Prostate Cancer Support Association of New Mexico

LIFELINE

Celebrating over 30 years of supporting men and their families

PCSANM Quarterly
April 2023
Volume 30, Issue 2

Issue Highlights

Visit our website:
www.pcsanm.org

Email us:
pchelp@pcsanm.org

Support Group Meetings

Meetings are held at Bear Canyon Senior Center, 4645 Pitt St. NE in Albuquerque, from 12:30 – 3 p.m. on the first and third Saturday of most months. Some meetings may also be accessed virtually.

Meeting topics and login information may be found at:

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

Please call 505-254-7784 or email pchelp@pcsanm.org with questions.

Just Too Old to Matter

By Hank Witek, PCSANM Member

Cruising through retirement, not a care in the world. Results from annual PSA tests always unremarkable and below concern thresholds.

But here comes 2016, and at age 70, there is a blip on my biological radar. PSA now 1.24. But no sweat because the "concern threshold" rises with age, at least that is what I am told by my urologist. Radar echo scores continue to increase over the next two years, and there is a PSA score of 4.1 in 2018. My urologist expresses little concern because of my excellent health but suggests a biopsy just to make sure. The results come back clean as a whistle, and a complementary diagnostic MRI at age 72 confirms a clean bill of health.

Then comes a 2019 PSA test, which results in a ramped up 7.22 score. Let's try some potent antibiotics to rule out prostatitis, says my urologist. Nope, that didn't work. Year 2020 PSA hits 13.3; time for another biopsy. All samples benign for cancer; time to go home and have a good day.

Then 2021 PSA test results come in. Yikes, there's a significant blip on the radar. PSA now 18.5. How about another friendly biopsy? All specimens are benign. How about another a different broad spectrum antibiotic prescription? That didn't change PSA results. It is time to go home and have *another* good day. Then there's word that my urologist is traveling to "greener" pastures out of state, along with other urologists in that medical group, and it may be a while before a new urologist is assigned to my case.

While in "Never-Ever-Land," I started attending twice monthly meetings held by the Prostate Cancer Support Association of New Mexico. I wanted to learn about the spectrum of other diagnostics that could be useful in identifying root causes of an alarming PSA value. I also learned how others advocated for themselves by getting multiple medical opinions, and, when necessary, getting treatment out of state.

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PLEASE SUPPORT PCSANM!
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or
By check: PCSANM
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In Memory

With deep sympathy and regret, we list these names:

Ken Wischmann

Sherwin Mellins

Wayne Miller

PCSANM *Lifeline*
A quarterly newsletter addressing issues of prostate cancer

Months Published:

January April July October

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Just Too Old to Matter

By Hank Witek, PCSANM Member

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I decide to switch to another medical group in Albuquerque, and finally there is an appointment with a urologist in October of 2021. During my first and only office meeting with him, he suggested that because of my good health, because of my age (now 75), and because three previous biopsies and one MRI showed no signs of cancer, that I should consider doing nothing. Armed with my ”advocate for myself” armor, I replied that I would be willing to have that conversation, after one more MRI, that I hoped he would authorize. That MRI (very high resolution), taken in March of 2022, showed a 2-3 cm lesion on the anterior side of the prostate, which translates into a high Pi-Rads 4 score, and my PSA had reached 25.5.

With New Mexico still in a urologist-limited situation, I decided that my confirmation fusion (MRI guided) biopsy would be performed at the Anschutz Medical Campus – University of Colorado Cancer Center in Aurora Colorado, by a urologist who was very skilled at getting anterior samples. That, it turned out, was vitally important. Results of that biopsy were a Gleason 7 (4+3) for the anterior samples, and cancer free on for all posterior samples.

Three weeks later, I received a full body nuclear medicine and CT scan. Although there was no evidence the cancer had metastasized, there was one suspicious lymph node in the abdomen. The same day, a team of cancer specialists at the University of Colorado reviewed my results and provided a consensus recommendation. My PSA was now near 28; and because it took so long to get a cancer diagnosis, I was now in the “HIGH RISK” category and would require treatment protocols that were standard for that category.

