Alliance.

At the daylong event, IPCR experts gave their insights about the current state of the science and recent discoveries in prostate cancer risk reduction, screening, imaging, treatment and more. Here are five things that men should know about this cancer:

**1.Prostate cancer is different in black men compared with white men** "Prostate cancer isn't colorblind," said Dr. Ruth Etzioni, a Fred Hutch biostatistician who studies racial disparities and screening in this and other cancers. "Not by any stretch of the imagination is this a one-size-fits-all situation."

In her talk at the symposium, Etzioni highlighted the racial disparities in this cancer. While it is becoming less common and less deadly across the board, black men are still more likely to get it and to die from it than white men, and "this is one of the most dramatic disparities in cancer," she said.
Etzioni and colleagues' recent work suggests that black men might benefit from screening for this cancer 10 years earlier than the current national screening guideline recommends (age 55). Such screening involves testing a man's blood for levels of a marker called PSA, which can indicate the presence of cancer.

However, screening comes with risks — most notably, the risk of treating a cancer that may be too slow-growing to cause the man harm. So risks and benefits of screening must be carefully balanced, Etzioni emphasized.

She and colleagues have recently kicked off a task force dedicated to overcoming the racial disparity in prostate cancer by gathering detailed data on this disease in black men. She hopes that the evidence they gather will inform better, tailored screening recommendations for black men, catching more cancers earlier, saving lives and reducing the lingering racial disparity.
"Our work will provide concrete guidance to policy panels about what to do," Etzioni said.

2.**Side effects of prostate cancer treatment can be countered with exercise** A standard treatment for advanced prostate cancer is androgen-deprivation therapy, or ADT. Such drugs include Lupron (leuprolide) and others that work through a similar mechanism, and Firmagon (Degarelix), which works a different way. ADT blocks the testicles' production of androgens, "male" hormones such as testosterone that are like fuel for prostate cancers. Taking away the cancers' fuel causes them to stop growing or shrink, at least for a while.

In the last year, a growing body of evidence has made it clear that moderate exercise of any type is an excellent antidote to many unwanted side effects of ADT, such as loss of muscle, fatigue and weight gain, said Dr. Jonathan Wright, a urologic oncologist at UW Medicine and Fred Hutch. He rattled off the results of several studies published in the last year:

Exercise improves men's feelings of masculinity, body image, and quality of life while they receive ADT or other prostate cancer treatment; it improves muscle performance and the body's fat-to-lean ratio after ADT is finished; and it benefits cardiovascular health and metabolism during ADT. It improves physical function and strength in men whose prostate cancer has metastasized to the bones, without causing bone pain or other bad side effects. It also counters loss of muscle mass, a normal byproduct of aging that can lead to falls and fractures and which is accelerated by ADT.

So if moderate exercise can help, an audience member asked Wright, does especially vigorous exercise help even more? "Be safe," Wright cautioned. If you overdo it and get injured, that will be counterproductive, he said. **NEXT PAGE**

**3. Erectile dysfunction after prostate cancer therapy: Many good solutions are available**
Problems with sexual function are common after treatment for prostate cancer, said urologist Dr. Niels Johnsen of UW Medicine. Both surgery and radiation alike can have harmful effects on the nerves, blood vessels and tissues in the penis necessary for erections, Johnsen said.
However, he said, "it's important to know that there's lots of options" that can help men and couples fulfill their needs for sexual intimacy.

First, he said, it's important for doctors to know what problem the man is experiencing and what his and his partner's goals are. Different solutions will work for different patients, he explained. The next step is for the man to work on improving any relevant health factors under his control that might affect his ability to maintain an erection, Johnsen said, such as blood pressure, diet and exercise. If the man's goals aren't reached after these factors improve, doctors may discuss oral medications such as Viagra (sildenafil citrate) and Cialis (tadalafil).

The next tier of options is local therapies. These include hand-operated vacuum pumps and medications that increase penile blood flow, which the patient can insert into the opening of his penis or inject through the wall of his penis before having sex. (The injection option evoked some skeptical murmuring in the audience, and Johnsen reassured his listeners that men who try it receive a lot of coaching from the medical team on how to do the shots and are often very satisfied with the treatment.)

