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P R O S T A T E

Health & Nutrition News

Man to Man (M2M) is an educational, not for profit, prostate cancer (PCa) support program of the American Cancer Society (ACS). M2M does not dispense medical advice. Protocols discussed at M2M meetings and in this newsletter are sometimes based on anecdotal information. It is always advisable to consult a physician before adopting any form of treatment.

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"We must use time as a tool, not as a couch."

- John F. Kennedy

From the Editor

I'll start by apologizing for the delay in getting this issue out to the newsstands. (No, I'm kidding we don't sell this on the newsstands. It is free for the asking.) We went on vacation for a few weeks. In the meantime, I have been receiving numerous informative articles for publication from our editors and readers. Unfortunately I can't print them all. It would cause such a large issue that the American Cancer Society would probably fire me. (can they fire a volunteer?) We try to get a broad perspective of interest in the articles and hope you find something of interest. I sincerely appreciate all those articles and links folks are sending me. If you don't see yours here, it may make another issue. Please don't feel slighted, and keep sending me the items.

We are still trying to include recipes on a regular basis. This issue's recipe is appropriate for the warmer months. Hope you like it.

It comes with great sadness again that I have to tell you of the loss of another Warrior in the fight against Prostate Cancer, John Wiuff. John, a long time facilitator of the Toms River US, Too!, succumbed to his Prostate Cancer at the end of May. We offer his family and friends our sympathies. I have only known John a short time, but will miss his smiling face and cheerful approach to life. More on John in the next issue.

Please remember to let us know how you prefer your subscription to be delivered – email or "snail mail". It can also be found on the PCCCNJ Website, **www.pcc-nj.org.** Patti Allen at the Shrewsbury ACS office maintains the mailing lists. Please let her know your preferred delivery method.

As always, please let me know how you like the Articles of Interest and other items in the newsletter; and your suggestions for other items you might want to see us cover.

Enjoy the issue.

- Jeff Ozimek, Editor
anjoz@comcast.net

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Neptune Prostate Cancer Support Meeting April 19, 2007

by Donald Blue and Rich Guilfoyle

Thirteen individuals plus two spouses attended at the meeting. Marc G. opened the meeting by welcoming the members and wives. He reported on the recent, non PCa related death of Gary Fichter. Several members attended the viewing in Long Branch. They expressed condolences to the family for the Neptune PCa Support Group.

Marc and James A. will attend the UsToo International University Leader's training class scheduled for 11-13 May 07, in Austin, TX. This will be Marc's second time attending a UsToo University sponsored training session.

There was no Guest Speaker scheduled for the April meeting, therefore a DVD was shown titled: ProtaScint Scans by Bruce Sodee. The DVD generated good discussions by the members. The plan is to alternate Guest Speakers and DVDs is working very well.

See the following Guest Speaker/DVD schedule for May to December:

May, Guest Speaker: Cyberknife at Riverview M.C. by Nate Kaufman FACRO, Medical Director Cyberknife Center Medical Director, Radiation Oncology, Meridian Health
June, DVD: Diet for PCa Patients (Charles Myers)
July, Guest Speaker: Arthritis, Preventing and Handling Pain
August, DVD: MRI, CFD and Other Novel Methods for PCa Staging and Treatment (Michael Dattoli)
September, Guest Speaker: Natural Solutions to Headaches
October, DVD: ProstaScint with CT, MRI and PET (Sodee)
November, Guest Speaker: Allergy Releif Workshop
December, DVD: Advances in Combination Radiation Therapy, MD-4D, IG-IMRT, Dart and Seed Implant (Michael Dattoli)

Note 1. The schedule depends on availability of Guest Speakers and DVDs.

Note 2. Guest Speakers for July, September and November will be provided by the Garden State Spine & Pain Institute.

Rich provided an overview of how members can join the Support Group's online Yahoo account for obtaining PCa related information. He prepared instructions via a handout. Arrangements will be made with the Early Childhood Center for the Group to access the Internet during meetings. This will be a very useful tool.

Marc provided information on the Corporate Angel Network (CAN). CAN offers free air travel on corporate aircraft for PCA patients to receive treatment throughout the US. The program has helped thousand of patients. See www.corpangelnetwork.org for CAN details.

The next meeting is schedule for 17 May 2007 at the Neptune, Early Childhood Center.

Marc Gordon, Rich Guilfoyle, Donald Blue and Jim Allen

CentraState Support Group Meeting

April 23, 2007, Health Awareness Center Gibson Place, Freehold, NJ

by Chris Papa

Ten men and three spouses were present for the April 23, 2007 meeting. With the last minute cancellation by the scheduled guest, radiation oncologist Dr.E. Soffen, it was fortuitous that George Giffen attended and gave a lively presentation, which extolled the virtues of cryotherapy. As none of our regular attendees have had experience with this form of treatment they were interested in the anecdotal details of Mr. Giffen's history. He is a long term survivor of the good care afforded to him by Dr. Lee of enhanced color Doppler ultrasound fame. He would recommend the trip

to Michigan to others, except for the fact that Dr. Lee is no longer doing the procedure. He noted that Dr. Katz at Columbia Presbyterian Hospital in New York does have extensive experience with this treatment modality. Although Mr. Giffen has had nothing but good effects from his therapy, it was pointed out that published studies of large numbers of patients have yielded results that were not as splendid, with numbers of patients experiencing incontinence, impotence and recurrent prostate cancer. Another member recounted that a physician promoting lumpectomy localizes the prostate cancer prior to therapy using a 60 needle biopsy technique.