To end this saga, I completed my radiation treatment in October 2022 at the University of New Mexico Comprehensive Cancer Center and will continue ADT treatment for another 6 to 18 months.

I suspected prostate cancer since 2018; I knew that doubling of PSA within a year was not a good sign, and that had happened several times during this 6-year discovery period. Thank God that I sought the wisdom, consul, and advice of members of the PCSANM organization, even before I had a diagnosis of cancer. Thank God that I did not follow the advice of urologists who suggested that at my age, I should just ignore those “suspect elevated” PSA readings and move on with life.

I believe, and hope to convince you through this story, that “It Is Never Too Old to Matter,” and that PCSANM and its many dedicated volunteers and members is an amazing resource that can assist you even prior to getting a definitive diagnosis of cancer.

PCSANM is a ZERO: The End of Prostate Cancer-affiliated support group. ZERO offers direct resources, including:

ZERO360 Comprehensive Patient Support:
1-844-244-1309, zerocancer.org/zero360

Peer Support: zerocancer.org/mentor

ZERO Caregiver Connector Program
zerocancer.org/caregiver-connector

Educational Resources
zerocancer.org

Urology Times: January 31, 2023

Urologists and Radiation Oncologists Often Differ in Prostate Cancer Treatment Recommendations

Hannah Clarke

A secondary analysis of data from a randomized clinical trial (NCT02053389) was recently published looking at the level of concordance or discordance between physician recommendations for treatment of patients with prostate cancer.[1] In this interview, Angela Fagerlin, PhD, discusses some of the key findings and takeaways from the study, highlighting how the results point to a need for increased shared decision-making. Fagerlin is the Chair of the Department of Population Health Sciences at the University of Utah School of Medicine, Salt Lake City.

Could you describe the background for this study?

Back in the 1990s, there were a couple of studies showing that in survey studies where physicians would read scenarios about different patients, urologists would recommend surgery for those patients and radiation oncologists would recommend radiology for the same patient. This was published in *JAMA*,[2,3] and there was a little bit of an uproar about how there could be bias here and that people were being driven by their specialty in the recommendations they made for patients.

At the time, I was at a different institution than I am now, and that institution had multidisciplinary clinics where a patient would see both a urologist and a radiation oncologist, often at the same visit in a random order. Sometimes they would start with a urologist, sometimes they would start with the radiation oncologist. We thought that this setting would be a really great place to test whether surgeons and radiation oncologists are still making different recommendations based on their own specialty and potentially the biases that their specialty training has brought out to them.

This scenario, this multidisciplinary clinic, would be a place where it would be less likely, potentially, for that to happen, because the radiation oncologists and urologists work together to develop this clinic. They work well together and [although] I'm not a physician, my sense of the interactions suggested they really respected each other and each other's specialty. We thought it'd be a great place to test out whether this was still happening, this tendency to recommend your specialty for any given patient.

What were some of your notable findings? Were any of those surprising to you and your coauthors?

What we found is that when a urologist and a radiation oncologist saw the same exact patients —this is a real patient in the clinic, just like in the studies— urologists were more likely to recommend surgery and radiation oncologists were more likely to recommend radiation. To put some numbers behind that, urologists recommended surgery for 79% of the patients that they saw. Interestingly, radiation oncologists recommended surgery for 57% of the patients, so there was about a 25% difference.

Similarly, radiation oncologists recommended radiation 68% of the time, but surgeons only recommended radiation therapy about a third of the time. So, they did still recommend each other's specialty on occasion, but by far were more likely to recommend their own type of treatment than the others.

Physicians—either type—can recommend surgery, radiation, or active surveillance. We looked to see how often they agreed in their recommendation of 1, 2, or 3 of these. We found that very rarely did they actually agree on the recommendation in terms of how many they recommended. In fact, I think only about a third of the patients did they completely agree on the recommendations that they made.

