Prostate Cancer Support Association of New Mexico

LIFELINE

Celebrating 26+ years of supporting men

PCSANM Quarterly
October 2018
Volume 25, Issue 4

Issue Highlights

Our website address
www.pcsanm.org

E-mail us at
pchelp@pcsanm.org

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**

The full November 10 conference schedule is on page 3.

It's Possible to THRIVE With Prostate Cancer

Learn how at

Living and Thriving With Prostate Cancer

A Free Informational Conference

November 10, 2018 9:00 AM - 5:00 PM

Sandia Prep Auditorium
532 Osuna Road NE
Albuquerque, NM

9 informative presentations
Morning Moderator - Joe Diaz KOAT Meteorologgist
Afternoon Moderator - Dr. Thomas Schroeder

Attendance is free
Lunch available for a nominal charge

Brought to you by
The Prostate Cancer Support Association of New Mexico

FOUNDER : Rae Shipp, established 1991, celebrating 26+ years of supporting men

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Las Cruces	John Sarbo or Ron Childress	(915) 503-1246 (575) 522-1083
Silver City	Herb Trejo	(575) 574-0225 C (575) 538-3522 H

In Memory of

George Fries
Charles Johnson
Richard B. Kinney
Ray Lamont
Harry Mattox
Joe Stephenson
William Williamson

With deep sympathy and regret, we list these names

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Please contact your physician for all your medical concerns.

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PCSANM *Lifeline*

A quarterly newsletter addressing issues of prostate cancer

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Program Manager
Ann Weinberg

PROSTATE CANCER SUPPORT ASSOCIATION OF NEW MEXICO'S

Conference: Living and Thriving with Prostate Cancer

A conference dedicated to the memory of Dr. Peter Lindberg

Saturday, November 10, 2018 9:00 am to 4:45 pm

Sandia Preparatory School 532 Osuna Road NE Albuquerque, NM

Morning — 9:00–9:15 — Welcome — Steve Denning (PCSANM Board Chairman)

Intro to Morning Moderator — Joe Diaz (Action 7 News Chief Meteorologist)

9:15–10:15 — Panel – Informing Friends, Family, Coworkers and Others about your PCa; presented by 4 members of PCSA. What worked and what didn't work.

10:00–10:30 — Break

10:30–11:15 —Diet and Nutrition — Jan Esparza (Presbyterian)

11:15–12:00 —Bone Health for Prostate Cancer Patients —Dr. Ken Smith (Presbyterian)

12:00–1:00 — Lunch Break; lunch, snacks, and drinks are available for purchase in the school cafeteria

Afternoon —1:00 -1:15 — PCSA — Steve Denning (PCSA Board Chairman)

Intro to Afternoon Moderator — Dr. Thomas Schroeder (UNMCCC)

1:15–2:00 — Sexual issues after PCa Treatment — Molly Adler (Sex Therapy NM)

2:00–2:15 — Break

2:15–3:50 — Breakout sessions (2 cycles of 45 minutes each, 5 minute shift time between cycles) each session will be on a different topic

Exercise and fitness – George Frazier (Fifty and Fit)

Improv Medicine – an Entertaining Way to foster communication between patient & medical professionals –Jason Pfiefer & Irene Loy (Improv Medicine, Taos)

Travel Issues- Urological, Meds, Comfort, TSA help — Judy Fuller (Sun Tours)

Costs, Insurance - paying for medical treatment— Stephanie Michnovicz (Cancer Services of New Mexico)

3:50–4:35 — Being Alert for Potential PCa Recurrence — Dr. Fabio Almeida (Phoenix Molecular Imaging)

4:35–4:45 — Thanks/Closing Remarks — Steve Denning (PCSANM Board Chairman)

