Informed Prostate Cancer Support Group Inc.
"A 501 C 3 CORPORATION ID # 54-2141691"

MAY 2015 NEWSLETTER

P.O. Box 420142 San Diego, CA 92142
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We Meet Every Third Saturday (except December)

Thursday, May 07, 2015 Volume 8 Issue 3

Next Meeting
May 16, 2014
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.

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Editor: Gene Van Vleet

PROSTATE CANCER IT'S ONLY 2 WORDS NOT A SENTENCE

The attendance for the April Meeting was 102! We were pleased to see so many women participating.

Our guest speaker was Dr. Steven Pratt, a world-renowned authority on the role of nutrition and lifestyle in the prevention of disease and optimizing health. He is the author of the New York Times bestselling SuperFoods Rx, and has appeared on major national media. He is also a senior staff ophthalmologist at Scripps Memorial Hospital in La Jolla, California, and a clinical assistant professor of

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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.

The DVD of each meeting is available by the next meeting date.

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ophthalmology at the University of California, San Diego.

Dr. Pratt opened with saying the best way to deal with all kinds of cancer and heart disease is by being physically active, getting a minimum of 7 hours of sleep and staying with "Superfoods" in their diet. " Superfoods" is the subject of his books and surprisingly include commonly available foods with no hype on cure-all stuff. The following are some of what he recommends:

FRUITS: Apples, Avacados, Blueberries, Dried & Freeze-dried fruits, Oranges, Pomegranates, Kiwis

VEGETABLES: Beans of all kinds, Brocolli, Garlic, Onions, Pumpkin, Spinach, Tomatoes

OTHER: Dark Chocolate, Honey, Oats, Extra Virgin Olive Oil, Spices, Tea (Green, Black, Oolong, White, Rooibos), Turkey breast-skinless, Walnuts, Wild Salmon, Yogurt (Non-fat Organic).

His lecture expanded on specific information and he showed samples of each of the "Superfoods" all of which are readily available. Notably missing from his recommended foods are red meats--which include pork. He softened it somewhat by indicating eating a small amount (about the size of a deck of cards) once or twice a month is tolerable.

Your Editor found this to be a refreshing presentation that didn't lead us to a "cure all" but rather a logical diet easily followed with foods easily attainable.

To get the full benefit of his more detailed discussion of many of the foods and lengthy Q&A, a copy of the DVD of this meeting will be available by the May 16th meeting at the library or through the website: www.ipcsg.org/shop/

FUTURE MEETINGS

May 16th - Ross E. Schwartzberg, MD. Neuroradiologist, Imaging Healthcare Specialists. Detecting prostate cancer with MP-MRI. Why And How. A source for image guided biopsies.

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

July 18th - Donna Hansel MD, PhD, Division Chief of Anatomic Pathology UCSD and an expert in genitourinary pathology, will speak about the Gleason biopsy test.

Aug 15th - Not yet committed

Sep 19th - Not yet committed

Oct 17th - Not yet committed

Nov 21st - Richard Lam, M.D., Research Director, Prostate Oncology Specialists: : Updates and recent treatment developments

December - No Meeting

ON THE LIGHTER SIDE

Murphy's Lesser Known Laws:
A fine is a tax for doing wrong. A tax is a fine for doing well.
The shin bone is a device for finding furniture in a dark room.
The things that come to those who wait will be the things left by those who got there first.
He who laughs last, thinks slowest.

If you want to have breakfast in bed, sleep in the kitchen.

An elderly man went to his doctor and said, "Doc, I think I'm getting senile. Several times lately, I have forgotten to zip up."
"That's not senility," replied the doctor. "Senility is when you forget to zip down."

A young woman went to her doctor complaining of pain.
"Where are you hurting?" asked the doctor.
"You have to help me, I hurt all over", said the woman.
"What do you mean, all over?" asked the doctor, "be a little more specific."
The woman touched her right knee with her index finger and yelled, "Ow, that hurts." Then she touched her left cheek and again yelled, "Ouch! That hurts, too." Then she touched her right earlobe, "Ow, even THAT hurts", she cried.
The doctor checked her thoughtfully for a moment and told her his diagnosis, "You have a broken finger."

