Informed Prostate Cancer Support Group Inc.

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

December 2014 NEWSLETTER

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We Meet Every Third Saturday (except December)

Tuesday, December 23, 2014

Volume 7 Issue 12

Next Meeting
January 17, 2015
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 PCa 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 manaer!!

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Editor: Gene Van Vleet

PROSTATE CANCER IT'S ONLY 2 WORDS NOT A SENTENCE

From the Editor

As the year draws to a close, it is fitting to reflect on our operations this last year. Our attendance averaged 86 per meeting which included 9 newcomers, 5 of which were newly diagnosed and the rest experiencing recurrence. Your contributions continue to provide support to our outreach efforts.

We had leading edge speakers that provided the latest information about imaging techniques, new medications and treatment techniques. Visit our website www.ipcsg.org and click on VIDEOS to view some recent live videos or click on PUR-

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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CHASE DVD'S to get copies of any meeting.

Our urgent charge now is to increase our outreach efforts to get men to understand the need for regular PSA testing. Because of the recommendations of the US Preventative Services Task Force (USPSTF) to discontinue PSA testing, Urologists and Oncologists are already seeing men with more advanced disease at first diagnosis. By nature, many men don't want to test anyhow, so now they have more reason to procrastinate. Women are still authorized and reminded by their doctors to have a mammogram. Please do your part to help get out the message that men still need a "man-o-gram" (PSA test).

Recap of November Meeting

Dr. Richard Lam, Research Director of Prostate Oncology Specialists, returned for his annual visit and spoke about androgen deprivation therapy (ADT) and recent treatment techniques.

The androgen receptor is the target of prostate cancer growth. The cancer evolves by changing that receptor over time which is why cancers become resistant to hormone deprivation.

New drugs are already on the market and more are coming that target the receptor. It is expected that less and less chemotherapy will be needed because of these new anti-androgen treatments. ADT is known by many names—hormone blockade, androgen suppression therapy or testosterone inactivating pharmaceuticals. Testosterone (androgen) is produced mostly in the testicles and some in the adrenal glands. The androgen cell becomes attached to the androgen receptor and gets taken into the nucleus of the cancer cell which stimulates the DNA of the cancer cell to replicate. Over time those cells become little tumors and then bigger tumors which can invade the area outside the prostate, going to the seminal vesicles or near the bladder and even into the bones.

ADT can be accomplished with injections that lower testosterone such as Lupron, Trelstar, Firmagon and Zoladex. When is ADT useful? Newly diagnosed men with higher risk disease may require ADT to improve one's cure rate. Another can be when one has had surgery or radiation and the cancer comes back—usually evidenced by a PSA rise. It should never be believed that ADT is a cure, but rather a means to control the cancer, possibly for decades. Dr. Lam showed statistics verifying the use of ADT in conjunction with radiation that showed improved survival rates. Generally ADT is not used prior to surgery.

If relapse or recurrence is experienced it is not a death sentence. Such patients are commonly living 10 years or more. When to implement ADT is judgmental based on the aggressiveness of the cancer. ADT has some potential side effects such as osteoporosis, anemia, hot flashes, loss of sex drive, muscle loss, breast growth, depression, memory loss, tiredness and diarrhea. Of course not everyone gets every side effect nor is everyone affected to the same degree. Intermittent ADT allows "holidays" from treatment effects. This may also delay the time when ADT stops working. Dr. Lam showed studies discussing the benefits of intermittent ADT.

An alternative to ADT is anti-androgen monotherapy. This is taking bicalutamide pills (Casodex) by itself to block the receptor rather than lowering testosterone. It is a weaker treatment and has lesser side effects but may not result in better overall outcome. Libido is more often maintained and there is less fatigue but "holidays" are usually shorter.

