Prostate Cancer Support Association of New Mexico

LIFELINE

Since 1991, supporting those affected by prostate cancer

Quarterly Newsletter
January 2026
Volume 33, Issue 1

Issue Highlights

Scan to learn more about PCSANM or to donate

Support Group Meetings

Meetings are held at Bear Canyon Senior Center, 4645 Pitt St. NE in Albuquerque, from 12:30 p.m. to 2:45 p.m. on the first and third Saturdays of most months.

For meeting topics and information:

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

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

Do Second Opinions Matter?

By Stan Mathews, PCSANM Participant

In April/May of 2025, I was not feeling right. My primary care doctor wanted to get a prostate-specific antigen (PSA) blood test done on me. When my PSA number came back and it was a 10 (and previously it had always been a low number), my doctor wanted to run another PSA due to thinking the first PSA test was a false positive. A second PSA test was done. It came back with an even higher PSA number at 10.6. He immediately wrote a referral to a urologist.

I went to the urologist. He told me that I needed to get a biopsy done and made an appointment. I went to the biopsy appointment and got a six-core biopsy done (with three biopsy samples being taken from each side of my prostate). The results came back. The urologist told me that I had prostate cancer: my Gleason scores were all sevens on my right side of my prostate and a seven, eight, and nine on the left side of my prostate. He told me that I needed to get a Computed Tomography abdomen and pelvis with IV contrast scan and a nuclear bone scan of my entire body. Both tests were done on June 19, 2025. My urologist told me that the prostate cancer was contained in my prostrate due to what the two tests showed him. These results decided for me that I was going to get a prostatectomy (removal of the prostate) on August 7, 2025, by my urologist. I went to my final blood test at the end of July to get current results to be given to my anesthesiologist. Then, I was hit by a bolt of lightning in the waiting room! An individual told me that he had the same doctor and that I should do my research before getting this surgery because it would change my life and I needed to really think about the treatment and all potential side effects.

A friend who also had his prostatectomy (about 12 years ago and recently went through radiation therapy), suggested that I go to the Prostate Cancer Support Association of New Mexico (PCSANM). My wife and I attended the July 18, 2025, meeting. I was asked by the group to share my story being a first timer of what brought us to this meeting. I told my story and fellow attendees asked why I had not gotten a 12-core biopsy test, a Prostate-Specific Membrane Antigen (PSMA)-Pet scan, and a Magnetic Resonance Imaging (MRI) scan.

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or send a check payable to:
PCSANM
2533 Virginia St. NE, Suite C
Albuquerque, NM 87110

Board of Directors

Prostate Cancer Support Contacts Around the State

City	Contact	Phone
Clovis	Kim Adams	(575) 769-7661
Farmington	Deb Albin	(505) 609-6089
Los Alamos	Michael Smith	(505) 709-5021
Las Cruces	John Sarbo, Ron Childress	(915) 503-1246 (602) 312-9289
Santa Fe	Guy Dimonte	(505) 699-2139

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

(505) 254-7784
(505) 254-7786 (fax)
(800) 278-7678 (toll free in NM)

Office is open
Monday-Thursday
10 a.m. - 2 p.m.

EMAIL
pchelp@pcsanm.org

VISIT OUR WEBSITE
http://www.pcsanm.org

EDITOR
Gerald Bowe

MEETING MODERATORS
Jonathan Brown
James Whitfield

FACEBOOK

Second Opinions

Stan Mathews, PCSANM participant

Continued from front page

Everyone in the room said that a PSMA-PET scan was a great specific test and it would indicate if the cancer had escaped from my prostate. Attendees of the support group also suggested I seek a second opinion, just to be safe.

After the PSCANM meeting, I needed time to digest the information that I had heard. I also needed to figure out what I was going to do next. On Monday, I called my insurance company and asked if I could "self-refer" myself for specific doctors and services. The representative on the phone told me that I could self-refer (I verified this twice with different representatives before proceeding forward). I immediately called another cancer treatment center and scheduled a second opinion with the urologist. I also reached out to a different center and scheduled an appointment with one of their oncologists. Lucky for me, I was able to schedule a second free opinion through my wife's insurance.