5:00 — Clear the building

Exhibitors (invited)— AccumetRx/Urology Group of New Mexico

Albuquerque Urology Associates	**American Cancer Society**	**Bayer (Xofigo)**
Cancer Center at Presbyterian	**Cancer Services of New Mexico**	**Dendreon (Provenge)**
Genomic Health (Oncotype DX)	**Janssen Biotech (Zytiga)**	**New Mexico Cancer Center**
Pfizer Inc./Medivation (Xtandi)	**Santa Fe Radiology**	**UNM Cancer Center**

Schedule current as of print date, most current info will be on website

Marijuana: Most oncologists are having the conversation

By Bianca Nogrady May 10, 2018 **Journal of Clinical Oncology**

Key clinical point: The majority of medical oncologists discuss medical marijuana use with their patients, though few feel knowledgeable on the subject.

Major finding: Nearly 80% of medical oncologists have discussed medical marijuana use with their patients, but only 29.4% of those surveyed felt sufficiently knowledgeable.
Study details: Survey of 237 medical oncologists.

Disclosures: No funding was declared. Two authors declared royalties and honoraria from medical publishing and a research institute, and one declared fees for expert testimony.
Source: Braun I et al. J Clin Oncol. 2018 May 10. doi: 10.1200/JCO.2017.76.1221.

The vast majority of oncologists discuss medical marijuana use with their patients, and around one-half recommend it to patients, yet many also say they do not feel equipped to make clinical recommendations on its use, new research has found.

A survey on medical marijuana was mailed to a nationally-representative, random sample of 400 medical oncologists and had a response rate of 63%; results from the 237 responders revealed that 79.8% had discussed medical marijuana use with patients or their families and 45.9% had recommended medical marijuana for cancer-related issues to at least one patient in the previous year.

Oncologists in the western United States were significantly more likely to recommend medical marijuana use, compared with those in the south of the country (84.2% vs. 34.7%, respectively; P less than .001), Ilana M. Braun, MD **http://www.dana-farber.org/find-a-doctor/ilana-m-braun/** , and her associates reported in Journal of Clinical Oncology **https://dx.doi.org/10.1200/JCO.2017.76.1221**

Doctors who practiced outside a hospital setting were also significantly more likely to recommend medical marijuana to their patients, as were medical oncologists with higher practice volumes.
Among the oncologists who reported discussing medical marijuana use with patients, 78% said these conversations were more likely to be initiated by the patient and their family than by the oncologist themselves.

However only 29.4% of oncologists surveyed said they felt "sufficiently knowledgeable" to make recommendations to patients about medical marijuana. Even among those who said they had recommended medical marijuana to a patient in the past year, 56.2% said they didn't feel they had enough knowledge to make a recommendation.

Overall, oncologists had mixed views about medical marijuana. About one-third viewed it as equal to or more effective than standard pain treatments, one-third viewed it as less effective, and onethird said they did not know. However two-thirds viewed medical marijuana as a useful adjunct to standard pain therapies.

Two-thirds of oncologists surveyed believed medical marijuana was as good as or better than standard treatments for poor appetite or cachexia, but less than half felt it was equal to or better than standard anti-nausea therapies.

The data revealed a "clinically problematic discrepancy" between medical oncologists' their perceived knowledge about medical marijuana use and their actual beliefs and practices, said Dr. Braun of the Dana-Farber Cancer Institute and her associates.

"Although our survey could not determine why oncologists recommend medical marijuana, it may be because they regard medical marijuana as an alternative therapy that is difficult to evaluate given sparse randomized, controlled trial data," they wrote.

"[The results] highlight a crucial need for expedited clinical trials exploring marijuana's potential medicinal effects in oncology (e.g. as an adjunctive pain management strategy or as a treatment of anorexia/cachexia) and the need for educational programs about medical marijuana to inform oncologists who frequently confront questions regarding medical marijuana in daily practice."
No funding was declared. Two authors declared royalties and honoraria from medical publishing and a research institute, and one declared fees for expert testimony.

