Prostate Cancer Support Association of New Mexico

Celebrating 26+ years of supporting men

LIFELINE

PCSANM Quarterly April 2018 Volume 25, Issue 2

Issue Highlights

Our website address
www.pcsanm.org
e-mail
pchelp@pcsanm.org

Meeting Place:

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

PCSANM helping men get PSA tests

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

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, give the PCSANM a call at 505-254-7784 or drop by the 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, co-worker, or friend, for example – let them know about it.

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

Board Members

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Silver City	Herb Trejo	(575) 574-0225 C (575) 538-3522 H

In Memory of

Robert Brown

Lee Courtnage

Jack C. Fuller

Burt Garner

Francisco Hernandez

With deep sympathy and regret, we list these names

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MEETINGS Lou Reimer

Adjuvant Radiotherapy and Chemotherapy in Node-Positive Prostate Cancer

Alberto Briganti, MD, PhD From Urotoday.com

San Francisco, CA (UroToday.com) The use of adjuvant treatment for patients with high risk or node-positive prostate cancer patients remains controversial despite level 1 evidence demonstrating a benefit. The controversy revolves around the risk of overtreatment in addition to the lack of evidence demonstrating the superiority of adjuvant over early salvage therapy. Today, Dr. Alberto Briganti, from Urologic Research Institute at the University of San Raffaele, presents the data available supporting the use of adjuvant radiation therapy and systemic therapy for patients with nodal disease.

Improvement in the surgical and radiation techniques have improved the outcomes of patients with aggressive prostate cancer which in the past were treated with hormone deprivation therapy. As a result, there has been stage migration towards the increased diagnosis of patients with nodal disease, especially in those who undergo an extended lymphadenectomy. The best available evidence of the use of adjuvant therapies in this patient population is the one provided by ECOG-3886 trial which showed adjuvant treatment with ADT improved overall survival (OS) compared to placebo. This trial has been widely criticized due to its historic population which included bulky nodal disease and likely undiagnosed metastatic disease which is far different from patients currently undergoing treatment.

In the contemporary setting, there have been some trials (TAX-3501, SPCG-12, and GETUG-12) that have tried to address the controversy, but these have been faced with accruement issues, and the ones that reported have shown conflicting results. The trials run by the STAMPEDE collaborators, which assess the survival benefit of early use abiraterone and docetaxel on high-risk prostate cancer patients, have the potential to shed light into the potential benefit of these agents on node-positive patients. Subtype analysis from the STAMPEDE abiraterone trial where recently reported showing that N1 patients receiving abiraterone were less likely to recur compared to ADT alone, no difference in overall survival was noted at a median follow-up of 3 years.

The use of radiation therapy on patients with N1 disease has been underutilized and understudied due to the association of nodal involvement with a systemic state rather than a local state. As a result, most the data available in the added value of radiation therapy in N1 patients is in combination with hormonal therapy and remains mainly from retrospective single center and multicenter retrospective trials. The best data in the use of adjuvant therapy for patients with N1 disease comes a retrospective multicenter trial which included 1,300 patients showing that those undergoing combination therapy with ADT showed better overall survival compared to those in the ADT only and placebo arms. Smaller single-center trials have echoed similar results, but selection bias remains a significant limitation due to the retrospective nature of this publications. Currently, there are no planned clinical trials on the matter, which is likely related to the overall feeling that these patients are likely to faced overtreatment. Unfortunately, patients with nodal involvement were excluded from the prospective randomized adjuvant vs. early salvage trials, limiting the conclusion we can gather from those trials.

In summary, a significant number (20%) of patients undergoing radical prostatectomy with lymph node dissection are noted to have nodal involvement. There is weak evidence on the added benefit of adjuvant radiation therapy in the setting of nodal disease, based retrospective analyses. The data in favor of adjuvant systemic therapy is stronger but more robust prediction markers are needed to better select patients who would benefit from the added therapy.

Early detection and advances in treatment are saving lives. Finding prostate cancer when it is still at an early stage offers the best hope for living cancer free for a long time. The most recent research shows the five-year survival rate for all men with prostate cancer is nearly 100 percent. The relative 10-year survival rate is 98 percent, and 96 percent for 15 years. From Zerocancer.org

Second Cancers After Prostate Cancer

from https://www.cancer.org/cancer/prostate-cancer/after-treatment/second-cancers.html

Cancer survivors can be affected by a number of health problems, but often a major concern is facing cancer again. If a cancer comes back after treatment it is called a recurrence. But some cancer survivors may develop a new, unrelated cancer later. This is called a second cancer.