We're a little surprised that number was so low. We thought that there would be more concordance, especially because most of these patients were early-stage prostate cancer where likely, surgery, radiation, and active surveillance would have been an appropriate treatment for most of the patients. We were surprised that there wasn't that much agreement between the radiation oncologists and the urologists.

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Urology Times: January 31, 2023

Urologists and Radiation Oncologists Often Differ in Prostate Cancer Treatment Recommendations

Hannah Clarke

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Is any further research on this topic planned? If so, what might that focus on?

We're still thinking about that a little bit. I have moved institutions and am doing a little bit different research now, but there seems to be an area where we could move this work forward. One of the issues is how do we get patients involved in the decisions? If there is such a clear difference between what different physicians are recommending, that calls into the need for patients to be more involved in decisions.

Other work that I have done and have published has shown that the primary driving factor of what treatment a patient gets is a physician's recommendation. So, not the patient's preferences, their goals, not any of those things, but rather it was the physician recommendation. If we could work with physicians to help when they're making those recommendations pull out more about what the patient wants, I think that would be really powerful. Getting to do that is tricky. These appointments are complex and long as it is, but that's where I would think would be the next place to go. How can we get the patient's voice more activated? In a couple of studies that we've recorded the visits between patients and their prostate cancer physicians, there's not a lot of talking about the patients. That's where it would be really interesting to see if we could change that dynamic and interaction between patients and their providers.

What is the take-home message for practicing urologists based on this study?

I would just ask that urologists really think about their biases. It's been interesting. In a number of cases, we've seen urologists say, "Hey, I'm biased. I'm a surgeon. I was taught that this is a great method. You need to go talk to my colleagues who are radiation oncologists, just so that you can balance this out." We actually showed in a study in the *Proceedings of the National Academy of Science*[4] that when the physician said that, the patients actually trusted them more, because they acknowledged that they have this potential bias.

We're all human, including urologists and radiation oncologists, so we need to be aware of those biases and be honest about it. Though, that often made people trust the urologist so much that they didn't go to see the radiation oncologist, so that might be not exactly what we're hoping for. It really suggests that before you make these recommendations—because of this underlying potential for bias—it’s important to ask the patient questions that get at what they want. In a lot of our recordings, we heard "so you know, I really think that this treatment would be best. What do you think? That sounds good? Patient: 'Yes.’”

There hadn't been talk about [things like] how much [they are] sexually active. Different treatments have a very big difference in impact on erectile dysfunction. People who are not planning to have sex, they're 75 and they're widowed, or they're no longer having a lot of sex with their partner, that might not be a condition. But a newly married 65-year-old with an active sex life, that might be a real factor in their decision-making. What we've seen from tapes from this study and others is that there aren't a lot of questions about how important these are or how much it would stress them out to do active surveillance and have to worry about the cancer growing. There isn't a lot of this in-depth discussion.

It's more like a data dump: "Hey, here are the treatments, either of the 3 treatments. These are the risks and the benefits." They do a phenomenal job, the radiation oncologists and urologists, of telling you all the risks and benefits and providing all this information. Where we really need to see change is talking about what the patient wants, what they're worried about, and what would work best for them. Do they have a job where they can go to the bathroom frequently if they're having incontinence issues? Or are they a truck driver, where it's really hard to go to the bathroom? Asking these questions and involving the patient is what I would ask urologists to try to incorporate a little bit more in their practice.

Urology Times: February 6, 2023

Liquid Biopsy Test Can Detect Prostate Cancer in Microscopic Amounts

Hannah Clarke

Investigators at Cedars-Sinai Cancer Center in Los Angeles, California have developed a liquid biopsy test that can detect and profile prostate cancers, even in microscopic amounts.[1] Findings on the nanotechnology were recently published in *Nano Today*.

"This research will revolutionize the liquid biopsy in prostate cancer. The test is fast, minimally invasive and cost-effective, and opens up a new suite of tools that will help us optimize treatment and quality of life for prostate cancer patients," said Edwin Posadas, MD, in the news release. Posadas is the co-director of the Experimental Therapeutics Program at Cedars-Sinai Cancer Center.