SOURCE: Braun I et al. J Clin Oncol. 2018 May 10. doi: 10.1200/JCO.2017.76.1221
https://dx.doi.org/10.1200/JCO.2017.76.1221

PCSANM is helping men get PSA tests

The Prostate Cancer Support Association of New Mexico (PCSANM) has launched 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.

PCSANM 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 guys 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 gentlemen who haven't had a recent PSA test for reasons such as, but not limited to, no primary care physician or regular health care program, no insurance, or if you are showing troubling symptoms, or simply want reassurance that things are OK. It is not designed for our current members.

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.

So, drop by the PCSANM office at 2533 Virginia St. NE, Suite C, 87110. The office is open Monday thru Thursday, 10 a.m.-2 p.m. That is how you can get complete details and restrictions, and you must pick up a voucher from our office, that will be honored only at Any Lab Test Now, 2305 San Pedro NE, Suite D1, 87110.

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 has been in the process of redesigning their website to give it a more appealing look and allow site visitors to do more. This should be completed by mid August, or before you receive this newsletter, so please visit it and use it.

Genetics and Genomics

Genetics looks at specific genes responsible for inherited traits, such as hair or eye color or the risk for certain cancers. The study of genetics in prostate cancer is important because family predisposition may be responsible for five to 10 percent of all prostate cancers. A family history increases a man's risk for prostate cancer by 60 percent.1 And the presence of the BRCA gene can be a high-risk indicator for prostate cancer in men as it is for breast cancer in women.2

Genomics looks at how certain sets of genes interact and function, including their role in specific diseases. In the case of prostate cancer, a genomic test can help predict the aggressiveness of the tumor, enabling the patient to select the most appropriate course of care.

We had an excellent presentation given by Shawnia Ryan from UNM Cancer Center about genetic counseling and genetic testing at a recent meeting.

15-20% of prostate cancers could have the BRCa1 and BRCa2 mutations. These can affect your likelihood to get PCa, and to increase your female descendants risk to get ovarian or breast cancer. This author had genetic testing done to see if he could pass those 2 gene mutations on to his daughter/granddaughters, because he was adopted as a child and had no family history.

This list of Genomic tests and info is huge and growing. The categories of tests are: The Following Genomic Tests Help Determine if an Initial or Repeat Biopsy is Needed; Genomic Tests to Consider When Choosing a Treatment; Genomic Tests That Analyze Tissue from the Prostate After Surgery (Prostatectomy).

The list, and explanations, is at **http://www.ustoo.org/genetics-and-genomic-testing** and will also be posted online.

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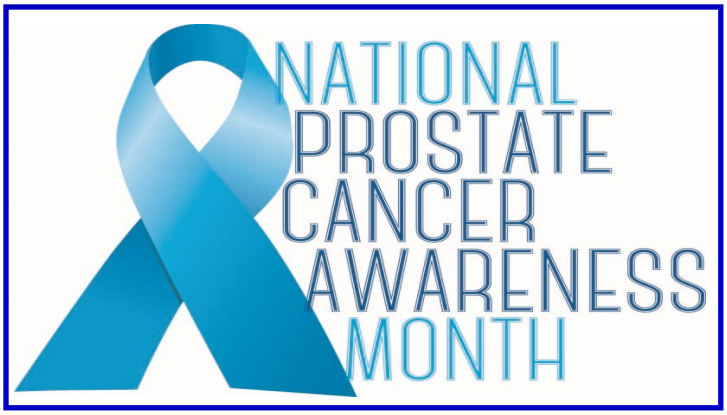


