Informed Prostate Cancer Support Group Inc.

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

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, September 05, 2013 Volume 6 Issue 8

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Editor: Gene Van Vleet

Next Meeting
Sep 21
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!!

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

Our August meeting was well attended by 80 people.

Dr. Annette Conway spoke to us about managing stress. Stress is defined as the body's automatic response to any physical or mental demands placed on it. Adrenalin is a naturally produced hormone that responds to stress. When you feel endangered or threatened you either "fight or flight". Moderate levels of stress actually increase your levels of performance or efficiency. Too little stress can result in boredom. Too much stress can result in non-productive anxiety. 75-90 percent of visits to physicians are stress related. The primary symptoms of

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 DVDs" button.

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stress are:

1. Do minor problems and disappointments upset you excessively?
2. Do small pleasures of life fail to satisfy you?
3. Are you unable to stop thinking about your worries?
4. Do you feel inadequate or suffer from self doubt?
5. Are you constantly tired?
6. Do you experience flashes of anger over minor problems?
7. Have you noticed a change in eating or sleeping patterns?
8. Do you suffer from chronic pain such as headaches or backaches?

Stress can be a result of loss of activities in later life, loss of sensory capacities such as hearing or eyesight, changes in family structure and living accommodations, dwindling financial resources and declining social contact. The negative effects of stress can include:

1. Weight loss
2. Unexpected hair loss
3. Heart Palpitations
4. High blood pressure
5. Mood swings
6. Depression. Only 10% of depression is clinical—the other 90% can be stressful conditions.

Strategies for managing your stress:

1. Interconnecting with other human beings. Our support group is a good example of doing this.
2. Set limits. Make lists and cut back on or delegate anything non-essential. Set aside "me" time. Avoid procrastination.
3. Make one health related commitment and do it every day, such as cutting back on caffeine consumption or doing exercise.
4. Strive for a positive outlook. Focus on strengths, not weaknesses. Ignore negatives and turn them into positives. Express gratitude.

The benefits of stress management are that your physical health gets better. You will have more energy and stamina. Your ability to focus and learn increases. Your emotions improve. YOU ARE HAPPIER.

Dr. Conway described the HELP organization she founded for servicing psychology related illnesses. Brochures are available in the library. The foregoing is a only a recap of her presentation. DVD's of the meeting will be available for purchase from our library at the next meeting and from our website: http://ipcsg.org .

FUTURE MEETINGS

September 21 - Patricia DeLeo, Independent Insurance Agent will be discussing "Health Insurance Changes and Options".

October 19 - Dr. Robert Princenthal, Director of Prostate Imaging, and President, Rolling Oaks Radiology Medical Group will be discussing Multiparametric prostate MRI; how to best utilize this functional in-

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formation 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

January 18, 2014 - Roundtable meeting. Networking among members.

February 15, 2014 - Not yet committed.

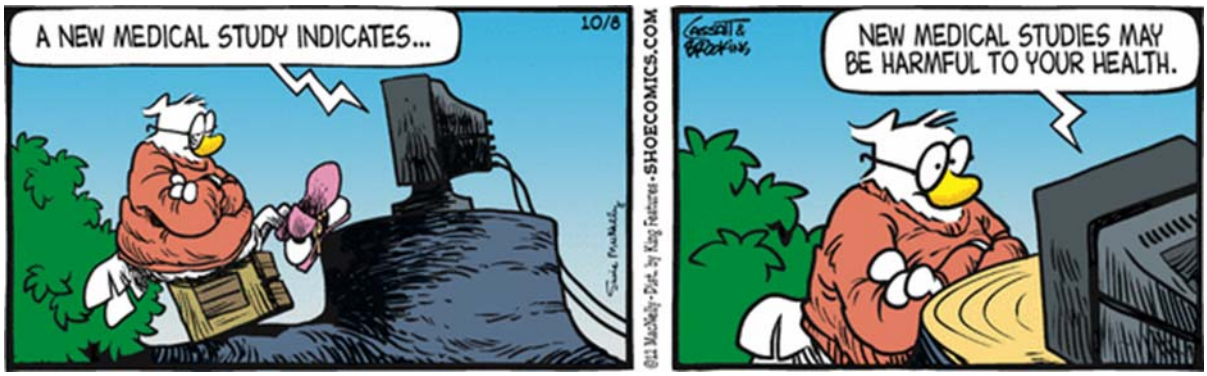
March 15, 2014 - Dr. Low, Russell, Medical Director of Sharp and Children's MRI Center. DCE MRI Techniques for Prostate Cancer Diagnosis and Surveillance.

