Prostate Cancer Support Association of New Mexico

LIFELINE

Celebrating 30 years of supporting men and their families

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Issue Highlights

Our website address:
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pchelp@pcsanm.org

Support Group Meetings

Due to COVID-19, PCSANM offers web-based meetings from 12:30-2:45 p.m. on the first and third Saturday of most months. In-person support group meetings have been suspended until further notice. Please call 505-254-7784 or email pchelp@pcsanm.org for information. Meeting topics by date may be found at:

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

9th Annual Conference a Success for PCSANM

Despite having to host this year's annual conference online, the PCSANM Conference Committee pulled off another valuable offering for New Mexico. Over 100 people from all over the state and even a few from out of state attended. Increased accessibility was a plus of offering the conference in this new format.

The Committee realized how difficult it would be for people to attend a full day online, so it scheduled the conference for two half days. The first day of the conference focused on detection and classification of prostate cancer, and the second day covered treatment options and medical availability in New Mexico.

To ensure the highest possible quality, the presentations were pre-recorded and edited before streaming during the conference. This eliminated technical issues and kept the pacing of the presentations going without interruptions. All presenters were well prepared and did outstanding jobs with their presentations.

The Committee aimed to make the offerings appealing not only to patients, but also to nurse practitioners and physician assistants in rural parts of the state because of the two latter groups' important role in the rural health care system. The first presentation addressed identifying prostate cancer via the PSA test and DRE. Jerome Baca, a Physician Assistant with Lovelace Medical Group, clarified the confusing positions concerning PSA testing. Dr. Larry Massie, Head of Pathology at the VA Hospital, helped everyone understand how a biopsy is studied and a determination made of a cancer's grade. He explained Gleason Scores, how the new Grade Grouping is determined, and what it implies for possible treatments. Dr. Satyan Shah from the UNM Urology Department then gave a comprehensive look at risk stratification and how it helps in the determination of what treatment is best. The day concluded with a live panel of the presenters to answer questions from conference attendees.

Day two started with a presentation by Dr. Aaron Geswaldo, a Urologist with Lovelace Medical Group, on active surveillance as a treatment option and what the factors are for deciding when this is appropriate. He was followed by Dr. Thomas Schroeder from the UNM Cancer Center, who presented a comprehensive look at all the treatment modalities currently available for localized prostate cancer. Dr. Barbara McAneny then closed with a detailed and sometimes disturbing look at the current and future of medical service availability in New Mexico. Dr. McAneny, Founder and CEO of the NM Cancer Center and a past president of the AMA, has a strong desire to make people aware of the looming medical crisis in rural New Mexico.

An advantage to a recorded, virtual conference is that if you missed it, you have another chance to see it. The conference can be viewed in its entirety on YouTube via a link on our website. It is definitely worth checking it out.

Special thanks to Presbyterian Healthcare Services for its generous support of this newsletter.

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In Praise of Our Officers

By Rod Geer, PCSANM Board Chairperson

During 2020 our board of directors experienced a number of changes. Four long-time members retired. New faces joined. The four who moved on had a combined 38 years on the board. Despite leaving, most are still engaged in important ways.

Steve Denning spent eight years on the board, with four as Chair, but he remained Fall Conference Director. COVID and the requirement to do things differently threw him a curve. And he probably worked harder that final half of the year than ever as producer/director/editor of our suddenly Zoom-based, primarily pre-recorded annual fall conference.

Dave Ball gave the board 11 years. Always a with quiet, thoughtful, yet persuasive approach, Dave could be counted on to offer the winning compromise when discussions seemed stuck. Dave and Steve still are on-call at least one week per month to answer off-hours phone queries and both are valuable Buddy List members.

Eli Maestas spent six years on the board engaged in varied activities such as spending time at a cancer retreat, lending a hand on various board committees and very importantly simply sitting and talking with men and their families with an always heart-felt empathy. He continues to serve on PCSANM's Outreach Committee.

Jan Marfyak's 13 years as a board member may be an unbreakable tenure. He had stints as secretary. He helped re-write the by-laws, carry the organization through some challenging fiscal times, and also nudge the group into new directions when needed. He concurrently served on national organizations devoted to prostate cancer outreach and support.

Now for current board members:

Michael Weinberg is the board's newest addition. Having worked for six years as a Program Evaluator at the Legislative Finance Committee and for five years as a Policy Officer at the Thornburg Foundation, he brings valuable insight into how PCSANM might pursue new funding opportunities.

