

WRNMMC Us TOO, Inc.
A PROSTATE CANCER SUPPORT GROUP
SPONSORED BY
WALTER REED NATIONAL MILITARY MEDICAL CENTER
NEWSLETTER

VOLUME 21

NUMBER 1

FEBRUARY 2012

◆ **AGENT ORANGE REVIEW** ◆

The Department of Veterans Affairs (VA) earlier determined that an association exists between exposure to Agent Orange and other herbicides and the development of prostate cancer and thirteen other diseases. (The three most recently added diseases are ischemic heart disease, b-cell leukemias, and Parkinson's disease). Veterans with prostate cancer and other designated diseases who served in the following locations and time periods may qualify for service-connected disability compensation and health care benefits from the VA. Surviving spouses, dependent children and dependent parents of veterans who were exposed to Agent Orange and died as the result of diseases related to Agent Orange exposure may be eligible for survivors' benefits.

- a. Vietnam (between 9 January 1962 and 7 May 1975)
- b. Korea (between 1 April 1969 and 31 August 1971)
- c. Thailand (between 28 February 1961 and 7 May 1975)
- d. Installations where Agent Orange and other herbicides were tested and stored inside and outside of the United States (dates vary by location).
- e. US Navy and Coast Guard ships operating in Vietnam waters (between 9 Jan 1962 and 7 May)

For more detailed information, visit the useful VA website at www.publichealth.va.gov/agentorange/. Information and assistance is also available from your state's Veterans Affairs Departments. Also, Ray Walsh, our support group's vice president, a Vietnam veteran, prostate cancer survivor, and a Red Cross volunteer at WRNMMC's Center for Prostate Disease Research, is very knowledgeable in Agent Orange matters. You may contact Ray at 703-425-1474 or email at raywalsh34@erols.com.

◆ **WE HAVE A NEW ACRONYM!** ◆

You may not have noticed that we are using a new acronym in the title of our prostate cancer support group. With the recent merger of the Walter Reed Army Medical Center and the National Naval Medical Center, Bethesda, our acronym has changed from "WRAMC" to "WRNMMC" (Walter Reed National Military Medical Center). We remain a chapter member of the Us TOO International, a Prostate Cancer Education & Support Network.

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◆ FROM THE EDITOR'S DESK ◆

This is the second edition of our quarterly newsletter that is now available only on line. We encourage you to share it with interested friends, and if any of them are interested in receiving their own notification directly, have them to contact Jane Hudak, at the Center for Prostate Disease Research at jane.hudak@med.navy.mil to be included on our email notification list. We also welcome your comments or suggestions about the newsletter and your "electronic experience" with it by contacting the editor as shown to the left on this page.

I am very grateful to US TOO International for recently selecting me as one of seven awardees of its Edward C. Kaps Hope Award for 2011 for my service on behalf of prostate cancer survivors and their families. My contributions were made possible by the support of the board of directors of the WRNMMC Prostate Cancer Support Group and the many volunteers within our chapter. In effect, I share the award with them.

◆ NOVEMBER SPEAKER'S REMARKS ◆

Our November program featured Dr. Patricia Lillis-Hearne, Radiation and Oncology Service at WRNMMC, Bethesda. Her topic was "Everything You Always Wanted to Know about Radiation Therapy and Prostate Cancer, and Maybe More!" Unfortunately, we had recording difficulties in our new location in Bethesda and we are unable to present her transcribed remarks. Instead, we are presenting selected material drawn from the slides she presented. The presentation begins on page 6.