Prostate Cancer Resources From www.PatientResource.com

Arkansas Prostate Cancer Foundation: **www.arprostatecancer.org**

Center for Prostate Disease Research: **www.cpdr.org**

da Vinci Surgery: **www.davincisurgery.com**

Ed Randall's Fans for the Cure: **fans4thecure.org**

Malecare, Inc.: **www.malecare.com**

Prostate Advocates Aiding Choices in Treatment: **www.paactusa.org**

Prostate Cancer Foundation: **www.pcf.org**

Prostate Cancer International, Inc.: **pcainternational.org**

Prostate Cancer Journey: **prostate-cancer-log.blogspot.com**

Prostate Cancer Networking group **www.prostatenetwork.org**

Prostate Cancer Research Institute: **www.pcri.org**

Prostate Cancer Roundtable: **www.prostatecancerroundtable.net**

Prostate Conditions Education Council: **www.prostateconditions.org**

The Prostate Health Education Network: **prostatehealthed.org**

The Prostate Net: **www.theprostatenet.org**

Prostate Problems Mailing List: **ppml-info.org**

Urology Care Foundation: **www.urologyhealth.org**

Us TOO International Prostate Cancer Education & Support Network: **www.ustoo.org**

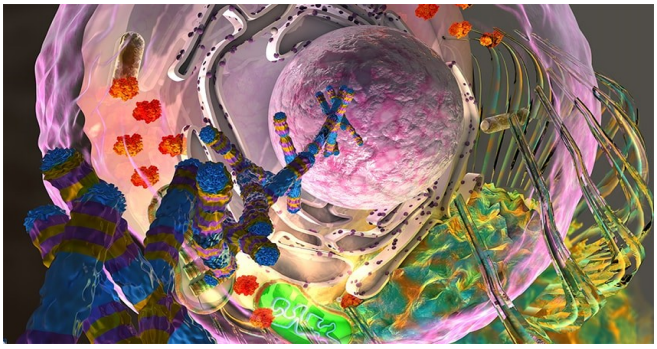
ZERO – The End of Prostate Cancer: **www.zerocancer.org**

Many, many, more resources for other cancers at **https://www.patientresource.com/Patient_Support_Groups.aspx?utm_source=061418&utm_campaign=061418&utm_medium=email**

Researchers Pinpoint New Subtype of Prostate Cancer

Nicole Fawcett June 14, 2018 University of Michigan Health Lab

Tumors with alterations in the CDK12 gene were more responsive to immunotherapy, suggesting a precision medicine approach.



Researchers led by the University of Michigan Rogel Cancer Center have identified a new subtype of prostate cancer that occurs in about 7 percent of patients with advanced disease.

The subtype is characterized by loss of the gene CDK12. It was found to be more common in metastatic prostate cancer compared with early stage tumors that had not spread.

Tumors in which CDK12 was inactivated were responsive to immune checkpoint inhibitors, a type of immunotherapy treatment that overall has had limited success in prostate cancer.

"Because prostate cancer is so common, 7 percent is a significant number. The fact that immune checkpoint inhibitors may be effective against this subtype of prostate cancer makes it even more significant. This is an exciting prospect for patients who have CDK12 alterations and may benefit from immunotherapy," says senior study author Arul Chinnaiyan, M.D., Ph.D., director of the Michigan Center for Translational Pathology.

Researchers at the Rogel Cancer Center will lead a multisite clinical trial to assess checkpoint inhibitors as a treatment for metastatic prostate cancer with CDK12 loss.

In this study, published in ***Cell***, researchers looked at DNA and RNA sequencing data from 360 tumor samples from patients with metastatic castration-resistant prostate cancer. This is an aggressive, advanced form of the disease in which the cancer has spread throughout the body and no longer responds to traditional hormone-based treatments. Tumor samples were from U-M's Mi-ONCOSEQ program and from samples collected through the Stand Up To Cancer-Prostate Cancer Foundation Dream Team.

Researchers found loss of CDK12 in only about 1 percent of early prostate cancer samples. That jumped to 7 percent for metastatic cancer, which indicates a more aggressive form of the disease.

"It suggests that those early stage patients who have CDK12 loss are the ones who will develop metastatic disease. This could be a harbinger in early cancer," Chinnaiyan says.

By following the mechanism of how CDK12 loss impacts the cell, researchers found a process in which cells create neoantigens that are foreign to the immune system. This boosts immune-fighting T-cells, which may explain why these patients benefit from immune checkpoint blockade.