Unfortunately, being treated for prostate cancer doesn't mean you can't get another cancer. Men who have had prostate cancer can still get the same types of cancers that other men get. In fact, they might be at higher risk for certain types of cancer.

Men who have had prostate cancer can get any type of second cancer, but they have an increased risk of certain cancers, including:

Small intestine cancer

Soft tissue cancer

Bladder cancer

Thyroid cancer

Thymus cancer

Melanoma of the skin

Men who are treated with radiation therapy also have a higher risk of:

Rectal cancer

Acute myeloid leukemia (AML)

This risk is probably related to the dose of radiation. Newer methods of giving radiation therapy may have different effects on the risks of a second cancer. Because these methods are newer, the long-term effects have not been studied as well.

Follow-up after prostate cancer treatment

After completing treatment for prostate cancer, you should still see your doctors regularly. Let them know about any new symptoms or problems, because they could be caused by the cancer coming back or by a new disease or second cancer.

Prostate cancer survivors should also follow the American Cancer Society guidelines for the early detection of cancer, such as those for colorectal and lung cancer. Most experts don't recommend any other testing to look for second cancers unless you have symptoms.

Can I lower my risk of getting a second cancer?

There are steps you can take to lower your risk and stay as healthy as possible. For example, prostate cancer survivors should do their best to stay away from all tobacco products and tobacco smoke. Smoking can increase the risk of bladder cancer after prostate radiation, as well as increase the risk of many other cancers.

To help maintain good health, prostate cancer survivors should also:

Get to and stay at a healthy weight

Stay physically active

Eat a healthy diet, with an emphasis on plant foods

Limit alcohol to no more than 2 drinks per day

These steps may also lower the risk of some other health problems.

PCSANM is working with two other cancer groups on their spring conference for survivors and caregivers

7th Annual Free Conference
Living With And Beyond Cancer

Saturday April 28, 2018
8:30 am to 3:30 pm
Includes Breakfast & Lunch

A collaboration of
Cancer Support Now, the
Prostate Cancer Support
Association of NM, and the
Gynecological Cancer
Awareness Project

Sandia Preparatory School Performing Arts Center, 532 Osuna Rd. NE

Go to CancerSupportNow.org to register or call Kyra at 575-442-8375

Features keynote speaker:
Christine Sherwood, LMT, DHM
Integrating yourself back into life

Additional break-out sessions include (choose 2):

- *Why So Tired: Fatigue & Sleep During & After Cancer*
- *Immunotherapy: A New Frontier of Cancer Treatment*
- Prostate cancer
- Gynecological cancer
- *Flip My Wig* wigs and scarves styling tutorial
- Diet & Nutrition
- *Surviving the Financial Impact of Cancer*

Take A Number

Nicholas Bakalar
January 5, 2018
www.NYTimes.com

From 1991 to 2015, the cancer death rate dropped about 1.5 percent a year, resulting in a total decrease of 26 percent — 2,378,600 fewer deaths than would have occurred had the rate remained at its peak. The American Cancer Society predicts that in 2018, there will be 1,735,350 new cases of cancer and 609,640 deaths.

The latest report on cancer statistics appears in CA: A Cancer Journal for Clinicians.

The most common cancers — in men, tumors of the prostate; in women, breast — are not the most common causes of cancer death. Although prostate cancer accounts for 19 percent of cancers in men and breast cancer for 30 percent of cancers in women, the most common cause of cancer death in both sexes is lung cancer, which accounts for one-quarter of cancer deaths in both sexes.

In women, 14 percent of deaths are from breast cancer, 7 percent from pancreatic cancer, and 5 percent from cancer of the ovaries.

In men, prostate cancer causes 9 percent of deaths, while 7 percent are due to pancreatic cancer and 6 percent to liver cancer. In both sexes, 8 percent of deaths are from colon and rectal cancer.

Cancer incidence in men rose sharply in the 1990s because of the widespread use of P.S.A. testing, which detected large numbers of asymptomatic prostate cancers. Rates of lung cancer in women are now approaching the levels in men.

Over the past decade, cancer incidence in men has dropped by about 2 percent a year, while it has remained the same in women. There are two reasons, researchers said.