◆ MEETING SCHEDULE FOR FEBRUARY 2, 2012 ◆

Colonel Robert C. Dean, M.D., is our speaker for Thursday, February 2, 2012, at 7 pm. He is the Director of Andrology (male sexual health) at WRNMMC. A graduate of the University of Rochester and the Uniformed Services University of the Health Sciences, he completed a fellowship in Andrology at the University of California, San Francisco, before becoming director of Andrology at WRNMMC. His interests include erectile dysfunction, medical management of erectile preservation, and male fertility. Your family members and friends are always welcome. Come join us. **See the back page for important information about this meeting.**

DISCLAIMER: The materials contained in this newsletter are solely the individual opinions of the authors. They do not represent the views of any Department of Defense agencies. This newsletter is for informational purposes only, and should not be construed as providing health care recommendations for the individual reader. Consult with your physician before adopting any information contained herein for your personal health plan.

Agent Orange Expanded. The Veterans Administration announced an expansion of its list of Navy and Coast Guard ships whose crews may be eligible for disability compensation as a result of exposure to the toxic defoliant Agent Orange during the Vietnam War. The ships, mainly landing vessels and destroyers, operated along the Vietnam coast or in its inland waterways during 1962-1975. The ship list is flexible, so additional ships may be added from time to time as evidence discloses their eligibility. The VA pays compensation to veterans or survivors for fourteen medical conditions associated with Agent Orange, including prostate cancer. The VA said it paid \$2.2 billion in the past year to 89,000 veterans or survivors affected by Agent Orange. There is still a substantial backlog of related claims from the Vietnam War. (Reference: *Military Times*, September 2, 2011, via the *UsTOO Hot Sheet*, October 2011)

PSA Testing in Men Disease-Free After Ten Years. One PSA-testing issue not often addressed is how long patients need to continue PSA testing after radical prostatectomy. Earlier studies have shown that biochemical recurrence usually occurs within 5 years of surgery; even when cancers return after 5 years, they're usually associated with less risk for morbidity and mortality. This new study followed 10,609 men from the Johns Hopkins database, some for as long as 25 years after surgery. The researchers reported that 1,684 men in the cohort had biochemical recurrences, defined as a PSA level above 0.2 ng/mL, without previous hormonal or radiation therapy.

The study showed that: (a) 77% of the recurrences occurred within 5 years of surgery, 16.6% occurred 5 to 10 years after surgery, 4.9% occurred 10 to 15 years after surgery, and 1.5% occurred more than 15 years after surgery; (b) even when cancers did recur, they were unlikely to metastasize or cause the patient to die from prostate cancer; (c) no patient with a Gleason score of 6 or less had metastases or death, even if they had late recurrence. Other study conclusions or recommendations were: (a) it is reasonable to discontinue pros-

tate-specific antigen (PSA) testing 10 years after radical prostatectomy if the patient has remained disease-free to that point; (b) men who remain disease-free 10 years after surgery should be counseled that their risk of subsequent cancer-related morbidity and mortality is low; (c) in very young patients it's probably a good idea to continue testing beyond 10 years, because there is more potential for bone metastases in those patients; (d) a reasonable alternative to stopping PSA testing completely after 10 years is to continue to testing, but at much less frequent intervals. (Source: 2011 Genitourinary Cancers Symposium (GUCCS): Abstract 179 via Medscape News, February 21, 2011)

Finasteride Combo Brings Down PSA After Biochemical Recurrence. A recent study indicates that finasteride and flutamide in combination produced significant declines in PSA in men with biochemical failure after local therapy. Monk, et al., Arthur G. James Cancer Hospital and Richard J. Solove Research Institute in Columbus, Ohio, note that about a third of men treated for localized prostate cancer will have biochemical failure. The conventional therapy for these men is androgen deprivation therapy (ADT) which has a high response rate but a myriad of side effects. As an alternative to AD the researchers propose peripheral androgen blockade with a 5-alpha reductase inhibitor (finasteride) and an antiandrogen (flutamide). They tested the effect of daily therapy with finasteride 5 mg and flutamide 750 mg in 99 men who each had a PSA increase of at least 1 ng/mL. The PSA level fell by at least 80% in 96% of subjects, and it became undetectable (<0.2 ng/mL) in 73%. The median time to a nadir value was 3.2 months.

