



Informed Prostate Cancer Support Group Inc.

"A 501 C 3 CORPORATION ID # 54-2141691"



June 2013 NEWSLETTER
P.O. Box 420142 San Diego, CA 92142
Phone: 619-890-8447 Web: www.ipcsg.org
We Meet Every Third Saturday (except December)



Thursday, July 11, 2013

Volume 6 Issue 5

Officers

President: Lyle La Rosh,
Vice President : Gene Van Vleet

Additional Directors

Dr. Dick Gilbert
John Tassi
George Johnson

Steering Committee

Judge Robert Coates
Victor Reed
Robert Keck, Librarian
Bill Manning
E. Walter Miles
Jerry Steffen

Next Meeting

July 20

10:00AM to Noon

Meeting at
Sanford-Burnham
Auditorium
10905 Road to the
Cure, San Diego CA
92121

**SEE MAP ON THE
LAST PAGE**

What We Are About

Our Group offers the complete spectrum of information on prevention and treatment. We provide a forum where you can get all your questions answered in one place by men that have lived through the experience. Prostate cancer is very personal. Our goal is to make you more aware of your options before you begin a treatment that has serious side effects that were not properly explained. Impotence, incontinence, and a high rate of recurrence are very common side effects and may be for life. Men who are newly diagnosed with PC are often overwhelmed by the frightening magnitude of their condition. Networking with our members will help identify what options are best suited for your life style.

Be your own health manager!!

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Editor: Gene Van Vleet

PROSTATE CANCER IT'S ONLY 2 WORDS, NOT A SENTENCE

Our guest speaker, Dr. Jay Cohen, was very well received for his presentation based on the book he published recently, "Prostate Cancer Break-throughs". "Dr. Jay" is a Psychiatrist and is also highly respected for his work on preventing medication side effects about which he has published his findings in 8 books, leading medical journals and many other publications.

Because he works Saturdays he has never attended one of our meetings but rather became familiar with our organization after calling Gene Van Vleet upon reference from the Kaiser support group. Gene invited him to join in the informal weekly

Video DVD's

DVD's of our meetings are available in our library for \$10ea. Refer to the index available in the library. They can also be purchased through our website: <http://ipcsg.org>

Click on the 'Purchase DVD's' button.

lunches attended by some IPCSG members. From them he learned pathways to realistically investigate the seriousness of his cancer and become his own case manager. His PSA had been inconsistent over several years which was justified by his doctors at Kaiser as perhaps relating to prostate infections and to the size of his prostate which was 75% larger than normal. Surprisingly his first Doctor did not want to do a biopsy. But in November 2011 his PSA score was 15.3 then on repeat was 13.4. He then underwent a biopsy which showed 4 of 14 cores were positive. This led to a recommendation for surgery and the mental shock of dealing with the prospects of the negative effects of surgery which often include varying degrees of impotence and incontinence. Fortunately their schedule was backed up for three months which gave rise to his research about the disease. He learned that PSA scores can be affected by an enlarged prostate, previous or current prostate infections, having an orgasm a day or two prior to the blood test, or bicycle riding or other exercise that puts pressure on the perineal area a day or two prior to the blood test. His Gleason score was 3+3=6 which is a low grade disease. It is now being suggested by some experts that this should not be called cancer in order to lessen the mental impact of investigating the disease. At the lunches he attended with guys from IPCSG there was discussion of a prostate MRI. It struck him that he could think of no other kind of cancer diagnosis that did not include an MRI. His doctors didn't know where it was for certain but were recommending surgery or radiation as treatment based just on his PSA being over 10 and 4 positive cores in the biopsy. He had an MRI performed at Sharp Childrens and MRI Center which showed a small tumor on the left side located in a safe zone. It didn't seem to be spreading and there was no evidence of cancer anywhere else. It is unfortunate that there is little knowledge of this type of procedure and it is not yet utilized by most urologists. This is game changing knowledge to help make treatment decisions. He also learned from the guys about the Color Doppler Ultrasound (CDUS) procedure which produces images of the cancerous area in the prostate similar to that of the MRI. He had the CDUS performed by Dr. Mark Scholz of Prostate Oncology Specialists who has become his doctor of choice. The result showed the same involvement as the MRI.

