



Prostate Cancer Support Association

of New Mexico

Celebrating
over 30 years of
supporting men
and their families

LIFELINE

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Our website address:
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Support Group Meetings

Web-based meetings are held from 12:30 – 3 p.m. on the first and third Saturday of most months.

Due to COVID, in-person 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/>

The Fight

By Melonie Reiter, Daughter of PCSANM Member

Stage 4 Prostate Cancer... words I never really thought about given I was 31 and have a uterus and not a prostate. Words that would change our world in ways we didn't know.

My dad was diagnosed with stage 4, metastatic prostate cancer in August of 2017 at the age of 60. He went from a PSA of 2.92 in 2016 to a PSA of 20.8 a year later. His primary care physician was not well informed and gave him antibiotics for suspected prostatitis without doing a prostate exam. When seeing the jump in his PSA from the year before, she finally referred him to a urologist where his biopsy showed a Gleason score of 9 (4+5). At this point a CT scan showed lymph involvement and bone metastases to his spine and pelvis. We became one of the outliers, one of the few whose initial diagnosis was stage 4.

I say "we" because this has been a family fight. My dad has most certainly been the most affected, but our family has fought this together. After his initial diagnosis I don't think any of us slept for weeks, maybe months. Every extra minute was spent researching prostate cancer, the treatments available and how to ensure that my dad was part of the 28% of men still alive 5 years after a stage 4 diagnosis.

In researching prostate cancer, I came across an international prostate cancer support group on Facebook called Prostate Cancer Awareness and Support, which listed more than 420,000 members. While browsing through posts, I came across one from a person whose profile listed New Mexico residence and involvement with the Prostate Cancer Support Association of New Mexico. Truly, I have no explanation as to why I clicked on his profile picture except that I must have been completely led to do so by the Holy Spirit.

Several days later, the man whose picture I had seen met with my dad, brother, and me at the PCSANM office. We reviewed test results and began talking about various options, local medical organizations that would be logical for us to contact, and very importantly getting the names of other men active in the support organization who had experienced or were familiar with situations similar to my dad's.

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

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In Memory

With deep sympathy and regret, we list these names:

Bruce Clyde

Francisco Hernandez

Russ Richards

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The Fight

Melonie Reiter, Daughter of PCSANM Member

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But published medical literature on prostate cancer treatment options seemed to offer minimal hope. Conservative treatment options that didn't seem to offer the long-term results we were seeking for my dad. For a man in my dad's position the options were basically: step 1: treat with hormone therapy; step 2: add Zytiga when the cancer became hormone resistant; step 3: do chemo when cancer continued to spread after Zytiga; step 4: radiate bone metastases that were sure to become painful as a way to manage end of life care but not to reduce disease. There didn't seem to be discussion about options such as treating the primary tumor either by a prostatectomy or radiation. Rather, options presented aimed to slow the disease, not to eradicate it.

These were not acceptable courses of treatment for us. Other types of cancer treatment were seeing great results when the primary tumor was treated, not just the systemic disease or distal metastases. This is what we wanted. We intended to fight, and to fight hard. We were going to be standing stronger in five years, not saying goodbye.

 It was disheartening how many times we heard, "not the standard of care" when proposing our own treatment strategy to oncologists and radiologists. We didn't care what the "standard of care" was, we were dealing with stage 4 cancer. In our eyes we had already been told our dad was going to die of this disease; if the treatment had poor consequences that was something he was willing to accept. Either the cancer would take him, the treatment would take him, or the treatment would work.

We pushed to incorporate chemo in conjunction with hormone therapy from the beginning instead of waiting to use it as a third line of defense. By Christmas of 2017 my dad was receiving his second Lupron injection and finishing his sixth round of chemo. A PET scan a few weeks later showed tremendous reduction in disease and his PSA had dropped to below 1.

While this was great news to celebrate, we knew we weren't done yet. Our goal was to rid him of prostate cancer, not just reduce it. We were still being told that radiating the prostate or undergoing a prostatectomy was not the "standard of care" for a man with stage 4 prostate cancer, but we didn't care. We knew the literature in treating the other types of cancer and was pointing to good success when the primary tumor was treated and so we insisted his prostate be addressed.