The final and most invasive option is a penile prosthesis, Johnsen explained. A surgeon implants an inflatable device in the tissues of the penis and hides the attached pump inside the scrotum. The man can squeeze the hidden pump to cause an erection.

**4.Newly diagnosed metastatic prostate cancer: better treatments on the horizon?** When men are newly diagnosed with metastatic prostate cancer, they often still have very little cancer outside of the prostate (a condition called "oligometastatic disease"), said IPCR Director Dr. Daniel Lin of UW Medicine and Fred Hutch.
Emerging research is pointing toward potential new treatment strategies to help men with oligometastatic prostate cancer have better health for more time, Lin said.

Experts currently think that surgery and radiation are not likely to cure metastatic prostate cancer, Lin said. But studies in mice have been building evidence that controlling the growth of the primary tumor (that is, the original tumor in the prostate) might help these men.
Why? Research points to several potential reasons for this, Lin said. For example, eliminating or greatly reducing the size of the primary tumor may disrupt a process called "self-seeding," through which travelling metastatic tumor cells travel back to the primary tumor through the bloodstream, releasing signals that make the cancer even more aggressive.

IPCR researchers in Seattle are just about to open a randomized clinical trial to test the benefits of adding local surgery or radiation to standard of care for men newly diagnosed with metastatic prostate cancer. Could local therapy to the primary tumor improve outcomes, including quality of life, for these men, or certain subsets of them? The trial will have more than 50 sites nationwide and will be run through the national clinical trials network known as SWOG, Lin said.

Numerous other ongoing clinical trials in the U.S. and Europe are testing treatment strategies specifically designed for men with newly diagnosed metastatic prostate cancer, Lin said, including large trials called STAMPEDE and PEACE1. (Click on the links to learn more; other clinical trials for prostate cancer can be found by searching on clinicaltrials.gov.)

**5. Could high-dose testosterone treat prostate cancer?** Could prostate cancer be treated with high-dose testosterone? This is still an open question, said Dr. Michael Schweizer of UW Medicine and Fred Hutch, but it is an area of active research, and results so far have been intriguing.

A big problem with ADT is that it doesn't work forever: Prostate tumors always eventually figure out how to get around the lack of testosterone and find a way to grow anyway. But research by Schweizer has shown that once a tumor becomes adapted to growing with little testosterone, high levels of the hormone can poison it.

The result of this idea is a strategy called "bipolar androgen therapy." In this "counterintuitive" approach, Schweizer explained, a patient alternates between ADT and high-dose testosterone therapy. "The idea is that you're staying one step ahead of the resistance, so the cancer doesn't have the chance to get used to either a high- or low-testosterone environment," he said.
Schweizer's recent small, proof-of-concept clinical trial of a type of bipolar androgen therapy in men with asymptomatic, ADT-resistant metastatic prostate cancers showed that it has promise in treating this cancer and in improving quality of life — a "pretty exciting finding," he said. Soon, his team will launch a clinical trial of an updated version of this protocol.

# Genomic Landscape of Metastatic Prostate Cancer Unveiled in New Study

Whole-Genome Analysis of Aggressive Disease Offers Insights into Possible Personalized Therapies

Felix Y. Feng, MD July 19, 2018

**https://www.pcf.org/news/genomic-landscape-of-metastatic-prostate-cancer-unveiled-in-new-study-2/**

A comprehensive genetic analysis of metastatic prostate cancer has, for the first time, revealed a number of major ways in which abnormal alterations of the genome propel this aggressive form of the disease.

As reported in the July 19, 2018 issue of *Cell*, a team led by investigators at UC San Francisco has discovered widespread structural changes in prostate cancer genomes that take the form of abnormal duplications, insertions, or deletions of genetic sequences. These structural changes are associated with the loss of function of genes that normally maintain the genome's integrity by repairing damaged DNA, and they also result in the activation of cancer-driving oncogenes and inactivation of genes that suppress tumor growth. In more than 80 percent of the patients studied, they also create numerous extra copies of "enhancer" sequences that promote the expression of a key prostate cancer oncogene known as the androgen receptor gene.

This last finding is particularly notable, because the androgen receptor, which is activated by testosterone and other male sex hormones, is the primary target of most medications used as second-line treatments when prostate cancer recurs after surgery and radiation therapy. Because extra copies of androgen-receptor enhancer sequences would presumably amplify the activity of these receptors, this structural change may help explain the stubborn resistance to androgen-blocking treatments that often emerges in metastatic disease.