The non-invasive test, called an extracellular vesicle (EV) Digital Scoring Assay (DSA), is comprised of an EV purification device called EV Click Chip and a reverse-transcription droplet digital polymerase chain reaction that quantifies mRNA markers from the purified EVs. EVs are microscopic packets of protein and genetic material shed by cells.

After blood samples are collected, the EV DSA isolates prostate cancer derived EVs from the blood and performs a rapid and sensitive analysis of the mRNA contents. The tool was shown to be efficient in the study conducted by Cedars-Sinai investigators, who used the tool to analyze blood samples from 40 patients with prostate cancer. They found that the tool could distinguish localized prostate cancer from metastatic prostate cancer and outperformed other methods of detection, such as ultra centrifugation and precipitation, in purifying EVs. These results point to an advantage in using the method for extraction of prostate cancer information in small volumes to help detect metastasis and monitor disease progression.

"This assay may complement current imaging tools and blood-based tests for timely detection of metastatic progression that can improve care for [prostate cancer] patients," the authors wrote.

A potential use for the tool could be for patients who undergo prostate removal and later experience elevated prostate-specific antigen levels.

If the remnants of the cancer have been left in the prostate bed, they can be managed with focused radiation therapy, though that comes with risks given that the prostate is also located near the bladder and rectum. If the cancer remnants have spread, focused radiation therapy will not prevent disease progression, and patients should instead receive systemic therapy.

However, the remnants are not always detectable using traditional methods, meaning that patients may undergo harmful radiation even when it is not effective. Investigators at Cedars-Sinai were able to detect remnants using the EV test, even when they were in trace amounts.

As a part of the study, 3 blood tests from patients with prostate cancer were retrospectively analyzed. The tool was able to detect changes in the mRNA signatures—even when the disease was undetectable by imaging—which correlated with the clinical behavior displayed by the patients. In 1 case, the patient had undergone focused radiation therapy despite them having metastatic disease. In the future, the tool could be used to avoid treating patients with radiation that isn't effective in targeting the cancer.

The Cedars-Sinai team has been working on developing breakthroughs in EVs, and they are hoping to refine and expand their work in the near future.

"This type of liquid biopsy, coupled with innovations such as our Molecular Twin initiative, is key to next-generation precision medicine that represents the newest frontier in cancer treatment. And the type of progress we are making is only possible at an institution such as Cedars-Sinai Cancer, where we have patients, clinicians, scientists, and creative engineering minds converging as one unit to address the most challenging problems in cancer," said Dan Theordorescu, MD, PhD, director of Cedars-Sinai Cancer Center.

Fidelity Learning Center: https://www.fidelity.com/learning-center/personal-finance/retirement/qcds-the-basics

Donating to Charity Using a Qualified Charitable Distribution (QCD)

Whether supporting PCSANM or another charity, donating with QCDs makes financial sense.

If you are age 73 or older, IRS rules require you to take required minimum distributions (RMDs) each year from your tax-deferred retirement accounts. (This change in the RMDs age requirement from 72 to 73 applies only to individuals who turn 72 on or after January 1, 2023. After you reach age 73, the IRS generally requires you to withdraw an RMD annually from your tax-advantaged retirement accounts, excluding Roth IRAs, and Roth accounts in employer retirement plans accounts starting in 2024).

A QCD is a direct transfer of funds from your IRA, payable directly to a qualified charity, as described in the QCD provision in the Internal Revenue Code. Amounts distributed as a QCD can be counted toward satisfying your RMD for the year, up to $100,000. The QCD is excluded from your taxable income. This is not the case with a regular withdrawal from an IRA, even if you use the money to make a charitable contribution later on. If you take a withdrawal, the funds would be counted as taxable income even if you later offset that income with the charitable contribution deduction.