Kat Lopez joined the board a couple months before Michael. She has worked as a Creative & Marketing Manager, a Marketing Supervisor, and a Mass Communications Coordinator. Thanks to her, we're becoming more social media-conscious and effective. In addition, she has experience being a caregiver for her father, who had prostate cancer.

Gene Brooks joined the board not quite a year ago, but his interest and enthusiasm led him to sit in on board meetings months before becoming "official." He has been focused on hosting some Saturday meetings, identifying meeting topics, and seeking out presenters for those meetings. He also hosted day two of our annual conference.

Audrey Sniegnowski, our secretary, has been an oncology nurse for more than 20 years. She works at the New Mexico VA hospital urology department as a Cancer Center Coordinator. Ours isn't the only support group that fills her time, however. She started a veteran-centered prostate cancer support group that partners with PCSANM. Because of this unique combination status, Audrey is able see things from a dual perspective.

Dave Turner is a retired nurse and our treasurer. At meetings some board members want pages of numbers. Others want just 4 or 5 numbers. Whatever is requested, Dave delivers. Dave's initiative and writing skill led to a successful national Paycheck Protection Program application that helped us avoid some financial challenges due to COVID.

Phil York excels during health fairs. When he and I have jointly staffed such events, it's been a joy to watch him engage people up close and personally. But, in COVID times, that platform is gone. So for much of the past year, Phil has focused more on other aspects of getting our name and main messages out to various audiences. He also serves as chair of the Outreach Committee.

Charles Rowland, our deputy board chair and one of the longest-serving members (now with a bit more than six years), has served as treasurer and now leads the Fundraising Committee. Charles also is the idea guy and our unofficial essayist. When an idea comes to him, it's reasonable to expect a nicely typed paper from him that lays out his logic.

Lou Reimer is our most tenured board member. His almost 11 years have included two terms as board chair. He's also offered much appreciated support and input for me. For more than several years now, Lou has played the primary role in developing our programs for the annual conferences and for the twice-monthly support group meetings. Lou's close and personal relationship with key doctors country-wide is also key to our success.

Getting It Done During a Pandemic

Rod Geer, Board Chairperson

COVID-19 came early in 2020 and with a year-long impact on what we do and how to do it. Despite an almost immediate need to change our way of providing men and their families with key prostate cancer information, statistics show we did well. The year's highlight is the number of one-on-one consultations we provided to discuss prostate cancer treatment options and side effects with men and women. The overall the number of consultations decreased slightly due to the effects of COVID: PCSANM provided 150 consultations from January through November, compared to 180 consultations from January through December of 2019, 90 in 2018, and 50 in 2017.

Attendance for our twice-monthly organization meetings dipped somewhat, but quite frankly, a lot of folks just aren't yet comfortable with virtual meetings that require sitting in front of a screen. From January through November of 2020, support group meetings have attracted 321 participants. This number reflects that no meeting was held on March 21 or April 4 due to COVID, and no meeting was held on July 4th due to that Saturday being a holiday. Virtual meetings have attracted far fewer attendees for virtual meetings in 2020 vs 23 individuals on average for in-person meetings in 2019.

2020 brought outstanding presentations, including but not limited to:

- BPH/Urolift, Dr. Andrew Grollman
- Managing PCa During COVID, Dr. Gregg Franklin
- Recurrent Prostate Cancer, Dr. Ken Smith,
- Immunotherapy, Dr. Pranshu Bansal
- Combination Therapies, Dr. Neda Hashemi
- Radiation Treatment, Dr. Heyoung McBride,
- Reclaiming Intimacy After PCa, Dr. Jeffrey Albaugh
- New Developments in PCa Treatments, Dr. Nicholas Vogelzang
- Laser Imaging, Bernadette Greenwood

Our fall conference attendance also dropped, likely due to its virtual nature. 105 individuals attended the conference in 2020, compared to 173 individuals in 2019, 85 in 2018, and 128 in 2017. The full conference video still can be watched on YouTube, thereby continuing to reach more individuals as the months go by.

Technology Networks - Cancer Research: October 20, 2020

A New Way to Personalize Prostate Cancer Treatment

Original Story from Rutgers University

Rutgers researchers have discovered human gene markers that work together to cause metastatic prostate cancer – cancer that spreads beyond the prostate.

The study, published in the journal *Nature Cancer*, explored prostate cancer cells from people and mice and found a wide collaboration among 16 genes that leads to metastasis, which often leads to treatment challenges.

