Prostate Cancer Support Association of New Mexico

Celebrating 26+ years of supporting men

LIFELINE

PCSANM Quarterly | January 2018 | Volume 25, Issue 1

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. Meetings are usually the first and third Saturdays of the month; from 12:30-2:45 pm.

Map: http://binged.it/1baQodz

When A Loved One is Diagnosed

The "C" word nobody wants to hear

Katie Frego Oct 24, 2017

https://www.theodysseyonline.com/when-loved-one-is-diagnosed

Cancer has been in my life in many different ways for almost all of my life. I don't remember ever not knowing someone who was suffering from cancer. My uncle died when I was very young from cancer, my step-dad's mom passed away from lung cancer when I was young as well, my brother has on and off bone cancer, a family-friend of mine passed away from stomach cancer a few years back, and now my father is diagnosed with prostate cancer.

When a loved one is diagnosed with cancer it seems as if the world around you is caving in and you can't find a minute to breathe. The worry, fear and anger that comes along with watching a love one suffer is constant. You can never seem to catch a break. The feeling is unexplainable. Throughout my whole life, the word "cancer" has become more and more dreadful.

Feeling helpless is something that nobody wants to feel. When a loved one is diagnosed, helplessness is all you feel. Since there is no cure for cancer, there is nothing you can do to stop the one who is suffering get away from this ugly disease. There are some things you can do to make them feel more comfortable, but over all there is not much you can do to solve the problem, which is frustrating and quite frankly depressing.

No matter how many times cancer has appeared in one of my loved one's life, it never gets any easier. Actually it gets harder each time. There is nothing about cancer that is easy, and watching someone you love suffer through the incurable pain is frightening. I would never wish this pain on anybody.

To anyone who is care-taking for a loved one with a terminal illness: Stay strong, even though you think you can't. Take care of yourself... don't put your health on the back burner. Reach out for help! There are a lot of people around you who are willing to help out, and remember that you are a great person for helping your loved one.

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

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Jan Marfyak, Secretary

Dave Ball
Jerry Cross
Rod Geer
Eli Maestas
Lou Reimer

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In Memory of

Fred C. Hannahs

With deep sympathy and regret, we list this name

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LIFELINE EDITOR/ WEBMASTER/FACEBOOK

Jerry Cross

MEETINGS Lou Reimer

Chairman's Message for January 2018

During this holiday season it is a common practice to look back and count all the things one is thankful for. Well it's my turn and I'm thankful for all the volunteers and board members that make this organization work. But it is not enough to thank the group so I'm going to thank them individually because you may not know what goes on behind the scenes at PCSANM.

First, I'm thankful for Jerry Cross who always seems to be there when the computers need attention, maintains our website and he's faithfully produced this newsletter for years, which is no small task. Of course he is a board member and volunteer that you'll see at numerous health fairs and other outreach efforts. You may not know that he is also a board member with a related organization we work with, Cancer Support Now (CSN), and produces their newsletter as well.

I'd also like to thank Lou Reimer who was the board chairman of PCSANM for 4 years and has been organizing all of the weekend speakers as well as the super successful conference we just put on. He's been a rock to this organization and he's the most knowledgeable of our board members concerning treatments for prostate cancer.

Charles Rowland is also a solid board member and our treasurer. He's often in the office, which he frequently rides his bike to, making out checks, depositing donations and keeping our books, which is way more than a normal organization treasurer is asked to do. And he is a regular at the table at health fairs.

Jan Marfyak is our longest term board member and remembers the hard times the organization went through to keep us from making less than solid decisions. He's kept our minutes faithfully as secretary and is our liaison with a national prostate cancer support organization, NASPCC.

Eli Maestas is a long time board member and you can see him regularly at health fairs and moderating weekend sharing sessions. He is currently heading up our outreach sub-committee.