After much deliberation, it was decided that he would undergo a nine weeks of radiation four days a week to involve lymph tissue, bone metastases, and the prostate. During this his PSA continued to fall. After giving him a couple of months to recover from the radiation and the inflammation it causes, another PET scan showed almost no disease at all. There was some question whether one or two lymph nodes and maybe one bone met still existed but the uptake of the radioactive tracer is so limited that could not be known for sure without a biopsy.

For almost a year and a half, my dad has been under active surveillance with no treatment at all, including no hormone therapy. His PSA has gradually increased but in August of 2021 was still below 2. An increase was to be expected as testosterone increases when androgen deprivation therapy is ceased. His most recent PET scan at the beginning of the summer still showed undetectable disease.

Throughout this exhausting and stressful period, my dad has attended the Prostate Cancer Support Association's Saturday meetings and annual conferences in November off and on both in-person and virtually. And I have been there as well on some occasions. Those were times when he felt a need simply to connect, to ask some specific questions, or because the program was specifically something he knew to know more about.

In November of 2021, he did experience a PSA jump which we are currently investigating. A new detection method has been developed since my dad was diagnosed in 2017 called PSMA-PET, prostate-specific membrane antigen PET scan. To our knowledge this scan is available in three locations in the country, two in California and one in Indiana. We are currently working with his local oncologist, insurance company, and the facility in Indiana to procure this scan and determine the next best route of treatment.

While we have been told one never really is cured of stage 4 cancer, we are rejoicing with his current results and we remain hopeful in his future. For now, family dinners consist of many more topics than prostate cancer and my dad's future is looking healthy and bright with travel, motorcycle riding and grandkids.

And all of this started because we learned that the Prostate Cancer Support Association of New Mexico office was only a short drive from my dad's home.

Review of PCSANM's 2021 Conference

Rod Geer, Board Chairperson

In spite of our preference for an in-person 2021 annual conference, circumstances (due to COVID precautions) did not permit that and our conference for the second year was held on line, virtually. Hopefully we'll truly be face-to-face next year.

The day began with a short overview of our 30 year history, emphasizing how we have focused on our mission of educating and supporting New Mexico men and families about prostate cancer

Next came one of our most popular regulars, Dr. Thomas Schroeder, Radiation Oncologist at the University of New Mexico Comprehensive Cancer Center (UNMCCC). He described the purposes for genetic testing, i.e., enhancing screening, enhancing staging, and enhancing the treatment of prostate cancer. There are different types of genetic tests: germline testing, somatic testing and testing for effectiveness of types of treatments (PARP inhibitors). Dr. Schroeder described the existing available genetic tests as "imperfect" but are another tool to be used in the diagnosis and treatment of prostate cancer.

Then we heard from a three-doctor panel each with different specialties in prostate cancer treatment: urologist, radiation oncologist, and medical oncologist, which, in essence, provided the audience with side-by-side comparisons of how doctors in each of those specialties approach prostate cancer treatment.

Dr. Michael Davis of the UNMCCC started the panel discussion by covering topics most men who have suspect symptoms or who are newly diagnosed want to know about: risk stratification and the treatments available for localized cancer. He described the urologist's role as "the gatekeeper" in the process of prostate cancer diagnosis and treatment.

During her talk, Dr. Heyoung McBride, Lovelace Cancer Center, discussed the applicability of Gamma Knife technology, an advanced radiation treatment, for prostate cancer. In addition, she covered the ins and outs of various scanning technologies (bone, CT, MRI, and Axumin PET) in the diagnosis or monitoring of prostate cancer. She also offered updates about brachytherapy, IMRT (Intensity-modulated radiation therapy), SBRT (Stereotactic Body Radiation Therapy), Radium 223, and combination therapy.

Dr. Jose Avitia, New Mexico Cancer Center (NMCC), addressed options for metastatic cancer treatment that include androgen deprivation, use of anti-androgens, chemotherapy, immunotherapy, and chemical trials. He and the other doctors on the panel then spent about 45 minutes answering questions submitted by the attendees.