The gene markers identified can predict if a prostate cancer patient has a high probability of developing metastasis, including bone.

Prostate cancer is the second leading cause of cancer-related deaths among men in the United States with a five-year relative survival rate of near 100 percent when diagnosed early. Metastatic prostate cancer has a five-year survival rate of 30 percent. Current therapeutics like first- and next-generation anti-androgens that target male sex hormones alongside radiation, chemotherapy and others are not always effective, and it's impossible to predict which patients are at risk of developing the advanced late stage of the disease.

"People diagnosed with prostate cancer should now be screened for the protein markers discovered to help determine their risk of developing metastatic prostate cancer, which can help inform more personalized therapy," said Antonina Mitrofanova, an assistant professor at the Rutgers School of Health Professions and research member at Rutgers Cancer Institute of New Jersey. "Our results show that molecular profiling at the time of diagnosis can help inform more personalized therapy leading to better outcomes for those with this advanced form of disease."

Researchers say testing for these gene markers can also predict which patients will fail to respond to normally used androgen targeting therapies in metastatic disease and can decrease multiple treatment rounds for patients. Researchers, in collaboration with Cory Abate-Shen's lab at Columbia University, have obtained a patent for their discovery and are looking to develop therapeutics and diagnostic tools.

Prostate Cancer Foundation: November 2020

5 Ways Al Roker Got It Right Regarding His Prostate Cancer Diagnosis

There is so much to learn from how Al Roker of the Today Show handled his prostate cancer diagnosis. Here are all of the ways that Al Roker got it right in regards to his prostate cancer:

1. **He was screened before showing symptoms.** Al Roker's cancer is an early-stage prostate cancer that is confined to the area of the prostate. This is good news and significantly increases his odds of survival. But it is important to note that his cancer was found early because he underwent a PSA (prostate specific antigen) screening at his routine checkup. It is important for men to talk to their doctor about getting screened for prostate cancer even if everything feels fine. PCF recommends that most men start to talk to their doctor about screening at age 45, but that drops to 40 if you have a family history of cancer or are of African descent.

2. **He practiced shared decision making with his doctors.** In an interview with his surgeon, Al Roker discussed that he was not a good candidate for active surveillance (monitoring the cancer closely and deferring treatment to only if and when the cancer shows signs of progression). This is because his cancer, while still within the prostate, appears to be an aggressive form of the disease. It is important to remember that not all prostate cancers are the same, and therefore, not all treatment options will be right for every man. It can be easy to get swept up in personal opinions from friends and family who have gone through a similar experience. But each prostate cancer, each man, and each family is unique.

3. **He shared his experience to help educate and save others.** All too many men choose to keep their prostate cancer diagnosis a secret, or worse: they are too embarrassed to even discuss regular screening with a doctor. But Al Roker has recognized how important it is to educate other men about this disease so that they can proactively talk to their doctor about prostate cancer screening. This is particularly true for African American men, who are more 79% more likely to be diagnosed with prostate cancer as compared to other ethnicities. Al's honesty has the potential to save so many lives and has already inspired others to be open about their own diagnosis. In fact, Al and his team chose to raise awareness about prostate cancer in 2017 and 2019, even before his own diagnosis, when he partnered with PCF to tell men to "Get Checked."

4. **He has maintained a relentlessly positive attitude.** Al Roker made it very clear in his Today Show announcement of his diagnosis that he is confident that he is going to be okay. He has acknowledged the seriousness of the disease, but he has also acknowledged that prostate cancer is one of the most treatable cancers, particularly when found early. By not viewing his diagnosis as a death sentence and allowing himself to focus on all he has to be grateful for, Al has set himself up to be in the best possible mental state for the recovery ahead of him.

5. **He is prioritizing his health and taking time off to heal.** This may seem like an obvious necessity, but it is an underappreciated step in the recovery process. It can be tempting to put off screening or treatment for as long as possible, especially with the reality of COVID-19 adding an extra layer of fear to medical treatment. Certainly, in some cases your doctor may advise you that it is okay, or even preferable to wait for treatment. But given that Al has an aggressive form of prostate cancer, he has taken the advice of his doctors and has allowed himself to take time out of his busy schedule to take care of his own health and heal.

Everybody who is diagnosed with prostate cancer has a unique journey, and we are grateful to Al Roker for being an example of courage and grace and using his platform to educate others and save lives.