The famous female skier Picabo Street (pronounced Peek-A-Boo) is not just an athlete, she is a nurse. She currently works at the Intensive Care Unit of a large metropolitan hospital. However, she is not permitted to answer the telephone, because it simply caused too much confusion when she would answer the phone and say....." Picabo, ICU."

INTERESTING ARTICLES

New Ways of Using "Old" Technology

BY MARK SCHOLZ, MD

Posted: 30 Apr 2015 In Prostate Snatchers Blog

My old professor from USC, Dr. John Daniels, once told me that most "new inventions" are usually the result of "old invention" being repurposed in a new way. His own company was an example. Dr. Daniels developed a process for extracting collagen from cow hides (before Botox came along, collagen was injected into wrinkles for cosmetic reasons). Collagen was FDA approved for injection into wrinkles, but Dr. Daniels readapted it for treating cancer. He performed studies that injected collagen into the blood vessel feeding liver tumors to block the blood supply.

A couple weeks ago at the PCRI's midyear update, Dr. Margolis spoke about the possibility of readapting multiparametric MRI (MP-MRI) for cancer screening in men with high PSA as an alternative to random biopsy. For those of you who don't know, MP-MRI has already gained widespread acceptance as a backup plan for finding prostate cancers in men with high PSA levels when an initial 12-core random biopsy fails to detect cancer.

Any logical person would think that, "If the MRI is more accurate, less invasive and less expensive, why not simply do the MRI first, before the biopsy?" Then, if the MRI is clear a biopsy can be avoided altogether. (And when the MRI does show a suspicious spot, only one or two cores are needed to biopsy it.)

However, the medical community, which has been doing random biopsy for the last 25 years, patiently awaits the results of studies to evaluate the accuracy of random biopsy and MP-MRI in head to head trials. Unfortunately, these studies will take many years to complete. And in the meantime, should we keep doing random biopsies in a million men every year?

We are all well aware of how quickly the development of new medical technology is accelerating. So in this blog, my goal is to point out that as all these new treatments are becoming available, it creates new uncertainties about how to use them in the most optimal fashion.

Newly-approved, more powerful hormone treatments like Zytiga and Xtandi are a good case in point. Studies clearly validate their superiority over traditional hormone shots and pills in men with advanced disease. But doctors are reluctant to prescribe such procedures for men with earlier-stage disease, even when the cancer is unequivocally high risk. Once again they cite, "The absence of clinical studies to support this new and expanded role."

One question always seems to arise when proposing to use a new treatment in an expanded role. The question is "Maybe we should reserve the new treatment in case the traditional treatment fails. After all, don't we need a backup plan?" The problem, at least as far as treating relapsed cancer is concerned, is that most cancer "backup plans" can't bring about a cure. The best chance for curing cancer is always with the first treatment. And it's not like this question hasn't been already looked into. Numerous studies have addressed the question of sequencing treatments versus using the same treatments simultaneously in combination. Almost every time the cure rates are improved by using the treatments in a combination, "up-front" approach rather than trying one treatment and waiting to see if it fails before starting the second treatment.

So in summary, this is a new era of hope and discovery. I'm sure none of us are complaining about having a whole bunch of new and effective treatments available. However, with this privilege come new

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responsibilities. But doctors and patients will need more flexibility in their thinking. In this era of rapid technological progress the standard preconceived notion that every treatment recommendation must be backed up by a scientific study will need to be reconsidered.