After a lunch break, Dr. Neda Hashemi, Hematologist/Oncologist, UNMCCC, covered how the treatment landscape of metastatic cancer has changed over the past decade. She pointed out that several agents approved by the FDA, including chemotherapy, hormonal therapy, genomically targeted therapy, and immunotherapy offer great promise. In particular she focused on Lu-PSMA-617. It is an investigational PSMA-targeted radioligand therapy for metastatic castration-resistant cancer. The process combines a targeting compound with a therapeutic radioisotope.

Next up came Dr. Mark Scholz, Oncologist and Executive Director of the Prostate Cancer Research Institute in Los Angeles. He emphasized that the immune system is a complex but important aspect of cancer therapy. For example, immunotherapy using Provenge to treat prostate cancer was FDA approved in 2020. More recently Keytruda, a drug that targets PD-1, a protein found on T cells and boosts the immune system's response to prostate cancer cells, has shown promise. It does not directly act on the tumor but boosts the body's own immune system to fight the cancer cells.

Dr. Scholz, a strong advocate for patient empowerment, has said the most asked question he gets is how to prevent prostate cancer. To that he replies, "That which is heart-healthy is prostate healthy."

The conference ended with Dr. Gregg Franklin, NMCC, discussing recent advances in use of radio-pharmaceuticals in treatment of advanced prostate cancer through the use of prostate-specific membrane antigen (PSMA) imaging. Typically, a PSMA PET scan is used after the more typical PSA testing to more accurately pinpoint where the cancer cells are located throughout the body.

The recent event was well attended virtually and it received encouraging feedback based on the post-event attendee survey (See Post-Conference Survey, Page 5).

A video recording of the conference is posted on the conference page of our website -- www.pcsanm.org

Post-Conference Survey: Summary of Responses

Rod Geer, Board Chairperson

Here are some comments from folks who attended the November 6, 2021, conference:

- Excellent presentations. All participants clear, precise, and expert in their presentations. I learned much about new areas of treatment.
- Super conference. I'm in San Diego so thank you for inviting me.
- The information was excellent, the doctors presented it well. The PCSA is an excellent organization to bring this together. I am grateful to Rod, Steve, and the specialists who donated their time and knowledge.”
- I have completed radiation therapy and am in the middle of hormone therapy. I had no knowledge of your support group until my wife saw it on TV.

Survey respondents also had recommendations for future conferences. Some topics to address include:

- Side effects of treatments. What are they, how do they affect our lives, and how long do they last? Temporary or permanent?
- Strategies and considerations when stage and risk is borderline or intermediate - to treat or not to treat
- Castrate sensitive metastatic disease treatment
- What comes after androgen deprivation therapy
- Pros and cons of active surveillance vs. treatment
- More about treated prostate cancer that returns- When and what to do other than active surveillance?
- More information about your support group and what you offer us who have prostate cancer

We are grateful for your feedback and will take your feedback and suggestions into consideration as we begin planning our next annual conference.

Us TOO/ ZERO Merger

Lou Reimer, Programs Chairperson, Board Member

In October, the national prostate cancer support organization, Us TOO merged with another national prostate patient organization, Zero—The End of Prostate Cancer. The following merger information is from the Zero website (<https://zerocancer.org/learn/prostate-cancer-news>.)

Together as one, ZERO and Us TOO create a stronger platform to provide comprehensive support to patients and their families. The need is urgent to directly address the increase of emotional, financial, and physical challenges caused by COVID-19 to those who are already in a health crisis fighting prostate cancer.

In addition, serving as a single educational resource will help reach more patients and communities on important issues including ever-developing treatment options, early detection and active surveillance, diagnostics, survivorship, and emotional and physical well-being.

The Prostate Cancer Support Association of New Mexico (PCSA) is one of the original chapters chartered by Us TOO; we were granted our charter in December 1991. All these years we have benefited by our association by being recognized by Us TOO as a place in New Mexico where they could refer patients to get information and support locally. Us TOO has provided some of the guidance material that we have been able to place in our library and share with our members and public. This was especially important in the early days when information about prostate cancer was difficult to find.