I exchanged emails with my current urologist's staff and asked if he did the PSMA-PET scan. They said that my urologist did not do this type of test and that the cancer was contained in my prostate. They also said I would have to see one of their oncologists. They did not immediately refer me to one of their oncologists, and a red flag went up in my mind that I was not getting the whole picture about my prostate cancer. I cancelled my prostatectomy about two weeks before it was going to be done.

At my first appointment with the new oncologist, he immediately set up a test to get a PSMA-PET scan, and an MRI test done at their center. A few days later I got my PSMA-PET scan, and my MRI test. The following week, I received my results: the prostate cancer had escaped from my prostate and gone into two of my lymph nodes right next to my prostate. Talk about a shock and surprise upon receiving this news.

I also realized that my biopsy could have been more complete. It should have been a 12-core biopsy. At this point, I realized that I did not get the two most important tests that I needed to make this crucial decision, which was the PSMA-PET scan and an MRI. What if I had gotten my prostate removed before having gotten these tests? I would have been going through a brutal recovery process with the possibility of lifelong incontinent issues and other terrible complications from this surgery that may have never been fixed or resolved. With all these issues going on, I would have been getting hormone therapy and radiation therapy.

At the original facility where I was getting my prostate diagnosis there was just the "doctor" mentality. Both second opinions agreed with each other that hormone therapy and radiation therapy were the correct path forward for me. At the centers that provided second opinions and at PCSANM, there was the "team" mentality. Imagine where I would be right now if I had stayed with the "doctor" mentality instead of moving over to the "team" mentality.

University of California Medical Centers, Bakar Cancer Hospital, University of California San Francisco (UCSF), among many other centers across the country, offers second opinions on biopsy results. PCSANM does not endorse or recommend any particular center, including the one noted here, but shares the following as an example and for informational purposes only.

For more information, contact customer service at (415) 514-3677 or https://pathology.ucsf.edu/clinical/ap/consult-instructions

Consultation-related questions:
UCSF Pathology Consultation
(415) 353-1613

A Review of Prostate Cancer Research Institute (PCRI): Your Patient-Centered Guide to Understanding Prostate Cancer

James Whitfield, PCSANM Interim Board Chairperson

The world of prostate cancer can feel overwhelming, complex, and full of jargon. When facing a diagnosis, or even just exploring the risk, finding clear, trustworthy, and **patient-centered** information is paramount. This is where the Prostate Cancer Research Institute (PCRI) and its excellent online resources—especially their website, **pcri.org**, and their extensive YouTube channel—stand out as absolute heavyweights in the field.

World-Class Education, Delivered Free

One of the most impressive aspects of PCRI's educational output is that their high-quality conferences and recordings are available free of charge. These materials aren't produced by just anyone; they are presented by many of the world's best doctors and researchers in prostate cancer.

These experts understand that the audience is not fellow medical professionals, but individuals who are wanting to understand much more about this very complex disease. The educational focus is on the nuances:

- **The disease itself**, including its various forms of spread and aggressiveness.
- **The various treatments** targeted to those specifics.
- **Managing side effects** and exploring options for fixing some of the difficult consequences of treatment.

The accountability is clear: the information is delivered to empower the patient, helping them gain the knowledge to make informed, joint decisions with their medical teams.

Conferences: Connecting with the Top Names

PCRI hosts two major events each year that draw attendees from around the globe. They hold a once-a-year in-person conference and a mid-year online conference. These are not small-scale gatherings; they feature top names in oncology, urology, and specialized research who present on the new advancements and latest studies in prostate cancer treatment.

What sets the in-person conference apart are the unique opportunities for direct interaction. Attendees can participate in breakout sessions with the speakers to ask questions directly. Even more profoundly, attendees can often make personal appointments by arrangement with some of these world-class clinicians. It's clear that these speakers, by sharing their knowledge and making themselves accessible, are attracting people who are seeking the absolute best care.

The mid-year virtual conference offers a similarly powerful lineup of speakers presenting on comparable topics and critical research updates, making this essential information available to anyone, anywhere.