April 19, 2014 - Roundtable meeting. Networking among members.

May 17, 2014 - Not yet committed.

June 21, 2014 - Dr. Irwin Goldstein, Director of Sexual Medicine, Alvarado Hospital speaks about the effects of PCa treatments on sexuality and Dr. Andrew Goldstein updates his work in stem cell research in relation to PCa.

ON THE LIGHTER SIDE



"Time is what keeps everything from happening at once."

"Go to heaven for the climate and hell for the company." — Mark Twain

"Have you ever noticed that anybody driving slower than you is an idiot, and anyone going faster than you is a maniac?" — George Carlin

"My grandmother started walking five miles a day when she was sixty. She's ninety-seven now, and we don't know where the heck she is." — Ellen DeGeneres

Be nice to your kids...They will pick out your nursing home.

"Be careful about reading health books. You may die of a misprint." — Mark Twain

Ever stop to think, and forget to start again?

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A customer asked, "In what aisle can I find the Polish sausage?
The clerk asks, "Are you Polish?"
The guy, clearly offended, says, "Yes I am. But let me ask you something.
If I had asked for Italian sausage, would you ask me if I was Italian?
Or if I had asked for German Bratwurst, would you ask me if I was German?
Or if I asked for a kosher hot dog would you ask me if I was Jewish?
Or if I had asked for a Taco, would you ask if I was Mexican?
Or if I asked for some Irish whiskey, would you ask if I was Irish?"
The clerk says, "No, I probably wouldn't."
The guy says, "Well then, because I asked for Polish sausage, why did you ask me if I'm Polish?"
The clerk replied, "Because you're in Home Depot."

NOTEWORTHY ARTICLES

New Studies Presented at the ASCO and AUA Annual Meetings
By Mark Scholz, MD
From PCRI Insights August, 2013

Scientific meetings are built around the presentation of results from new studies. For example, in the last issue of PCRI Insights I summarized the findings from several new studies presented at the February Genitourinary meeting of the American Society of Clinical Oncology (ASCO). Since that time, in May and June, two even larger medical meetings have occurred: the annual meeting of the American Urological Association, the AUA, and another, larger ASCO meeting. I have selected some reports from these two meetings and comment on them in this article.

Xtandi for Hormone Sensitive Disease and as a Primary Treatment Option for PCa

Over the years at Prostate Oncology Specialists where I work, we have championed the use of testosterone inactivating pharmaceuticals (TIP)—also known as hormone therapy or ADT—as a primary treatment alternative to surgery or radiation. Ten years ago, when severe radiation side effects were common, TIP was preferable to radiation because TIP had fewer side effects. However, as radiation technology has improved, we have been relying less and less on TIP.

However, Xtandi, a potent new type of TIP, may cause us to consider hormone therapy as an equally viable and effective primary treatment option. Even though Xtandi was FDA approved for treating advanced hormone-refractory prostate cancer, there is reason to believe it can be effective in the earlier stages of the disease. It's quite conceivable that Xtandi will be a more effectual treatment than the traditional LHRH agonists such as Lupron, Trelstar, Eligard and Zoladex, while causing less post-treatment side effects.

Abstract 5001

Dr. Smith and colleagues administered Xtandi 160 mg daily for 25 weeks to 67 men who had no previous TIP. The side effects reported were breast enlargement and fatigue in about a third of the men and hot flashes in one-fifth. Effects on libido and potency were not reported. Mean decrease in PSA was 99.6%. Testosterone and estrogen levels increased 114% and 72% respectively. Bone density and fat body mass

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were not substantially impacted.