The moderator bemoaned, as he often does, the indifference that urologists seem to have toward imaging techniques. He read a news report on a newly developed plastic and rubber, non-metallic robotic device that can be used directly in conjunction with the MRI, which the authors acknowledge as the best way to image prostate cancer.

One of the interesting theoretical points raised about cryotherapy was that in destroying the cancer cells, which Mr. Giffen dramatically simulated by popping cellophane air cushioning bubbles, the tissue released products to stimulate the body's natural defenses. It was emphasized that since the prostate gland was still there, it also presented a tissue source for future attempts at tailored personal therapy. This prompted the facilitator to remind the men that the biopsies and surgical specimens of their cancers are an already existing source of such material. The pathology labs which hold these tissues will discard them after 7-10 years. It was recommended that the patients request either the preserved block of the tissue or unstained slides made from the specimens which they can hold onto till needed at some time in the future.

A new attendee told an interesting story of how his prostate cancer had been accidentally discovered in an abdominal PET scan. With a PSA of only 4, a biopsy, however, was performed and the patient informed that "atypical cells" were present and an additional biopsy is scheduled. It will be very interesting to see how this story develops.

The other attendees had their turns to present updates on their status, and were generally positive in their outlook, and although several still have rising PSAs, their clinical status is satisfactory and they are considering changes in therapy..

CentraState Support Group Meeting

May 21, 2007, Health Awareness Center
Gibson Place, Freehold, NJ

by John Dabrowski and Chris Papa

The speaker, John Dabrowski, was a good lead in to what was to be a lively discussion centered around the four recently diagnosed men; many from the audience has something to add. John told his story of survivorship, which began in 1996 with Radical Prostatectomy shortly after diagnosis, after which the PSA never retreated to zero. After failure of continuous triple hormonal blockade (1997 was early days for intermittent blockade), John used PC Spes, Prostasol, low dose Ketoconozole, Celebrex/Dostinex/Calcitriol, Leukine and estrogen patches, all of which failed by the summer of 2006. In December 2006, he began Taxotere, which was largely ineffective; then had the Pelvic Mets irradiated at the Dattoli Center in Sarasota, FL, and went on Taxol/Carboplatin, which was also ineffective.

In mid-May Dr. Snuffy Myers proscribed Revlimid (more active derivative of thalidomide) with Leukine, a combination with which he has seen dramatic results, plus Prostasol (which has a new supplier apparently with the original active formula), pomegranate capsules and a few more drugs for good measure. John pointed out that while an endo-rectal MRI done locally did not reveal his pelvic tumors, this was immediately visualized at the Dattoli Clinic, and that PET scans picked up liver metastases, as well as an invaded seminal vesicle which had somehow been

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overlooked in the original surgery. This prompted Chris Papa to add, "Don't always trust your doctor." Chris was speaking about his own experience with radical prostatectomy - his physician told him that he had "gotten it all," but these words were at odds with the surgical pathology report, which showed a positive margin. He urged all patients to obtain copies of the tests, treatment reports, hospitalizations, etc. to make sure they had a true record of what was going on.

Then we talked with the newly diagnosed men............

The first new guy has a PSA of 3.04/Gleason grade 7, and is considering High Intensity Focused Ultrasound (HIFU). Also his physician is suggesting a second biopsy to discover whether there is active disease in his seminal vesicle, which might preclude using HIFU. We asked whether he has considered the side effects (incontinence and impotence) of this relatively new treatment. Also, the re-biopsy could be a hit/miss of any cancer present in the seminal vesicles. We advised him to take the time to research his options, and to have definitive imaging.

The second man has had a steeply rising PSA, which is now 19. This man is targeting robotic surgery, and we find this approach to be unusual considering his high PSA. We urged him to get a second opinion on the biopsy, interview the roboticist about his track record of : 1.surgical margin, and 2. incontinence/impotence. The record must be the physicians' record, not that of any other roboticist. To more fully determine extent of disease (staging) we recommend advanced imaging (endo-rectal MRI, and color Doppler enhanced ultrasound).

The third fellow, a man of 71, has a PSA of 5.9, Gleason 6 and one core showed up positive. We suggested that he might be a candidate for "active surveillance" by changing diet, getting exercise, and other techniques for keeping the PSA low.

The fourth chap has a PSA of 9.3 with Gleason 6, and has been subjected to a spate of biopsies, from the time his PSA was 5.4. All of 64 biopsy cores taken were negative until the most recent additional group of 16, where one was positive. We advised him to obtain definitive staging (imaging) so he can more accurately define the extent of disease.