Why is this distinction important?
If you take the RMD as income, instead of as a QCD, your RMD will count as taxable income. This additional taxable income may push you into a higher tax bracket and may also reduce your eligibility for certain tax credits and deductions. To eliminate or reduce the impact of RMD income, charitably inclined investors may want to consider making a QCD. For example, your taxable income helps determine the amount of your Social Security benefits that are subject to taxes. Keeping your taxable income level lower may also help reduce your potential exposure to the Medicare surtax.

Am I eligible for QCDs?
In prior years, the rules that permitted QCDs required reauthorization from Congress each year, and those decisions were sometimes made late in the calendar year. With passage of the Protecting Americans from Tax Hikes (PATH) Act of 2015, the QCD provision is now a permanent part of the Internal Revenue Code. This means you can plan your charitable giving and begin reviewing your tax situation earlier each year.
Tip: With the 2020 tax law changes, there's 1 additional factor to consider: you may take advantage of the higher standard deduction ($13,850 for single filers, $27,700 if married and filing jointly for 2023). This means that if you claim the standard deduction, you won't be allowed to itemize things like charitable donations. However since QCDs are not includable in income the QCD is also not deductible. As such, the QCD can remain an option for your charitable giving, even if you claim the standard deduction in a given year.

The rules of QCDs

A QCD must adhere to the following requirements:

- You must be at least 70½ years old at the time you request a QCD. If you process a distribution prior to reaching age 70½, the distribution will be treated as taxable income.
- For a QCD to count toward your current year's RMD, the funds must come out of your IRA by your RMD deadline, which is generally December 31 each year.
- Funds must be transferred directly from your IRA custodian to the qualified charity. This is accomplished by requesting your IRA custodian issue a check from your IRA **payable to the charity**. You can then request that the check be mailed to the charity, or forward the check to the charity yourself.

Note: *If a distribution check is made payable to you, the distribution would NOT qualify as a QCD and would be treated as taxable income.*

- The maximum annual distribution amount that can qualify for a QCD is $100,000. This limit would apply to the sum of QCDs made to one or more charities in a calendar year. If you're a joint tax filer, both you and your spouse can make a $100,000 QCD from your own IRAs.
- The account types that are eligible for QCDs include Traditional IRAs; Inherited IRAs; SEP IRA (inactive plans only*); SIMPLE IRA (inactive plans only).
- Under certain circumstances, QCDs may be made from a Roth IRA. Roth IRAs are not subject to RMDs during your lifetime, and distributions are generally tax-free. Consult a tax advisor to determine if making a QCD from a Roth is appropriate for your situation.

Tax filing for QCDs
A QCD is reported by your IRA custodian as a normal distribution on IRS Form 1099-R for any non-Inherited IRAs. For Inherited IRAs or Inherited Roth IRAs, the QCD will be reported as a death distribution. You should keep an acknowledgement of the donation from the charity for your tax records. Please consult a tax advisor to learn more.

Prostate Cancer Support Association of New Mexico

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

Prostate Cancer Support Association of New Mexico, Inc.
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Albuquerque, NM 87110

A Message from the Chairperson

April 2023

Well, here you are reading the last page. If you've reached this point, let's assume you're interested in prostate cancer for any of several reasons. Perhaps you've just been told you have prostate cancer and you're wanting to learn more about it. Or you've had prostate cancer and have learned it's important to advocate for yourself, so you want to stay up to date. Perhaps, you thought you were cured (be careful using that word) but the darn thing is back, and worse yet it has spread. Maybe someone else in your family has been diagnosed. Or maybe, just maybe, you've read this far because you're a regular participant in our support group, you realize you've received a lot of support throughout your experiences, and you're wondering how you could give a little something back and foster your own healing in the process. You are generous with your contributions. But what else could you do? I am eager to talk with you about opportunities and new ways you can contribute as a board member. The board has people from different backgrounds, professions, interests, talents, and different experiences with prostate cancer.

I'm eager for that first call or email from a person wanting to know how he or she can contribute. Please reach out to me at 505-203-5122, wrgeer@gmail.com, or the organization email address pchelp@pcsanm.org. Thank you for your consideration.

Rod Geer

Rod Geer
Chairperson of the Board, PCSANM