First, there has been a decline in male lung cancer because fewer men are smoking, and a decline in colorectal cancer because of men's increasing use of colonoscopy. Second, from 2008 to 2013, prostate cancer diagnoses declined with the decreasing use of P.S.A. testing.

"We're making progress in reducing death rates from cancer because of improvements in treatment and early detection," said the senior author, Ahmedin Jemal, a vice president of the American Cancer Society. "But prevention is the low-hanging fruit. We still have 40 million adult smokers in the U.S., which accounts for nearly a third of lung cancer deaths."

The UNM HERO 12 week exercise and meditation study continues to need enrollees. You may be eligible if you have been diagnosed with prostate cancer, are age 60 or older, and live within 75 miles of Albuquerque. The study does pay for your time. For more information and to see if you are eligible to participate, please contact the UNM HERO team at **505-272-6557**. There is a more detailed flyer on our website.

16 Superfoods to Supercharge Your New Year

Our seasonal guide and sensational recipes make it easy to stick to your nutrition resolutions By Katie Ressler **http://www.cancerfightersthrive.com**

After a holiday season filled with delicious treats and rich meals, you may feel like it's time to make more health-conscious nutrition decisions. You're not alone. Getting healthy is the most popular New Year's resolution for Americans. After a cancer diagnosis, eating healthier may feel even more important to you, but even with extra motivation, healthy eating can still be difficult when there are so many temptations in everyday life.

Start Small

The American Psychological Association suggests making small goals that you think you can achieve. If you want to improve your diet, think about small wins that you can easily accomplish rather than worrying about having a perfect diet. One idea that may work for you is simply adding nutritious foods to your diet. While this goal is simple, its benefits are numerous. "Variety in our diet may help with maintaining a healthy immune system. No one food has all the nutrients the body needs to function at its best. To kick up your focus on variety, try adding one superfood a month to your meals throughout 2018," suggests Kalli Castille, MS, RDN, LD, FAND, Director of Integrative and Culinary Services at Cancer Treatment Centers of America® (CTCA) at Southwestern Regional Medical Center in Tulsa, Oklahoma.

Superfoods for the New Year

While there are no standard criteria for what constitutes a superfood, according to Castille, superfoods are nutrient-rich. As an example, wild salmon is considered a superfood for its rich source of omega 3 fatty acids.

Many fruits and vegetables you can find at the grocery store are also considered superfoods. Plus, when you choose seasonal fruits and vegetables picked at their prime, they may contain more antioxidants and phytochemicals. A diet high in fruits and vegetable may also help maintain your immune system. Here are Castille's seasonal picks to help you increase variety and nutrition in your diet in 2018:

Winter (January – March)

Brussel Sprouts This wintertime favorite is a good source of dietary fiber, vitamin A, vitamin C, among many other nutrients. You can prepare them in many ways, ranging from roasting to steaming to shredding for salad. Try easy Brussel sprouts with pecans and dried cranberries or mustard glazed Brussel sprouts.

Grapefruit At its peak in the coldest months, this tart citrus fruit has 4g of dietary fiber per cup and is a good source of Vitamin A and Vitamin C. Simply peel and enjoy, or add over a spinach salad with a citrus vinaigrette.

Kale These flavor-packed green leaves pack a nutritional punch with large amounts of vitamin A, Vitamin C, Vitamin B6, and even some calcium. This Kale Salad with Quinoa, Tangerines and Roasted Almonds is a crowd pleaser! And, tropi-kale green smoothie can help you get your leafy greens in before starting your day.

Sweet Potatoes This versatile fan favorite adjusts to your whim, while providing you with 4g of dietary fiber per cup, plus large amounts of vitamin A, vitamin B6, and potassium . Feeling like a sweet side? Whipped Sweet potatoes will do the trick.

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Or, would you prefer a salty snack? Try savory sweet potato wedges spiced with garlic and rosemary.

Spring (April – June)

Asparagus Packed from end to end with nutrients, asparagus is both delicious and a good source of dietary fiber, vitamin A, vitamin C and many others. Asparagus Soup will warm you on colder days, while Spring Pasta Primavera will become a family favorite.

Broccoli While it might not be new to your plate, you may not know that broccoli is a good source of dietary fiber, vitamin A, vitamin C, vitamin B6, folate, and potassium . Eat it raw, steam it, roast it – no matter how you prepare it, broccoli is delicious and nutritious.