This suggests that a precision medicine approach to prostate cancer could help better direct immunotherapy treatment. It could also explain why some prostate cancer patients have had exceptional responses to immunotherapy while the treatment has had lackluster results overall in prostate cancer.

The team first recognized a possible role for CDK12 in a 2015 paper that evaluated the genomic landscape of advanced prostate cancers. CDK12 has also been linked to ovarian cancer.

Little is known about CDK12 on a molecular basis, but scientists do know that CDK12 regulates several critical cellular processes and is essential for development. Eliminating it is likely lethal to most cell types. So why can tumors lose CDK12 and survive? Researchers suspect cancer must inherit something that allows it to grow in the face of CDK12 loss. More study is needed to understand this.

"This very promising study suggests that CDK12 loss may be a biomarker for identifying prostate cancer patients who may respond to checkpoint immunotherapy," says Howard Soule, Ph.D., executive vice president and chief science officer of the Prostate Cancer Foundation.

New treatment lowers risk for death from aggressive prostate cancer by over 70 percent, study finds

By Ese Olumhense Chicago Tribune June 27, 2018
http://www.chicagotribune.com/news/local/breaking/ct-met-prostate-cancer-drug-20180626-story.html

A clinical trial led by an oncologist now at Northwestern Memorial Hospital in Chicago, shown here in 2007, points to a drug to help lower the risk of prostate cancer. (Charles Rex Arbogast / AP)

Some of the 165,000 U.S. men who are estimated to receive a new diagnosis of prostate cancer this year will develop resistance to hormonal therapies for the disease, but a new study by a doctor now at Northwestern Memorial Hospital points to use of an existing drug to help treat them.

This kind of aggressive cancer has challenged doctors, as effective treatment to improve outcomes for these men hadn't existed previously. But a clinical trial led by Dr. Maha Hussain, now an oncologist at Northwestern Memorial, showed that taking a drug, enzalutamide, resulted in a 71 percent lower risk of cancer spread or death, compared to those taking a placebo during the three-year trial. The patients involved all had prostate cancer that hadn't spread but that also had not responded to hormone treatment.

Men taking the drug also had delayed cancer reappearance for almost two years.

Enzalutamide, an oral medication, is effective because it targets — and shuts down — the receptor on the cancer cell that receives male hormones such as testosterone. Without these hormones, the cancer cell can die or go dormant. If deployed sooner, when there is less cancer in the body, the drug can be more effective, Hussain said.

Hussain, also a professor of medicine at Northwestern's Feinberg School of Medicine, began work on the international trial while at the University of Michigan.

"I met prostate cancer at its most aggressive," said Hussain, recalling some of her earliest days as a doctor at the Detroit Veterans Affairs hospital in the 1980s, when screening and tests for the disease were still being developed.

"There was no way of diagnosing prostate cancer, or doing early detection. I ended up meeting patients coming through the emergency room with (spreading cancer), and nobody knew. They'd show up and they'd have back pain, or some paralysis, or trouble passing urine, blockage of their kidneys, and so on."

Hussain and her colleagues would evaluate these patients and find out they actually had prostate cancer that was spreading elsewhere in the body, she said.

Back then, treatment options for prostate cancer were limited. Today, Hussain has helped develop new treatments for prostate cancer, a disease that is better understood.

"I'm delighted to say that in my lifetime, we have seen huge progress in managing this cancer," she said. "Now, we have really come a very long way. With the different options patients have in terms of treatment once they're diagnosed, and the work that's going on with regard to early detection, I think it's caused significant shift. Cancer is being diagnosed, relatively speaking, at a much earlier stage, where it is potentially curable."

Hussain's peer-reviewed study, sponsored by Pfizer and Astellas Pharma, which manufacture enzalutamide under the brand name Xtandi, will be published Thursday in the New England Journal of Medicine.