The researchers say their five-year metastasis-free rate of 97% compares favorably with the 67% rate reported in a recently updated retrospective study of 450 men who did not receive any additional therapies after surgery. They concluded that because patients with PSA-only recurrences after definitive local therapy are not necessarily destined to die of their disease,

they are excellent candidates for therapy that may have lower toxicity, while retaining the potential to control their disease; and the combination of finasteride and flutamide was well tolerated, durable and active making it a good option to incorporate in a controlled study in this important population of men. (Source: *Cancer* 2011, on-line December 16, 2011, via Reuters Health, January 12, 2012)

Sexual and Urinary Function after Prostate Surgery - What to Expect.

Men may have unrealistic expectations about their sexual and urinary function after undergoing prostatectomy. A new study finds that nearly 50 percent of men who had a prostatectomy expected better sexual function and urinary continence one year post-surgery than what they got, even though they had extensive preoperative counseling about the side effects of the procedure.

A total of 152 men scheduled to undergo prostatectomy received comprehensive preoperative counseling before surgery. After counseling, they completed a questionnaire which asked them about their expectations regarding side effects such as sexual function, urinary incontinence, bowel incontinence, urinary irritable symptoms, and hormone function.

One year post-surgery, the same men were again asked to complete a questionnaire about their side effects and expectations. How well did the men's pre-surgery expectations match their one-year post-surgery reality check?

When it came to the men's expectations regarding bowel and hormonal function, the before and after thoughts were fairly close. However, their expectations about urinary incontinence and sexual function did not fare as well. Thirty-six percent of men expected their urinary incontinence to be the same one year after surgery as before surgery, while 40 percent of men expected their sexual function not to change at all.

In addition, 47 percent of men had worse than expected outcomes in urinary incontinence and 44 percent had worse than expected outcomes in sexual function at one year post-surgery. A surprisingly significant percentage of men even expected their urinary incontinence and sexual function to get better after surgery than it was before going under the knife: 12 percent and 17 percent, respectively.

According to the researchers at the University of Michigan's prostate cancer survivorship program, preoperative counseling alerts men to urinary and sexual problems after surgery, but that it can only inform men in terms of overall statistics. It can't predict for the individual. This may mean that, if in doubt, men tend toward being hopeful and optimistic, perhaps overly so. The study suggests the importance that men about to undergo prostatectomy be provided with preoperative education as well as tools for urinary and sexual function recovery post-surgery. Men and their partners need help with the recovery process after surgery in order to help them regain intimacy. (Source: University of Michigan Health System/Wittmann, et al. *Journal of Urology* 2011 Aug; 186(2): 494-99)

Stent Eases Erectile Dysfunction. Men with erectile dysfunction caused by clogged arteries leading to the penis may be helped by a drug-coated stent, a device more commonly associated with treating heart disease.

Thirty million men in the U.S. and more than 300 million worldwide suffer from erectile dysfunction. The majority of the cases stem from vascular problems, including insufficient blood from the arteries, studies show. Mesh stents such as used in this study are routinely used to prop open diseased arteries to the heart. As many as 70 percent of men with heart disease also report problems achieving an erection.

Some doctors tested balloon angioplasty to clear clogged arteries in the pelvis in the 1980s to treat impotence, but their results were never systematically studied or published. Little progress was made in the following three decades, according to a commentator.

While drugs such as Viagra, Levitra and Cialis help many men, as much as half eventually stop taking the medicine because of inadequate response or side effects. The few alternatives include penile injections and prostheses.

The recent study presented at the annual meeting for Vascular Interventional Advances reported that the stent is safe and improves erectile function in men who don't respond to conventional therapy such as Viagra, Levitra, and Cialis. The clinical trial is the first to test stents

for treating impotence in men who don't respond to drug therapy, the researchers said.

The small study found 68 percent improvement in erectile function after three months in 30 men with an average age of 60 who were implanted with the stents. Their impotence was caused by narrowed pudendal arteries in the pelvis. There were no issues such as clots or the need for surgery one month after treatment in the study funded by Minneapolis-based Medtronic.