Rod Geer is our newest board member and he hit the pavement running. He's responsible for getting our endorsement spot on KNME/PBS which has been very successful at generating inquiries from men who are facing a new prostate cancer diagnosis. He also headed up the publicity efforts for our annual conference which we are convinced increased attendance.

Dave Ball is another long term board member who helps keep us on the right track. He is an idea man always on the lookout for outreach opportunities.

Although we saw the passing of a valuable board member this year I'm grateful for Gary Cable who headed up our outreach efforts until he became too sick. Even when he was weakening he made valiant efforts to attend board meetings. We miss him dearly.

John Williams is not a board member but a faithful volunteer none-the-less. He and his wife organized our library and maintain it while battling advanced prostate cancer.

We had numerous volunteers help us with our annual conference delivering posters, ushering and manning the signup table in addition to board members. Thanks to Carol Reimer, Julie Denning, Rick Babcock, Mike McCann, Lori Rowland and Percy Hill. And I can't forget those of you on our buddy list who take phone calls from men and women just starting their prostate cancer journey.

Last but not certainly least, and I think I speak for all the board members, we are grateful for Ann Weinberg our office manager. With very little guidance she has organized our office, setup outreach opportunities, organized our late summer potluck and has helped every one of us achieve more than ever this year for PCSANM. Of course, she's the first person you talk to when you call the office and who then makes sure that you get connected to the right person, and I mean she makes sure. And then there are all the people we try to serve.

We are grateful that we have connected with you in some way and hopefully helped you gain more understanding about the malady we all suffer. It is so encouraging when we hear from you that we have made a difference. Please don't be strangers and give us a call. We love to hear from you.

God bless you and have Happy Holidays

Steve Denning, Chairman of the Board

A Bill to 'Eliminate Prostate Cancer Misdiagnosis'

Nick Mulcahy November 17, 2017 **https://www.medscape.com/viewarticle/888840**

Larry Bucshon, MD, a cardiac surgeon and US Congressman from Indiana (R), wants to put an end to prostate biopsy results that are misdiagnosed as positive for cancer.

More than 1 million prostate biopsies are performed each year in the United States, and most are triggered by a blood test with an elevated prostate-specific antigen (PSA) level, which may indicate the presence of cancer.

A small percentage of the results are false positive, in which the biopsy results indicate cancer but are wrong because of human error — namely, specimen mix-ups or cross-contamination with other tissue. These are known as specimen provenance complications.

"It is estimated that 1.3% of patients are erroneously told they have prostate cancer when they do not," Dr Bucshon told ***Medscape Medical News*** in an email, referring to the frequency of specimen provenance complications among positive biopsies.

As a remedy for these mix-ups, Dr Bucshon is sponsoring the Prostate Cancer Misdiagnosis Elimination Act of 2017, which calls for Medicare to reimburse labs $200 for DNA testing that compares and matches the patient's biopsy tissue with cells from the inside the cheek that are taken with a cotton swab to ensure both came from the same person.

Medicare paid for 148,000 prostate biopsies in 2016, but it does not pay for DNA tests to double-check the identity of the biopsy.

Experts agree that DNA testing would reduce troublesome specimen complications.

"It's a fundamental way to assure that the biopsy material that shows cancer is from the same patient who gave the cheek swab," said Thomas Wheeler, MD, who is chair of the Department of Pathology and Immunology at Baylor College of Medicine in Houston, Texas, and was asked to comment.

But there is a caveat, said Dr Wheeler: "The result is going to be 100% accurate — but only if both the biopsy tissue and the cheek swab are from that patient."

Genetics labs can mix up samples, too, he added. In other words, the potential for human error exists in every lab.

Furthermore, DNA testing will not eliminate prostate cancer misdiagnoses because the problem is bigger than specimen complications, Dr Wheeler told ***Medscape Medical News*** in an interview.

Another problem that is "at least as significant," said Dr Wheeler, is when pathologists wrongly diagnose cancer, often because "the tissue mimics cancer." The medical literature indicates that pathologists' interpretive errors can occur at rates as high as 2%, he added.