Molecular Imaging Proving Valuable in Fighting Cancer

The Washington Post by Jonathan Kolatch

April 30, 2015

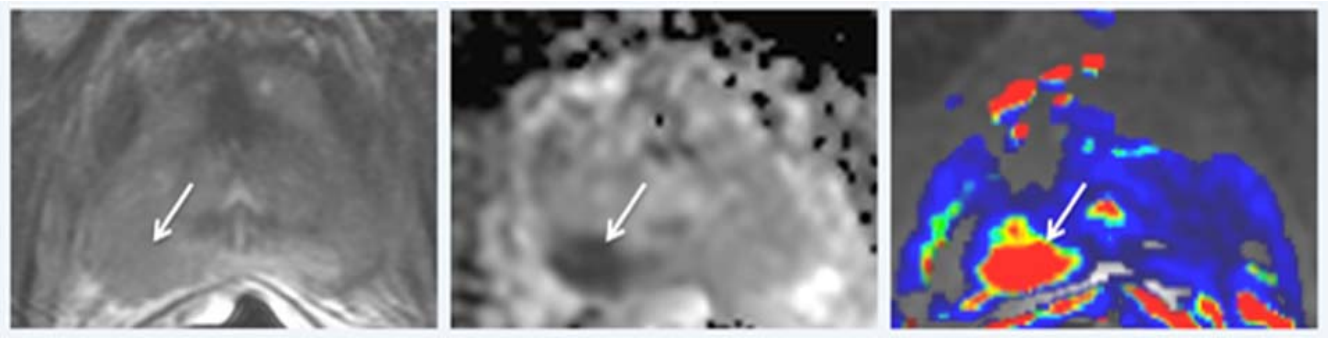
When actor Michael Douglas was diagnosed with throat cancer in 2010, he went through seven weeks of radiation and chemotherapy - "the seven circles of hell," as he described it, a period marked by an inability to swallow, gum pain, loss of taste, dental pain.

Had he been diagnosed just a year later, Douglas might have benefited from molecular imaging, an emerging technology that allows doctors to precisely target a patient's specific cancer cells. The approach allows for a reduction in radiation and chemotherapy and the debilitating side effects that accompany them. Standard radiation and chemotherapy treatment can spare, or extend, a patient's life, but they often leave behind pain and dysfunction that erode quality of life for both patient and family.

"Molecular imaging has made a major impact in the way patients with cancer are treated," says Peter Herscovitch, president of the Society of Nuclear Medicine and Molecular Imaging (SNMMI).

Consider the case of Humberto Laureano, who, beginning in January 2011, was treated by Nancy Lee, a radiation oncologist at New York's Memorial Sloan Kettering Cancer Center who 12 months earlier had treated Douglas. Laureano, 49, had come to the hospital with a one-inch mass of biopsy-confirmed throat cancer and a prognosis that he had a year to a year and a half to live.

Instead of having a standard computed tomography, or CT, scan, which uses a series of X-rays from various levels of the body, followed by wide-spectrum radiation and chemo, he was scanned by a machine that combines CT and 3-D positron emission tomography, or PET.



Magnetic resonance imaging provides the best picture of primary prostate cancer, but to give the optimum view of the tumor, ordinary MRI scans, left, must be enhanced with diffusion-weighted technology, centre, or dynamic contrast-enhanced technology, right. Such approaches are also useful for cancers of the brain, liver and pancreas. Images courtesy of Oguz Akin, Memorial Sloan Kettering Cancer Center

While CT provides information about the shape of the tumor , PET lights up the malignancy's most active cancer cells. It appeared from the images that the cancer had spread to Laureano's lymph nodes. Standard therapy would have included dousing Laureano's lymph nodes with radiation, with the harsh side

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effects that affected Douglas. But Laureano's hybrid scans allowed his doctors to do a carefully targeted biopsy, which turned up no cancer in his lymph nodes, sparing him additional radiation.

A second series of molecular images taken 2 1/2 weeks after chemo/radiation treatment began showed a significant reduction in the size of his throat tumor .

A normal X-ray would not have shown anything. After seven weeks of chemotherapy and radiation, Laureano's tumor disappeared, and there has been no recurrence. The only side effects he reported during treatment were weight loss and a small loss of hair, and "my favorite food, pizza, tasted like cardboard".