What happens when ADT or anti-androgen monotherapy stop working? Taxotere (chemotherapy) has been used for many years. Two newer treatments he discussed are abiraterone (Zytiga) and enzalutamide (Xtandi). Enzyme CYP17 is very important in testosterone production. Zytiga blocks this enzyme and is proving to be a viable second line treatment. Enzalutamide (Xtandi) blocks whatever testos-

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terone is in the body from attaching to the receptor. It also blocks the complex from going into the nucleus and blocks it from interacting with the DNA. Both new drugs were initially approved by the FDA for use following chemotherapy and are now used before chemotherapy. Both are too new to provide long-term benefit statistics, but he did show some study results. Costs are high, running $6,000— $8,000 per month. Check your insurance for coverage.

The foregoing is a recap of Dr. Lam's informative presentation. Copies of the DVD of the meeting are available now from our website: www.ipcsg.org Click on PURCHASE DVDS. They will also be available from the library at our next meeting on January 17th.

FUTURE MEETINGS

January 17, 2015 - Dr. John Feller and Bernadette Greenwood, BSc, RT(R)(MR) from Desert Medical Imaging will present information about the first site in the world to conduct transrectally delivered MRI-guided laser focal therapy of prostate cancer in an outpatient setting. They will further provide an update on the Phase I Clinical Trial (NCT02243033 on ClinicalTrials.gov).

February 21st - Member panel discusses experiences followed by networking among members.

April 18th - Steven G Pratt M.D., F.A.C.S., A.B.I.H.M The role of nutrition and lifestyle in the prevention of disease and optimizing health. www.superhealthyliving.com

June 20th - T. Mike Hsieh, MD. Asst Professor of Surgery, UCSD. Sexual dysfunction including low testosterone and erectile dysfunction

ON THE LIGHTER SIDE

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Real news headlines:
Squad Helps Dog Bite Victim
Juvenile Court to Try Shooting Defendant
Two Sisters Reunited after 18 Years in Checkout Counter
Homicide Victims Rarely Talk To Police

"I want my children to have all the things I couldn't afford. Then I want to move in with them." — Phyllis Diller
"Money may not buy happiness, but I'd rather cry in a Jaguar than on a bus." — Françoise Sagan
"When God made man she was practicing." — Rita Mae Brown, Cat on the Scent
"Cut my pie into four pieces, I don't think I could eat eight." — Yogi Berra
"I couldn't repair your brakes, so I made your horn louder." — Steven Wright
"Why isn't the word "phonetically" spelled with an "f"?" — Steven Wright

INTERESTING ARTICLES

Radiation for PSA-Relapsed Prostate Cancer, an Alternative to Lifelong Lupron

Posted: 09 Dec 2014 06:06 PM PST Prostate Snatchers Blog
BY MARK SCHOLZ, MD

About 60,000 men a year relapse after surgery or radiation with a rising PSA. In the old days, a rising PSA after surgery was treated with radiation to the prostate fossa, the area of the body where the prostate was previously located. One-fourth of the time these treatments cause durable lowering of PSA levels, essentially a cure. The other three-fourths of the time the PSA keeps rising and the men are relegated to lifelong hormone therapy with Lupron shots. This article is about what to do for the three-fourths whose PSA keeps rising despite undergoing radiation to the prostate fossa.

While hormone therapy is the standard approach because it effectively suppresses PSA for over ten years, the quality of life on long term Lupron is often poor, because Lupron causes hot flashes, tiredness, joint aches, muscle atrophy and loss of sex drive.

In the old days crude attempts to improve cure rates were made by extending the radiation field outside the prostate to cover the pelvic lymph nodes. (The lymph nodes are the first jumping off place for prostate cancer when it metastasizes outside the gland.) As might be expected the closely surrounding intestines often are caught in the radiation crossfire, creating nasty digestive disturbances such as chronic diarrhea and intestinal bleeding. However, due to an amazing breakthrough in radiation technology, that occurred in the mid-1990s— intensity modulated radiation (IMRT)—now the radiation beam can be sculpted to target the nodes and miss the intestines.

Excitement about the potential for this new technology ramped up even further with the advent of new cancer scans such as Combidex and C11 PET scans that can accurately detect which lymph nodes are diseased.