An observer noted that the stent procedure is not a panacea for erectile dysfunction. Rather, it was a first-in-man trial and the fact that it was feasible and improved blood flow is impressive. It may be the beginning of a whole new approach to erectile dysfunction.

In the study released at the medical meeting, a sexual encounter profile showed a significant improvement in intercourse, while ultrasound exams found increased blood flow to the penis. The men reported a 10 point improvement on a 30 point international index of erectile function, the main test used to evaluate new treatments.

While the results are promising, more work must be done to confirm the safety and benefit of the approach. A second study involving 350 men is in the works. (Source: Bloomberg News, October 20, 2011)

Advocacy Protects Prostate Cancer Research Program Funding for 2012. Congress recently passed a \$915-billion spending package to fund the federal government for the rest of the Fiscal Year 2012, including \$80 million for the Prostate Cancer Research Program (PCRP).

The PCRP, part of the Congressionally Directed Medical Research Programs at the Department of Defense, funds innovative high-risk, high-reward research projects supporting basic, translational and clinical research in both the individual and multidisciplinary, collaborative group setting. Funding for the PCRP enables research to advance faster and to be better prepared to apply for future funding from the National Institutes of Health or to advance through clinical trials. The PCRP has an exponential impact on the research that is advancing through the pipeline that will ultimately save

lives from or help men cope with prostate cancer.

Because prostate cancer survivors and advocates made their voices heard on Capitol Hill, the PCRP was the only non-combat related stand-alone program that maintained level funding from last year. All other programs were cut by 20 percent, including the Breast Cancer Research and Ovarian Cancer Research Programs. (Source: ZERO, the Project to End Prostate Cancer, Issue 24, January 10, 2012)

Top Doctors Survey on PSA Screening. In an exclusive new survey of "Top Doctors" conducted by U.S. News & World Report, virtually all responding urologists and more than 60 percent of internal-medicine specialists rejected the recent proposal by a high-level government advisory committee to end routine PSA testing, which is meant to catch prostate cancer early.

An estimated 20 million men a year undergo PSA screening, and nearly 250,000 of them are diagnosed with prostate cancer. The proposal, issued by the U.S. Preventive Services Task Force, advises doctors not to screen patients with the PSA test unless they have symptoms that are "highly suspicious" for prostate cancer.

The government task force found little evidence that screening men with the PSA test significantly reduces deaths from prostate cancer. Whatever small benefit there might be, the task force concluded, is outweighed by the risk of an incorrect diagnosis or unnecessary procedure leading to death or complications. About a third of men treated for prostate cancer suffer urinary incontinence, impotence, or both, and about 1 in every 200 dies within 30 days from complications of surgery.

Doctors have debated the risks and benefits of the PSA test since 1994, when the Food and Drug Administration approved it for cancer screening. Even the test's supporters acknowledge that it is inherently imprecise. A high PSA level may indicate the presence of a tumor—or it may not. Nor is a low PSA level necessarily an all-clear. Moreover, the test cannot distinguish between a typical tumor, which grows so slowly that the threat is minimal, and one that is aggressive and potentially lethal.

To determine whether some of the nation's best doctors agree with the task force's proposed recommendation, U.S. News surveyed more than 600 urologists and internists who are recognized as Top Doctors by U.S. News and Castle Connolly Medical Ltd. About 95 percent of the responding urologists felt that doctors should continue to advise men starting at age 50, when testing typically begins, to have PSA screenings as part of a routine physical exam, contrary to the task force's recommendation. They included themselves in that group; 97 percent indicated they would be tested starting at 50. The internists were less unanimous—about 40 percent agreed with the proposed recommendation to end routine testing. But 72 percent of the responding male internists indicated that they themselves would have the test starting at age 50.