Since the merger is still new it is suggested that the reader check the Zero website (<https://zerocancer.org>) and get familiar with the resources available from the new organization. Zero does not have any support groups in the Southwest region or the Rocky Mountain region, so the Us TOO groups, which are listed separately on the now joint website, will continue to help patients in these regions, including New Mexico.

Prostate Cancer Foundation (blog): November 12, 2021

Breaking News: FDA Approves a Highly Sensitive Prostate Cancer Imaging Agent

What this means for patients: Today, the FDA approved another highly sensitive imaging compound specifically for prostate cancer called ^{18}F -DCFPyL. This is the second such approval in less than six months; in December, the FDA approved ^{68}Ga -PSMA-11 PET. These pioneering new scanning tools will revolutionize prostate cancer detection. Both imaging agents are used to "light up" PET scans to help doctors find smaller tumors earlier.

Both compounds are part of a new type of scanning technology called *PSMA PET imaging*. ^{68}Ga -PSMA-11 and ^{18}F -DCFPyL (or *PyL* for short) are radioactive tracer molecules designed to bind to PSMA that doctors can use to "light up" PET scans for regions that contain cancer. PSMA ("Prostate Specific Membrane Antigen") is a protein found on the surface of prostate cancer cells. This new technology is more sensitive than conventional imaging (such as CT and bone scans) in finding areas of prostate cancer in the body.

Having more complete and accurate information about where cancer is located can help doctors make better treatment plans. Finding metastases earlier, when they are much smaller, will have a significant impact for patients.

PyL PET imaging is approved for two types of patients with prostate cancer: 1) those with suspected metastasis who are candidates for initial definitive therapy (e.g., newly diagnosed with high-risk disease) and 2) those with suspected recurrence based on elevated PSA level (e.g. who previously had their prostate cancer treated, and are now seeing their PSA rise, in order to determine if and where they have metastases).

See PCF FUNDING, Page 7

Newsire: Friday, November 12, 2021

Yale Medicine School Cancer Center Study Shows Rates of PSA Testing for Prostate Cancer Increased After Revised National Guidelines

Yale School of Medicine

In a large study led by Yale Cancer Center, more men received a prostate-specific antigen or PSA test to detect prostate cancer following revisions to the recommendation by the U.S. Preventative Services Task Force (USPSTF) on screening. The results also showed significant increases in PSA testing among older men, a group for whom screening is not routinely recommended. The findings will be published online today in the journal *JAMA Oncology*.

"The findings from our study are intriguing. Increases in PSA testing were expected based on renewed support the consideration of screening from the USPSTF. These findings underscore the importance of screening guidelines from the task force and the rapid responsiveness of clinicians and patients," said Michael S. Leapman, MD, Assistant Professor of Urology, Clinical Program Leader of the Prostate and Urologic Cancers Program at Smilow Cancer Center, and Yale Cancer Center and lead author of the study. "However, increases in all age groups, including those for whom screening is not recommended, also highlight challenges to achieving a nuanced, evidence-based national approach to screening."

According to the American Cancer Society, close to 250,000 men will be diagnosed with prostate cancer in the U.S. this year, with more than 34,000 deaths. Prior guidance from the USPSTF in 2012 discouraged prostate cancer screening in all patients and led to reduced national rates of PSA testing and early detection of the disease. But in a 2017 draft statement, the USPSTF reversed its 2012 guidance advising against PSA screening for prostate cancer in all men, instead endorsing individual decision-making for men aged 55 to 69 years. The agency recommends against PSA-based testing for men aged 70 years or older.

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Wayne State University Report: October 5, 2021

Urologists' Perceptions of Active Surveillance and Their Recommendations for Low-risk Prostate Cancer Patients – Wayne State University Report

By a News-Reporter Staff News Editor at Cancer Daily

Investigators publish new report on Oncology - Prostate Cancer. According to news reporting originating from Detroit, Michigan, by NewsRx editors, the research stated, "To assess practicing urologists' attitudes and perceptions of active surveillance (AS) and other treatment options for low-risk prostate cancer. This was a cross-sectional survey of urologists practicing in Michigan and Georgia."

Financial support for this research came from American Cancer Society.