Mushrooms Mushrooms contain some vitamin D, thiamin, riboflavin, niacin, vitamin B6, pantothenic acid, phosphorus, potassium, copper and selenium and make a great topping on a variety of dishes, especially pizza and soup, like butternut squash soup with leeks and wild mushrooms.

Onions A popular vegetable to incorporate into all three meals of the day, onions contain vitamin C. Consider adding them to your morning omelet, thinly slicing for your lunch salad or sandwich, and mixing in with any savory dinner recipe.

Summer (July – September)

Blackberries With 8g of dietary fiber per cup, blackberries are an exceptional fruit to add to your diet. They contain high amounts of vitamin C. Start your day with a pomegranate antioxidant smoothie or tame the summer heat with triple antioxidant yogurt popsicles.

Blueberries These sweet little fruits with a dark blue skin are a great source of vitamin C. Combine them with leafy greens for an extra nutritional punch, like with Spinach and Blueberry Salad.

Cucumbers Cool and crisp, cucumbers are low in calories, and are easy to prepare . Heirloom Tomato and Cucumber salad is perfect for a summertime picnic.

Kiwifruit Also known as Chinese gooseberries, this sweet green treat is an excellent source of vitamin C Try vibrant fruit salsa with cinnamon chips for a family-friendly snack.

Fall (October – December)

Mango In addition to being packed with vitamin A and vitamin C, this tropical fruit is also full of flavor. Enjoy it sliced, or try it with a savory protein, like chicken with mango salsa.

Cauliflower Cauliflower camouflages itself well in many dishes, increasing the nutritional value of your family's favorites with dietary fiber, vitamin C, vitamin K, vitamin B6, folate, pantothenic acid, potassium and manganese. Try Better for you Mac 'n' Cheese and pizza with a gluten-free cauliflower crust.

Beets Both red and golden beets make beautiful side dishes with their bright colors and sweet flavor. Beets are a good source of dietary fiber, folate, potassium and manganese. While they shine on their own, try complementing them with other flavors like in Fresh Beet Salad.

Parsnips Other than its cream-colored skin, this root vegetable closely resembles a carrot. Full of dietary fiber, vitamin C, vitamin K, folate and manganese, parsnips roast nicely, like in our Carrot & Parsnip Fries recipe.

Save the Date. The Annual PCSANM Conference:
"Living and Thriving with Prostate Cancer"
A conference dedicated to the memory of Dr. Peter Lindberg
is scheduled for November 10, 2018
At Sandia Preparatory School
532 Osuna Road NE, Albuquerque, NM

Cancer 'vaccine' eliminates tumors in mice

by Krista Conger January 31, 2018

https://med.stanford.edu/news/all-news/2018/01/cancer-vaccine-eliminates-tumors-in-mice.html

Activating T cells in tumors eliminated even distant metastases in mice, Stanford researchers found. Lymphoma patients are being recruited to test the technique in a clinical trial.

Ronald Levy (left) and Idit Sagiv-Barfi led the work on a possible cancer treatment that involves injecting two immune-stimulating agents directly into solid tumors.

Injecting minute amounts of two immune-stimulating agents directly into solid tumors in mice can eliminate all traces of cancer in the animals, including distant, untreated metastases, according to a study by researchers at the Stanford University School of Medicine.

The approach works for many different types of cancers, including those that arise spontaneously, the study found.

The researchers believe the local application of very small amounts of the agents could serve as a rapid and relatively inexpensive cancer therapy that is unlikely to cause the adverse side effects often seen with bodywide immune stimulation.

"When we use these two agents together, we see the elimination of tumors all over the body," said Ronald Levy, MD, professor of oncology. "This approach bypasses the need to identify tumor-specific immune targets and doesn't require wholesale activation of the immune system or customization of a patient's immune cells."

One agent is currently already approved for use in humans; the other has been tested for human use in several unrelated clinical trials. A clinical trial was launched in January to test the effect of the treatment in patients with lymphoma.

Levy, who holds the Robert K. and Helen K. Summy Professorship in the School of Medicine, is the senior author of the study, which was published Jan. 31 in *Science Translational Medicine*. Instructor of medicine Idit Sagiv-Barfi, PhD, is the lead author.