The group questioned this patient who had reported fluctuating PSA scores. Despite all the biopsies, his urologist had never considered a diagnosis of benign prostatic hypertrophy or prostatitis. This was highly reminiscent of a patient in a recent meeting, where even our visiting urologist, when presented the problem, said he would first rule those benign problems out with appropriate investigation and therapy, rather than rushing to simply doing prostate biopsies.

Bob Laufer then reminded us that the DNA is different for every man's cancer, so the treatment that works for one man may not work for the next. Bob then told us about the Provenge trial which was rejected by the FDA, in order to obtain more data. In this trial, a man's dendritic cells are extracted from the blood and treated with prostatic acid phosphatase,(PAP), and returned to the blood, so that the cells can recognize the cancer, and the man's immune system can kill them. There are many disappointed men, who were counting on Provenge to counter their disease.

Don't forget the annual JULY PICNIC, on the fourth Monday, July 23. This is a fun event: Entertainment by the Low PSA's, possibly a comedian (Chris is trying to line him up), and a delicious buffet meal provided by all of us. Just bring your favorite "Heart Healthy" dish for all to share. August will be our summer break - no meeting.

Finally, join us for the American Cancer Society, Relay for Life, "Cancer Survivors' Celebration" at Freehold Raceway on June 16, 12:00 PM - 2:00 PM; it will include a Buffet Lunch, Medallion Ceremony (optional) and the Survivors' Kick-off event and Opening Lap(1/4 mile - optional). It's a fun event with lots of survivors - a giant support group. Plan to attend.

Toms River MAN to MAN Meeting

May, 2007
ACS, Toms River, NJ
By Al Rosenberg

REVEALED!
MY SECRET OF SUCCESS!
How Each of Our Members is Winning His Own Personal War Against Prostate Cancer!

This was a very special meeting as we had two new returnees and one first-time visitor (with his lovely wife and daughter). These men were in the process of making what could very well be life-altering decisions regarding their recent diagnoses.

The news that, "you've got prostate cancer" comes with it a myriad of emotions ranging from denial to anguish to anger and depression. As Dr. Charles "Snuffy" Myers says in his new book, Healing Prostate Cancer, "Pessimism may be as deadly a disease as prostate cancer itself."

That's why we're thankful that the *American Cancer Society* provides forums for people affected with a diagnosis of any cancer.

In our case, the Toms River Man to Man group gives us a chance to meet once a month and discuss all the aspects –both physical and psychological—of what we prefer to describe as our "New Adventure."

And when things get a little slow, we may digress to the Kentucky Derby or the "Damn Yankees!" But, since we had a few newcomers, we started with a review of everyone's PCa status to date.

I CUT IT OUT AND NEVER LOOKED BACK!

Our group facilitator and fearless leader, "Dreadnaught Dick" started the go-round. "I chose to have a prostatectomy (surgery) several years ago and never looked back," he said. "I experience some stress incontinence, but not enough to be a problem." Then Dick continued, "I still work full-time and am active at our church and life is great."

HORMONES AND "HOT" SEEDS A WINNING COMBINATION!

Next your author, yours truly, told how—when first told he had cancer—went on a Caribbean cruise loaded with PCa reading material and spent many an hour under a palm tree or by the pool, studying all he could about PCa.

He explained how he chose to have permanent radioactive seed implants. But, due to an enlarged prostate he took Lupron and Casodex first to shrink his gland to avoid possibly severe, short-term urinary retention due to radiation prostatitis while the seeds were still "hot" (a few weeks for Palladium, a few months for Iodine).

Al said that the implants were done in 2002 and aside from a consistent regimen of recommended supplements, exercise and diet he has had no medical intervention since. After a radiation "bounce" in 2005 his latest PSAs were leveling off around 0.47.

TOM "THE BOMB" IS STILL IN "WW" …not the World War kind!

He was a bomb diffuser with nerves of steel in the military, but nothing prepared him for his finding of PCa.

Tom is currently working with the VA as they monitor his Gleason 6 PCa with "Watchful Waiting." Because his PSA was relatively low and he's in his mid 50s, it seems they feel safe in watching for a serial rise before taking any kind of invasive action.

Meanwhile, Tom is doing his part by watching his diet and taking vitamins and supplements that have been shown to possibly control the proliferation of PCa cells. We all realize that many of these tests were done in labs and not on humans, but if it kills PCa in a Petrie dish, we're gonna discuss it!

"GOT A FEW HOURS? HAVE I GOT A STORY FOR YOU!"

No Izzy, just try to be short and concise. Not a chance with our senior member. At 89 yrs old Iz, our PCa laureate, has the longest story to tell, but we prevailed upon him to

shorten it up a bit as they throw us out promptly at nine o'clock.

"I had surgery 17 years ago," he said. "Everything was fine for 10 years, then the PSA started creeping up," Iz explained and went on, "I've had many therapies since, you know, hormones, different chemos, even the now-banned PC-Spes. They all worked for a time, but then that damn cancer started creeping up again, sometimes pretty fast.

"Would you believe in 2003 my PSA hit 940 (yes 940)? But then a combination of Taxotere and Prednisone dropped it to 3 (yes 3)! I'm still on Tax/Pred and Lupron and you know what?—I just got my tomatoes in and I feel pretty good!" laughed farmer Iz!