♦**Comment**: Xtandi seems like the logical choice for men interested in TIP as a primary form of therapy because it "blocks" testosterone activity rather than completely shutting it down (as do the LHRH agonists). As such, the recovery period when the treatment is over should be much shorter. At Prostate Oncology Specialists we are presently investigating the use of six months of Xtandi with Femara (to prevent breast growth) in men with Intermediate-Risk Disease.

Aspirin, Metformin, Sulforaphane (Broccoli), Polyphenols and Vitamin D for PCa

Prostate cancer tends to be a slow-growing disease. Survival, even after relapse from surgery or radiation, is similar to men who don't have prostate cancer. Even so, many who relapse require intermittent therapy with TIP to control the disease. After a period of years, some men can become refractory to TIP and some of these who are refractory will have their lives shortened by the disease. Agents that can further impede the already slow growth rates of prostate cancer have the potential to significantly improve survival (for example, if a hypothetical cancer is doubling at a rate of every six months and could be slowed down to a doubling rate of every nine months, life expectancy could be prolonged 50%). A number of supplements have shown cancer inhibitory qualities. Several reports presented at the cancer meeting confirmed their effects on PCa.

Abstract 5084, Aspirin

Cyclooxygenase-2 (COX-2) expression in prostate cancer has been associated with high-grade tumors and poorer prognosis. Use of aspirin, a COX-1 & 2 inhibitor, have been associated with reduced prostate cancer mortality in some studies.

♦**Methods:** National Cancer Registry Ireland data was used to identify men with stage I-III prostate cancer, diagnosed from 2001-2006. Aspirin use in the year preceding prostate cancer diagnosis was identified. Cox proportional hazards models, adjusted for age, smoking status, year of incidence, comorbidity score, Gleason score, tumor size, prediagnostic statin use, and receipt of radiation (time varying) were used to estimate hazard ratios (HR) for associations between aspirin use and all-cause and prostate cancer-specific mortality.

♦**Results:** 2,936 men were identified. Median followup was 5.5 years. Aspirin use was associated with a significantly lower risk of prostate cancer-specific mortality in men receiving >75mg of aspirin. Stronger associations were observed in men with higher aspirin dosing or a Gleason score >7.

♦**Conclusions:** Pre-diagnostic aspirin use was associated with a significant reduction in prostate cancer-specific mortality in men receiving >75mg of aspirin.

♦**Comment:** We know that aspirin 81 mg daily cuts the risk of coronary events in men by one-third. Typically, side effects, mainly gastric upset or ulcers are rare. One of the good things about aspirin is that it is a blood thinner. Other blood thinners (such as Coumadin) have been shown to prolong prostate cancer survival (see the article I wrote in the last issue of Insights). This new report on aspirin supplies further evidence that daily aspirin should be considered routine in men with prostate cancer.

Abstract 5007, Metformin

Data were obtained from several Ontario health care administrative databases

♦**Results:** The cohort consisted of 3,837 patients. Cumulative duration of metformin treatment, after prostate cancer diagnosis, was associated with a significant decreased risk of prostate cancer-specific and all-cause mortality in a dose-dependent fashion. The adjusted hazard ratio, for prostate cancer-specific mortality was 0.76 for each additional six months of metformin use. The association with all-cause mortality was also significant but declined over-time from a HR of 0.76 in the first 6 months to 0.93 between 24-30 months.

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♦**Conclusions:** Increased cumulative duration of metformin exposure after prostate cancer diagnosis was associated with decreases in both all-cause and prostate-cancer-specific mortality among diabetic men.
♦**Comment**: This report substantiates other previously published studies on the anticancer effects of metformin (otherwise known as Glucophage). Like vegetarian and macrobiotic diets, metformin lowers insulin levels. Insulin, which is like a type of growth hormone, has been implicated as a causative agent that accelerates cancer growth. In my book, Invasion of the Prostate Snatchers, a whole chapter was devoted to the important topic of how insulin affects prostate cancer.