'Amazing, bodywide effects'

Levy is a pioneer in the field of cancer immunotherapy, in which researchers try to harness the immune system to combat cancer. Research in his laboratory led to the development of rituximab, one of the first monoclonal antibodies approved for use as an anti-cancer treatment in humans.

Some immunotherapy approaches rely on stimulating the immune system throughout the body. Others target naturally occurring checkpoints that limit the anti-cancer activity of immune cells. Still others, like the CAR T-cell therapy recently approved to treat some types of leukemia and lymphomas, require a patient's immune cells to be removed from the body and genetically engineered to attack the tumor cells. Many of these approaches have been successful, but they each have downsides — from difficult-to-handle side effects to high-cost and lengthy preparation or treatment times.

"All of these immunotherapy advances are changing medical practice," Levy said. "Our approach uses a one-time application of very small amounts of two agents to stimulate the immune cells only within the tumor itself. In the mice, we saw amazing, bodywide effects, including the elimination of tumors all over the animal."

Cancers often exist in a strange kind of limbo with regard to the immune system. Immune cells like T cells recognize the abnormal proteins often present on cancer cells and infiltrate to attack the tumor. However, as the tumor grows, it often devises ways to suppress the activity of the T cells.

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Levy's method works to reactivate the cancer-specific T cells by injecting microgram amounts of two agents directly into the tumor site. (A microgram is one-millionth of a gram). One, a short stretch of DNA called a CpG oligonucleotide, works with other nearby immune cells to amplify the expression of an activating receptor called OX40 on the surface of the T cells. The other, an antibody that binds to OX40, activates the T cells to lead the charge against the cancer cells. Because the two agents are injected directly into the tumor, only T cells that have infiltrated it are activated. In effect, these T cells are "prescreened" by the body to recognize only cancer-specific proteins.

Cancer-destroying rangers
Some of these tumor-specific, activated T cells then leave the original tumor to find and destroy other identical tumors throughout the body.

The approach worked startlingly well in laboratory mice with transplanted mouse lymphoma tumors in two sites on their bodies. Injecting one tumor site with the two agents caused the regression not just of the treated tumor, but also of the second, untreated tumor. In this way, 87 of 90 mice were cured of the cancer. Although the cancer recurred in three of the mice, the tumors again regressed after a second treatment. The researchers saw similar results in mice bearing breast, colon and melanoma tumors.

I don't think there's a limit to the type of tumor we could potentially treat, as long as it has been infiltrated by the immune system.

Mice genetically engineered to spontaneously develop breast cancers in all 10 of their mammary pads also responded to the treatment. Treating the first tumor that arose often prevented the occurrence of future tumors and significantly increased the animals' life span, the researchers found.

Finally, Sagiv-Barfi explored the specificity of the T cells by transplanting two types of tumors into the mice. She transplanted the same lymphoma cancer cells in two locations, and she transplanted a colon cancer cell line in a third location. Treatment of one of the lymphoma sites caused the regression of both lymphoma tumors but did not affect the growth of the colon cancer cells.

"This is a very targeted approach," Levy said. "Only the tumor that shares the protein targets displayed by the treated site is affected. We're attacking specific targets without having to identify exactly what proteins the T cells are recognizing."

The current clinical trial is expected to recruit about 15 patients with low-grade lymphoma. If successful, Levy believes the treatment could be useful for many tumor types. He envisions a future in which clinicians inject the two agents into solid tumors in humans prior to surgical removal of the cancer as a way to prevent recurrence due to unidentified metastases or lingering cancer cells, or even to head off the development of future tumors that arise due to genetic mutations like BRCA1 and 2.

"I don't think there's a limit to the type of tumor we could potentially treat, as long as it has been infiltrated by the immune system," Levy said.

The work is an example of Stanford Medicine's focus on precision health, the goal of which is to anticipate and prevent disease in the healthy and precisely diagnose and treat disease in the ill.

The study's other Stanford co-authors are senior research assistant and lab manager Debra Czerwinski; professor of medicine Shoshana Levy, PhD; postdoctoral scholar Israt Alam, PhD; graduate student Aaron Mayer; and professor of radiology Sanjiv Gambhir, MD, PhD.

Levy is a member of the Stanford Cancer Institute and Stanford Bio-X.

Gambhir is the founder and equity holder in CellSight Inc., which develops and translates multimodality strategies to image cell trafficking and transplantation.