The Cancer Daily editors obtained a quote from the research from Wayne State University, "Urologists were asked about perceptions and practices pertaining to AS. Overall, 225 urologists completed the survey; 147 (65%) were from Michigan and 78 (35%) were from Georgia. Most urologists reported they provided (99%), discussed (97%), and offered (61%) AS to all of their low-risk patients. Most believed AS is effective (97%) and underused (90%), while 80% agreed that curative therapy (surgery, radiation) is overused in the United States. Although most (79%) endorse that Black men are more likely to have aggressive low-risk disease, 89% reported feeling comfortable recommending AS to Black men. In multivariable analysis, significant provider-related predictors of AS recommendation were practice location, number of years in practice, beliefs pertaining to survival benefit of prostatectomy and effectiveness of AS, and expectation that patients are not interested in AS. The patient characteristics of race, age, life expectancy, fear of cancer progression, and fear of treatment side effects were also significant predictors of AS recommendations. Most urologists surveyed stated that AS is effective and underused for low-risk prostate cancer. Overall, urologists are much less likely to recommend AS to younger men and slightly less to Black men. AS recommendations varied by practice location and by years in practice."

According to the editors, the research concluded: "These findings indicate targeted educational efforts in the US are needed to influence urologists toward greater acceptance of AS."

This research has been peer-reviewed.

For more information on this research see: Urologists' Perceptions of Active Surveillance and Their Recommendations for Low-risk Prostate Cancer Patients. *Urology*, 2021;155:83-89.)

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PCF funding was critical to the development of PyL. It was initially developed for PET imaging by Dr. Martin Pomper, of Johns Hopkins, and colleagues. Pomper, Dr. Steve Cho, Dr. Steven Rowe and others led a series of PCF-funded clinical studies to investigate the potential for PyL. PCF supported a Phase 2 clinical trial of PyL PET in patients previously treated for prostate cancer with rising PSA and no visible cancer on standard imaging. Since 1994, the year after its inception, PCF has funded over 80 investigations into PSMA-targeted diagnostics and therapeutics totaling more than \$28 million.

The main difference between PyL (trade name: PYLARIFY®) and ⁶⁸Ga-PSMA-11 (approved in December, 2020) is that PyL can be commercially produced and shipped, which will make it available to any medical facility able to perform PET imaging. Now, with 2 PSMA PET radiotracers approved, this type of imaging will become more widely available for patients. For information about locations offering this type of scan, ask your doctor or contact customer service at Lantheus, the manufacturer of PYLARIFY."

Prostate Cancer Foundation (November NewsPulse): November 29, 2021

Stay Bone-Healthy

Janet Farrar Worthington

In addition to all the other rotten tricks advanced prostate cancer plays on a man, here's a biggie: It messes with your bones. Moreover, androgen deprivation therapy (ADT) and androgen receptor-blocking drugs can also raise your risk of bone fracture. But there's good news: you can do a lot to protect your bones!

Being bone-savvy is the key to staying bone-healthy.

The first thing to know is that **prostate cancer really likes bone**. In 90 percent of men who have metastatic prostate cancer, metastasis happens in the bone. Prostate cancer causes changes in two different types of bone cell that, confusingly, sound a lot alike: *osteoblasts* and *osteoclasts*.

Osteoblasts can make the bone thicker, denser, and hard, like concrete. But this doesn't mean the bone is stronger, says Harvard medical oncologist Matthew Smith, M.D., Ph.D., Director of the Genitourinary Oncology Program at Massachusetts General Hospital Cancer Center. "Even though it might seem dense on an X-ray, there are dents, also called sclerotic or osteoblastic bone lesions, and the bone is structurally weak." Osteoclasts also cause bone to become more brittle.