If legislators want to reduce prostate cancer misdiagnoses, then they should consider further investing in second opinions, argued Dr Wheeler.

"Getting a second opinion by an expert pathologist on everything that is called cancer would probably do as much or more good to correct overtreating cancer than doing some kind of identity test." Medicare currently will pay for second opinions, and this costs "a lot less than $200 [the proposed reimbursement] for the DNA test," he added.

Deepak Kapoor, MD, a urologist, already uses DNA testing. He is chairman of Integrated Medical Professionals in the metropolitan New York City area, which is the largest urology group practice in the United States.

He emphasized that the DNA test ensures that a prostate cancer diagnosis is given to the correct person.

"These errors are frighteningly common," testified Dr Kapoor before the US House of Representatives' Committee on Energy and Commerce, which conducted a hearing about the bill in July. He said provenance errors (ie, switching and contamination) occurred at a rate of 1.28% among all prostate biopsy specimens that are positive for cancer, echoing Dr Bucshon.

The DNA test "definitively rules out" these errors, said Dr Kapoor, who is also a clinical professor of medicine at the Icahn School of Medicine at Mt Sinai Hospital in New York City.

He added that 60,000 DNA tests are used on biopsied prostate tissue each year in the United States.

The value of DNA testing for prostate cancer is partly based on its projected cost-effectiveness, according to its advocates.

Perhaps surprisingly, Dr Bucshon's bill would decrease Medicare's direct net spending — by more than $7 million from 2018 to 2027, according to the Congressional Budget Office (CBO). That's because the cost of the test for tens of thousands of men annually (estimated at $46 million over 10 years) would be recouped by the savings associated with avoiding treatment of men who did not have prostate cancer.

But Baylor's Dr Wheeler has doubts about that assessment.

While acknowledging that DNA testing would correct some cases of specimen mix-ups, he points out that the total number of prostate cancers does not change. Thus, there is no reduction in savings from treatment.

Dr Wheeler also believes the assumed rate of errors in the CBO's calculations is questionable. They estimated that 1.5% of all biopsy results among Medicare beneficiaries were false positive because of specimen mix-ups or contamination. Both the 1.5% and 1.3% rates (cited by Dr Bucshon) are too high, he argued.

Medscape Medical News asked the American Urological Association (AUA), which has endorsed the bill in a letter to Congress and cited the 1.3% rate, what the source of the number was, but there was no answer at the time this article was published.
In a 2013 study, researchers prospectively looked at a databank of 13,000 prostate biopsy specimens obtained at 54 labs in the United States. The combined rate of specimen mix-ups and cross -contamination errors was 0.93%. In other words, it was less than 1% (***Am J Clin Pathol.*** 2013;139:93-100).

Another study using data from the Reduction by Dutasteride of Prostate Cancer Events (REDUCE) prostate cancer risk reduction trial, which required biopsies from all participants, also indicated a combined rate of less than 1% (***J Clin Oncol***. 2011; 29:1744-1749).

Using the 1.5% rate of specimen provenance complications, the CBO estimates that the number of Medicare beneficiaries who would not be wrongly treated for prostate cancer thanks to DNA testing would be 60 in 2019 and rise to 450 in 2027, as the test becomes increasingly used.

Dr Wheeler believes that DNA testing has utility, but perhaps not en masse via Medicare.

He recalled a case at his institution, where a patient was "convinced" he did not have prostate cancer despite biopsy findings. "He refused to believe it. The DNA test is very useful in such circumstances because it provides an element of reassurance that the cancer sample is yours."

Other pathologists say that DNA testing has evolved and improved in recent years, which has led to its use beyond specimen mix-up detective work.