These techniques can be used to guide biopsies in order to get more accurate pathology reports about the grade of cancer. Rather than do random biopsies taken in a predetermined pattern, why not biopsy the known areas. Although many institutions are now utilizing multi-parametric MRI's, Dr. Jay predicted it may take 5 years or more for these procedures to evolve into general usage because of the initial studies followed by verification studies that are necessary to clear them for usage by the American Urological Association.

Based on his discoveries, Dr. Jay is pursuing active surveillance wherein he will have regular DRE's, along with PSA and imaging tests to monitor his cancer.

Through his research he discovered that another aspect of the newer imaging techniques is the ability to perform focal therapy on the precise location of the lesion rather than the entire prostate area. Cryoablation (freezing), high intensity focused ultrasound-heating (HIFU) and a very new process called focused laser ablation (FLA) which burns the lesion all make use of these new techniques. These will become equivalent to a lumpectomy in women and side effects of impotence and incontinence should become less of an issue.

Dr. Jay closed by saying that he believes that a renaissance of prostate cancer treatment advances has begun and will continue for the many years. Carbon 11-Acetate and Carbon 11-Choline are new imaging techniques to precisely locate cancerous areas. Already we have new drugs Zytiga, Xtandi and, recently, Xofigo (Alpharadin) which are extending lives of those experiencing recurrence. Many more are in the pipeline.

The foregoing is just a recap of Dr. Jay's presentation. Details are chronicled in his book "Prostate Cancer Breakthroughs" which we recommend you purchase from our library or through www.amazon.com. A copy of the DVD of his presentation based on the book is available from our library or through our website: <http://ipcs.org/shop/>

FUTURE MEETINGS

July 20. Forum on prostate cancer treatments including member surveys of experiences. This is a good chance for newly diagnosed men (and their supporters) to get their questions answered by men who have gone through diagnosis and treatment.

August 17. Annette Conway, Psy.D. HELP Mental Health & Counseling Services. Subject: Depression. When Its More Than Just the Blues,

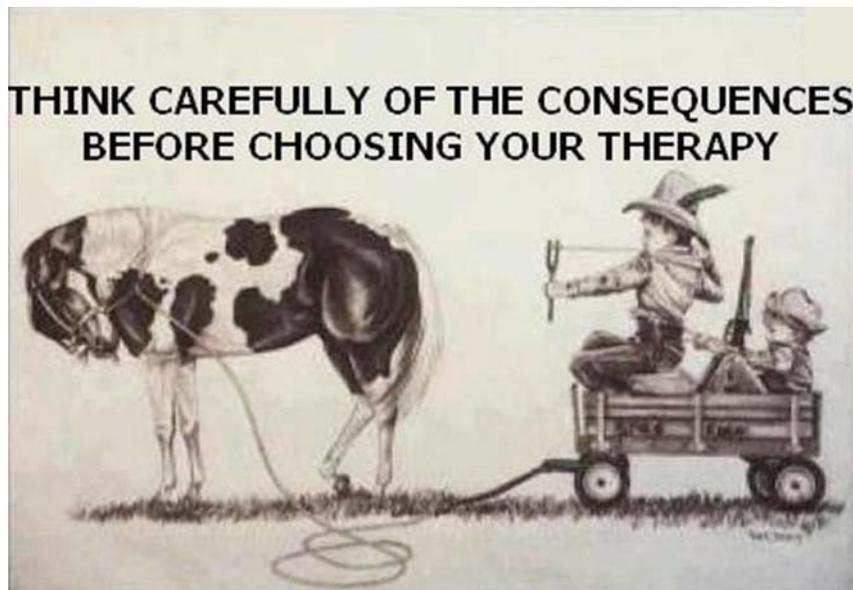
September 21. Not yet committed.

October 19. Dr. Robert Princenthal, Director of Prostate Imaging, and President, Rolling Oaks Radiology Medical Group. Subject: Multiparametric prostate MRI; how to best utilize this functional information for patient management.

November 16. Dr. Fabio Almeida, Medical Director, Southwest PET/CT Institute-Arizona Molecular Imaging Center. Subject: Updated information on Carbon-11-Acetate PET/CT imaging for Prostate Cancer

December. NO MEETING

ON THE LIGHTER SIDE



“You only live once, but if you do it right, once is enough.” — Mae West **NOTEWORTHY**

Remember - Don't take life too seriously. You won't get out of it alive anyway!