However: **bone metastases can be treated**. There are several good bone-targeting drugs that zero right in on these lesions, including radium-223 (Xofigo), as well as supportive care treatments such as zoledronic acid (Zometa), and denosumab (Xgeva). Bone metastases can also be treated with stereotactic body radiation therapy (SBRT), intense, highly precise doses of radiation. **Treating the cancer in the bones not only improves quality of life; it can improve survival, as well.**

A second issue is that **ADT raises your risk of osteoporosis**. If you are on ADT, whether or not you have metastasis in the bone, "you are *separately* at risk for accelerated bone loss and greater risk for osteoporotic fractures from a fall or minor trauma," says Smith. So, to sum up: "Men who are on systemic treatment for prostate cancer are at risk for osteoporotic fractures, and patients with bone metastases, additionally, are at risk for skeletal complications."

By "systemic treatment," Smith doesn't just mean ADT, but androgen directed therapies such as enzalutamide, apalutamide, or abiraterone, which add their own wrinkle: "They increase the risk of falls, likely due to their effect on the central nervous system. It's kind of a bad setup: if you're on long-term ADT, you can lose bone mass and have a greater risk for fracture. Add a second drug – and these are meaningful and important drugs – and the unintended consequence is a greater risk for falls in men who are already vulnerable."

Oh, no! So, what's the plan? Should every man who starts ADT immediately start taking a bone-protective agent (such as zoledronic acid or denosumab) to prevent osteoporosis? No, says Smith. "If we did that, we would be overtreating, with a drug that many men don't need." And why is this? Because "osteoporosis and fractures are not an inevitable consequence of ADT. **Not every man is going to develop osteoporosis and fractures.**" To repeat: **Osteoporosis is not a done deal!** "Osteoporosis drugs have their own side effects; we don't want to do more harm than good."

Thus, Smith says, what makes the most sense for men on ADT is to evaluate everyone, and intervene *only* in patients at risk, "for whom osteoporosis treatments would do more good than harm. In my opinion, the best method of doing that is using the very thoughtful guidelines developed by the National Osteoporosis Foundation for fracture prevention in men. **We don't have to reinvent the wheel.** There are abundant evidence-based recommendations; we just need to apply those principles."

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Prostate Cancer Foundation (November NewsPulse): November 29, 2021

Stay Bone-Healthy

Janet Farrar Worthington

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Are you at higher risk? A good place to begin is an assessment tool called FRA_X. Smith notes that “it just takes a couple minutes to put in the information and get results, and then you’ll have a good idea of your risk based on clinical features: your age, height, and weight, and your bone mineral density measurement, if you know it.” Smith recommends that men get a baseline bone density scan at the time they start ADT. “Some patients should have prompt intervention to reduce their risk of fractures. Others would do better just to be followed. I typically repeat the bone density scan after a patient has been on ADT for a couple of years.” Note: “If you are only undergoing a short course of ADT, your risk is basically the same as that of the general population,” says Smith. “The risks of short-term ADT are very different from those of lifelong ADT.”

What else can you do? Should you be taking a horse-pill-sized dose of calcium? Smith says no; it’s better to help your bones through a good diet. “Diet, not supplements, and vegetables rather than lots of dairy.” Dark and leafy greens, such as kale, collard greens, and bok choy, have calcium. They also have bone-strengthening vitamin K. Sweet potatoes have magnesium and potassium, which your bones need. Fatty fish, like salmon, has vitamin D, which helps your bones absorb calcium, and the omega-3 fatty acids are also good for bones. Conversely: **Drinking alcohol and smoking cigarettes both increase your risk of falling.** (For more on the benefits of brightly-colored vegetables, download PCF’s guide, *The Science of Living Well, Beyond Cancer.*)

“Another issue with ADT is that men tend to gain weight and lose muscle,” says Smith. But **you can fight what ADT does to your metabolism with regular physical activity, “30 minutes a day, five days a week at least.”** Don’t be alarmed: you don’t have to start training for a triathlon! Just walking or riding an exercise bike can help a lot! “Some weight-bearing exercise will have a beneficial effect on your bone mass, but more importantly, it will reduce your risk for a fall.” The key here, he adds, is “**use it or lose it. If you spend most of your time being sedentary, when you do walk, you are at a greater risk of having a fall.**”

Take vitamin D. Vitamin D helps your body absorb calcium. Smith says this is the one dietary supplement that he *does* recommend: 2000 IU a day.