Abstract 5017--Sulforaphane

Patients with PSA recurrence were treated with 200 μmol of sulforaphane extract for up to 20 weeks.
♦**Results:** Sixteen patients completed 20 weeks of treatment. One patient experienced a PSA decline >50%. Thirty-five percent of patients had lesser PSA declines (3% to 20%), and 15% of patients had a final **PSA lower than baseline.** There was a significant reduction in PSA doubling time (6 months pre-study vs. 9.4 months on-study, p=.013). One patient discontinued study treatment for grade one GI discomfort.
♦**Conclusions:** This study provides a preliminary observation of improved PSA modulation with sulforaphane in men with prostate cancer.
♦**Comment:** Sulforaphane is thought to be the active ingredient in broccoli. Sulforaphane increases the intracellular concentration of an important anti-oxidant enzyme called glutathione transferase, which is abnormally suppressed in prostate cancer cells. This small study provides further evidence for the possible anticancer effects of sulforaphane.

Abstract 5008, Polyphenol-rich food

Foods such as pomegranate, green tea, broccoli and turmeric have anti-neoplastic effects in cell lines and animal models.
♦**Methods:** 203 men with localized prostate cancer after PSA relapse were randomized to receive an oral capsule containing a blend of pomegranate seed, green tea, broccoli and turmeric or placebo for 6 months.
♦**Results:** The median rise in PSA was 14.7% versus 78.5% with Placebo, p=0.0008. 46% of men had stable or lower PSA at trial completion versus 14% in the men treated with placebo. Mild gastro-intestinal issues were the only side effects.
♦**Conclusions:** This study found a short-term favorable effect on the percentage rise in PSA.
♦**Comment:** All these substances; pomegranate, green tea, broccoli and turmeric (curcumin) have been previously implicated as having inhibitory effectson cancer growth. In this study all four substances combined had a fairly dramatic effect on PSA progression.

Abstract 5036, Vitamin D

Emerging evidence in the literature suggests a positive association between serum 25-hydroxyvitamin D and survival in certain types of cancer.
♦**Methods:** A case series of 54 newly diagnosed stage IV prostate cancer patients underwent vitamin D evaluation prior to receiving treatment. We defined vitamin D insufficiency as serum 25(OH)D levels of <=32 ng/ml. Cox regression was used to evaluate the prognostic significance of vitamin D on survival after adjusting for age, PSA and functional status.
♦**Results:** Mean survival was 32.6 months and 62.4 months for patients in <=32 ng/ml and >32 ng/ml groups respectively (p = 0.02). On multivariate analysis controlling for age, performance status and PSA, patients with levels >32 ng/ml demonstrated significantly lower mortality (HR=0.13; p=0.05) compared to those with levels <=32 ng/ml.
♦**Conclusions:** Higher circulating levels of Vitamin D were positively associated with survival in patients

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with metastatic prostate cancer.

♦**Comment:** All the agents listed in this section; Aspirin, Vitamin D, Curcumin, Sulforaphane, pomegranate and green tea have shown potential anticancer effects. Generally, these agents cause little to no side effects. Their usage in men with prostate cancer, along with diet and exercise, is considered routine in our medical practice at Prostate Oncology Specialists.

The Danger of Mindless Prostate Biopsy

For several years I have been cautioning about the overuse of random prostate biopsy. My main concern is the over diagnosis of a small, slow growing, innocuous prostate cancer, the diagnosis of which frightens men into unnecessary radical treatment. In addition, the biopsy procedure itself can have direct deleterious effects on the patient, such as infection, bleeding, and impotence. Despite my concern about the overuse of biopsy, I don't ascribe to the concern that that biopsies spread cancer.

Abstract 5022, Mortality from Biopsy

Only one previous study has evaluated mortality following prostate biopsy (Gallinal, Int J Cancer 2008;123:647-52). They reported an increase of 2 deaths per 1,000 biopsies.

♦**Methods:** Extracted data from the PLCO study.