This type of precision therapy, which visualizes cells down to the molecular level, has succeeded in deactivating throat tumors in more than 90 per cent of 41 cases in an ongoing clinical study, according to Lee.

Scientists have been exploring molecular imaging since the 1950s, according to Jason Lewis, president of the World Molecular Imaging Society. But it began to enter mainstream practice only in the past two decades as human genome studies provided intricate information about the molecules that make up cells, both healthy and diseased. (New Zealand got its first PET/CT scanner in 2006, with a machine at Wellington's Wakefield Hospital, and now has several around the country).

Molecular imaging can be used to show "how the body is functioning and to measure its chemical and biological processes," as SNMMI puts it. While more-basic tools such as X-rays, CT and ultrasound portray physical characteristics, molecular images offer additional information. As a result, the technology is increasingly being used to help diagnose and treat cardiovascular disease, epilepsy, Parkinson's disease and Alzheimer's. But its largest application - about two-thirds, doctors say - is in cancer treatment.

At its core, cancer care involves detecting, monitoring and disabling out-of-control cells. Molecular imaging is on the front lines.

Molecular imaging researchers have begun to identify biological markers of some diseases and have created radiotracers (mildly radioactive chemicals) that are injected before a scan is taken to find such markers and bind to them, allowing them to be seen in scans. A biomarker for prostate cancer, for instance, is prostate-specific antigen, or PSA, while alpha fetoprotein is a biomarker of primary liver cancer related to hepatitis B and C.

Most large US hospitals now routinely give a patient suspected of having cancer a hybrid PET/CT or PET/MRI scan because they are so accurate at identifying the location of a tumor and highlighting its most active parts. The radiotracer most commonly used, called FDG, helps measure the uptake of glucose. (High uptake of glucose is characteristic of many cancer cells.) When FDG images pinpoint a tumor , biopsies are done, with the tissue analyzed for genetic information that helps determine what type of chemotherapy will be most effective.

The goal of cancer treatment is to shrink or remove the tumor. However, the regular CT follow-up after radiation and chemotherapy very often shows no change in tumor shape. That is an indication to the oncologist to modify chemotherapy.

But molecular images might show that, while a tumor's shape has not changed, its cells have become much less active and that, in time, the tumor will collapse. Molecular images can also detect cancer at its earliest stages, before it causes any changes in body functions or anatomy. Early detection makes it possible to monitor the disease and begin treatment at the most opportune stage.

Some molecular techniques do not rely on tracing via FDG. For example, dynamic contrast-enhanced imaging uses a nonradioactive substance injected into a patient to light up the tumor area; another, diffusion-weighted imaging, reveals details about a tumor's structure. These are useful for cancers of the pros-

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tate, brain, liver and pancreas.

Molecular imaging is key for prostate cancer because the organ is so small and thus hard to biopsy, says Oguz Akin, director of MRI at Memorial Sloan Kettering . With prostate cancer, a biopsy is key to figuring out whether a tumor is aggressive and thus should be considered for treatment. "The ultimate goal is to make prostate imaging so precise that there will be no need for biopsies. But we're still far from that," Akin says.

Zaver Bhujwalla, director of cancer imaging research at Johns Hopkins Medical School, is working on an imaging technique that uses enzymes - chemicals that speed up cell activity - to detect and disable tumors. With this technique, an enzyme is injected into cancer tissue, where it binds to cancer cells. Molecular imaging verifies that the enzyme has bound to the cancer. Doctors then intravenously inject a drug that, when activated by the enzyme, kills the cancer cells. Because the drug affects only the cancer cells, damage to healthy adjacent cells is kept to an unprecedented minimum.

Researchers say the use of molecular imaging is just beginning. The number of biomarkers and tracers is limited, and finding new ones is "like digging with a toothpick," says Lawrence Schwartz, who is chief radiologist at New York-Presbyterian Hospital.