Looking Beyond the Cancer: A Focus on Whole-Body Health

An interesting and patient-first perspective embraced by the conference organizers is the recognition that most treated people will not die of prostate cancer. This shifts the focus from solely battling the disease to managing overall health for a long life.

The presentations often speak about taking care of the real, long-term risks: heart health and general well-being. This includes a strong message stressing that lifestyle interventions like exercise and weight lifting have enormous benefits for well-being during prostate cancer treatments and, crucially, after for heart health. This holistic view is a breath of fresh air and a testament to their patient-centered approach.

Bite-Sized Education for Busy Lives

Beyond the conferences, PCRI also publishes weekly videos on its YouTube channel, usually in about 10-minute segments. These are often presented in an interview style, focusing on a very narrow topic, such as a specific treatment side effect, a new diagnostic tool, or a novel therapy.

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MedPage TODAY: October 29, 2025

PSA Screening Reduces Prostate Cancer Deaths, Long-Term Data Show

Mike Bassett, Staff Writer

A sustained reduction in deaths from prostate cancer was observed with prostate-specific antigen (PSA) testing in long-term follow-up results from the European Randomized Study of Screening for Prostate Cancer.

After a median follow-up of 23 years, prostate cancer mortality was 13% lower in the PSA screening group versus the control group (rate ratio 0.87, 95% CI 0.80-0.95), and the absolute risk reduction was 0.22% (95% CI 0.10-0.34), reported Monique J. Roobol, PhD, of the Erasmus MC Cancer Institute at University Medical Center Rotterdam in the Netherlands, and colleagues.

Cumulative mortality from other causes at that point was an identical 49% in both groups (risk ratio 1.00, 95% CI 0.98-1.01).

Compared with a previous update to the trial at 16 years of follow-up, the number needed to invite for screening to prevent one prostate cancer death fell from 628 to 456, and the number needed to diagnose fell from 18 to 12, while the excess incidence of prostate cancer in the screening group decreased from 31 to 27 extra cases per 1,000 men.

Taken together, these reductions result "in a more favorable harm-to-benefit profile than previously estimated," the authors wrote in the *New England Journal of Medicine*.

The cumulative incidence of prostate cancer was 14% in the screening group and 12% in the control group (rate ratio 1.30 (95% CI 1.26-1.33). Along with the absolute excess incidence of 27 cases of prostate cancer per 1,000 men, these findings suggested that the harms associated with PSA-based screening -- including unnecessary testing, biopsies, overdiagnosis, and subsequent over-treatment -- remain a "critical concern," Roobol and colleagues noted.

"These findings highlight the need for a more targeted strategy for prostate cancer screening that focuses on identifying population subgroups that are most likely to benefit from early detection while reducing unnecessary interventions for those with the highest risk of overdiagnosis," they wrote.

In an accompanying editorial, Andrew Vickers, PhD, of Memorial Sloan Kettering Cancer Center in New York City, noted that "there can be little doubt that PSA screening reduces prostate cancer mortality."

However, whether the benefit of reduced mortality outweighs the harms associated with PSA screening remains a critical question, he said.

In the case of this study, that question is complicated by the fact that by the time long-term results were available, "diagnostic and treatment methods have evolved, leaving us with an effect estimate for an outdated approach," Vickers wrote.

That said, he suggested that the benefits of PSA screening are probably underestimated in this trial because international guidelines now call for screening at an earlier age and treatments given to trial participants were "far from the state of the art."

In addition, the harms associated with screening are likely overestimated because current guidelines recommend conservative management for low-risk disease, he added.

The trial was initiated in 1993 in the Netherlands and Belgium, and eventually included centers in Sweden, Finland, Italy, Spain, Switzerland, and France.

Men ages 50 to 74 years were eligible for the study, with each center defining its own specific age range.

A total of 162,236 men were included in the study, with 72,888 assigned to the screening group and 89,348 assigned to the control group. The median age at the time of randomization was 60 years.

Men who were assigned to the screening group underwent an average of two screenings, with 83% undergoing at least one screening. Among those who participated, 28% had at least one positive screening result.

Men who had a positive result on the PSA test underwent transrectal ultrasound-guided systematic prostate biopsies (with the number of cores taken during biopsy increasing from 6 in the early years of the study to 12 in later years). Most centers used a PSA level of 3.0 ng/mL as the cutoff for biopsy.