Let me recount the story of a PSA-relapsed gentleman who has now passed his fifth anniversary off Lupron, with this revolutionary approach. Initially, in 1992, he underwent a prostatectomy, but by April of 2003 his PSA had risen to 0.07. He was treated with standard radiation to the prostate fossa. His PSA briefly dropped, but by February 2007 it was back up to 1.83 and in May 2008 his PSA was 7.3. A Combidex scan showed cancerous lymph nodes extending from the pelvis up through the abdomen all the way

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to the diaphragm. He started Lupron and Casodex and underwent another Combidex scan in June 2009 that showed substantial improvement but incomplete resolution of the cancerous nodes. He started IMRT directed at all the cancerous nodes in late July 2009. The Lupron was stopped in June 2009. At his last visit to my office in November 2014, testosterone was normal at 433 and PSA was 0.040.

Sometimes a "breakthrough" in medical care simply results from a new application of existing technology. This case illustrates how the results of targeted treatment with IMRT can be further enhanced with optimal scanning technology to achieve durable remission and freedom from lifelong dependency on hormonal therapy.

Common Prostate Cancer Treatment Associated With Decreased Survival In Older Men

From Science Daily December 3, 2014. Source: Henry Ford Health System

A common prostate cancer therapy should not be used in men whose cancer has not spread beyond the prostate, according to a new study led by researchers at Henry Ford Hospital.

The findings are particularly important for men with longer life expectancies because the therapy exposes them to more adverse side effects, and it is associated with increased risk of death and deprives men of the opportunity for a cure by other methods.

The research study has been published online in European Urology.

The focus of the new study is androgen deprivation therapy (ADT), in which an injectable or implanted medication is used to disrupt the body's ability to make testosterone. ADT is known to have significant side effects such as heart disease, diabetes, increased weight gain and impotence; however a growing body of evidence suggests ADT may in fact lead to earlier death.

Since the 1940s, the therapy has been a mainstay of treatment for prostate cancer that has metastasized, or spread beyond the prostate gland. Still other studies support the use of ADT when it is used as an adjuvant, or in addition to, radiation therapy for higher risk prostate cancer. No evidence exists to support the exclusive use of ADT for low risk or localized prostate cancer.

"The use of ADT as the primary treatment for localized and low risk prostate cancer increased over time, despite known harmful side effects and a lack of data to support such use," says Jesse D. Sammon, D.O., a researcher at Henry Ford Hospital's Vattikuti Urology Institute and lead author of the new study. "In the 1990's it became exceedingly common to use ADT in place of radical prostatectomy or radiation therapy."

Concerns over the possible misuse of ADT alone in the treatment of prostate cancer, as well as a growing awareness of its potential damage, led to changes in Medicare reimbursement policies for ADT in 2004.

This resulted in a 40 percent drop in reimbursement, and a reduction in inappropriate use of ADT from 38.7 percent to 25.7 percent for newly diagnosed localized prostate cancers.

"At the same time, there was a growing awareness of ADT's many possible adverse effects, including decreased libido, anemia and fatigue, and a higher risk of metabolic and cardiovascular disease," Dr. Sammon says.

"In designing our study, we hypothesized that the adverse effects of ADT might be more pronounced in men with longer life expectancies since they would likely be treated with ADT for a longer period- and be exposed to more treatment-related side effects."

Drawing on data from nations largest cancer registry (SEER) (Surveillance, Epidemiology, and End Results) the researchers then linked to records from Medicare and identified 46,376 men diagnosed with

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localized prostate cancer who did not undergo radical prostatectomy or radiation therapy for prostate cancer, diagnosed between 1992-2009. Among them, 38.5 percent were treated with ADT.

Further statistical analysis confirmed the study's hypothesis, notes Dr. Sammon.

"No evidence supports the use of ADT in men with low risk, localized prostate cancer, while use of this therapy is decreasing over time it is still very common," he says

"We found that primary ADT is associated with decreased survival in men with localized prostate cancer relative to men who receive no active treatment, particularly in men with longer life expectancies. So we concluded that ADT should not be used as a primary treatment for men with prostate cancer that has not spread beyond the prostate or men with moderate to high risk disease undergoing radiation therapy."