One respondent noted that when he began his practice before the advent of the PSA test almost all the prostate cancer patients he saw had metastatic disease at diagnosis. Now, in patients who have their PSAs checked, he almost never sees metastatic disease at the time of diagnosis. (Source: U.S. News & World Report, October 28, 2011)

Vitamin E and Prostate Cancer. New evidence about the effect of vitamin E on prostate cancer risk may make some men think twice before taking the daily supplement. Researchers at the National Cancer Institute found that men who took a high daily dose of vitamin E had a 17 percent greater risk of developing prostate cancer.

The report in the Journal of the American Medical Association, adds to a growing list of studies suggesting that supplemental vitamins have few benefits and could even be harmful. Data from previous studies suggested that taking vitamin E might help protect men against prostate cancer, so Minasian, et al., at the NCI decided to take a closer look at the connection between the two. Beginning in 2001, they started the Select trial, studying more than 35,000 men age 55 and older in the U.S., Canada and Puerto Rico. They divided the men into four groups, each with different kinds of daily diet supplements: vitamin E, selenium, both vitamin E and selenium, or a placebo pill. After seven years, the researchers detected more prostate cancer in men taking one or both of the supplements,

but the men taking vitamin E showed the most significant increase in their rates of prostate cancer. And the numbers of prostate cancer diagnoses kept climbing after the men stopped taking the vitamins. Of the 8,737 men taking vitamin E, 620 of them got prostate cancer, compared to 529 of the 8,896 men taking a placebo – a 17-percent increased risk for men taking the supplement.

The authors of the study noted the findings were particularly concerning, considering how many people take supplemental vitamin E every day. Fifth percent of people over age 60 reported taking daily supplements containing vitamin E, and 23 percent of them took supplements with more than 13 times the recommended amount of vitamin E.

Some experts say that the findings from the Select trial are interesting, but the results don't necessarily mean there is an association between vitamin E and prostate cancer. Two previous studies looked at a large number of men taking the supplement and each reached different conclusions on how vitamin E affects prostate cancer.

In 2003, data from the Alpha-Tocopherol, Beta-Carotene Cancer Prevention trial showed that smokers taking 50 mg of vitamin E each day had a 35 percent reduction in prostate cancer. In the Physicians Health Study II, participants took the same amount of vitamin E as the men in the Select trial – 400 IU, but it had no effect on their risk of prostate cancer. A commentator noted that scientists should weigh the findings of all of these studies when thinking about the link between prostate cancer and vitamin E. He viewed the NCI study as contributing to an overall pattern showing little or no association [between vitamin E and prostate cancer] rather than to an overall conclusion of proven harm. For now, experts say men shouldn't take vitamin E with the hope that it will prevent prostate cancer. Some question the need for any vitamin supplements. (Source: ABC News (Medical Unit), October 11, 2011)

Testosterone and Erectile Dysfunction. Testosterone supplementation failed to improve

outcomes among elderly men with mild to moderate erectile dysfunction scores, even though testosterone levels were improved, according to a recent study by Roth, et al., University of Colorado.

The Sexual Health Inventory for Men (SHIM) scores showed no differences if the men in the study were treated with testosterone 25 mg a day, testosterone 50 mg a day, or placebo. The SHIM scale ranges from 1-25, with a score of 1-7 reflecting severe erectile dysfunction and a score of 22-25 indicating no erectile dysfunction. The 167 study participants were about 65-years-old and more 90% were Caucasian. They men did not take other erectile dysfunction medications. The researchers said that men did experience an increase in testosterone levels at six months and one year for both the low-dose and high-dose treatment when compared with baseline levels. But that change did not translate into better sexual improvement for the men.

One commentator observed that erectile dysfunction is not just a problem of low testosterone. Men with diabetes, high blood pressure, high cholesterol and other factors that impact erectile function often perceive that low testosterone is causing their erectile dysfunction. This study did not surprise him because in his practice perhaps only 10% to 15% of men with erectile dysfunction are helped with testosterone supplementation. (Source: MedPage Today, October 18, 2011, via Prostate.net (Prostate Cancer Institute))

Robotic Surgery and the Conventional Prostatectomy. The robotic prostatectomy has caught on rapidly in the U.S as a treatment for prostate cancer, notwithstanding that there is little evidence to show it is better than traditional prostate removal. It is, however, much more costly, adding some \$2,000 in hospital costs per procedure.