"FAN? WHAT FAN?
I'M NOT ON LUPRON ANYMORE!"

Not long after his prostatectomy and while he was on hormone therapy, big Dom came in sweating like a racehorse after the Derby. He sat down, opened a small plastic bag and extracted a little battery-operated fan that he waved around his head. "Don't mind me," he told us, "I'm just having a Lupron hot flash." The wives at the meeting smiled all-knowingly.

Dom had his surgery in 2002 when his PSA went from 2 to 4 and the biopsy showed a Gleason score of 3+3=6. Now, 5 years later, his PSA is still less than 0.1. Oh, and he's lost 40 lbs. and looks great! "Now if it wasn't for this darn **P**ain and **T**orture (**P**hysical **T**herapy) I'm going through after my knee surgery, I'd be walking in the ACS's *RELAY FOR LIFE!"*

OVERKILL? GREAT!
THAT'S JUST WHAT I WANT!

Bob 67 was diagnosed in June 2005 after his PSAs went from 4 to 5 to 6. After several consults he chose to have palladium seeds implanted and when he asked about additional external radiation both his urologist and radiation oncologist thought that due, to his low estimated PCa volume, it might be overkill "Great, make sure you overkill it all!" he insisted.

So they added daily IMRT for several weeks after his implant and the latest PSA is 0.52. Bob and his spouse are glad he went with two local specialists, whom he felt treated him with candor, respect and were more than competent.

WE PLANTED SEEDS OF HOPE
AND FRIENDSHIP TOO!

Charlie and Sam are neighbors who became good friends after discovering they both had PCa. Charlie was diagnosed in 2000, but he took his time to investigate his situation before deciding on permanent palladium seed implants alone which he had about a year later. He also chose a local radiation oncologist with a good reputation and lots of positive patient feedback. Charlie's latest PSA was 0.1.

Sam was also diagnosed through biopsy in March 1999. Like Charlie he also had seed implants but with external radiation at a prominent New Brunswick facility. He later suffered some radiation proctitis, but is feeling fine now and his PSA is currently around 0.07.

The friendship Charlie and Sam developed through our **Man to Man** group meetings has endured through the years. They regularly show up together and it's not just for the refreshments!

NEW MEMBERS UPDATE
One Surgery, Three Still Undecided!

Wil is our very well-read 77 year-old returnee who was angry when they told him he was too old for surgery. His brother had PCa and now Wil just wanted his out, but when he was told of the possible long-term after-effects, he began looking into other therapies.

He asked us about High Dose Radiation (HDR). We described that several temporary catheters are inserted into the prostate using a template not unlike that used in permanent seed implants. Then a computer-controlled machine pushes radioactive wires into the catheters and they are left there for a few seconds and removed. The procedure is then repeated later on.

The aim of HDR is to kill the cancer quickly with hotter doses than permanent

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seeds. There have been some positive results noted with HDR recently and with reportedly less side effects for some patients. Both Wil and his wife seem to be pretty savvy and are asking a lot of questions before *they* make *his* final decision.

WHAT DO YOU DO WITH A LITTLE BIT OF PROSTATE CANCER?

If there could be a positive way to be told "you've got prostate cancer" Bob, our next returning newbie, is a case in point.

During a DRE (digital rectal exam) his uro commented that his gland felt somewhat firm and along with his PSA of around 2.4, plus the fact that a close family member also had PCa, he suggested a biopsy early this year.

Of the twelve samples, Bob said that only one was positive, but he couldn't tell us how much of the core sample was cancerous. If it was only a small percentage then the watchful waiting he was presently doing might make sense.

But Bob is only 55 years old and wants to take action about it now. He said he was leaning toward surgery, but was worried about long-term incontinence he had heard so much about post-RRP. He would also like to father children and the loss of his prostate—an integral part of his reproductive system—is a big concern.

I DON'T EVEN WANT TO BE HERE!

That was Fred's response when his loving wife and daughters finally convinced him to come to his first **Man to Man** meeting. We agreed he should be out tossing the caber at the games instead of worrying about a little cancer, but "stuff happens."

Fred was diagnosed from a biopsy in April after his PSA had risen from 3.7 to 4.1 to 5 with a Gleason six and several samples positive, but each no more than 5%. His gland size of 33 grams is about normal so if the pathology reading is validated, he could have a variety of primary treatment choices.

We look forward to getting a follow-up from Fred at succeeding meetings and pointed out what a lucky guy he is to have his devoted family by his side…literally!

"I LOVE LAPAROSCOPY!"

Finally, we have an update on our 63 year-old, fit as a fiddle Jim. At his initial visit to our clan, he told us of rising PSA (1.7 to 2.7 in six months) and positive biopsy in March.

He said he had done his homework and was seriously considering Laparoscopic Robotic Prostatectomy. Well since Jim didn't attend this meeting I spoke to him on the phone earlier and he said he in fact did have the LRP done at an excellent teaching hospital in New Brunswick. As a matter of fact, he just had his catheter removed two days earlier and was feeling fine.