"Testing is now performed in the absence of any direct indication that a specimen mix-up or contamination has occurred, namely when pathologic findings are unexpected or the clinical setting is atypical," write the authors of a 2015 review paper, led by John Pfeifer, MD, professor of pathology and immunology at Washington University in St Louis, Missouri (***Am J Clin Pathol.*** 20115;135:132-138).

In a recent ***New York Times*** article, Dr Pfeifer advocated for DNA testing of all cancer biopsy specimens. "All the process improvement in the world does not get rid of human errors," he said. "Millions get biopsies every year. Is society going to say, 'Yeah, mistakes happen but we're not going to look for them?'"

Dr Wheeler argued that pathologists have put many safeguards in place and that errors, especially in prostate cancer, are rare.

He finds one innovation at Baylor to be especially helpful: putting the same colored ink on the slides of all 12 prostate tissue cores from a single patient. At the same time, the pathologists will indicate that specific color in the case description. "When I look at a slide, I make sure the colors match up," he said.

In their letter to Congress this past July, the AUA and its co-signers, such as the Men's Health Network and Prostate Health Education Network, urged Congress to pass the Prostate Cancer Misdiagnosis

Continued on page 10

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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.

Just a Reminder:

The DVD sets of the speakers talks from the November 4 Conference should be available by the time you read this. Those who ordered a set should have received theirs. There are a few more sets in the PCSANM Library for borrowing. Stop by to check them out. We have sets from many years back.

The 11 slide show presentations only are available on the PCSA Fall Conference page **http://www.pcsanm.org/?page_id=27**

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Tapeworm Medicine Stops Prostate, Colon Cancer Cells from Growing, New Study Finds Alice Melão 11/17/2017

www.prostatecancernewstoday.com/2017/11/17/tapeworm-medicine-stops-prostate-colon-cancer-cells-from-growing/

A medicine that is commonly used against parasites like tapeworms contains a substance that stops prostate and colon cancer cells from growing, a new study found.

The substance, called nitazoxanide, decomposes a protein called beta-catenin, which is required for increased cancer cell proliferation and survival, and is often involved in resistance to cancer treatments.

The study, "Small molecule promotes β-catenin citrullination and inhibits Wnt signaling in cancer," was published in ***Nature Chemical Biology.***

Cancer cells often acquire new features that are not normally found in healthy cells, allowing them to proliferate without restrictions and to survive for longer periods. In some cancers, overactivation of the Wnt/β-catenin signaling pathway is one of these features, making cancer cells two times more likely to develop resistance to treatment.

Now, researchers at the University of Bergen (UiB) in Norway found that the broad spectrum anti-parasitic and anti-viral drug nitazoxanide — which has been approved by the U.S. Food and Drug Administration since 2004 to treat diarrhea caused by *Cryptosporidium parvum* or *Giardia lamblia*is — can efficiently block the Wnt/β-catenin pathway, making it a potential anti-cancer drug.

"We discovered that this specific substance is blocking the signaling pathway in the cancer cells, and make them stop growing," Karl-Henning Kalland, professor at the Department of Clinical Science at UiB, and author of the study, said in the university's news release.

"It is not often that researchers discover a substance that targets specific molecules as precisely as this one," he added.

After testing 460 approved drugs, the team found that nitazoxanide specifically inhibits the activity of the enzyme PAD2, which in turn would promote the degradation of activated β-catenin protein in cancer cells. The findings suggest that in addition to nitazoxanide's well-known anti-parasitic properties, the drug may be able to treat cancers in which the Wnt/β-catenin signaling pathway is overactivated.

"We are the first researchers who have mapped the complex molecular mechanisms involved in this process," Kalland said.

Nitazoxanide is already known to be safe for humans, with no serious side effects associated to its use, "which means that a future treatment may happen quicker," Kalland said.