"This study has provided a tremendous resource that will be publicly available to the prostate cancer research community," said physician-scientist Felix Y. Feng, MD, associate professor of radiation oncology at UCSF and co-senior author of the new study. "The data should now generate a very large number of scientific hypotheses that will collectively improve our understanding of what drives metastatic prostate cancer, and down the road, which genomic alterations can be used to guide personalized therapies."

The prognosis for primary, localized prostate cancer varies depending on risk factors, such as a patient's level of prostate-specific antigen, or PSA, and many cases are effectively treated with a combination of surgery and radiation therapy.

In some cases, however, cancer will persist or recur. Male sex hormones are known to drive prostate tumor growth, and in these patients, and in patients whose cancer has already metastasized, therapy known as androgen deprivation therapy—the therapeutic withdrawal of male sex hormones—is highly effective. But most patients eventually develop resistance to this therapy and the cancer recurs, resulting in the "metastatic castration-resistant" form of the disease that was the subject of the new study.

Previous genomic studies of prostate cancer have focused on the primary, localized form of the disease, or have only examined the "exome," the 1.5 percent of the genome that includes genes, which in turn contain instructions for the manufacture of proteins. By contrast, the new study—led by first authors David Quigley, PhD, of the UCSF Helen Diller Family Comprehensive Cancer Center (HDFCCC), Ha X. Dang, PhD, of Washington University in St. Louis, and Shuang G. Zhao, MD, of the University of Michigan—employed a whole-genome approach, which deciphers the sequences of important regulatory regions in the massive swath of the genome that lies outside genes.

Beginning about five years ago, the research team began collecting biopsy samples from men with metastatic refractory prostate cancer. They now have about 300 such samples, "one of the world's best biorepositories" for the study of the disease, said Feng. The project was made possible by a $10 million grant awarded in 2012 by three philanthropic organizations—Stand Up To Cancer, the Prostate Cancer Foundation, and the Movember Foundation—to a West Coast–based "Dream Team" of researchers led by UCSF's Eric J. Small, MD, co-senior author and chief scientific officer at HDFCCC, and co-led by Owen N. Witte, MD, co-author and

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Joining Feng and Small as co-senior authors were Christopher Maher, PhD, of Washington University in St. Louis, and Arul M. Chinnaiyan, MD, PhD, of the University of Michigan.

In addition to many-fold abnormal copies of the androgen-receptor enhancer, the new research, in which biopsy samples from more than 100 men were analyzed, reports structural genomic alterations that activate well-known cancer-driving genes such as *MYC*, and conversely, alterations that would reduce the activity of "tumor suppressor" genes such as *TP53*and *CDK12*. Genes involved in DNA repair, such as *BRCA1* and *BRCA2*, previously implicated in whole-exome studies of prostate cancer, were also found to be damaged by structural changes.

"This landmark study by the West Coast Dream Team reveals that metastatic castration-resistant prostate cancer is driven by vast genomic structural variations, and provides new insights into the mechanisms of disease progression and treatment resistance," said Howard Soule, PhD, executive vice president and chief science officer of the Prostate Cancer Foundation. "This wealth of data will enable many new discoveries and change the way we think about prostate cancer biology and treatment."

Feng said that the new work should build on a recent trend toward more personalized therapies for metastatic prostate cancer. He said that recent studies suggest, for example, that prostate cancer characterized by *CDK12* mutations may respond to the form of immunotherapy known as checkpoint inhibitors, and that another class of drugs called *PARP* inhibitors may help prostate cancer patients in whom the *BRCA* DNA-repair genes are affected.

"The impact of the observations from this project reflect a remarkable collaborative effort across the multiple institutions of the West Coast Prostate Cancer Dream Team, and beyond," said Small, also professor of medicine and of urology at UCSF, and chief of the Department of Medicine's Division of Hematology and Oncology. "These whole-genome sequencing data are particularly impactful in that they are derived from biopsies of metastases in men with castration-resistant prostate cancer, for whom careful, longitudinal, clinical annotation exists."