Jim said he was in the hospital just overnight and went home the next day. "The surgery was a breeze and I'm so glad I chose this procedure." He promised to come to the next meeting and give us the whole story direct from the horse's mouth!

Well boys, we crammed a lot of work in our two hours this month and all without a guest speaker. *Everyone* had something to contribute in our collective battle plan to conquer this beast within and that's what it's all about!

We welcome everyone interested in PCa including friends and lovers! We're not medical practitioners, but we know a little something due to our own experiences and knowledge we've gathered in our individual quest for control or cure.

Join us every first Thursday evening at 7:00 at the American Cancer Society conference room at 1035 Hooper Avenue northbound. For more info or driving directions just call ACS at 732-914-1000. We look forward to meeting you!

And please remember…***NO DUES, NO REGISTRATION, NO CO-PAYS, NO DEDUCTIBLES and NO PRESSURE EVER!***

And now for something completely different:

A note of thanks to New Jersey's *Horizon Blue Cross/Blue Shield* for giving us a table at their Health Fair at the Lakewood Blue Claws baseball game May 9th.

Horizon's Chris Bryan was instrumental in helping us deliver *ACS* cancer and screening materials and information to the many fans that showed up to watch our Blue Claws lose yet another heartbreaker.

News and Good Stuff:

In the News department this issue, we have more Articles of Interest. These were uncovered by Chris Papa.

This is a disturbing Danish report with gloomy statistics even in men who haven't had PCa. I wonder if our urologists will accept the quote in the opening sentence. On the other hand it not only gets them off the hook, but provides a new source of potential patients.
-Chris

J Urol. 2007 May 11;

Ejaculatory Disorders May Affect Screening for Prostate Cancer.

Walz J, Perrotte P, Gallina A, Benard F, Valiquette L, McCormack M,
Montorsi F, Karakiewicz PI.
Cancer Prognostics and Health Outcomes Unit (JW, AG, PIK).

PURPOSE: Ejaculatory disorders will be experienced in most men who are treated for localized prostate cancer. Baseline rates of ejaculatory disorders are unknown in men at risk for prostate cancer. Therefore, we explored the prevalence of those disorders and associated bother in men without evidence of prostate cancer who participated in an annual prostate cancer screening event.

MATERIALS AND METHODS: A cohort of 1,273 men without clinical evidence of prostate cancer completed the self-administered Danish Prostate Symptom Score for sexual dysfunction. This questionnaire quantifies the rate of reduced ejaculatory volume, ejaculatory pain and the rate of coexistent erectile dysfunction. RESULTS: Mean age was 57.6 years (range 40 to 89). Of all men 46% (563) had reduced ejaculatory volume and 66% (356) of affected men were bothered by this condition. Ejaculatory pain was reported in 11% (134) and 89% (118) of these men reported associated bother. Finally, 45% (554) reported erectile dysfunction and 73% (403) reported associated bother. Reduced ejaculatory volume was associated with erectile dysfunction ($p < 0.001$) and advanced age ($p < 0.001$). Ejaculatory pain was not associated with one of these variables.

CONCLUSIONS: Virtually all men will be affected by ejaculatory disorders after definitive treatment for localized prostate cancer. Therefore, it is important to observe that half of these individuals already have underlying reduced ejaculatory volume before treatment. Moreover, 1 of 10 men will be affected by ejaculatory pain. Both disorders are a significant source of bother and should be considered when treatment related quality of life is assessed.

More interesting reading. More business for the urologists.
-Chris

: J Urol. 2007 May 10;

Under Diagnosis and Over Diagnosis of Prostate Cancer.

Graif T, Loeb S, Roehl KA, Gashti SN, Griffin C, Yu X, Catalona WJ.
Department of Urology, Northwestern Feinberg School of Medicine (TG, SNG, CG, XY, WJC), Chicago, Illinois.

PURPOSE: We quantified the rates of over and under diagnosis of prostate cancer in 2 large patient cohorts during the last 15 years.

MATERIALS AND METHODS: A total of 2,126 men with clinical stage T1c prostate cancer were treated with radical prostatectomy during 1 of the 3 periods 1989 to 1995, 1995 to 2001 and 2001 to 2005. The respective proportions of men with a tumor that met our criteria for over diagnosis (0.5 cm(3) or less, confined to the prostate with clear surgical margins and no Gleason pattern 4 or 5) and under diagnosis (nonorgan confined, pathological stage T3 or greater, or positive surgical margins) were examined.

RESULTS: The proportion of men with an over diagnosed tumor was 1.3% to 7.1%. The proportion with prostate cancer that was under diagnosed was 25% to 30%. An ancillary finding was that decreasing the prostate specific antigen threshold for biopsy from 4.0 to 2.5 ng/ml in the screened population resulted in a lower rate of under diagnosis from 30% to 26%, a higher rate of over diagnosis from 1.3% to 7.1% and an increase in the 5-year progression-free survival rate from 85% to 92%. Men who were 55 years or younger were significantly more likely to meet our criteria for over diagnosed cancer.

CONCLUSIONS: Under diagnosis of prostate cancer continues to occur more frequently than over diagnosis. Lowering the prostate specific antigen threshold for recommending biopsy to 2.5 ng/ml resulted in a lower rate of under diagnosis and a higher progression-free survival rate.