Compliance with undergoing a prostate biopsy after a positive result was 89%.

The authors acknowledged the study had several limitations, including the fact that differences in population characteristics and baseline prostate cancer risks, and slight variations in protocols across centers, may have affected the results.

MedPage Today: October 28, 2025

Mixed Results with Metformin for Men on ADT for Prostate Cancer

Charles Bankhead, Senior Editor

Metformin failed to prevent metabolic syndrome in men on hormonal therapy for prostate cancer but did improve risk factors associated with the syndrome, an abbreviated randomized trial showed.

The proportion of patients with metabolic syndrome increased in both treatment groups and was not significantly different when the trial ended (55% in the metformin arm and 68% in the placebo arm, *P*=0.2). Men randomized to receive metformin in addition to androgen deprivation therapy (ADT) had statistically significant weight loss, reductions in hemoglobin (Hb) A1c, and smaller increases in waist circumference. Transient improvement in cholesterol levels also occurred in the metformin arm. Biochemical control of prostate cancer, as assessed by prostate specific antigen (PSA), did not differ between the groups.

Although the trial missed the primary endpoint, the beneficial effects on individual metabolic parameters suggest metformin may help minimize ADT-associated adverse effects, reported Nawaid Usmani, MD, of the University of Alberta and Cross Cancer Institute in Edmonton, and coauthors in the *Journal of Urology*.

The favorable effects observed in the study "consolidate the finding that metformin not only improves anthropometric outcomes, but also has a favorable modulatory effect on glucose and lipid metabolism, suggesting a potential role in decreasing ADT-induced adverse effects," the authors stated.

"In terms of the absolute differences in MS [metabolic syndrome] rates between the two groups, this was not very different at baseline and at subsequent follow-up timepoints," they added. "The lack of significant changes in MS from metformin, in contrast to the secondary outcome changes observed, probably reflects the complex nature of MS, which is a collection of variables that have varying effects from metformin."

The so-called PRIME trial ended after enrollment of 166 of the planned 300 patients because of inability to obtain the study drug. The trial design called for assessment of the primary endpoint after 18 months of ADT, and some patients did not continue hormonal treatment that long.

The authors of an accompanying editorial noted that a phase III trial in colorectal cancer showed that exercise was associated with improved survival, suggesting lifestyle interventions, not just drugs, might offer the best chance for metabolic health and cancer control.

"This study reminds us that asking important questions leads to relevant answers, whether they support or refute our hypothesis," wrote Stephen J. Freedland, MD, of Cedars-Sinai Medical Center in Los Angeles, and colleagues. "After all, medical advances often come from discovering what we were not even looking for."

The PRIME trial had similarities to another recent study that showed no effect of metformin on metabolic syndrome in men on ADT for prostate cancer. That study ended early because of slow accrual, after only 36 patients had been enrolled. Additionally, the patients had a short treatment window of 6 months, said Devalingam Mahalingam, MD, of Northwestern University in Chicago, a researcher on that study.

"Of interest, we noted 20% or so of patients in the treatment arm had no detectable metformin levels in blood despite being compliant," Mahalingam told *MedPage Today*. "So a pharmacogenomic effect that prevents adequate drug absorption may play a role in some patients not benefiting from metformin therapy."

The favorable impact on weight, waist, and HbA1c suggests metformin might be able to mitigate "metabolic drift" (but not metabolic syndrome) in some patients on ADT.

"Metformin may be reasonable for glycemic/weight control during ADT in men edging on prediabetes or who perhaps have central adiposity, but expectations should be set that it's not proven to prevent metabolic syndrome," said Mahalingam. "Ultimately to me, exercise, nutrition, and cardiometabolic monitoring remains the standard for these men."

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MedPage Today: October 28, 2025

Mixed Results with Metformin

Charles Bankhead, Senior Editor

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The PRIME trial added to those of a much larger randomized trial of metformin that failed to meet the primary endpoint of overall survival in metastatic prostate cancer. However, adverse metabolic effects of ADT occurred significantly less often in the metformin arm.