NEW TECHNOLOGY TESTS TUMORS INSIDE THE PATIENT TO FIND BEST TREATMENT

From Prostate Cancer Research News By Alan Mozes HealthDay Reporter
Experimental devices might reduce risk of side effects, lower costs, researchers say

April 22, 2015 (HealthDay News) -- Two new devices may eventually lead to more accurate, less toxic methods of predicting how well a specific cancer drug might work on an individual's cancer, researchers report.

The goal: to construct a "laboratory in a patient" method for safely exposing tumors to tiny samples of many different drugs all at once, to observe each drug's preliminary impact on the cancer, without exposing patients to the drug's potential side effects.

New Technology Tests Tumors "Different patients can respond completely differently to the same drug," explained the lead author of one of the studies, Oliver Jonas. Jonas is a post-doctoral associate in the Robert Langer Lab at the Massachusetts Institute of Technology's Institute for Integrative Cancer Research, in Cambridge.

"And normally in cancer, and in some other diseases as well, there aren't good predictive markers. So you have to test therapies sequentially. And it can take several weeks to many months to see the effect of a single therapy," Jonas said.

"So the motivation of this whole study was to find ways to identify the optimal therapy in a patient before a treatment decision is actually made," he added.

The study authors designed a 3-millimeter long device outfitted with isolated pockets. Each pocket was loaded with very small sample of a cancer drug. Currently, 16 different cancer drugs can be tested at once, according to the study.

The device was injected directly into melanoma, prostate, or breast cancer tumors in a group of mice. Tissue samples were then tested to see how the tumor reacted to the drugs. Those samples were then compared to how the mice reacted when given a drug's full dosage.

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The device proved to be a reliable and accurate way to predict each drug's effectiveness.

"First, it's important to note that what we're testing is only about a millionth of a (full) dose," said Jonas. "But just that tiny amount is enough to try out on the order of about 10,000 cancer cells. So it's very safe, but enough for testing," he said, adding that the small dose correlated strongly with the effect of what could be expected with a full-dose treatment.

"So this is no-risk and effective, and a big time-saver for patients," Jonas said. "It's also likely to significantly reduce the costs of care. Because some of the new cancer therapies we have, many of which will prove to be ineffective for any one patient, cost about $100,000 per treatment cycle. And this testing method will cost just a fraction of that."

Jonas said that theoretically -- pending the results of ongoing clinical trials involving actual patients -- the new test could be available in some form within one to two years.

But commenting on the research by Jonas and colleagues, Dr. Peter Kozuch, an associate professor of medicine, hematology and medical oncology at Beth Israel Medical Center in New York City, cautioned that it's too soon to know how well this device might work in people, given that testing to date has been confined only to animals.

"The field of oncology is increasingly trying to become more precise," Kozuch said. "Patient-specific and tumor-specific. But this is brand new technology. And unfortunately there is simply no shortcut to clinical development," he added.

"While it may be terrific that this technology seems to accurately predict which drugs will be effective in which tumors in laboratory animals, those early signs of promise unfortunately do not always translate into benefits for people. So we have to do these tests in people with cancer," Kozuch said.

A second device actually has been tested on four humans, but only in a safety trial.

This device -- from researchers at the Fred Hutchinson Cancer Research Center and Presage Biosciences in Seattle -- is a handheld microinjection device called "CIVO." It's specifically designed to test up to eight drug samples in tumors located near the surface of the skin, such as skin cancer, breast cancer, and lymphoma.

The researchers have demonstrated early success with this device in tests on mice and dogs, according to their latest study.

The initial human tests were designed to assess the safety of the device, and to evaluate the patient and physician experience with the process, the researchers said. Initial results in people showed no serious side effects from the micro-injections of the drugs.

Findings from both studies were published online April 22 in Science Translational Medicine.

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.