Medscape Medical News: December 2, 2020

FDA Approves First Agent for PSMA-PET Imaging in Prostate Cancer

Zosia Chustecka

A new radioactive diagnostic agent for use in prostate cancer has been approved by the US Food and Drug Administration (FDA).

The product, Gallium 68 PSMA-11 (Ga 68 PSMA-11), has been approved for institutional use at the University of California, Los Angeles (UCLA) and the University of California, San Francisco (UCSF) under an academic new drug application (NDA).

The FDA approval was based partly on a clinical trial conducted by the UCSF and UCLA research teams on the effectiveness of PSMA PET.

"It is rare for academic institutions to obtain FDA approval of a drug, and this unique collaboration has led to what is one of the first co-approvals of a drug at two institutions," said Thomas Hope, MD, an associate professor at UCSF. "We hope that this first step will lead to a more widespread availability of this imaging test to men with prostate cancer throughout the country."

This approval allows use of PSMA PET only at these two centers. Some other US centers are currently using PSMA as an investigational technique, generally as part of a clinical trial, and they can apply for expedited FDA approval.

The drug itself, Ga 68 PSMA-11, was developed outside the United States by the University of Heidelberg, in Heidelberg, Germany.

A commercial NDA from Telix Pharmaceuticals for TL591-CDx, a radiopharmaceutical cold kit for the preparation of Ga 68 PSMA-11 injection, is under consideration by the FDA.

This is the first drug approved specifically for use in positron-emission tomography (PET) imaging of prostate-specific membrane antigen (PSMA)–positive lesions in men with prostate cancer, the agency noted.

This new imaging approach can "detect whether or not the cancer has spread to other parts of the body," commented Alex Gorovets, MD, acting deputy director of the Office of Specialty Medicine in the FDA's Center for Drug Evaluation and Research.

The product is indicated for use in patients with suspected prostate cancer metastasis whose conditions are potentially curable by surgery or radiotherapy, the agency noted. It is also indicated for patients with suspected prostate cancer recurrence, as determined on the basis of elevated serum prostate-specific antigen (PSA) levels.

The FDA notes that two other PET diagnostic agents — fluciclovine F18 and choline C11 — are approved for prostate cancer imagining. However, they are only approved for use in patients with suspected cancer recurrence.

Ga 68 PSMA-11 used in PET imaging specifically indicates the presence of PSMA-positive prostate cancer lesions in the tissues of the body.

"PSMA PET/CT is a novel molecular and functional imaging modality specific for prostate cancer cells that has good sensitivity and outstanding specificity in detecting metastasis," commented T. Martin Ma, MD, PhD, of UCLA.

Ma presented a US study on the technique at the recent annual meeting of the American Society for Radiation Oncology. That study showed that PSMA PET/CT led to nodal upstaging in 19.7% of patients and metastasis upstaging in 9.4%.

He said these results were similar to those from the Australian proPSMA trial, which was published in *The Lancet* earlier this year. That trial found PSMA PET/CT to be superior to conventional imaging with CT and bone scanning for primary staging of high-risk prostate cancer.

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Medscape Medical News: December 2, 2020

FDA Approves First Agent for PSMA-PET Imaging in Prostate Cancer

Zosia Chustecka

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"These findings carry significant clinical implications and can affect treatment decision making," Ma commented.

"PSMA PET has been a real game changer in high-risk prostate cancer and has implications in the various stages of prostate cancer management from diagnosis and staging to theranostics," said Renu Eapen, MBBS, of Peter MacCallum Cancer Center, Melbourne, Australia, who was not involved in either study.

"PSMA PET/CT has challenged conventional imaging in staging before curative-intent surgery or radiotherapy," Eapen added.

The accuracy of PSMA PET/CT was 27% higher than that of conventional imaging in the proPSMA trial, she noted in an interview last month. This superior accuracy can ultimately affect management. The imaging has additional benefits of lower radiation dose as well as reproducibility with high reporter agreement, potentially making it a "one-stop-shop" scan.

Clinical Data From Two Trials

The FDA noted that the safety and efficacy of Ga 68 PSMA-11 were evaluated in two prospective clinical trials with a total of 960 men with prostate cancer, each of whom received one injection of the product.