“A day without sunshine is like, you know, night.” — Steve Martin

“The reason I talk to myself is because I’m the only one whose answers I accept.” — George Carlin

“Life's hard. It's even harder when you're stupid.” — John Wayne

ATTORNEY: Now doctor, "isn't it true that when a person dies in his sleep, he doesn't know about it until the next morning?"

WITNESS: Did you actually pass the bar exam?

“God gave men a penis and a brain, but unfortunately not enough blood supply to run both at the same time.” - Robin Williams

It is often easier to ask for forgiveness than to ask for permission. ~Grace Hopper

Confucius say: "Baseball wrong, man with four balls cannot walk."

NOTEWORTHY ARTICLES

Dying for a Biopsy?

Posted Prostate Snatchers blog: 02 Jul 2013 08:45 AM PDT

MARK SCHOLZ, MD

Screening for prostate cancer is big business. The PSA blood test, first implemented in the late 1980s, resulted in a doubling in the number of new cases, from 100,000 a year to more than 200,000 annually. The cost of simply diagnosing prostate cancer—after adding up doctor, lab and pathology charges—easily surpasses a billion dollars annually.

Cancer is diagnosed by a specially-trained doctor, a pathologist, who examines the prostate tissue under a microscope. Tissue is extracted by needle biopsy, a procedure that is performed in a doctor's office. The patient lies on his side and an ultrasound probe is inserted into the rectum. Then after Novocain is injected, 12 to 14 tissue samples are removed using a spring-loaded needle gun that is fired in a grid pattern over the surface of the prostate. The tissue samples are then transported to the pathologist who determines whether or not cancer is present.

Over a million men undergo a prostate biopsy each year. Immediate biopsy at the first sign of PSA elevation has been the standard approach for more than 30 years. However, this policy needs to be reconsidered. Last year the US Preventative Services Task Force reconfirmed their strong warning against PSA screening, pointing out that it leads directly to an egregious degree of overtreatment in men with microscopic amounts of harmless low-grade prostate cancer. The problem is that surgery and radiation induce shockingly high rates of permanent sexual dysfunction and loss of urinary control. These are distressingly serious problems when considering that treatment is frequently unnecessary in the first place.

Until recently, the needle biopsy procedure itself was perceived as being reasonably safe. However, two just-released studies indicate that it is nowhere near as innocuous as most physicians had assumed. For example, at the American Urology Association meeting in May, doctors from Memorial Sloan Kettering reported that infectious complications requiring hospitalization occur 2.8% of the time.* In a separate study at the American Society of Clinical Oncology meeting, Dr. Boniol from the International Prevention

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Research Institute reported that 1.3 deaths occurred for every 1,000 men who undergo biopsy. To put this latter finding in perspective, Dr. Boniol commented, "This prostatic biopsy mortality would occur earlier than any benefit from a screening program and could reverse any potential gain from screening..."

Fortunately, there is an alternative to immediate biopsy. MRI scanners can guide a biopsy needle directly to the area of the prostate gland where the disease is located, thus allowing a reduction in the number needle biopsies by 90%. While there are drawbacks to this new technology—it requires special training and the equipment is expensive—the risk of serious infections should be much lower.

Change is often resisted by the status quo, especially when it involves a major shift in reimbursement patterns. Doctors who do random prostate needle biopsies will likely view these technological advancements with suspicion. Even so, the 30-year old methodology of puncturing the prostate with multiple random needle sticks is overdue for replacement. Noninvasive MRI imaging technology to detect prostate cancer is a far more sensible way to evaluate men with rising PSA levels.

*Abstract 1244 -The Impact of Repeat Biopsies on Infectious Complications in Men with Prostate Cancer on Active Surveillance: a Prospective Study

New, Pricey Prostate Cancer Treatments May Be Overused: Study

More men who have low-risk disease are choosing procedures that may not benefit them, researcher says

June 25, 2013 RSS Feed Print

By Dennis Thompson

Health Day Reporter

TUESDAY, June 25 (HealthDay News) -- The use of advanced prostate cancer treatments has increased among men who arguably will derive little benefit from the expensive new technologies, a new study suggests.