♦**Results:** Among 12,300 prostate biopsies, 36 deaths occurred within 120 days: Thirty-two deaths out of 9,124 (0.35%) occurred in the positive biopsy group compared to 4 out of 3,176 (0.13%) in the negative biopsy group. In this latest group, this represents1.3 deaths per 1,000 biopsies.

♦**Conclusions:** The mortality rate at 120 days following prostate biopsy of 1.3 deaths per 1,000 biopsies, in a population free of cancer, is a serious concern for the computation of benefit risk associated with PSA testing. This figure is in line with the risk reported by Gallina et al (2008) and is now based on a properly monitored population. This prostatic biopsy mortality would occur earlier than any benefit from a screening program and could reverse any potential gain from screening such as recorded in ERSPC study.

♦**Comment:** PSA screening followed by random biopsy was shown to reduce all-cause mortality in a 180,000 man study done in Europe. However, the US Preventative Services Task Force has cautioned that the negative effect of unnecessary treatment in men with low-grade prostate cancer outweighs the survival benefits. Studies like this one show there is a small but real risk of death from prostate biopsy. This is a strong indication that some form of imaging such as mulitparametric MRI or Color Doppler ultrasound should be performed rather than jumping immediately to a random needle biopsy.

Final Thoughts

Although no groundbreaking treatments were presented at this year's urology and oncology meetings, some thought provoking study results were presented. Xtandi shows important advancements that could potentially revoultionize hormone treatment, providing an attractive alternative for men with intermediate stage prostate cancer. Reports are providing strong evidence that supplements and pharmaceuticals like Aspirin, Metformin, Sulforaphane, Polyphenols and Vitamin D have genuine, visible anti-cancer effects. Lastly, a rigorous study further confirms that subjecting men to prostate biopsies can be unnecessarily dangerous, even fatal.Hopefully, prostate imaging rather than biopsy will become the first course of action for evaluating men with high PSA levels.

What If What You 'Survived' Wasn't Cancer?

From BLOMBERG VIEW

By Virginia Postrel posted 8/18/13

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For decades, the reigning theory has been that the earlier a cancer is spotted and treated, the less likely it is to be lethal, because it won't have time to grow and spread. Yet this theory infers causality from correlation. It implicitly assumes that cancer is cancer is cancer, even though we now know that even in the same part of the body, cancer is many different diseases -- some aggressive, some not. Perhaps people survive early-stage cancers not because they're treated in time, but because their disease never would have become life-threatening at all.

This isn't just logical nit-picking. Thanks to widespread screening, the number of early-stage cancers identified has skyrocketed. In many instances -- including types of breast, prostate, thyroid and lung cancers -- more early diagnoses haven't led to proportionate decreases in mortality. (New drugs, not early detection, account for at least two-thirds of the reduction in breast-cancer mortality.) The cancers the tests pick up aren't necessarily life-threatening. They're just really common. So more sensitive tests and more frequent screening mean more cancer, more cancer treatment and more cancer survivors.
"We'll all be cancer survivors if we keep going at the rate that we're going," says Peter Carroll, the chairman of the department of urology at the University of California at San Francisco and a specialist in prostate cancer.

Distracting Doctors

In a well-intended effort to save lives, the emphasis on early detection is essentially looking under the lamp post: Putting many patients who don't have life-threatening diseases through traumatic treatments while distracting doctors from the bigger challenge of developing ways to identify and treat the really dangerous fast-growing cancers.

"Physicians, patients, and the general public must recognize that overdiagnosis is common and occurs more frequently with cancer screening," argues a recent JAMA article by the oncologists Laura J. Esserman (a surgeon and breast-cancer specialist), Ian M. Thompson Jr. (a urologist) and Brian Reid (a specialist in esophageal cancer). They argue for limiting the term "cancer" to conditions likely to be life-threatening if left untreated.
That's going to be a tough change for a lot of people to swallow. For patients and the rest of the public, getting tested offers a sense of control, encouraging an almost superstitious belief that frequent screening will ward off death. (A few years ago, when the actress Christina Applegate was making the talk-show rounds urging young women to get breast MRIs, my own oncologist told me he was getting calls from women who thought the tests would not merely detect but prevent breast cancer.)