The UCSF, UCLA, Washington University, and University of Michigan researchers were joined by scientists from Illumina, Inc.; Oregon Health and Science University; the University of British Columbia; the University of Minnesota; UC Davis; UC Santa Cruz; Thomas Jefferson University; the University of Toronto; Duke University; and the University of Minnesota. A complete list of authors is available in the published study.

In addition to Stand Up to Cancer, the Prostate Cancer Foundation, and the Movember Foundation, the work was supported by the Goldberg-Benioff Research Fund for Prostate Cancer Translational Biology; the V Foundation for Cancer Research; the BRCA Foundation; the Department of Defense; the Early Detection Research Network of the National Cancer Institute; and the National Institutes of Health.

**About UCSF:** UC San Francisco (UCSF) is a leading university dedicated to promoting health worldwide through advanced biomedical research, graduate-level education in the life sciences and health professions, and excellence in patient care. It includes top-ranked graduate schools of dentistry, medicine, nursing and pharmacy; a graduate division with nationally renowned programs in basic, biomedical, translational and population sciences; and a preeminent biomedical research enterprise. It also includes UCSF Health, which comprises three top-ranked hospitals – UCSF Medical Center and UCSF Benioff Children's Hospitals in San Francisco and Oakland – as well as Langley Porter Psychiatric Hospital and Clinics, UCSF Benioff Children's Physicians and the UCSF Faculty Practice. UCSF Health has affiliations with hospitals and health organizations throughout the Bay Area. UCSF faculty also provide all physician care at the public Zuckerberg San Francisco General Hospital and Trauma Center, and the SF VA Medical Center. The UCSF Fresno Medical Education Program is a major branch of the University of California, San Francisco's School of Medicine. Please visit **www.ucsf.edu/news**

**On November 21, 2018, Hyman Eisenberg, a 27 year PCa survivor, passed away at the age of 97.**

As far as we know, he was the longest tenured member in our group, having been there at the founding in 1991. We did a profile on Hyman in the April 2014 newsletter, page 5. It can be found **here:**

**If there are any other members from that era, please let the office know.**

# Deadly form of advanced prostate cancer is common, calls for distinct treatment

Elizabeth Fernandez July 9, 2018 University of California - San Francisco
https://www.sciencedaily.com/releases/2018/07/180709161551.htm

A new study of prostate cancer in 202 men, whose cancers had spread and were resistant to standard treatment, found that a surprisingly large number of these cancers -- about 17 percent -- belong to a deadlier subtype of metastatic prostate cancer.

Previously, it was thought that these cancers constituted less than 1 percent of all prostate cancers.

The study, which was led by researchers at UC San Francisco and published online July 9 in the *Journal of Clinical Oncology*, suggests that this prostate cancer subtype, called treatment-emergent small cell neuroendocrine prostate cancer (t-SCNC), might in the future be routinely and more successfully treated with targeted drugs that already are being developed or tested in clinical trials.

"Think of advanced, hormone-treatment-resistant prostate cancers as a pie," said Rahul Aggarwal, MD, assistant professor of medicine in the UCSF Division of Hematology and Oncology and the study's corresponding author. "Instead of treating these advanced cases homogenously as we do with today's standard treatments, we want to split the pie according to tumor characteristics, and develop treatment protocols tailored to individual slices, based on the cancers' distinctive growth-driving genetic mutations and gene expression patterns."

The research team identified specific genetic mutations and patterns of gene expression that are found in t-SCNC, but are distinct from the more common type of prostate cancer known as adenocarcinoma. Among the patterns identified in t-SCNC was higher activity of specific "transcription factor" proteins -- proteins that switch on production of other proteins that drive cancer growth.

Two of the transcription factors over-activated in t-SCNC are targets of drugs already in clinical trials, Aggarwal said, with several more in pre-clinical testing. Aggarwal is a member of the UCSF Helen Diller Family Comprehensive Cancer Center.

In contrast, mutations that previously have been discovered to play a role in many adenocarcinomas were almost never present in t-SCNC, the researchers found.

"It is important to provide hormonal therapy in metastatic prostate cancer, because these hormonal treatments prolong survival," Aggarwal said. "But they are not curative. In nearly every patient the cancer will become resistant to these treatments. It's just a matter of when. We want to know why prostate cancer becomes resistant, and we believe the emergence of t-SCNC is one important mechanism through which they evolve and evade treatment."