There is not anything earth shaking in this report, which merely backs up generally known perils to quality of life for men regardless of how their cancer is treated. It is may be useful to present such information to new candidates for therapy, since their particular physicians rarely seem to do so. We have already heard that our support groups "scare patients" I would like to think we are merely informing them.

-Chris

Cancer. 2007 Apr 23;

Quality of life after surgery, external beam irradiation, or brachytherapy for early-stage prostate cancer.

Litwin MS, Gore JL, Kwan L, Brandeis JM, Lee SP, Withers HR, Reiter RE.
Department of Urology, David Geffen School of Medicine at UCLA, University of California-Los Angeles, Los Angeles, California.

BACKGROUND.: The primary treatments for clinically localized prostate cancer confer equivalent cancer control for most patients but disparate side effects. In the current study, the authors sought to compare health-related quality of life (HRQOL) outcomes after the most commonly used treatments.

METHODS.: A total of 580 men completed the Medical Outcomes Study Short Form-36, the University of California-Los Angeles (UCLA) Prostate Cancer Index, and the American Urological Association Symptom Index before and through 24 months after treatment with radical prostatectomy (RP), external beam radiation therapy (EBRT), or brachytherapy (BT).

RESULTS.: General HRQOL did not appear to be affected by treatment. Obstructive and irritative urinary symptoms were more common after BT ($P < .001$). Urinary control and sexual function were better after EBRT than BT ($P < .001$ and $P = .02$, respectively) and better after BT than RP ($P < .001$ and $P = .01$, respectively). Among potent men, recovery of sexual function was best after EBRT and was equivalent after bilateral nerve-sparing surgery or BT. Sexual bother was more common than urinary or bowel bother after all 3 treatments. Bowel dysfunction was more common after EBRT or BT than RP ($P < .001$).

CONCLUSIONS.: In the current study, treatment for localized prostate cancer was found to differentially affect HRQOL outcomes. Urinary control and sexual function were better after EBRT, although bilateral nerve-sparing surgery diminished these differences among potent men undergoing RP. BT caused more obstructive and irritative symptoms, while both

forms of radiation caused more bowel dysfunction. These results may inform medical decision-making in men with localized prostate cancer. Cancer 2007. (c) 2007 American Cancer Society.

From Medscape- April 16,2007

This is an interesting and disturbing article. In Europe, where PCa is not picked up at the very early stages, as it is in the U.S., their data suggests that the PSA may have little predictive value. Publications like this are troublesome because it supports the FDA's stance that they will not accept PSA values as a surrogate marker for clinical disease progression or regression. This drives all the clinical studies toward men with advanced cancer where the results are bound to be dismal. The men with early stage disease never get to find out if the drug might be useful to them. Then there is the suggestion that the US, in particular, is spending a lot of money spinning wheels, finding cancers that really don't need to be treated, and creating other unnecessary health problems when they are. It all goes to show that there really is urgent need for better research aimed at finding more specific biological indices of how dangerous the cancer might be and how it is affected by the old and new therapies. Meanwhile, most of our survivors and their physicians remain fixated on PSA values. It's all that we have right now. The other interesting point is to note how socialized medicine is able to run trials where, after the PCa is diagnosed, they simply watched the men for two years, many of which obviously were in more advanced cancer stages than commonly seen in the US. It gets valuable information, but it does seem to skirt the issue of medical ethics. The people who are pumping for governmental universal health care might be cautioned, they may just get their wish.

-Chris

PSA Value Is a Poor Predictor of Prostate Cancer Outcome

April 16, 2007 — A study shows that while prostate-specific antigen (PSA) measurement remains an important monitoring tool, it performs poorly in distinguishing those who will develop lethal prostate cancer from those at low or no risk of disease progression. The results are reported in the April 4 issue of the Journal of the National Cancer Institute, where the authors call for better decision-making tools for active monitoring of patients with early disease.

"In this study, both baseline PSA and rate of change in PSA during the first 2 years of follow-up carried prognostic information," write Katja Fall, MD, PhD, from the Karolinska Institutet in Stockholm, Sweden, and colleagues. "However, despite extensive exploration of different statistical models, we could not substantiate any PSA curve characteristic as a good classifier of who would develop lethal disease and who would not."

In an accompanying editorial, Dipen J. Parekh, MD, from the University of Texas Health Science Center in San Antonio, and colleagues point out that the patients in the current study were substantially different from most patients with localized prostate cancer today in countries where PSA screening is highly prevalent, such as the United States. "PSA levels were above 10 ng/mL in 48% of the patients in that population and more than 60% of men had tumors that were palpable on rectal examination," they write. "At diagnosis, these were high-volume tumors, tumors more likely to exhibit stronger PSA kinetics driving more favorable PSA operating characteristics than would be expected from populations containing higher fractions of screen-detected cancers. As a result, we would expect less optimistic performance of these PSA measures in a typical US population."