Early detection of non-life-threatening cancers also produces a steady supply of "cancer survivors," who work to support cancer charities and make their efforts look successful. There's an entire industry devoted to celebrating "breast cancer survivors" in particular, and many women are heavily invested in that identity. It offers a heroic honorific as a reward for enduring horrible treatments. A term originally coined to remind cancer patients that their disease need not be fatal has become a badge of personal achievement.

Fearing Mistakes

Physicians, meanwhile, fear making a mistake. It seems safer to treat someone who doesn't really need it than to miss something potentially fatal. But, warns Esserman, director of the Carol Franc Buck Breast Care Center at UCSF, "the cancers that grow and spread very quickly are not the ones that you can catch in time with screening." If anything, emphasizing early detection misdirects research and funding. "We have to come up with better treatments, we have to figure out who's really at risk for those and figure out how to prevent them," she says. "We're not going to fix it with screening."

There are plenty of scientific unknowns. Take the commonly diagnosed breast cancer called ductal car-

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cinoma in situ, which accounts for about a third of new U.S. diagnoses, 60,000 a year. In these cases, the cells lining the walls of milk ducts look like cancer, but they haven't invaded the surrounding breast tissue. DCIS was a rare diagnosis before the introduction of mammograms, which are highly sensitive to milk-duct calcifications, and the JAMA article labels it a "premalignant condition" that shouldn't even be called cancer. Arguably, a lot of women who think of themselves as "breast cancer survivors" have survived treatment, not cancer.

Yet oncologists who identify DCIS have been surgically removing it (and in many cases the entire surrounding breast) for 40 years, so it's hard to know how dangerous it actually is. "Since we really don't know the true natural history of DCIS we do not know if DCIS always progresses to invasive cancer or not," says Colin Wells, a radiologist at the University of California at Los Angeles specializing in breast imaging. "There are some reasons to think not, but this needs to be worked out" with further research. If DCIS does spread to invade breast tissue, the question remains whether that cancer threatens to go beyond the breast, becoming lethal if untreated.

By contrast, we do know that a lot of prostate cancer isn't dangerous. Autopsy studies show it's quite common in older men who die from unrelated causes. "Out there in the street, if you remove the prostates in men over the age of 50, 30 to 40 percent would have some kind of cancer," Carroll says, "most likely, low grade and low volume."

Distinguishing Tumors

Thanks to more sensitive tests, he notes, the prostate "cancers we're detecting today are totally different than the cancers we saw two decades ago. And our ability to distinguish these tumors is much better. We have the wherewithal now to be able to tell a patient that your cancer is highly likely confined to your prostate, of small volume, slow growing, and something that may not need immediate treatment at all."

Carroll has more than 1,000 patients under "active surveillance," getting regular PSA tests, imaging and biopsies. Only about one in three turns out to need treatment within five to 10 years. (An additional 10 percent opt for surgery simply because they get tired of all the tests or can't take the anxiety.) The program is also working, Carroll says, to "decrease the burden of testing," ideally by eliminating the need for repeated biopsies.

Prostate cancer illustrates the cultural barriers to abandoning what Esserman calls today's "scorched earth policy." Despite the widespread awareness that many prostate cancers aren't life-threatening, many physicians are determined to find and treat it any time a PSA score comes in a little high. "I saw a gentleman this week who had had 12 biopsies, no cancer, and they said there must be cancer in there and they did 24," says Ian Thompson of the University of Texas Health Science Center at San Antonio, who is one of the JAMA authors.

A prostate-cancer diagnosis is still terrifying to patients and their families. Thompson describes many of his conversations with patients -- and especially with their wives -- as "talking them off the ledge." When he tells patients they're likely to be fine without immediate treatment, they often worry how they'll explain the good news to their children or neighbors. People expect a cancer diagnosis to entail trauma.

Although Carroll thinks calling slow-growing prostate tumors "cancer" is important to encourage vigilance, Thompson wants to change the nomenclature, using the term IDLE (indolent lesions of epithelial origin) to describe low-risk cases where waiting isn't likely to make a difference. Just using the word "cancer," he argues, creates unnecessary suffering.