According to a recent survey, there is little difference in the results of the robotic (da Vinci) surgical procedure compared to the conventional prostatectomy for treating prostate cancer. The new survey that found complaints about erectile dysfunction and incontinence in men were equally common after the two procedures.

The new study, published in the Journal of Clinical Oncology, is based on responses from more than 600 prostate cancer patients on Medicare, the government's health insurance for the elderly. About 400 of the men in the study had robotic-assisted laparoscopic prostatectomy. The rest of the patients had traditional open surgery, in which the prostate is removed through one long cut in the abdomen..

Barry, et al., Massachusetts General Hospital, found that nearly nine out of 10 men had a moderate or significant problems with erectile dysfunction 14 months after their surgery. They also found that about a third of the men reported incontinence trouble after their surgery. Overall, there were no differences between the two patient groups, although incontinence problems appeared to be slightly more common after the robotic procedure for prostate cancer. (Source: Prostate.net (Prostate Cancer Institute), January 7, 2012)

OUR PRESIDENT IS RECOGNIZED



Thomas N. Kirk, president and CEO of US TOO International, the national Prostate Cancer Education & Support organization, recently presented its annual Edward C. Kapps Award to Vincent P. McDonald, president of the WRNMMC Prostate Cancer Support Group. The award recognizes Vin's eleven-year service in leadership positions within our support group. The award was presented in Chicago on December 2, 2011.

EVERYTHING YOU ALWAYS WANTED TO KNOW ABOUT RADIATION AND THEN SOME!

By Colonel Patricia Lillis-Hearne, MC, U.S. Army

(A summary of a presentation to the WRAMC Prostate Cancer Support Group on November 1, 2011)

(Editor's note: Due to technical difficulty in recording Dr. Lillis-Hearne's remarks, we are unable to present a verbatim summary of her remarks as is our custom for speakers. Instead, we are summarizing selected power point slides she used that convey the general concepts she addressed.)

INTRODUCTION

Dr. Lillis-Hearne presented basic radiation concepts, historical perspectives regarding surgery and radiation as therapies for prostate cancer, as well as newer techniques and emerging technologies for radiation therapies. At the outset, she noted that prostate cancer in the United States is the most common cancer in the United States with the exception of skin cancer. New cases increased by 50% between 1980 and 1990 due to enhanced detection techniques. An estimated 27,360 men will succumb to the disease this year, however, early detection has resulted in an increasing number of "non-lethal" tumors being diagnosed.

Prognostic factors in treating prostate cancer are Gleason grading, and PSA level, as well as certain predictive models for identifying organ-confined versus no-organ confined disease. Recurrence risk may be categorized as low, intermediate, high and very high based on Gleason score and PSA upon diagnosis. The risk factor and patient life expectancy (less than ten years versus more than ten years) guide treatment decisions for clinically localized prostate cancer. In general, clinically localized tumors may be treated by radical prostatectomy or high-dose radiation therapy.

BASIC RADIATION CONCEPTS

Dose: Dose is measured in Gray (Gy) or centigray (cGy). For those familiar with the term rad, one rad = 1cGy and one Gy = 100 rads.

External beam radiation therapy (EBRT) aims X-rays directly at the prostate. Brachytherapy is the

implantation of radioactive seeds into the prostate.

Fractionation: The dose is spread out to allow for healing of normal tissues, but not the regrowth of tumor cells. Standard dosing is 1.8-2.0 Gy given five days per week. Fractionation has implications for both acute and late toxicity, as well as potential tumor control. Fractionation may be accelerated, i.e., completed in shorter than the usual time; or given in smaller doses multiple times per day (hyperfractionation); or given in larger doses often less than five days per week (hypofractionation).