And, take heart: “Osteoporosis and fractures are not inevitable, and for patients at greater risk, they are preventable. If necessary, we can intervene with medicine to reduce the risk for fractures.” Lifestyle changes – eating bone-strengthening foods and exercising, cutting out smoking and alcohol – can make a big difference, too. “It is not at all the case that there’s nothing you can do. You can do a lot!”

Continued from Page 6

In this retrospective cohort study, researchers accessed claims data from BCBS Axis of more than eight million Blue Cross Blue Shield beneficiaries from 2016-2019. The results showed a relative 12.5 percent increase in rates of PSA testing in men aged 40 to 89 years. The relative increase among men aged 55 to 69 years, for whom screening is specified by the guideline, was 12.1 percent. PSA testing rates increased a relative 10.1 percent among men aged 40 to 54 years and 16.2 percent for men aged 70 years or older, for whom screening is not recommended.

“The consequences of increased PSA testing remain to be appreciated,” added Xiaomei Ma, PhD, Professor of Epidemiology, Co-Leader of the Cancer Prevention and Control Research Program at Yale Cancer Center, and senior author of the study. “Further study is needed to better understand patient perspectives and potential quality of life implications for both younger and older men.”

Other Yale authors contributing to this research include: Rong Wang, PhD, Henry Park, MD, MPH, James Yu, MD, MHS, Preston Sprenkle, MD, and Cary Gross, MD.

Prostate Cancer Foundation (blog): November 12, 2021

The Complex, Natural Biochemistry of a Healthy Diet

During Prostate Cancer Awareness Month, Prostate Cancer Foundation (PCF) hosted a webinar, “The Science of Nutrition and Prostate Cancer.” One of our panelists, the accomplished nutrition researcher Professor Richard Mithen, presented an overview of diets and foods that have been linked to a lower risk of cancer, and in some cases, prostate cancer. Mithen, professor of nutrition at the University of Auckland and PCF Challenge Award recipient, has been a leader in this field for decades.

Professor Mithen began with the “Big Picture” by outlining the benefits of plant-based and Mediterranean diets, emphasizing the importance of eating a large variety of plant-based foods. Oily fish, such as salmon, is a healthier animal protein alternative. These general principles, along with regular exercise, offer a path to good overall health.

Professor Mithen then went on to discuss a variety of fruits, vegetables, protein sources, and even spices that have the potential to affect health, and possibly prostate cancer specifically. Although it’s tempting to believe that diet is an exact science, there is a lot of complex biochemistry associated with it. This is because unlike taking a medicine (which has a high concentration of one molecule made to target a specific protein or chemical reaction in the body), diet means that you eat small amounts of a large number of molecules, creating an intricate web of reactions with many changing variables. Broccoli, for instance, contains many phytochemicals and nutrients in addition to cancer-fighting *glucoraphanin* (more on that below), including: fiber, vitamins, and minerals. All of these affect the body in some capacity, and may differ somewhat from person to person.

Broccoli remains at the forefront of Professor Mithen’s research, as current evidence suggest that it offers meaningful potential to reduce prostate cancer risk or risk of cancer progression. This is because broccoli contains *glucoraphanin*, which is converted to the active molecule *sulforaphane* by the gut microbiota (a.k.a., “bugs in your gut”). Within a few hours, sulforaphane is absorbed throughout the body and accumulates in the prostate gland. Sulforaphane has general health benefits due to its ability to turn on hundreds of genes in the liver associated with anti-oxidant defense, anti-inflammation, and the excretion of foreign pollutants. Beyond that, sulforaphane may directly affect the prostate itself by fighting the growth of tiny cancers that have the potential to become larger. Professor Mithen has developed new varieties of broccoli with different amounts of glucoraphanin, including those with up to 7 times higher than regular broccoli. In a PCF-funded study, men with localized prostate cancer on active surveillance consumed a “broccoli soup” weekly. After 12 months, men who ate the broccoli soup containing the highest amounts of glucoraphanin had reduced changes of expression in their prostate gland of genes that are thought to drive cancer progression, suggesting that glucoraphanin (sulforaphane) may indeed directly affect the risk of aggressive prostate cancer.