The first trial involved 325 patients with biopsy-proven prostate cancer who underwent PET/CT or PET/MRI scans performed with Ga 68 PSMA-11. "These patients were candidates for surgical removal of the prostate gland and pelvic lymph nodes and were considered at higher risk for metastasis. Among the patients who proceeded to surgery, those with positive readings in the pelvic lymph nodes on Ga 68 PSMA-11 PET had a clinically important rate of metastatic cancer confirmed by surgical pathology," the agency noted.

"The availability of this information prior to treatment is expected to have important implications for patient care," the FDA commented. "For example, it may spare certain patients from undergoing unnecessary surgery.

"The second trial enrolled 635 patients who had rising serum PSA levels after initial prostate surgery or radiotherapy, and thus had biochemical evidence of recurrent prostate cancer. All of these patients received a single Ga 68 PSMA-11 PET/CT scan or PET/MR scan. Based on the scans, 74% of these patients had at least one positive lesion detected by Ga 68 PSMA-11 PET in at least one body region (bone, prostate bed, pelvic lymph node, or extra-pelvic soft tissue). In patients with positive Ga 68 PSMA-11 PET readings who had correlative tissue pathology from biopsies, results from baseline or follow-up imaging by conventional methods, and serial PSA levels available for comparison, local recurrence or metastasis of prostate cancer was confirmed in an estimated 91% of cases," the agency noted.

"Thus, the second trial demonstrated that Ga 68 PSMA-11 PET can detect sites of disease in patients with biochemical evidence of recurrent prostate cancer, thereby providing important information that may impact the approach to therapy," it added.

The FDA also noted that no serious adverse reactions were attributed to Ga 68 PSMA-11. The most common adverse reactions were nausea, diarrhea, and dizziness.

Prostate Cancer Foundation: October 20, 2020

New Genetic Test Could Be the Ultimate in Early Detection

Janet Farrar Worthington

What if you could walk into a room full of guys and know who's probably going to get prostate cancer? Not because you're some sort of psychic cancer whisperer, but because you have a test. And what if you could also tell which of these guys has a high likelihood of *never* getting prostate cancer?

And what if these guys were young, much younger than the typical prostate cancer patient? The ones who are at high risk could start getting their PSA checked in their thirties. Men with Gleason 8, 9, and 10 cancer could have it detected and treated at its earliest manifestation. The number of men dying of metastatic prostate cancer could plummet!

One day soon, a young man and his parents may even work with "his pediatrician to determine his polygenic risk score and create a lifetime prostate cancer risk reduction strategy," says molecular biologist and medical oncologist Jonathan Simons, M.D., CEO of the Prostate Cancer Foundation (PCF). "That's going to be the future."

The Smith Polygenic Risk Test for Prostate Cancer is very simple for the patient; it starts with a saliva or blood sample. This score could also be obtained with a cheek swab – or any routine blood test, "although it would only need to be done once in the life of a patient," says Simons. Step right up – spit in a tube (or get swabbed, or take a blood test), and get your prostate cancer fortune read! In this case, the fortune is in the germline DNA, the genes we are born with; *all 20,000 or so of them* are present even in a teaspoon or so of spit or a small vial of blood.

But here's the key: It turns out that it's not *this* one particular gene, or *that gene right next to it*, that suddenly determines your prostate cancer fate. It's certain **bad combinations of genes.** Scientists led by Christopher Haiman, Sc.D., a PCF-funded investigator and cancer and genetic epidemiologist at the University of Southern California, have identified specific – and testable – changes, called **single-nucleotide polymorphism (SNPs)** in more than 250 genes. There are many possible combinations of these SNPs, but they could raise a man's risk of getting prostate cancer by a little, or a lot. Or, if a man doesn't have *any* of these changes, it's almost – not quite, but damn close – a genetic "get out of jail free" card. Lucky guy!

How does it work? It's actually pretty simple, once you get past the extremely sophisticated technology that allows scientists to analyze vast amounts of information all at once.

Consider, if you will, a hand of cards in your basic game of poker. You might get dealt five completely unrelated cards. This would be like the fortunate man mentioned above – the man who will never know what it's like to have needles stuck in his prostate for a biopsy, the man who probably won't need many PSA tests in his life, because he's got an extremely low risk of ever getting prostate cancer. He doesn't have any of the bad combinations of genes. This man, by the way, is probably Asian. Haiman and colleagues in the U.S., including William Isaacs and UK have shown that **race matters in the genetic lottery of prostate cancer-causing genes**. More on this in a minute. Back to the poker game. Your imaginary hand could have three unrelated cards and a pair; it could be a **pair of twos, or a pair of Aces**. You could have three of a kind – **three Jacks**, perhaps. Or **two pair** – a couple of sixes and two eights.