The U.S. Food and Drug Administration also is reviewing approval of enzalutamide for this specific group of patients, though the drug is already used for men with visibly spreading prostate cancer that isn't responding to traditional hormone treatment. The trial included roughly 1,400 men between the ages of 50 and 95 whose cancer progressed on hormone therapy.

"This is really a remarkable landmark, but I do think there is plenty more to do to try and significantly impact outcomes," Hussain said. "Obviously, when we deal with cancer, the hope is to cure it. … At this moment, cure in advanced spread cancer is not realistic. But I do think there is hope."

MFS as a new endpoint in prostate cancer drug development

June 28, 2018 https://prostatecancerinfolink.net/2018/06/28/mfs-as-a-new-endpoint-in-prostate-cancer-drug-development/

An article by staff at the U.S. Food and Drug Administration (FDA) in this week's ***New England Journal of Medicine*** (NEJM) addresses the use of **metastasis-free survival (MFS)** as the primary endpoint in the trial that led to approval of apalutamide (Erleada) earlier this year.

Apalutamide was approved, based on data from the SPARTAN trial, for the treatment of men with non-metastatic, castration-resistant prostate cancer (nmCRPC) — because there was a large and clinically significant difference between the time to median MFS for the men taking standard androgen deprivation therapy (ADT) + apalutamide (40.5 months) and those taking ADT + a placebo (16.2 months).

The article by Beaver et al. addresses

- The background to the decision to use MFS as a primary endpoint to support the approval of drugs for the treatment of specific sets of patients with progressive forms of prostate cancer

- The upsides and the downsides of using MFS as a primary endpoint to support the approval of drugs for the treatment of prostate cancer (and perhaps other forms of cancer too)

Critical points made in this article, which will certainly impact the future approval of other drugs developed for the management of advanced forms of prostate cancer, include the following:

- New developments in our ability to identify earlier and smaller foci of metastasis are almost certainly going to affect the definition of MFS over time, and this will also — probably — affect the details of trials designed to seek an improvement in metastasis-free survival. Clearly MFS as defined by a metastatic tumor site visible on a bone scan is almost certainly a later event than MFS as defined by a metastatic tumor site visible on (say) an Axumin scan or a gallium-68 PET/CT scan. But in a clinical trial the actual form of imaging to be used to assess what is and what is not MFS has to be determined prospectively.

- How should we manage patient anxiety in clinical trials when men with significant, rising PSA levels are demonstrating serial negative scans and are therefore still — from a clinical perspective — metastasis free?

- What is a "metastasis" (at least in prostate cancer)? Does this only include metastasis to the bones or other distant metastasis to soft tissues like the liver, or can it include evident "metastasis" to the lymph nodes?

- The approval of apalutamide for treatment of nmCRPC has already made the future approval of other drugs for the treatment of nmCRPC harder because the standard of care has now changed and treatment of such patients in clinical trials for this indication will require any new drug to be studied in a head to head trial compared to ADT + apalutamide — or perhaps ADT + enzalutamide (see below).

But on the upside,

- The FDA has now clearly acknowledged that "a prolonged delay in development of metastatic disease is an objective and clinically relevant measure" (at least in the progression of prostate cancer).
- It is certainly possible that other, future drugs may well be approved for the treatment of nmCRPC (or perhaps for the treatment of hormone-sensitive prostate cancer) on the basis of MFS.

Indeed, in this same issue of the NEJM, Hussain et al. report the complete results of the PROSPER trial, in which enzalutamide (Xtandi) demonstrated comparable effects to apalutamide in the treatment of men with nmCRPC. Although enzalutamide has not yet been formally approved for the treatment of nmCRPC, it was granted a priority review for this indication by the FDA earlier this year, and expects approval of enzalutamide for this indication pretty much any time now. Whether any other drug will ever be approved for the treatment of nmCRPC ***without*** having to be compared to the new "standard of care" for this set of men with prostate cancer remains to be seen.

Note that the results of the SPARTAN trial and the results of the PROSPER trial were both initially presented at the Genitourinary Oncology Symposium in February this year and reported on this web site at that time. The results of the SPARTAN trial were also previously reported in the NEJM.