Treatments targeting specific mutations in prostate cancer are not yet available in standard practice, which relies on hormonal treatment and chemotherapy as the mainstays of treatment. However, as the number of targeted treatments available for cancer grows, genetic analysis of tumors is expected to become increasingly valuable in helping to guide treatment. "Obtaining tumor biopsies in metastatic cancer has not in the past been the standard of care, but it is being done more often, in part to look for neuroendocrine tumor cells, but more generally to get an idea for what mutations are driving cancer growth," Aggarwal said. "This trend has lagged in prostate cancer because most metastasis occurs in bone, and it is more difficult to do biopsies in bone in comparison to other tissues."

The American Cancer Society estimates that 29,430 men will die from prostate cancer in 2018, making it second only to lung cancer as a cause of cancer death among U.S. men. About one in 10 prostate cancers has spread beyond the prostate at the time of initial diagnosis and is more difficult to treat successfully. In these advanced cancers, additional mutations and alterations in gene expression patterns give rise to treatment-resistant tumor cells. These treatment resistant cells and the clones they generate through cell division live on and enable the tumor to grow again, according to Aggarwal. The pattern of gene mutations observed in the study suggests that t-SCNC in these advanced cases of treatment-resistant prostate cancer arises from a pre-existing adenocarcinoma, he said.

"It is important to provide hormonal therapy in metastatic prostate cancer, because these hormonal treatments prolong survival," Aggarwal said. "But they are not curative. In nearly every patient the cancer will become resistant to these treatments.

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The study, which was undertaken by a consortium of five different academic medical centers, enrolled patients at the time their cancers were discovered to have become resistant to conventional hormonal treatment, known as androgen deprivation therapy.

Among patients who had previously stopped responding to second-line hormonal treatment with abiraterone or enzalutamide -- drugs usually administered when initial hormone therapy fails -- men with the t-SCNC subtype survived on average just 36.6 months, compared to 44.5 months for men without t-SCNC. Three-quarters of men in the study had received one or both these drugs.

"An understanding of the biology of this important mechanism of resistance is essential to our developing novel therapeutics designed to prevent the development of this lethal prostate cancer subtype, or, once developed, to effectively treat it," said senior author Eric Small, MD, professor of medicine and chief of the Division of Hematology and Oncology at UCSF. Small is also deputy director of the UCSF Helen Diller Family Comprehensive Cancer Center.

In 160 of the men, there was enough tumor in biopsy specimens to classify the cancer, which was done independently by three different pathologists blinded to clinical and genetic characteristics of the cancers. They found t-SCNC in specimens from 27 of these men. The researchers surveyed genetic mutations and gene activation within tumor cells and identified patterns of genetic mutations that were associated with t-SCNC and with worse survival.

The study was funded by the Prostate Cancer Foundation, Movember, and Stand Up To Cancer through a Stand Up To Cancer Dream Team Award, which Small led.

**Article Continued from page 3**

## Are There Side Effects?

The treatments for prostate cancer also can affect your body in other ways. Side effects can include:

Bowel problems
Lower sex drive
Erectile dysfunction
Loss of your ability to get a woman pregnant

Leaky bladder or loss of bladder control. You might also need to pee a lot more often.

Side effects are another factor to think about when you're choosing a treatment. If they're too tough to handle, you might want to change your approach. Talk to your doctor about what you can expect. He can also help you find ways to manage your side effects.

## What Else Should You Consider?

Remember, you have options, and it's important to choose the one that works best for you. When choosing a treatment, think about:

**The risks**. Talk to your doctor about the pros and cons of each type of therapy.

**The side effects.** Consider whether or not you're willing to deal with how the treatment might make you feel.

**Whether or not you need it.** Not all men with prostate cancer need to be treated right away.

**Your age and overall health.** For older men or those with other serious health conditions, treatment may be less appealing than watchful waiting.