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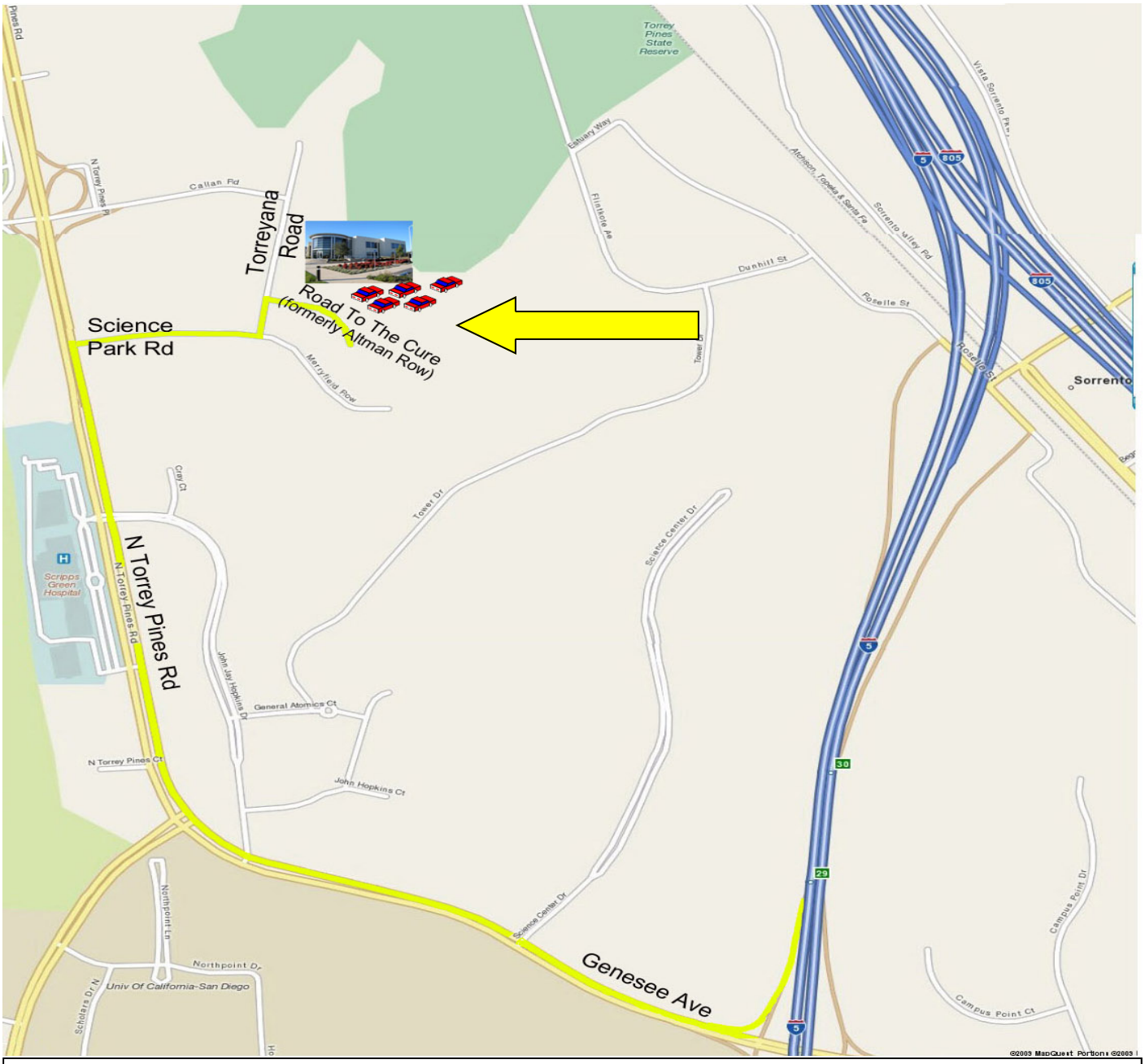
Member and Director, John Tassi is the webmaster of our website and welcomes any suggestions to make our website simple and easy to navigate. Check out the Personal Experiences page and send us your story. Go to: http://ipcsg.org

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).