While nitazoxanide affects cancer cells directly, it also appears to stimulate the immune system. The UiB research team is now evaluating how nitazoxanide affects the immune response against cancer cells

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

Does Your Junk Look Smaller? You Might Have a 'Buried Penis' And what to do to uncover yours.

by Cassie Shoortsleeve October 24, 2017

https://www.menshealth.com/health/what-is-a-buried-penis?utm_source=(direct)&utm_medium=email&utm_campaign=sharebutton

You wake up one morning and notice your penis looks a little shorter. Soon, you're convinced your losing length by the day. After a while, if you don't take action, your member is practically gone.

It sounds like a nightmare, but it's actually a real medical condition. It's called a buried penis—also known as a hidden penis—and doctors are seeing more and more cases of it.

Simply stated, "a buried penis is one where the penis itself does not extend outside the body," says Drogo Montague, M.D., a urologist at the Cleveland Clinic. "There is an opening where the penis would normally hang, and the head is usually plush with skin, but there's no shaft outside of the body."

In an extreme case, your member might look more like a clitoris than a penis, says Ming-Hsien Wang, M.D., an associate professor of pediatric urology Johns Hopkins University School of Medicine.

Of course, change occurs on a continuum, notes Dr. Montague. You might notice at first, for instance, that your penis just seems to get shorter and shorter.

WHAT CAUSES A BURIED PENIS?

There tend to be two different types of buried penis. The first is a pediatric problem. Often, it's the result of a bad circumcision where too much of a boy's foreskin has been removed, says Dr. Wang.

The skin that's left can form scar tissue and become so tight that the skin pulls forward, covering the penis, she says. This can also happen in men who get circumcised as adults.

If the issue is a circumcision gone wrong, it may also hurt when you get an erection, thanks to pulling on the scar tissue, says Dr. Wang.

A buried penis caused by circumcision can be fixed through surgery, she says. A doctor would remove the scar tissue and reconstruct the area.

The adult variety, on the other hand, is mostly due to one thing: obesity. "Obesity is an epidemic," says Dr. Montague. While the rates of buried penises haven't been thoroughly studied, he sees more men in his office today suffering from the issue than he has in the past.

HOW DOES OBESITY CAUSE A BURIED PENIS?

First, a little refresher about your penis's anatomy: The penis itself has two erection chambers, says Dr. Montague.

"About one-third of these are inside the body and two-thirds are outside in the penile shaft," he says.

But if you're severely overweight—and noticing a change in length—what's changing is basically how much of your penis is inside your body and how much is outside.

"With extreme obesity, it's like the obese body engulfs the penis. A full buried penis is when the entire penis shaft is buried below the surface of the skin," says Dr. Montague.

There are other reasons someone could wind up losing length down there beyond obesity, though. In radical prostatectomies—where the prostate is removed, like because of prostate cancer—men may lose about an inch of penile length, says Dr. Montague

That's the result of pulling the urethra up to attach to the bladder." (Still, it seems like most penile shortening rebounds as time passes after your surgery, as we reported.)

Peyronie's disease—when scar tissue forms in the penis, often due to repeated injury—can also cause an erection to become shorter and curved, he says.

WHAT ARE THE EFFECTS OF A BURIED PENIS?

Beyond the psychological impact, buried penises can be seriously problematic.

For one, penetrative sex is also an obvious issue. "These men can't have sex or sex is very difficult," says Dr. Montague. Plus, it's hard to stay clean, says Dr. Wang. You have to pee sitting down—and when you urinate, you can urinate all over yourself, she says.

Because it's easier for this area to stay wet, Dr. Montague says hygiene becomes a big issue. Men can suffer from issues like diaper rash.

If you've had a buried penis for years, you may be at risk of some serious—though rate—health complications. In an extreme case, if the entire penis disappears, 20 years or so of chronic inflammation that occurs as a result could make penile cancer a worry, says Dr. Montague.

In fact, that inflammation, along with more frequent, low-grade infection as a result of the difficulty keeping clean, could make the development of cancer there more likely, according to ***Case Reports in Urology***.

HOW DO YOU TREAT A BURIED PENIS?