HISTORICAL PERSPECTIVE

More powerful computers and improved radiation technologies allow high-dose and high-precision treatment of prostate tumors. And better anatomic imaging (CT and MRI) and better functional imaging (PET) have improved our ability to target prostate disease.

Standard 2-dimension radiation planning techniques in the early 1990s limited total dosages due to acute and chronic toxicities. The advent of 3-dimensional planning techniques allowed higher dosages while causing fewer toxicities. The second generation 3D technique, intensity-modulated radiation therapy (IMRT), further reduces gastrointestinal toxicities while improving biochemical (PSA) outcomes. IMRT is now the state-of-the-art radiation planning technique.

Image-Guided Radiation Therapy (IGRT) is the latest innovation in radiation therapy. It is used before treatments to fine tune beam locations, and during treatment to adjust beam location.

TOXICITY

Acute toxicity. An effect that occurs during radiation treatment or within ninety days after treatment.

Late toxicity. An effect that occurs six months after treatment, but which may occur many years later.

Subacute toxicity. A term sometimes used to refer to effect(s) in the interval from the end of treatment to six months post-treatment.

COMPARING EBRT AND BRACHYTHERAPY

EBRT maps the precise area that will receive radiation. It involves multiple treatments usually five days per week for up to eight weeks. Each treatment takes about ten minutes and no anesthesia is required. IMRT causes less acute and late genitourinary toxicity while experiencing similar freedom from biochemical failure.

With EBRT most symptoms occur during the treatments and generally subside after completion. These include diarrhea, rectal irritation, fatigue, frequent and painful urination, and blood in the urine. Erectile dysfunction is less common compared to radical prostatectomy following therapy but there is slower recovery.

Brachytherapy involves the implantation of 40-100 rice-sized radioactive seeds into the prostate via ultrasound-guided needles. General anesthesia is required. Treatment is completed in one day and cancer-control rates are comparable to radical prostatectomy for low-risk patients. The initial high dosage slowly fades over the course of one year. The risk of incontinence is minimal and erectile dysfunction is preserved in the short term. Patients with high-risk cancers are considered poor candidates for permanent brachytherapy.

Brachytherapy has the potential disadvantages of acute urinary retention and lingering irritative voiding symptoms and many patients develop progressive erectile dysfunction over several years. Other more rare symptoms include persistent urinary and bowel frequency and urgency. In general erectile dysfunction is similar to that associated with EBRT.

CYBERKNIFE

Cyberknife (stereotactic body radiotherapy or SBRT) is a promising minimally invasive radiation technique that is attracting patient attention, due in part to the fact that it is being marketed by some medical centers. It requires fewer treatments but each treatment is substantially longer than the conventional IMRT. Three-year follow-up indicates that it is safe and efficient. Some early studies at individual institutions report 90-100% freedom from biochemical failure. However, fur-

ther investigation of its long term effects and toxicity is required.

PROTON BEAM THERAPY

Proton beam may be used as an alternative radiation source. Protons may be able to reach deeply-located tumors with less damage to surrounding tissues. Proton beam radiotherapy is available at relatively few medical centers. However, it is not recommended for routine use at this time because clinical trials have not shown its equivalence or superiority to conventional external beam therapy for the treatment of prostate cancer.

MANAGING BONE METASTASES

The goal of managing of prostate cancer bone metastases is the maintenance of acceptable quality of life by preventing pain, improving mobility, and preventing complications such as fractures or compression. The common methods are bisphosphonates, radiation of detected metastatic lesions, and surgery. Symptomatic metastatic disease is treated by hormones, chemotherapy, and radiation therapy. Radiation therapy relies on external beam radiotherapy, radioisotopes, such as Strontium 89 or Samarium.

RISK FACTORS FOR PROSTATE CANCER

Some studies claim that lifestyle changes can alter prostate cancer gene expression. A diet with reduced consumption of red meat and high fat dairy products and increased consumption of fruits, vegetables, and grains, as well as exercise and maintenance of health and weight are often cited for playing a role in prostate cancer avoidance.