"The number of people that will die from those slow-growing prostate cancers is really low," he says,

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but the unacknowledged costs of giving them a cancer diagnosis are huge: "the person who can't sleep for two weeks before his next test results, and all the follow-up biopsies and all the lost wages, and the people who can't get life insurance because they now have a new cancer diagnosis, the person whose firm says, 'Well, we're concerned you have cancer and therefore you can't be promoted to this job.'"

It's a compelling case, but changing the vocabulary finesses the fundamental cultural issue: the widespread and incorrect belief that "cancer" is a single condition, defined only by site in the body, rather than a broad category like "infectious disease." Someone doesn't develop "cancer" but, rather, "a cancer." How frightening that diagnosis should be depends on which one.

Scripps: Proton center unchallenged by Blue Shield move

From U-T San Diego By Paul Sisson 4:43 p.m. Aug. 29, 2013

Scripps Health said Thursday that a decision by Blue Shield of California to stop covering proton beam therapy for prostate cancer will not challenge the financial viability of a new $230 million proton therapy center set to open in October.

On Thursday, Blue Shield confirmed that it has notified doctors that it will stop paying for the treatment on Oct. 28. The insurance company cited cost effectiveness as the main reason.

In recent years, several research papers have questioned the utility and cost effectiveness of proton treatment, which uses a massive linear accelerator called a cyclotron to shoot charged particles into cancerous tumors. The studies have found that, in general, a cheaper technology that uses converged X-ray beams instead of a beam of protons is just as effective at killing tumors and is much less expensive.

One study published in late 2012 by Yale University found that Medicare paid $32,000 for proton treatment compared to only $19,000 for the equivalent X-ray-based treatment.

Scripps announced in 2010 that it would be the first health system in the region, and one of 12 in the nation, to offer proton therapy, which it billed as offering a new range of options for San Diego County residents. It partnered with a private company, San Diego-based Advanced Particle Therapy, to build the facility on a seven-acre plot in Mira Mesa. UC San Diego Health System briefly considered building its own proton accelerator but downsized its plans in 2012.

Dr. Carl Rossi, medical director of the Scripps Proton Therapy Center, said prostate treatments are expected to make up about 40 percent of the center's patient volume, which is expected eventually to hit 2,400 per year.

He agreed that X-ray-based technology kills tumors just as dead as protons do. But he said the latest studies fail to take into account that proton technology does much less damage to surrounding tissue. That damage, he said, causes an increased risk of additional cancers in tissue that radiation passes through.

"It's quite clear that the biggest factor in getting a second cancer from radiation is not just the dose (strength) but also the amount of tissue that ends up getting treated," Rossi said.

He said proton therapy is useful in treating tumors in other organs, including the breast, lung and pancreas, adding that, in some cases, using proton instead of X-rays can be cheaper because fewer sessions are required.

But some aren't buying that explanation and are citing huge investments in proton technology as a prime example of the arms race in health care that is pushing the cost of treatment ever higher, often without better efficacy for the patient.

In a Los Angeles Times story Thursday, Cary Gross, a researcher at the Yale School of Medicine called proton "the perfect example of all that is wrong with our health care system."

"The rush to adopt proton beam is far outpacing the amount of evidence to support its use," he said.

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Rossi said that Scripps plans to consider all technologies on a case-by-case basis and make a recommendation to patients based on whether X-ray offers a 10 percent or less chance of injury to surrounding organs.

"We'll discuss the pros and cons with each patient. What's the pro of proton? It will treat less tissue. What's the con? It will probably cost more," Rossi said.

Chris Van Gorder, Scripps' chief executive, said the project is not likely to become a financial burden for the health system. It is fully funded by Advanced Particle Therapy; Scripps will simply run the center, he said.

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.

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.