**PCSANM has redesigned their website to give it a more appealing look and allow site visitors to do more. This was completed in mid August, so please visit it and use it. Thanks to Marlena Shirley at Azure Mar Digital Consulting for her help.**


# Drugs Approved for Prostate Cancer

This page lists cancer drugs approved by the Food and Drug Administration (FDA) for prostate cancer. The list includes generic names and brand names. The drug names link to NCI's Cancer Drug Information summaries. There may be drugs used in prostate cancer that are not listed here. Drug links are clickable. June 2018

FROM **https://www.cancer.gov/about-cancer/treatment/drugs/prostate**

**Abiraterone Acetate**
**Apalutamide**
**Bicalutamide**
**Cabazitaxel**
**Casodex (Bicalutamide)**
**Degarelix**
**Docetaxel**
**Eligard (Leuprolide Acetate)**
**Enzalutamide**
**Erleada (Apalutamide)**
**Firmagon (Degarelix)**
**Flutamide**
**Goserelin Acetate**
**Jevtana (Cabazitaxel)**
**Leuprolide Acetate**
**Lupron (Leuprolide Acetate)**
**Lupron Depot (Leuprolide Acetate)**
**Mitoxantrone Hydrochloride**
**Nilandron (Nilutamide)**
**Nilutamide**
**Provenge (Sipuleucel-T)**
**Radium 223 Dichloride**
**Sipuleucel-T**
**Taxotere (Docetaxel)**
**Xofigo (Radium 223 Dichloride)**
**Xtandi (Enzalutamide)**
**Zoladex (Goserelin Acetate)**
**Zytiga (Abiraterone Acetate)**

**Editor Note: To understand where we are now and are going in the future, we should be aware of our past.**

**Virginia K. Shipp, the widow of Vonrae Shipp, the founder of PCSANM, passed away September 2, 2018 at the age of 91.**

**Virginia K. Shipp, born in Los Angeles, CA on October 14, 1926, was carried to heaven by the Lord on September 2, 2018 at 9:00 PM. She passed peacefully at home surrounded by her loving family. She was the matriarch of our family, the glue that held us all together, and the lover of all card games. Her true passion was playing bridge with her family and friends.**

**She was preceded to heaven 20 years ago by her husband Vonrae Shipp. Vonrae was the founder of The New Mexico Prostate Cancer Support Group. Virginia was essential with the start of the Support Group, even started a mini support group for women of husbands with prostate cancer.**

**She is survived by her four children, Lonny Shipp, Linda Sue Topka, Lynnette Herring, and Lisa and Loel Hansen. She also had 6 grandchildren and 9 great grandchildren.**

**Services were held at Daniels Funeral Home, 7601 Wyoming Blvd. NE, on Saturday, September 8, 2018 at 2:00 PM (Alb. Journal)**

**This family spent a great deal of time getting newsletters ready for mailing on their dining room table before we had an office.**

**In this picture, Vonrae and Virginia are seated in front. Granddaughter Samantha Trimble is in front center, daughter Lisa Hansen in back. They both wrote articles about their father/grandfather in the July 2013 Lifeline, pages 6-7, https://www.pcsanm.org/wp-content/uploads/2015/08/July-20131.pdf**

**The Shipps in younger days.**

**Pictures courtesy of the Shipp/Hansen/ Trimble family.**

We have a new public service announcement running on KNME-TV Monday nights. You can see it **here:**

# Prostate Cancer Support Association of New Mexico



**PCSANM *Lifeline* Newsletter January 2019**
**Celebrating 27 years of supporting men**

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

## A Message from the Chairman January 2019

It has been a busy year for the Prostate Cancer Support Association. Although that sounds cliché it's true. We've seen the addition of a couple of new board members, expanded our office hours, made important presentations to organizations and medical professionals, appeared at numerous health fairs, maintained a steady schedule of Saturday meetings and hosted another successful conference. But more importantly we have increased the number of consultations with newly diagnosed men and their families to 84 so far this year.

Helping men make more well-informed decisions about their treatment and recovery is what we are about. That is what energizes us as volunteers and an organization. Seeing someone leave the office with a smile on their face and a plan in their head makes all the hard work worthwhile. And even though 84 doesn't seem like a terribly big number when there are an estimated 1000+ newly diagnosed cases per year in New Mexico it says to me that we are moving in the right direction. What is even more gratifying is that out of all our events 118 members participated actively by attending meetings and volunteering. I am humbled that we are impacting lives positively enough that we have built a community of prostate cancer survivors.

Our goal for next year is to increase these numbers not for the sake of increasing numbers but in the hope that we can ease a few more anxious minds. Won't you join us in the effort? Call the office and see how you can help the newly diagnosed in New Mexico.

**Chairman of the Board, PCSANM**