In ideal circumstances, the editorialists write, a man undergoing active surveillance for prostate cancer expects that his PSA data will tell his clinician 1 of 2 things: (1) he has a potentially deadly tumor that must be treated now or (2) he has an indolent tumor that can be safely watched, sparing him the adverse

effects of treatment. "If we simply use a PSA doubling time of 5 years as a guide, in this group of patients approximately 36% of deadly tumors would be missed and 40% of men with indolent tumors would be treated unnecessarily," they explain. "If our goal is to find all lethal cancers, the very best trigger for treatment would be a PSA value of 7 ng/mL. The trade-off for this threshold is that approximately 80% of men with nonlethal tumors would then be treated."

In the current study, Fall and colleagues concur that many patients with prostate cancer undergo aggressive local treatment without any survival benefit. The implications from these data are troublesome, the editorialists comment. "Without becoming despondent and simply treating all men with prostate cancer — accepting the substantial risk of over treatment and its consequences — how can we better identify the patient with low-risk disease in whom active surveillance is a reasonable option for management?"

Not Sensitive or Specific Enough to Identify Lethal Tumors In their editorial, Parekh and colleagues propose that the first step is to acknowledge that, although PSA level and its kinetics are clearly associated with the behavior of individual prostate cancers, they are not sensitive or specific for the tumor that will ultimately cause harm to a patient. "We have found the same results with PSA as a measure of the risk of prostate cancer," they point out. "Specifically, in our analysis of the Prostate Cancer Prevention Trial, we found that other measures such as rectal examination findings, family history, ethnicity, age, and prior prostate biopsy results all provided independent predictive value of prostate cancer risk."

In the current study, part of the Scandinavian Prostate Cancer Group research, Dr. Fall and colleagues analyzed the rate of change of PSA levels in 267 men from Sweden, Finland, and Iceland who were diagnosed with early localized prostate cancer. The researchers recorded the PSA levels for the first 2 years after diagnosis to capture the patients' early PSA patterns. The men in the study received no curative treatment for the first 2 years but were closely watched for signs of progression.

At the end of follow-up, 34 (13%) patients died from prostate cancer and 18 (7%) developed metastatic prostate cancer. Although initial PSA values and the rate of change were associated with later development of lethal prostate cancer, they were not accurate enough to predict lethal cancer.

"Strengths of our study include its prospective design, large size, complete follow-up, and standardized classification of deaths with blinding for any antecedent treatment," Fall and colleagues write. "As a corollary, our findings should be generalizable also to other settings, such as screening," they note. "In addition, the results seemed independent of Gleason score — a fact that further underpins their generalizability."

The Swedish Cancer Society and the National Institutes of Health supported this study. Dr. Fall has disclosed being supported partly by a Postdoctoral Traineeship Award from the US Department of Defense.

J Natl Cancer Inst. 2007;99:526-532

News From the American Cancer Society: In the last issue, we mentioned the passing of Gary Fichter. His family sent this note of thanks to Patti Allen at the American Cancer Society. She passed it along to be included in our newsletter.

The Family of
Gary J. Fichter
Acknowledges with grateful
Appreciation your kind expression
Of sympathy

Dear Patti,
The outpouring of support from all the support Groups that Gary was involved with was just wonderful.

We have not been able to locate many addressees.
Please extend our sincere thanks to all of Gary's dear friends.
We know how much he enjoyed their company.
Sincerely,
Dianne Fichter and family

Here's something that may be of interest for some. This article is provided to us courtesy of the American Cancer Society.

Telephone Workshop

CancerCare will present a one hour Telephone Education Workshop entitled:

Living with Advanced Prostate Cancer: Update from the Annual Meeting of the American Society of Clinical Oncology (ASCO).

Time: Friday, June 29, 2007,
1:30-2:30 PM EDT

You may register online at www.cancercare.org or by calling 1-800-813-4673.

After you register, you'll receive additional information and instructions.

Registration is free. No phone charges apply.

Topics covered:
*Overview of Advanced Prostate Cancer
* Current Standard of Care
* New Treatment Approaches from ASCO
* Clinical Trails
* How Clinical Research Affects Patient Care
* Managing Discomfort and Pain
* Questions for the Panel

Faculty:
Leonard A. Gomella, MD, FACS
Chairman, Dept. of Urology
Kimmel Cancer Center
Thomas Jefferson University

Susan Slovin, MD, PhD
Associate Attending Physician
Genitourinary Oncology Service
Memorial Sloan-Kettering Cancer Center

Nutrition:

In honor of the upcoming summer, we are providing a simple, staple recipe for warm, sunny days.. This recipe is graciously provided for our publication by the American Cancer Society. It looks like an interesting version of the usual Fruit Salad. …Makes me hungry… We greatly appreciate the support of American Cancer Society in so many ways, which includes providing us with some healthy eating tips and recipes. Enjoy!

Glorious Fruit Salad

¼ cup fresh lime juice
¼ cup honey
¼ cup chopped fresh mint
1 (three pound) cantaloupe, halved and seeded
1 (12 ounce) basket strawberries, hulled and halved
4 kiwis, peeled and cut into ½ inch pieces
1-1/2 cups seedless grapes

In a small bowl, whisk together lime juice, honey, and mint. Set aside.
Using a melon baler, scoop out cantaloupe into a large bowl. Add strawberries, kiwis, and grapes.
Pour syrup on top of the prepared fruit and toss to coat. Let stand at least 15 minutes for flavors to combine.
Cover and chill if not serving immediately.