The use of intensity-modulated radiotherapy (IMRT) and robotic prostatectomy to treat prostate cancer patients at low risk of dying from the disease increased from 32 percent in 2004 to 44 percent in 2009, researchers found in reviewing Medicare patient data.

These technologies also were utilized more often to treat men with prostate cancer who were at high risk of dying for some reason other than their cancer, increasing from 36 percent in 2004 to 57 percent in 2009.

Use of advanced technology to treat those with both low-risk disease and a high risk of non-cancer mortality went from 25 percent in 2004 to 34 percent in 2009.

"The implementation of these technologies occurred in populations at a time when there was an increase in awareness that some prostate cancers might not warrant treatment," said study co-author Dr. Brent Hollenbeck, an associate professor of urology and director of the Herbert H. and Grace A. Dow Division of Health Services Research at the University of Michigan.

The findings were published in the June 26 issue of the Journal of the American Medical Association.

Doctors who treat prostate cancer are rethinking the options they should pursue with patients, said Dr. Durado Brooks, director of prostate and colorectal cancers for the American Cancer Society. Most prostate cancers are slow-growing, and the surgeries and therapies used to treat them can drastically affect a man's quality of life, causing incontinence and impotence.

"Many of these men have a variety of other health issues that are likely to shorten their lives," Brooks said.

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What's more, new technologies like IMRT, robotic prostatectomy and proton beam therapy have not been shown to be any more effective in treating prostate cancer or avoiding side effects than established procedures like traditional external beam radiation treatment (EBRT) and open radical prostatectomy.

"The hope with these advanced treatments is that we would decrease these side effects, but it hasn't been borne out in clinical trials," Brooks said.

This has led to a movement toward observational approaches like watchful waiting, where the doctor only steps in when symptoms appear or worsen, or active surveillance, in which testing continues but no therapeutic action occurs.

"In both situations, no active treatment is applied until evidence shows the prostate cancer is progressing," Brooks said.

The research team, led by doctors at the University of Michigan, reviewed thousands of Medicare patient records, focusing on men who underwent treatment using IMRT, EBRT, robotic prostatectomy, open radical prostatectomy or observation.

IMRT uses multiple small radiation beams to precisely target a tumor, changing the intensity and shape of the beams to reduce exposure of healthy tissue and limit side effects. Robotic prostatectomy uses robot technology to create precise incisions that are more likely to spare the nerves surrounding the prostate.

The researchers found that the older, time-tested procedures are being shunted aside in favor of the more advanced technologies, which could have a huge impact on health care spending in the United States.

"Both treatments are considerably more expensive than the prior standards," the authors wrote. "Start-up costs for both approach \$2 million. Further, IMRT is associated with higher total episode payments, which translate into an additional \$1.4 billion in spending annually. Thus, the implications of any potential overtreatment with these advanced treatment technologies are amplified in financial terms."

Brooks said patient demand could be one explanation for the increasing use of advanced technology.

"Less than 10 percent of U.S. men who are diagnosed with prostate cancer opt for an observational approach, and the fact is about 30 percent to 40 percent have slow-growing prostate cancer or other health issues that would make them candidates for observation," he said. That demand, however, is being driven in part by hospitals and treatment centers touting the potential benefits of new technologies. For example, a 2011 study found that nine out of every 10 hospitals with robotic prostate surgery facilities claimed on their websites that robotic prostatectomy is better than conventional surgery -- less pain, shorter recovery, less scarring and less blood loss.

"Aggressive direct-to-consumer marketing and incentives associated with fee-for-service payment may promote the use of these advanced treatment technologies," the study authors wrote. "The extent to which these advanced treatment technologies have disseminated among patients at low risk of dying from prostate cancer is uncertain."

Drug-Resistant Prostate Cancer Treated With New Medication In The Laboratory 18 Jun 2013 Medical News Today

A new drug called pyrvinium pamoate inhibits aggressive forms of prostate cancer that are resistant to standard drugs, according to a study conducted in an animal model. The results were presented at The Endocrine Society's 95th Annual Meeting in San Francisco.

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"Our novel prostate cancer drug works by a unique mechanism of action," said study lead author Jeremy Jones, PhD, assistant professor of molecular pharmacology at City of Hope, Beckman Research Institute, in Duarte, CA. "Thus, it has the potential to treat cancers resistant to currently approved therapies."