A big thank you to **Marlena Shirley** at Azure Mar Digital Consulting for the professional upgrade of our website.

What Men Need to Know About Factors that Impact Risk of Prostate Cancer

By Rachael Bieschke from http://www.cancerfightersthrive.com/

Race, ethnicity, and socioeconomic status matter when it comes to choices about prostate cancer screening and treatment.

While anyone may be diagnosed with cancer, everyone has varying levels of risk based on genetics, environment and lifestyle. Certain larger populations may also be at increased risk compared to other groups. For instance, your risk of cancer may vary according to your race, ethnicity, socioeconomic status, geographic location or gender. In the case of prostate cancer, disparities exist in access to care, tumor biology and response to treatment.

The biological makeup of a tumor, as well as how you respond to treatment, may relate to your ethnicity, according to Dr. Farshid Sadeghi, medical director of the Genitourinary Center and urologic oncologist at Cancer Treatment Centers of America® (CTCA) near Phoenix. African American men, for instance, are more than **twice as likely to die of prostate cancer** than European American men and **five times more likely to die** of the disease than Asian Americans.

"There are disparities in both the incidence and outcome for prostate cancer in African American men. This means that they get prostate cancer more often and when they do they are more likely to die from the disease," says Dr. Sean Cavanaugh, national director of the CTCA® Genitourinary Cancer Institute. African American men are about **1.6 and 2.6 times more likely** to develop prostate cancer than whites and Asian Americans, respectively.

Why Are African American Men at Increased Risk of Prostate Cancer?

Both genetics and environmental factors play a role, Dr. Sadeghi states, and lack of access to health care can negatively impact patients in that they may be diagnosed later or not have access to all the available treatment options. Research published in Cold Spring Harbor Perspectives in Medicine suggests that inequities in health care access strongly influence prostate cancer disparities, which means, if you're an African American man, making sure you visit your physician regularly for check-ups and receive the recommended cancer screenings is of utmost importance. But there's likely more to the story than this.

In fact, according to Dr. Sadeghi, "In African American men, when we control for socio-economic factors [such as access to health care], the higher incidence of disease, the more aggressive nature of prostate cancer and the higher mortality rates from prostate cancer persist." This suggests that access to health care alone does not explain prostate cancer health disparities.

There can even be downsides to increased access to health care, particularly as it relates to prostate cancer, which is sometimes over-treated. "It should be noted that increased access to health care can also lead to over treatment of low-risk prostate cancer, which can, in many cases, pose a greater risk to the patient than the disease itself," Dr. Cavanaugh says. It's important to discuss the pros and cons of active treatment and active surveillance with your doctor in the event prostate cancer is detected — and knowing whether you're at a heightened risk may ultimately help you in your decision.

Biological differences are also likely involved in prostate cancer disparities — an area of research that continues to be explored. In a recent study, researchers analyzed prostate cancer samples and found interleukin-6 (IL6), a signaling molecule, is overexpressed in tissues adjacent to tumors in African American men compared to European American men. IL6 is known to make p53, a tumor suppressor protein, inactive and may fuel aggressive prostate cancer stem cells that lead to metastasis and resistance to cancer treatment.

"In my mind, there is no question that the disease acts differently on a biological level in an African American man relative to, say, a Korean American man," Dr. Cavanaugh says. "In fairness, there is disagreement and healthy debate among experts on this issue." Further, this isn't only an issue affecting African American men; disease rates often vary among different ethnic groups, and African Americans tend to have the highest death rate for many types of cancer, although this disparity has gotten somewhat smaller in recent years, according to Dr. Cavanaugh.

Prostate cancer rates also vary worldwide and knowing your heritage may be helpful information. "There are tremendous variations in prostate cancer incidence across the world," he says. "For example, the incidence of prostate cancer is twice as high in Helsinki, Finland relative to Tallinn, Estonia, which is only 50 miles away. In general, rates are much lower in Asia and higher in parts of Europe, North America and Africa."