Serves eight.

Approximate per serving: 137 Calories
1 gram of fat.

This newsletter is a compendium of prostate, health and nutrition news collected by a team of prostate cancer survivor-patients. None of the editors or anyone associated with developing this newsletter receives any sort of compensation to create the articles or put together this newsletter. It is truly a labor of volunteers seeking only to help prostate cancer patients and their loved ones.

The goal of this newsletter is to provide a "grass-roots" view to help educate and support prostate cancer patients, survivors and loved ones. With that in mind, and unless noted elsewhere within this newsletter, you have our permission to copy and pass on this newsletter for that purpose. If you reproduce only a portion of the newsletter please be sure to credit its source. You may not charge a fee or sell copies of this newsletter.

We wish to help PCa patients make an informed decision in their choice of a treatment. We do not endorse a specific type of treatment or medication nor recommend a particular product to anyone; a person's physician should do this.

>>> From time to time our editorial staff will make a comment on some subject and we will identify it as being an editorial comment by enclosing it in bold italic carets such as: ***>>>Editorial Comment… Jeff <<<*** .

When reporting on a meeting we try to be as accurate as possible, though from time to time we might misinterpret a speaker's statement, or only get a part of it, or make some other oversight. For this we apologize to those speakers and to you, the readers.

From time to time we use copyrighted material, which will be identified as such. We will make a reasonable effort to do everything possible to insure its proper use and credit. As there is no charge for this newsletter, and we are putting it together to educate prostate cancer patients and their loved ones in their struggle with this disease, we believe it constitutes a fair use of such material.

Anyone wishing to help support this newsletter should make a donation to Man to Man, at the American Cancer Society, 801 Broad Street, Shrewsbury, NJ 07702.

The ACS supports us with the reproduction and mailing cost.

The American Cancer Society

Hope, Progress, Answers
1 (800) ACS- 2345
> www.cancer.org <

The American Cancer Society is the nationwide community-based voluntary health organization dedicated to eliminating cancer as a major health problem by preventing cancer, saving lives, and diminishing suffering from cancer through research education, advocacy, and service.

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For email or paper subscriptions and to Subscribe or Unsubscribe to this newsletter, please contact Ms. Patti Allen at:
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(732) 758-8220 press option 3, then ext 213

Benediction:
I place my hands in yours and together we can do what I cannot do alone.

LOCAL PROSTATE CANCER SUPPORT GROUPS

Monmouth County

Freehold CentraState Medical Center
Health Awareness Center, 65 Gibson Place, Freehold, NJ 07728
4th Monday 7:00 - 8:30 PM
Contact: Karen Scott, (732) 308-0570, email: > kscott@centrastate.com <
Facilitators: Chris Papa, (732) 946-2694, email: > doxite@verizon.net <
John Dabrowski, (732) 946-0495, all email through C. Papa

Long Branch The Cancer Center at Monmouth Medical Center
300 Second Ave., Long Branch, NJ 07740
Steinman-Housman Room 114
1st Thursday 7:00 - 9:00 PM
Contact: Anita Pfisterer, (732) 923-6961, email: >ampfisterer@aol.com <
Facilitator: Jeff Ozimek, (732) 542-6335, email: > anjoz@comcast.net <
To register call (732) 923-6575

Neptune Neptune Prostate Cancer Support Group
Meeting location: Early Childhood Education Center
11 Memorial Drive, Neptune (Corner of Rt. 33 and Memorial Drive)
3rd Thursday 7:00 - 9:00 PM
Contact: Rich Guilfoyle (732) 493-3913, email: > rguilfoy@monmouth.edu <
Facilitator: Marc Gordon (732) 774-3683

Red Bank Riverview Medical Center
1 Riverview Plaza, Red Bank, NJ 07701
Meeting location-Booker Health Center, 1st Floor, Cancer Center Conference Room
2nd Thursday 3:00 - 4:30 PM
Contact: Joan Toole, (732) 530-2468, FAX: (732) 345-2010, email: > jtoole@meridian.com <

Ocean County

Toms River American Cancer Society-Toms River Office
1035 Hooper Ave., Toms River, NJ 08753
1st Thursday 7:00-9:00 PM
Contact: Patti Allen, (732) 758-8220 press 3, ext 213, FAX: (732) 758-8225, email: > patti.allen@cancer.org <
Facilitator: Dick Muller, (732) 240-5717, email: > ram645@comcast.net <

Toms River Community Medical Center-The Lighthouse Network
591 Lakehurst Road, Toms River, NJ 08755
3rd Thursday 2:00 - 3:30 PM
Contact: Andrea Brandsness, (732) 557-3212, FAX: (732) 557-3218, email: > abrandsness@sbhcs.com <
Facilitator: Larry Puccio, (732) 349-2950, email > lpuccio1@comcast.net <

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To submit an item for posting on the Bulletin Board go to
> http://www.pcc-nj.org/bbsubmit.php <