Now, let's raise the stakes. Let's say you have **three of a kind** – three Queens, perhaps. Or a **straight** – five consecutive cards of different suits. Or a **flush** – five cards of the same suit; hearts, perhaps. In poker, four hands are more powerful than this: a full house; four of a kind; a straight flush, or – a certainty to win – **a royal flush**. The man who inherits this, the worst gene combination, is more likely to be of **African descent**, or to have a **family history of prostate cancer**, or a **family history of other kinds of cancer**. We've known that these are the men at highest risk of getting prostate cancer; we just didn't know why, until now.

A man born with the genetic equivalent of a royal flush is at very high risk of getting prostate cancer. Worse, he's at very high risk of getting aggressive, high-grade cancer. If that man waits until his mid-fifties to start getting his PSA checked, he might be diagnosed with cancer that has already spread outside the prostate. But soon, that man will have a secret weapon: the multi-gene (polygenic) test. In the future, a young man who spits into

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Prostate Cancer Foundation: October 20, 2020

New Genetic Test Could Be the Ultimate in Early Detection

Janet Farrar Worthington

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a tube or gets a blood draw and finds out he's got this "royal flush" combination of prostate cancer genes will be lower PSA threshold – a lower cutoff number for PSA that monitored closely. He will probably start getting his PSA checked when he's in his thirties, and he may have a lower cutoff number for PSA that would signal the need for further testing, including an MRI and a biopsy.

How soon? Well, the answer is… soon. In PCF-funded studies, Haiman and scientists in the U.S., and **scientists in the UK led by cancer geneticist and medical oncologist Rosalind Eeles**, F.R.C.P., F.R.C.R., are investigating the test – hoping to confirm the results Haiman and colleagues found in the smaller study – in larger groups of men of different races. They are looking to improve the risk stratification (basically – going back to our poker game – to determine whether a man has three of a kind, a straight, etc.) and to make sure they're looking at the right gene combinations for men of various races.

Eeles, who specializes in early, targeted screening and cancer genetics at The Institute of Cancer Research, London, and The Royal Marsden NHS Foundation Trust, is principal investigator of the PROFILE study, which correlates germline genetic profiling with targeted prostate cancer screening and treatment. In groundbreaking research using a massive genetic databank, Eeles and her team have identified risk SNPs in the genes of tens of thousands of men – those with prostate cancer, and those without. Her current study has two groups of participants aged 40-69: one is Caucasian men with a family history of prostate cancer, and the other is black men of West African or African-Caribbean ancestry. When the risk test becomes widely available, it will assess different genetic profiles based on race. **"It's obviously silly to use a profile that's genetically most relevant for the African-Caribbean man if you're a European man,"** notes Eeles.

Men in the PROFILE study, in addition to having their saliva analyzed, receive a PSA test, an MRI, and a prostate biopsy. The goal, Eeles says, is to make reliable predictions of risk with the test – to tell, for example, "what would his MRI look like? What would his biopsy look like? The long-term aim is that you will do a saliva test, look at the genes, and tell whether that man is high-risk or not. Then we'll know which men to target with more intensive screening." For countries (such as the U.S.) where MRI is expensive, "men could have the profile done first, have more intensive PSA monitoring, and have a trigger for biopsy, which will almost certainly be age-dependent." The family history study began nearly two years ago, with funding from Movember, Prostate Cancer UK, and Cancer Research UK. Eeles and colleagues have enrolled about 250 men, and the target is 350. The UK study of black men started recently, with 25 men tested so far. Incentive for taking part in this study: if you are found to have prostate cancer, you will find out right away and get immediate treatment.
Here's a link to more information.

If you are a Hispanic man, your bad combinations of genes will probably be different from the bad combinations of a Caucasian man, and both of your bad combinations may be very different from those of a man of African ancestry.

One more thing: just because you have the key combination – the three lemons on a slot machine – doesn't make it absolutely, 100 percent certain that you are going to develop prostate cancer, says Haiman. Other factors – diabetes, obesity, smoking, or conversely, a healthy diet and exercise – undoubtedly play at least a small role, even in men at the very highest risk. But giving men a lifetime risk, and custom-tailoring their prostate cancer screening, "is going to change everything," says Simons. "We just don't know by how much, and in what way; I can't tell you how many men would start getting their PSA tested at 35, and how many would wait until 55, have a couple of tests and never need to be tested again." Nonetheless, "the evidence is overwhelming that we can stratify risk," Simons continues. "We can tell a man whether he has a three-times or a ten-times higher risk versus a normal risk. We can dramatically fine-tune which men are going to need a biopsy. We can save lives. That's why PCF is funding this: we are going to drive the national testing of this in the U.S. and the UK.