The best fix for a buried penis that occurs as a result of obesity is simple: weight loss.

If patients are able to drop back down to a more normal body weight, that can fix the problem entirely, says Dr. Montague. "The more weight they lose, the more helpful it is."

But sometimes, surgery is necessary—particularly in those who don't lose weight.

Surgery often entails removing tissue, says Dr. Montague. Often, this can be through sucking fat out through liposuction and removing excess skin around where the pubic bone is.

"That allows the penis to come outside of body," he says. "In most buried penis surgeries, skin and fat are cut out."

Doctors might also remove a large, triangle-shaped area of skin and fat, and fix the penis at its proper location to the fascia, or connective tissue, to keep it in its new and proper place, he says.

Even after natural weight loss, sometimes excess skin that's hanging down into your pubic area must be removed, says Dr. Wang. "That's the best way to prevent a buried penis from coming back."

I know the right mindset is important for beating cancer and that's why I am doing all I can to develop it.

http://www.freeaffirmations.org/fighting-prostate-cancer-positive-affirmations

A Bill to Eliminate PCa Misdiagnosis

Continued from page 5

Elimination Act of 2017, saying that the DNA Specimen Provenance Assay was "standard of care" with "widespread adoption."

However, the National Comprehensive Cancer Network (NCCN) clinical practice guidelines for the diagnosis and treatment of prostate cancer do not mention the DNA Specimen Provenance Assay or any other type of DNA testing. Nor do the AUA's clinical guidelines for the early detection of prostate cancer.

Furthermore, in 2013, the Centers for Medicare & Medicaid ruled that this DNA testing does not explicitly diagnose or treat disease and therefore did not qualify as a Medicare benefit.

The AUA and its fellow letter writers disagree with this interpretation. "To deprive Medicare beneficiaries of access to an important test which eliminated medical errors is contrary to the best interests of patients," reads the letter.

However, the US courts later agreed with Medicare. In 2015, a US judge in Indiana found that the DNA Specimen Provenance Assay from Strand Diagnostics was not covered by Medicare because it was not "reasonable and necessary for diagnosis or treatment" of prostate cancer, as required by Medicare, according to a news report.

Despite the setbacks with Medicare and US courts in recent years, Strand Diagnostics offers their ***Know Error*** DNA Specimen Provenance Assay kit online directly to men with prostate cancer diagnoses for $299.

Strand Diagnostics is also the sole company lobbying for the Prostate Cancer Misdiagnosis Elimination Act of 2017.

The company, which is headquartered in Indianapolis — about 165 miles away from Dr Bucshon's home in Newburgh, Indiana — spent $40,000 from April through September of this year on lobbying members of Congress about the bill, according to OpenSecrets.org, the website of the Center for Responsive Politics.

The bill is still in the legislative process, having passed unanimously through the Energy and Commerce Committee earlier this year, but still needs a "path" to full passage in the House of Representatives, said Dr. Bucshon.

The bill has bipartisan support, with additional sponsors from both the Republican and Democratic parties.

However, the bill's passage in the House and then the Senate is not guaranteed. In fact, a similar bill was introduced in the House in 2016 by Dr Bucshon. Thus, the Prostate Cancer Misdiagnosis Elimination Act of 2017 is at least a second legislative go-round for the idea.

Cochrane on Surgical Approaches for Prostatectomy

Cochrane; 2017 Sep 12; Ilic, Evans, Allan, et al

From Clinical Edge

http://www.mdedge.com/oncologypractice/clinical-edge/summary/genitourinary-cancer/cochrane-surgical-approaches?group_type=week

Patients receiving laparoscopic radical prostatectomy (LRP) or robotic-assisted radical prostatectomy (RARP) experience less near-term postoperative pain and shorter hospitalizations than those undergoing open radical prostatectomy (ORP), according to a Cochrane review of 2 randomized controlled trials involving 446 men. There appear to be no other differences, however. Among the findings:

- No differences in prostate cancer-related mortality, recurrence, or overall death rates were seen.
- Men's quality of life relative to urinary and sexual function was comparable.
- Postoperative surgical complications also appeared to be similar.
- Pain 1 to 7 days after surgery appeared to be lessened with LRP or RARP, but no difference in this regard was seen at 12 weeks.