Mithen concluded his presentation by emphasizing that while there is no dietary magic bullet—not even broccoli—lifestyle changes including more plant-based foods, less red meat and dairy, and increased exercise lead to better health, and certainly will not cause harm. Examples of foods containing important phytonutrients include broccoli, turmeric, tomatoes, garlic, Brussels sprouts, and berries...and there are so many more to choose from.

PCSANM Programs Chairman and Board Member Lou Reimer Retires

Charles Rowland, Board Vice Chairperson

Lou Reimer has announced that he will step down from the Board of Directors effective January 1, 2022. Lou has been on the Board for the past eleven years, serving as Chairman from 2012 to 2016. As chairman, he steered the Association through the recession, keeping the organizing principle of education front and center.

Lou was diagnosed in 2002 while living in southern California. He soon found US TOO, where he learned about alternative modes of treatment. Initially, Lou was planning on having surgery. His employer advised him to consult with a gentleman associated with the support group in Orange County, California who had been through the same process just a year or so earlier. Thereby he learned that surgery would very likely not address the cancer completely; i.e. his cancer had an 85% probability of already being metastatic, therefore requiring additional therapy. He ultimately selected androgen deprivation therapy. It was a realization of the benefit of knowledge that inspired Lou to devote himself to providing education to the newly diagnosed.

His PSA has remained below 0.01 for almost 19 years. Lou has made it his guiding principle to help other men learn as much as possible about prostate cancer prior to making their own selection of treatment.

Lou enjoyed a career as a geological engineer, which took him to Texas, Colorado, Arizona, California, and New Mexico, as well as Australia, New Zealand, New Guinea, Zaire, Paraguay, and Canada.

His travel experiences, education, and natural curiosity motivated him to learn exactly what each cancer-related technical term means. He has been our “go-to guy” for the past ten years when one of us needs to understand the options regarding diagnosis, treatment, and the benefits and drawbacks of each.

In addition to his natural ability to grasp the intricacies of medical science as it relates to cancer, Lou has a remarkable ease when it comes to establishing personal relationships with medical professionals. He initiated our annual conferences in 2011 and has regularly invited many nationally known cancer specialists to make presentations. These individuals have delivered talks that have often been the highlights of their respective conferences.

Among his many endeavors on behalf of PCSANM, for the past several years Lou has filled the role of editor of our quarterly newsletter, The Lifeline. In this capacity he has fulfilled the premise that our organization provide knowledge about prostate cancer to the newly diagnosed and those whose cancers have returned. Lou stays up-to-date on the newest developments in diagnosis of prostate cancer, and he has tracked the various treatments that are recognized and certified, always with an eye to what forms of treatment are still in the development stage. These activities, combined in one individual, make Lou Reimer an absolute star in our association. We have benefited from his diligence for 11 years, and now we must honor him by continuing to provide our best services to the men of New Mexico.



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RETURN
SERVICE
REQUESTED

A Message from the Chairperson

January 2022

One of the most interesting comments found in the post-annual conference survey back in November was a desire for “more information about your support group and what you offer us who have prostate cancer.” Frankly I thought we were doing a pretty good job of that, but there seems to be room for improvement in describing the support group to those we seek to support. So, here comes an honest request. Please let us know where we can do better explaining and delivering on what we do for you.

Here are several services that aren’t stressed as much as they could be:

- If you’ve never had a PSA test and know it’s something that would help you get going with your prostate gland education, give us a call. If you meet certain conditions you could qualify for a free PSA test.
- Crank up that computer, tablet, or cell phone and visit our website – www.pcsanm.org. There are loads of landing places. Try the Education & Info tab at the top of the page. Click Education & Info. A world of info is now at your fingertips.
- Under the Resources tab there’s a Spanish language guide to prostate cancer. There’s a guide to navigating insurance, employment and finances for cancer patients.

Now, if these suggestions haven’t yet at least addressed the concern that we should be better explaining and promoting “what we offer,” please call or email. Better yet, come by for a visit. Office hours are Monday-Thursday, 10 a.m.-2 p.m.

A handwritten signature in cursive script that reads "Rod Geer".

Rod Geer
Chairperson of the Board, PCSANM