The research was supported by the National Institutes of Health (grant CA188005), the Leukemia and Lymphoma Society, the Boaz and Varda Dotan Foundation and the Phil N. Allen Foundation.

Stanford's Department of Medicine also supported the work.

Your chances of getting prostate cancer are 1 in 3 if you have a close relative with the disease. The risk jumps to 83 percent if two close relatives – father or brothers – have been diagnosed with the disease. From GenesisHealth.com

Two Prostate Cancer Drugs Delay Spread of Disease by two Years

Pam Belluck February 8, 2018

https://www.nytimes.com/2018/02/08/health/prostate-cancer-drugs.html

They are among the most challenging prostate cancer patients to treat: about 150,000 men worldwide each year whose cancer is aggressive enough to defy standard hormonal therapy but has not yet spread to the point where it can be seen on scans.

These patients enter a tense limbo which often ends too quickly with the cancer metastasizing to their bones, lymph nodes or other organs — sometimes causing intense pain.

Now, for the first time, researchers have results from two independent clinical trials showing that two different drugs help these patients — giving them about two more years before their cancer metastasizes. That means two additional years before pain and other symptoms spread and they need chemotherapy or other treatments.

"We're going from rags to riches," said Dr. Judd Moul, a professor of surgery and director of the Duke Prostate Center, who was not involved in either study. "Up until now, we haven't had anything for these guys. We just had to tell them 'We'll keep an eye on it.'"

The studies, each involving more than 1,200 patients in countries around the world, were presented Thursday at the Genitourinary Cancers Symposium in San Francisco. They used very similar drugs — both androgen receptor inhibitors, which block testosterone from binding to prostate cancer cells and entering them.

The study of an experimental drug called apalutamide was published Thursday in the New England Journal of Medicine. The other study of a drug called enzalutamide, currently approved for treating prostate cancer that has already metastasized, has not yet been peer-reviewed for publication, the authors said.

Prostate cancer is the second most common cancer in men worldwide. The American Cancer Society estimates that in 2018, there will be about 164,690 new cases and about 29,430 deaths. Worldwide, there were 1.1 million new cases and about 307,000 deaths, 1.1 million new cases, and about 307,000 deaths in 2012, according to the most recent data available from the World Health Organization.

The patients in both studies were men who had previously received some treatment for prostate cancer, such as surgery or radiation, but who later began to show rapid increases in their prostate-specific antigen or PSA, a protein associated with prostate cancer. They did not respond to the standard treatment to suppress testosterone, called androgen deprivation therapy.

Each year, about 30,000 to 50,000 American men and about 150,000 worldwide, fall into this category, called nonmetastatic castration-resistant prostate cancer. (The medical term for blocking male hormones is chemical castration.) Globally, about 200,000 of the four million men with prostate cancer are estimated to have this diagnosis, said Dr. Matthew Smith, director of the Genitourinary Malignancies Program at Massachusetts General Hospital's Cancer Center, who co-led the apalutamide study with Dr. Eric Small, deputy director of the Helen Diller Family Comprehensive Cancer Center at University of California, San Francisco.

In the studies, two-thirds of the men took one of the androgen receptor inhibitors, while a third took a placebo. They all continued to receive androgen deprivation therapy.

In the study of men receiving apalutamide, it took, on average, 40.5 months for cancer to spread to the point where it could be detected by conventional scans. For men receiving the placebo, the cancer spread in 16.2 months, on average. In the enzalutamide study, metastasis took 36.6 months on average in men receiving that drug compared to 14.7 months with placebo.

"Delaying median time to metastases by over two years is a big deal," said Dr. Scott Eggener, a urologic oncologist and professor of surgery at University of Chicago, who was not involved in the studies. He said the

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studies were also important scientifically because they show that "maximally decreasing testosterone production and its ability to bind or enter cancer cells leads to meaningful clinical improvement for these men."

Still, he said, while the studies both show preliminary indications that the drugs might extend patients' survival, researchers will have to follow the patients longer to know. Both studies were funded by the companies that make the drugs. Janssen Pharmaceutical Companies of Johnson & Johnson, the maker of apalutamide, has applied for approval from the Food and Drug Administration, which has put it under priority review, Dr. Smith said.