CONCLUSIONS

Risk factors for prostate cancer are age, family history, race, and possibly diet and exercise; overall survival rates are excellent; early detection can find localized cancer, but survival benefits are still uncertain; treatment depends on grade, extent and location of the disease; surgery and radiation are equivalent therapeutic tools for localized prostate cancer; hormonal therapy is effective for metastatic prostate cancer; and hormone refractory prostate cancer responds to chemotherapy, with occasional long term improvement.

◆ **WRAMC US TOO COUNSELORS** ◆

(As of January 1, 2012)

(THESE PERSONS ARE WILLING TO SHARE THEIR EXPERIENCES WITH YOU. FEEL FREE TO CALL THEM.)

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PROSTATE CANCER AND SEXUAL FUNCTION

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WATCHFUL WAITING

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SPOUSE SUPPORT

| | | | |
|---------------|--------------------|----------------|--|
| Kay Gottesman | North Bethesda, MD | (301) 530-5504 | |
|---------------|--------------------|----------------|--|

OTHER THERAPIES/MULTIPLE THERAPIES

| | | | |
|------------------|-------------------|----------------|--|
| Howard Bubel | Fairfax, VA | (703) 280-5765 | (Cryosurgery, Hormonal, Sexual Function) |
| Arthur E. Clough | Kerryville, TX | (210) 896-8826 | (Surgery and Radiation) |
| Pete Collins | Mechanicsburg, PA | (717) 766-6464 | (Surgery, Radiation, Hormonal) |
| S.L. Guille | Sumerduck, VA | (540) 439-8066 | (Surgery, Radiation, Hormonal) |
| Richard Leber | Chapel Hill, NC | (919) 942-3181 | (Surgery, Radiation, Hormonal) |
| Charles Preble | Annandale, VA | (703) 560-8852 | (Cryosurgery, Hormonal, Intermittent Hormonal) |
| Emerson Price | Absecon, NJ | (609) 652-7315 | (Hormonal, Radiation, Cryosurgery) |
| S.L. Ross | Alexandria, VA | (703) 360-3310 | (Brachytherapy, Radiation, Hormonal) |
| Jon Schmeiser | Aiea, HI | (571)243-8198 | (Chemotherapy) |
| Ken Simmons | Alexandria, VA | (703) 823-9378 | (Radiation and Hormonal) |
| Bill Stierman | Vienna, VA | (703) 573-0705 | (Surgery and 2nd Line Hormonal-Ketoconazole) |
| Ray Walsh | Annandale, VA | (703) 425-1474 | (Surgery and Hormonal) |

◆ MEETING ANNOUNCEMENT ◆

THURSDAY, FEBRUARY 2, 2012
7 PM

RIVER CONFERENCE ROOM
AMERICA BUILDING (3D FLOOR)
WALTER REED NATIONAL MILITARY MEDICAL CENTER

◆ SPEAKER ◆

COLONEL ROBERT C. DEAN, MD

Director of Andrology

Walter Reed National Military Medical Center

◆ TOPIC ◆

"MEDICAL AND SURGICAL TREATMENTS FOR SEXUAL DYSFUNCTION"

We meet at the River Conference Room (3d floor) at the Walter Reed National Military Medical Center located at 8901 Wisconsin Avenue, Bethesda, MD 20889. This is the same location as our monthly meetings.

Gate/Parking: If you enter the base through South Gate (Gate 2) off Rockville Pike/Wisconsin Ave, take the first right (Palmer Road South). On your left you will see the Emergency Room. Continue to follow signs to the America Building and the America parking garage.

Security: A military ID is required to get on base. Persons without a military-related ID card who are attending the meeting are required to register in advance in order to gain entry. To register, contact Jane Hudak at 301-319-2918 or jane.hudak@med.navy.mil no later than Monday, October 31 so she can arrange for entry. Have a photo ID card ready.