Men who had LRP or RARP were more likely to have shorter hospital stays and require fewer blood transfusions.

Citation:

Ilic D, Evans S, Allan C, Jung J, Murphy D, Frydenberg M. Laparoscopic and robotic-assisted versus open radical prostatectomy for the treatment of localised prostate cancer. ***Cochrane Database of Systematic Reviews***. 2017, Issue 9. Art. No.: CD009625. doi:10.1002/14651858.CD009625.pub2.

Small protein modification can trigger invasive properties of prostate cancer cells, research finds

November 22, 2017 http://www.rapamycinpress.com/

A small protein modification can trigger the aggressive migratory and invasive properties of prostate cancer cells, according to new research published on the cover of ***Oncotarget.*** The findings give greater insight into how cancers can move from one location in the body to another, and could help develop more effective therapies in the future.

When cells break free from the original tumor and migrate to another location through the bloodstream, they become metastatic. The emergence of secondary tumors is often correlated with a poor prognosis.

The cellular process that allows these cells to migrate is known as epithelial-to-mesenchymal transition (EMT). One of the proteins thought to activate EMT is called transforming growth factor β (TGFβ), which exerts its effects by activating several other proteins, including one called Snail1. While the activation of Snail1 is recognized as an important event in EMT, how it happens has remained unclear. Revealing this mechanism could give scientists a way to target EMT, thus preventing cancer metastasis.

The Oncotarget study, carried out by researchers from two Swedish universities, Umeå University and Uppsala University, now reveals a key step in Snail1 modification. The team found that modifying a single amino acid - the building block that makes up proteins can alter Snail1 and make cancer cells grown in the lab more invasive. This modification, called 'sumoylation,' involves the attachment of other small proteins, which change the structure and function of Snail1. Importantly, the researchers found that preventing the sumoylation of Snail1 by genetic modification abolished the migratory and invasive properties in human prostate cancer cells.

The team also found that modified Snail1 regulated the expression of specific genes and proteins involved in EMT. Furthermore, the researchers identified that in prostate cancer cells, sumoylated-Snail1 can further enhance TGFβ signaling and EMT in prostate cancer. Lastly, when they compared the levels of proteins involved in EMT in prostate cancer tissues and normal tissues, they found levels of several proteins including Snail1 were elevated in the cancer.

"These results suggest that sumoylation of Snail1 might be a marker for prostate cancer progression," said Professor Marene Landström. "As sumoylation inhibitors are currently being tested to combat the development of breast cancer tumors, it would be interesting to see the effects of targeting Snail1 sumoylation in prostate cancer."

Future studies in different cancers is necessary to understand whether sumoylated-Snail1 is a universal trigger for cancer cell invasiveness.

PCSANM *Lifeline* Newsletter
January 2018

Celebrating 26+ years of supporting men
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Www.ClinicalTrials.gov
has the entire database of clinical trials in the country.

Currently, there are 259,961 research studies going on.

There are 494 Prostate Cancer Studies in the US

There are 11 Prostate Cancer Studies Recruiting just in New Mexico as of November 28, 2017

At this site

https://clinicaltrials.gov/ct2/results?cond=prostate+cancer&term=&cntry1=NA%3AUS&state1=NA%3AUS%3ANM&Search=Search&recrs=a&recrs=b

The Board of PCSNM wants to wish all our members, readers, and supporters a very

Merry Christmas

Happy Hanukkah

Season's Greetings

Happy Kwanzaa

Happy Winter Solstice

Happy Festivus

And a Happy New Year