Prostate cancer is the second-leading cause of cancer death, after lung cancer, among men in the United States, according to the American Cancer Society. The disease affects about one out of every six men, and more than 29,000 will die of prostate cancer this year alone.

An age-related disease, prostate cancer usually affects men who are 65 or older. In addition to advanced age, genes and certain environmental factors influence the development of prostate cancer, although the exact causes remain unknown.

In a healthy prostate gland, cells express a protein called androgen-receptor, or AR, which is activated by male sex hormones, or androgens, including the primary male hormone testosterone. These same receptors also play a role in promoting the growth of the abnormal cells of prostate cancer.

The drugs that are currently available to treat prostate cancer work by preventing androgen from binding to the AR. Specifically, the drugs block androgen from attaching to a certain part of the AR known as the ligand-binding domain. This domain is the part of the receptor that hormones bind to when they activate the receptor. By blocking all androgen activity, these drugs induce chemical castration.

The problem is that prostate-cancer cells usually become resistant to androgen blockage. After initially responding, these aggressive cancers develop mutations that enable them to spread, or metastasize, without the influence of androgens. For this reason, these aggressive prostate cancers are called castration-resistant.

In contrast, the study drug binds to a different part of the AR that does not require androgen, according to Jones. "Our new lead compound, pyrvinium pamoate, works by a unique mechanism that involves binding to a different site on the AR and inhibiting its activity without preventing androgen binding," he said. "We are hopeful that an optimized derivative of pyrvinium will be able to inhibit all AR activity and inhibit the growth of human prostate cancers that become resistant to other AR-targeted therapies and perhaps result in a curative metastatic prostate cancer therapy."

Investigators conducted this pre-clinical study using prostate-cancer cells in an animal model

NETWORKING

The original and most valuable activity of the INFORMED PROSTATE CANCER SUPPORT GROUP is "networking". We share our experiences and information about prevention and treatment. We offer our support to men recently diagnosed as well as survivors at any stage. Networking with others for the good of all. Many aspects of prostate cancer are complex and confusing. But by sharing our knowledge and experiences we learn the best means of prevention as well as the latest treatments for survival of this disease. So bring your concerns and join us.

Please help us in our outreach efforts. Our speakers bureau consisting of Lyle LaRosh, Gene Van Vleet and George Johnson are available to speak to organizations of which you might be a member. Contact Gene 619-890-8447 or gene@ipcsg.org to coordinate.

Member and Director, John Tassi is the webmaster of our website and welcomes any suggestions to make our website simple and easy to navigate. Check out the Personal Experiences page and send us your story. Go to: <http://ipcsg.org>

Our brochure provides the group philosophy and explains our goals. Copies may be obtained at our meetings. Please pass them along to friends and contacts.

Ads about our Group are in the Union Tribune 2 times prior to a meeting. Watch for them

WE NEED HELP

All services for our group are performed by volunteers. As is usual in our type of organization we have a few doing a lot for many. We need people to step up and help in the following areas:

1. Fund Raising. We need help from anyone with any knowledge or willingness to become involved in acquiring grants to support our organization. We need someone to organize fund raising activities.
2. Information Technology. Any techies out there that can help take advantage of the facilities available where we meet--such as live remote conferencing.

Anyone interested please contact:

Gene Van Vleet, Vice President. 619-890-8447 gene@ipcs.org

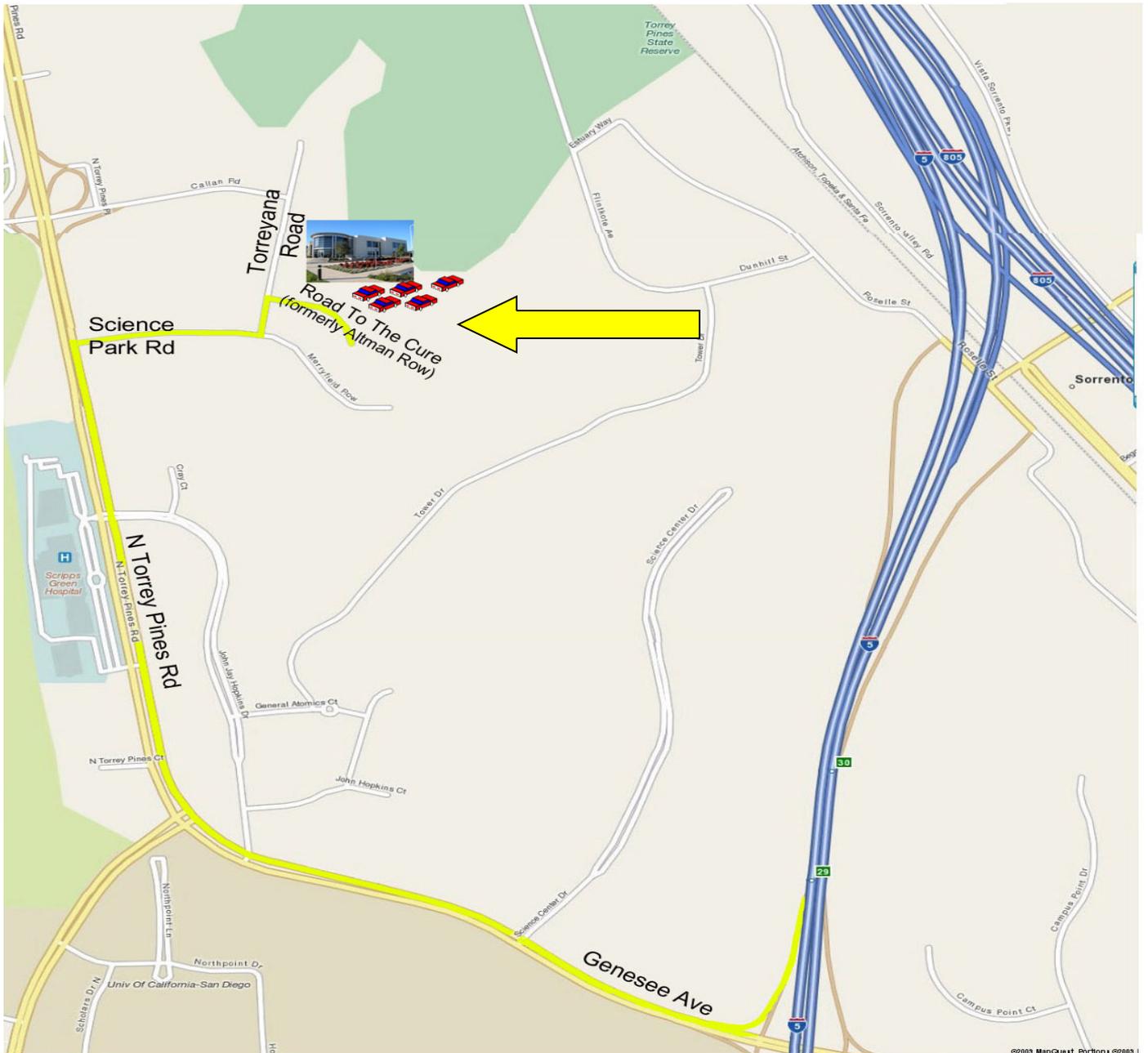
Lyle LaRosh, President 619-892-3888 lyle@ipcs.org

FINANCES

We want to thank those of you who have made special donations to IPCSG. Remember that your gifts are tax deductible because we are a 501(c)(3) non-profit organization.

We again are reminding our members and friends to consider giving a large financial contribution to the IPCSG. This can include estate giving as well as giving in memory of a loved one. You can also have a distribution from your IRA made to our account. We need your support. We will, in turn, make contributions from our group to Prostate Cancer researchers and other groups as appropriate for a non-profit organization. Our group ID number is 54-2141691. Corporate donors are welcome!

If you have the internet you can contribute easily by going to our website, <http://ipcs.org> and clicking on "Donate" Follow the instructions on that page. OR just mail a check to: IPCSG, P. O. Box 4201042



**Directions to Sanford-Burnham Auditorium
10905 Road to the Cure, San Diego, CA 92121**

Take I-5 (north or south) to the Genesee exit (west).

Follow Genesee up the hill, staying right.

Genesee rounds right onto North Torrey Pines Road.

Do not turn into the Sanford-Burnham Medical Institute or Fishman Auditorium

Turn right on Science Park Road.

Turn Left on Torreyana Road.

Turn Right on Road to the Cure (formerly Altman Row).