"There are men walking around in their forties with an 11-times higher risk of prostate cancer. I could tell you every one of them, if they all spit into a tube. Will all of them get prostate cancer? No; not everybody at high risk gets the disease. How many will get Gleason 9 versus Gleason 7 disease? We don't know, but you'd still want them all to get a PSA test. With the Smith test, it becomes unethical for men at higher risk not to screen for prostate cancer."

Prostate Cancer Foundation: November 2020 (Blog)

Vegetables: Cooked or Raw?

You've heard it your whole life: Eat your veggies. From your childhood dinner table to the latest fad diets, the health of veggies has never been in question. And for good reason! Increased vegetable intake is associated with lower risk of chronic disease and a number of cancers, including prostate cancer. Almost all vegetables, cooked or raw, contain an array of vitamins, other nutrients, and immune-boosting fiber for your microbiome.

But what's the best way to eat vegetables, raw or cooked? You may have heard lots of armchair opinions on this. Is there a "best way" to way to prepare vegetables and/or cook vegetables, and are you killing or reducing the "good stuff" when you cook them? The answer is: it depends.

Although nutrient loss following the cooking of vegetables has gotten a lot of attention, it turns out that many vegetables provide more bioavailable nutrients after being cooked. This includes cruciferous vegetables like cabbage and broccoli, and one other prostate favorite: tomatoes. Technically a fruit, tomatoes are generally healthy eaten raw, but cooking them in extra-virgin olive oil gives tomatoes a health boost. The added heat works alongside the olive oil to assist in the absorption of lycopene, a powerful carotenoid that is responsible for the tomato's antioxidant capability as well as its bright red color. Interestingly, lycopene accumulates in prostate tissue – all the better to do its cancer-fighting work – which may partially explain why eating tomato products may be associated with a lower risk of lethal prostate cancer.

On the other hand, there are certain nutrients, such as vitamins C and B1 (thiamine), as well as some polyphenols (antioxidants) that are easily destroyed when exposed to heat. For example, one study found that most common cooking techniques lowered the vitamin C content in several different types of vegetables.

So if you are going to cook vegetables, how should you do it? Science has pointed out that boiling may be one of the worst options, since many water-soluble vitamins and antioxidants are leached out from the vegetable and into the water that's left behind. But it's not just the water-soluble vitamins that get destroyed in boiling. Let's use broccoli as an example. Broccoli and other cruciferous vegetables are high in beneficial glucosinolates. In order for your body to access the good stuff in the glucosinolates, it needs the aid of a helper enzyme that also exists inside the broccoli. If you chop or chew *raw* broccoli, it releases the helper enzyme from the broccoli cells. On the other hand, if you *overcook* your broccoli with excessive boiling, the helper enzyme is destroyed. Light cooking, such as steaming, preserves both the enzyme and the glucosinolates.

Steaming vegetables may be the cooking gold standard in terms of both preserving and enhancing nutritional value. There's minimal water added, and while a few nutrients may be destroyed in the heating process, you typically maintain the micronutrient profile, especially with cruciferous vegetables. Roasting and grilling vegetables is also an option. Unlike grilled meat, grilled vegetables do not contain the same potentially harmful compounds (e.g., HCAs) that have been indicated in animal studies to be carcinogenic. And last but not least, while microwaving may be *safe* to your food, it can cause substantial culinary damage if not done carefully – resulting in soggy and unevenly heated product. While a well-functioning microwave is safe to use, remember that microwave radiation has the same effect on humans as food, so a malfunctioning or ill-closed device can leak radiation. It's temptingly easy to reheat leftovers in plastic containers, but many types of plastic leach hormone-disrupting chemicals (such as phthalates) into the food when microwaved. Follow standard operating procedures and stand a few feet away from the machine while it's in operation.