PRIME evaluated metformin for decreasing the risk of metabolic syndrome in men with prostate cancer treated with ADT. The patients were randomized 2:1 to metformin or placebo, continued for 18 months. The primary endpoint was the proportion of patients with metabolic syndrome at 18 months. The researchers had hypothesized that metabolic syndrome would increase in both arms, but significantly less so in the metformin arm.

Data analysis included 90 patients who received metformin for at least 9 months and 45 allocated to placebo. The trial had a median follow-up of 24 months.

At enrollment, 42% of patients in the metformin arm and 58% in the placebo group met diagnostic criteria for metabolic syndrome. The imbalance was not statistically significant (P=0.09). At no point during follow-up did the absolute difference in prevalence of metabolic syndrome differ significantly between the groups (metformin vs placebo):

- 9 months: 49% vs 61%
- 12 months: 52% vs 57%
- 18 months: 55% vs 68%
- 24 months: 44% vs 59%

Assessment of individual components of metabolic syndrome showed that mean body weight was significantly reduced from baseline with metformin at 9 and 12 months versus the placebo group (P<0.001, P=0.004). Waist circumference increased over time in both arms but significantly less in the metformin arm at 9 and 18 months (P=0.03). Body mass index was improved with metformin at 9 months (P<0.001). Glucose metabolism was significantly better with metformin at 9 and 12 months (P=0.02 for both), and total cholesterol was significantly improved with metformin at 9 months (P=0.03). Blood pressure did not differ significantly at any timepoint.

A Review of Prostate Cancer Research Institute (PCRI)

James Whitfield, PCSANM Interim Board Chairperson

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For the most part, most people are interested in just their specific conditions and not the whole expansive field of prostate cancer. These short, focused videos have become an incredibly valuable searchable data library. A patient or caregiver can easily search the YouTube channel for their specific concern—say, "Gleason 7" or "Brachytherapy side effects"—and pull up a concise, expert discussion on that exact issue.

Making Joint Decisions with Confidence

As the PCRI wisely notes, **none of the presentations constitute medical advice but only education**. However, the value of this education cannot be overstated. I find that when patients truly understand their options, the possible outcomes, and the rationale behind their doctor's recommendations, they feel significantly more comfortable with the joint decisions they make with their medical teams. Understanding these options is the first step toward getting comfortable with your treatment plan or seeking a possible second opinion.

If you or a loved one are navigating the complexities of prostate cancer, I encourage you to visit the PCRI website at pcri.org and subscribe to their youtube.com channel. The resources we've discussed here are a critical tool for empowerment.

You can also find links to these resources and more through our local website at pcsanm.org.

The next review in this series will focus on the California Prostate Cancer Coalition.

Prostate Cancer Support Association of New Mexico

PCSANM *Lifeline* Newsletter
Celebrating 35 years of supporting individuals with prostate cancer and their families

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

A Message From the Chairperson

January 2026

Dear Readers,

As 2025 comes to a close, I want to thank everyone who helped make this another strong year for PCSANM. We also mark important transitions: Rod Geer retired after five years as Board Chairperson, and David Turner concluded his board service after serving as Treasurer for most of his tenure since 2018. We are grateful for their steady leadership and dedication.

With the support of our committed volunteers, PCSANM participated in numerous community health fairs, hosted a successful golf tournament, and held our 14th Annual Conference. We provided nearly 200 one-on-one support sessions, and support group sign-ins exceeded 600—signs of the trust our community places in us.

Thanks to generous donors, our summer matching campaign reached its full $10,000 match, helping us improve the quality of our services. Volunteers strengthened their mentoring skills through participating in events led by national groups such as the Prostate Cancer Research Institute, the National Alliance of State Prostate Cancer Coalitions, and ZERO Prostate Cancer, ensuring high-quality support for those who reach out to us.

Thank you for being part of PCSANM in so many ways this year—by attending meetings, contacting us for one-on-one support, volunteering, donating, and sharing your time and experiences with our community.

Wishing you a healthy and peaceful 2026. We look forward to another successful year together.

Warm regards,

James Whitfield

James Whitfield
Interim Chairperson, Board of Directors