Continued page 11

Continued from page 10

Spreading the Word About Prostate Cancer Disparities

"It may not be possible to eliminate disparities that are genetic or biologic in nature," Dr. Cavanaugh notes. "We need to accept that there may be a biologic difference in the way this disease affects African American men and therefore resources must be dedicated to studying better screening and treatment techniques in that patient population."

This is why it's so important to raise awareness about the existence of prostate cancer disparities. Many men are unaware that they may be at an increased risk of prostate cancer., If they had this knowledge, they would be able to proactively seek increased screening or earlier diagnosis and treatment.

For instance, when it comes to the prostate-specific antigen (PSA) test, which screens for prostate cancer, there are different screening guidelines depending on your race/ethnicity. "Although public health policy references the increased risk for African American men, the message is not getting to the community and very few of my patients are aware that African American men have different PSA screening guidelines," according to Dr. Cavanaugh.

Raising awareness will also help to instill the importance of maintaining a regular relationship with your health care provider, so you don't miss out on important screenings, especially if you're at increased risk. "As physicians, we must realize that education is the key. We have to promote education at every level, and we have to build a culture where people make connections to the health care community early in their life and use that access with confidence," Dr. Sadeghi says.

Who Should Seek Earlier Screening

Be sure to talk with your physician about whether prostate cancer (or other cancer) disparities affect you and what that means for your health care going forward. If you have a friend or loved one who is at **increased risk, be sure to share this information so they can also make informed health care decisions.**

While guidelines suggest that men at average risk of prostate cancer begin screening for prostate cancer at age 50, those at high risk, which includes African American men, should begin screening at age 45, according to the American Cancer Society. Because prostate cancer in African Americans may be more aggressive and faster growing than in men of other races, earlier screening may help detect cancer before it has a chance to spread.

Most of the time, annual screening is recommended, but depending on your PSA levels, some physicians may recommend twice yearly follow-up screening for African American men. Your doctor can help you decide what level of screening is right for you. Remember, too, however, that cancer disparities are not the last word in dictating your overall risk of the disease, and there are many choices you can make, lifestyle-based and otherwise, that can influence your health outcomes.

Even if you're at higher risk of prostate cancer due to a factor you can't control, it doesn't mean you're guaranteed to be diagnosed with the disease (or a more aggressive form of it). As Dr. Sadeghi notes, "While we are aware of these disparities, the earlier we diagnose prostate cancer, the better the patient's chance of beating the cancer. We treat patients as individuals and try to tailor our evaluation and treatment to balance the probability of full recovery and their quality of life."

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, and answer questions.

Contact the office to see how you can help.

We would also like all of our members to help increase our outreach by telling friends and coworkers about us and our free resources, our meetings, our conference, our library, newsletter, buddy list , website, one on one support with newly diagnosed, and help us continue to grow in the peer led cancer support movement.

PCSANM *Lifeline* Newsletter

October 2018

Celebrating 26+ 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 October 2018

We've been busy the last few months making changes and preparing for the fall. The first change is to our website which we hope you will visit soon. You'll find it easier to navigate and exciting to share with others. I want to thank Jerry Cross for all his hard work in the process. He found a real professional website designer who took all of our input and has created something that will really work for all of us.

And if you've seen our KNME spot airing on Mondays with news programs you'll soon be seeing a difference there as well. Rod Geer and his team have created a fresh image that we hope will resonate with more men and their caregivers.

Of course we're well underway to putting on our 7th annual conference. Lou Reimer has pulled together an excellent slate of presenters to help us better our lives with the theme of Living and Thriving With Prostate Cancer.

But these changes and presentations are designed with you in mind. Our total reason for existence is to help you, prostate cancer survivors and caregivers, make the best decisions about your treatment and live well with the changes prostate cancer makes in your lives.

Steve Deming

Chairman of the Board, PCSANM