There is a lot of science focused on vegetables and cooking, and it can be easy to get lost in the details. Here's a great principle to not overthink it: **eat vegetables, however you like them.** Don't let the details distract you from incorporating vegetables, one of the healthiest foods on the planet, into your diet. Instead, focus on what you're pairing with these vegetables, and do your best to avoid cooking with processed sauces and high-fat ingredients. And one last tip: mind your vegetable prep. While Michelin 5-star restaurants might spend a lot of time peeling those unwanted skins and straining those unwanted seeds, microbiome science dictates exactly the opposite: more roughage is better. To maintain as much of the rough fiber as possible, you may consider buying organic so that you can eat the nutrient-dense peels and seeds that go along with all of nature's richness.

Medscape Medical News: November 9, 2020

Longer Survival With Sipuleucel-T in Advanced Prostate Cancer (edited)

Roxanne Nelson, RN, BSN

The first and only immunotherapy product for advanced prostate cancer, sipuleucel-T (Provenge), has not been widely used clinically since its launch 10 years ago, and has been largely eclipsed by two drugs launched since then — the androgen-receptor signaling pathway inhibitors (ASPIs) abiraterone acetate (Zytiga) and enzalutamide (Xtandi).

But new data from a retrospective observational study involving more than 6000 participants show that men with advanced prostate cancer who received sipuleucel-T had a significantly prolonged overall survival.

The median overall survival was 34.9 months with sipuleucel-T vs 21.0 months in men who were treated with ASPIs in the first-line setting.

The study was published October 7 in *Advances in Therapy*.

"These data highlight that Provenge is a viable option for patients with metastatic castration-resistant prostate cancer and should be considered and used as a treatment for a subset of patients eligible to receive this medication," said lead author Rana McKay, MD, an associate professor of medicine at the University of California-San Diego School of Medicine.

However, an expert approached for comment cautioned that these new data should be viewed as hypothesis-generating only.

Daniel Geynisman, MD, assistant professor, Department of Hematology/Oncology, Fox Chase Cancer Center, Philadelphia, Pennsylvania, pointed out that sipuleucel-T is the only immunotherapy FDA-approved specifically for castration-resistant prostate cancer.

Often referred to as a vaccine, the product is an autologous active cellular immunotherapy, made from the patient's own white blood cells, which are collected and then reprogrammed to attack cancer cells.

"It is infrequently used in clinical practice compared to androgen pathway inhibitors such as abiraterone acetate or enzalutamide, due to perceived marginal survival benefit, lack of a PSA response, and inability to gauge a patient's response, and also cost," Geynisman commented.

Although this new analysis suggests a survival benefit with use of sipuleucel-T, it should be considered "as hypothesis-generating only, given its severe limitations in controlling for key clinical variables — such as PSA, Gleason score, performance status and other key laboratory values — that may severely differentiate the group of men who did vs did not receive sipuleucel-T," said Geynisman.

"Sipuleucel-T remains an option for men, but guidelines and clinical practice cannot be altered based on this analysis alone," he added.

He emphasized that these results do not suggest that sipuleucel-T is superior to abiraterone acetate or enzalutamide in improving overall survival. "They suggest that men who at some point in their treatment trajectory received sipuleucel-T have superior overall survival," he explained.

"These results are once again intriguing and supportive of the use of sipuleucel-T, but as any claims-based research remain only hypothesis-generating given the multiple possible confounders."

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Prostate Cancer Support Association of New Mexico

PCSANM *Lifeline* Newsletter
Celebrating 30 years of supporting men and their families

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

A Message from the Chairperson

January 2021

Previous pages described achievements enjoyed and challenges battled during 2020. Your Prostate Cancer Support Association of New Mexico weathered things admirably well. One particularly large group – you, our members, participants, supporters, newsletter readers – had a stellar year despite this year's pandemic and all its attendant stresses. Your willingness to open pocketbooks showed your appreciation of and dedication to our 30 year-old organization. Donations admittedly dropped some this year. That's not really a surprise. However, as COVID ramped up just as summer drifted into fall, contributions shot up. In fact, 70% of 2020 donations were made between August and when this newsletter went to press in early December. We are so grateful for your support.

A final thought – if you've made it to this point of the newsletter but somehow missed the article on page 5 about a long-time TV weatherman and personality, please go back and read it. Al Roker's approach to dealing with his prostate cancer – early screening, learning of the diagnosis, getting educated and being personally involved, sharing his situation as a way to help educate others – is what we try to do in pursuing our mission and what we hope transfers to those who seek out the Prostate Cancer Support Association of New Mexico.

Rod Geer

Chairperson of the Board, PCSANM