The developers of enzalutamide, Pfizer and Astellas Pharma, have applied to the F.D.A. for approval to expand the use of the drug, marketed as Xtandi, to patients in this category, said Dr. Maha Hussain, deputy director of the Robert H. Lurie Comprehensive Cancer Center at Northwestern University's Feinberg School of Medicine. She co-led that study with Dr. Cora Sternberg, chief of medical oncology at San Camillo and Forlanini Hospitals in Rome.

Both drugs appear to be safe with relatively few serious side effects, experts said. Negative effects for some patients included fatigue, hypertension, rashes, fractures, falls, nausea, and mild cognitive and memory slippage.

Ron Scolamiero, 72, of Marshfield, Massachusetts, a patient of Dr. Smith's, began taking apalutamide in 2012 for an earlier phase of the clinical trial. He still takes a four-pill dose daily.

In the drug's initial formulation, side effects included hot flashes, diarrhea and nausea, but those diminished greatly after it was reformulated, said Mr. Scolamiero, who owns a financial services company. About 18 months ago, a tumor that developed at the site of his prostate had to be removed but had not metastasized to other parts of his body.

"It's controlled my cancer," he said. "I'm so grateful."

Still, some experts said enthusiasm about the new drugs should be tempered by other changes occurring in the prostate cancer landscape.
"I don't want to say this is the best thing since sliced bread — it's not," said Dr. Oliver Sartor, medical director of Tulane Cancer Center.

"You're taking a person with no symptoms and potentially giving them side effects, definitely giving them an expensive drug. And it is unclear if this is the optimal management of these patients."

The current list price of enzalutamide is more than $10,000 a month; a price hasn't been set for apalutamide, which is not yet on the market
Dr. Sartor and others noted that another androgen receptor inhibitor, abiraterone, which is used to treat cancer once it metastasizes and is also produced by Janssen, is likely to go off-patent soon and will become much cheaper because generic versions will be produced. Since abiraterone operates on the same biological pathway, experts expect that it will be tried for patients with cancer that hasn't metastasized and could end up working as well.

Increasingly sophisticated imaging techniques are allowing doctors to spot previously undetectable signs of metastasis. While some patients in these trials might have had cancer spread that was not detected by conventional scans, Dr. Smith said what matters is that they were early in the cancer trajectory and the drug helped them stay in that early state longer.

The two new studies did not compare the drugs against each other, only against a placebo. "You can look at that as being a challenge for physicians," said Dr. Ian Thompson, Jr., president of CHRISTUS Santa Rosa Hospital-Medical Center in San Antonio. "You can also look at that as being an advantage for the patient."

PCSANM depends on a NM Department of Health grant, and member donations for its livelihood. We are a 501© 3 Non-Profit organization, and gladly accept any donations through the year, and especially IRA Directed Distributions. We thank all who have supported us over the years. We also depend on manpower to get things done; we can always use members to sit at our table at health fairs or other community events. Contact the office to see how you can help.

PCSANM *Lifeline* Newsletter
April 2018

Celebrating 26+ years of supporting men
Prostate Cancer Support Association
of New Mexico, Inc.
2533 Virginia St. NE, Suite C
Albuquerque, NM 87110

Chairman's Message for April 2018

It has been another busy quarter but we hope we haven't missed any opportunities to serve you, our friends and fellow prostate cancer survivors. Ann Weinberg, our office administrator, has been doing an excellent job of making sure that we are making our calls and meeting the expressed needs. We as board members and volunteers want more than anything to make sure that men and their families are receiving all the most complete information in order to make the best decision for them about their treatment and beyond. We have been trained to provide one-on-one consultation but if no one calls we can't provide the education and support. We have been busy attending health fairs and making presentations but we believe we can do more to reach more men.

That's where you might be helpful. We need you to help us spread the word by sharing this newsletter with friends and especially your doctors. And if you have social media/web skills we are looking to improve our website, Facebook and Twitter presence. We are all volunteers trying to do a big job and we could use some help. One important role that we need to fill is that of Volunteer coordinator. If you have skills that you think could help us, please call the office between 10AM and 2PM Monday through Thursday.

Finally, we want to welcome Celia Cable to our board of directors. Celia is the wife of our former board member, Gary, who passed away last year. She is passionate about reaching the wives and families of prostate cancer patients and we welcome her perspective. We look forward to Celia's participation and discussion with us. Having a wife and caregiver's perspective is long overdue.

Steve Denning, Chairman of the Board, PCSANM