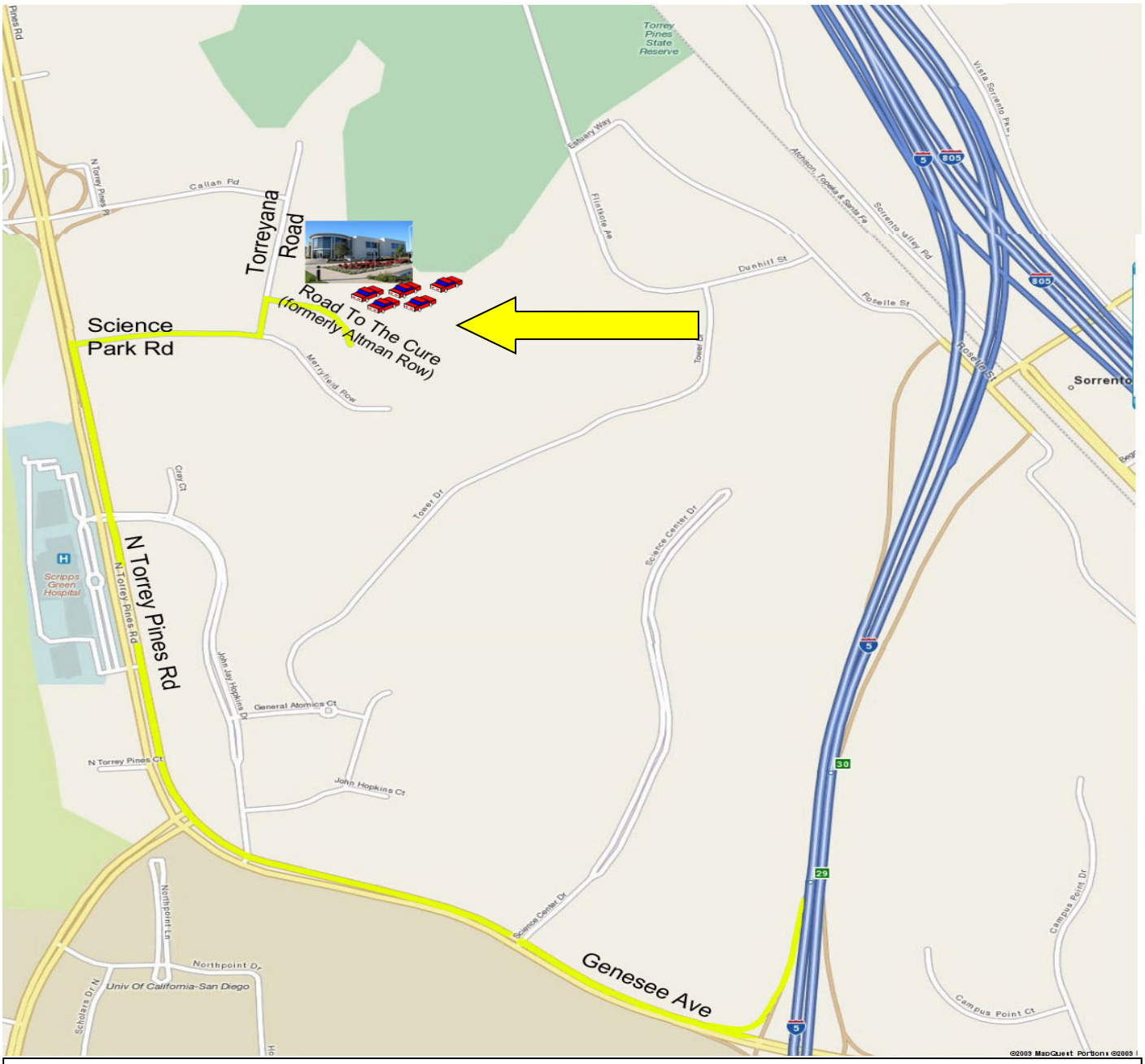
Anyone interested please contact: Gene Van Vleet, Vice President. 619-890-8447 gene@ipcsg.org or-Lyle LaRosh, President 619-892-3888 lyle@ipcsg.org

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://ipcsg.org and clicking on "Donate" Follow the instructions on that page. OR just mail a check to: IPCSG, P. O. Box 4201042, San Diego CA 92142



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).