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.

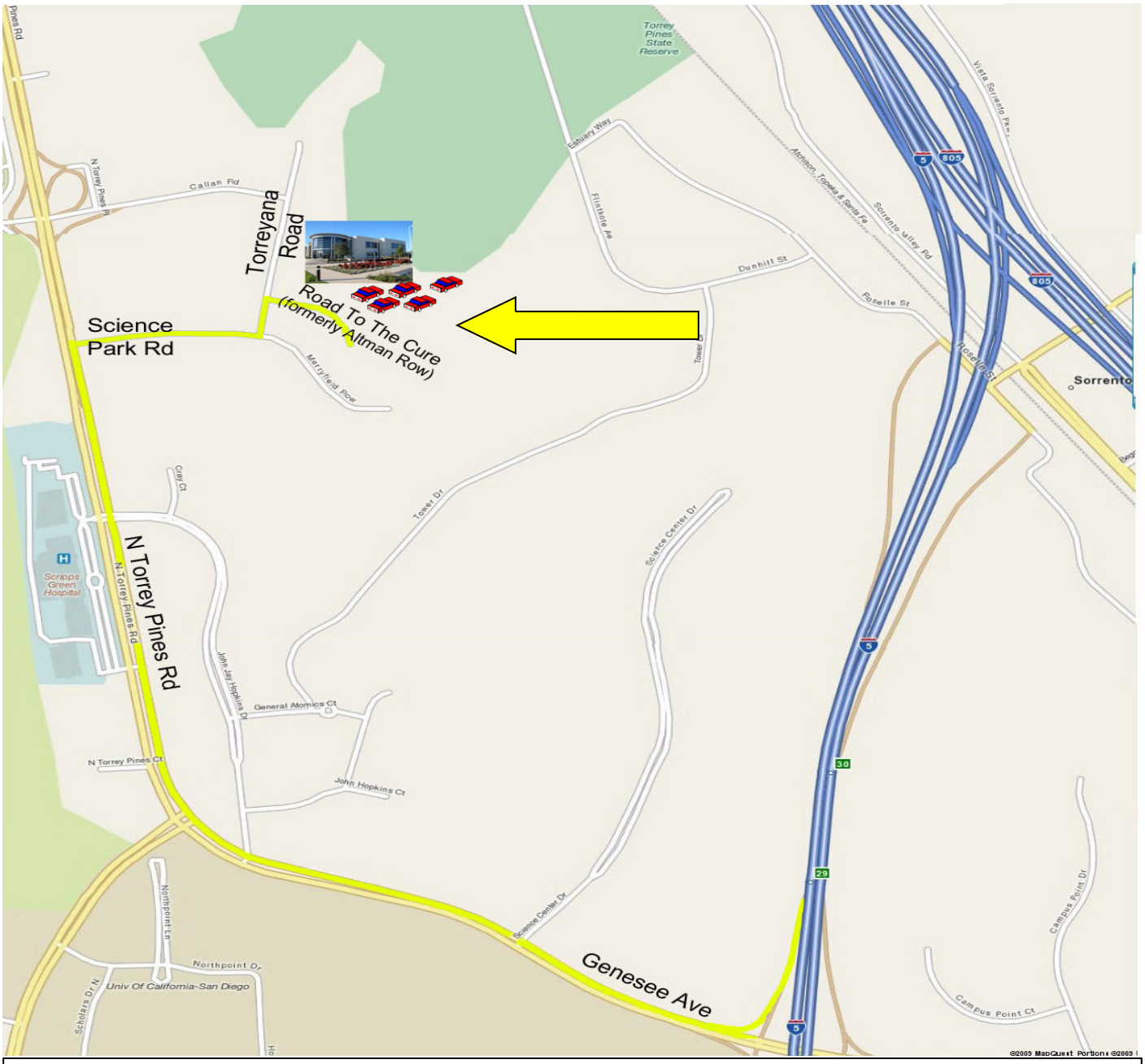
Ads about our Group are in the Union Tribune 2 times prior to a meeting. Watch for them

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).