

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

VOLUME 24

NUMBER 1

FEBRUARY 2015

◆ **ADVANCES IN PROSTATE CANCER: 2014** ◆

The year 2014 has again provided important developments in the area of prostate cancer. New data and new treatments span the spectrum of prostate cancer management, from prevention and screening to optimal strategies for localized, locally advanced, and metastatic disease.

PROSTATE CANCER PREVENTION

Epidemiologic and case-control studies in the past have suggested that several agents may lower the risk for prostate cancer; however, these types of studies are not sufficient to prove benefit. Now randomized controlled trials have been conducted with 5-alpha reductase inhibitors, vitamin E, and selenium. For example, studies that were not designed specifically for prostate cancer suggested these agents were effective in preventing prostate cancer.

The SELECT trial was a randomized controlled study designed to evaluate vitamin E, selenium, and the two in combination in the prevention of prostate cancer. Unfortunately, this study failed to show a benefit from either supplement. Many people were critical of the choice of vitamin E and selenium; these agents were chosen because they had been used in the studies that formed the basis for the SELECT trial.

Now, an update of this study has shown that these agents actually harmed some men. Men with high levels of toenail selenium upon entering the study and who were randomly assigned to receive selenium (either with or without vitamin E) had a 91% increase in high-grade prostate cancer. In addition, men with low selenium levels who received vitamin E alone had a significantly increased risk for total, low-grade, and high-grade prostate cancer.

These findings have two important implications. First, the public needs to recognize that it is false to assume herbs, vitamins, and supplements cannot cause harm. Second, this study again illustrates the importance of properly testing supplements in randomized trials rather than making conclusions from epidemiologic or uncontrolled case studies. **(Continued on page 3)**

◆ **INSIDE THIS ISSUE** ◆

Advances in PCa. Page 1
PCa Specific Issues. Page 8

Quality of Life Page 10
Counselors Listing Page 14

**WRNMMC Us TOO
NEWSLETTER EDITOR**

**Write or Call
Vincent P. McDonald
8661 Chase Glen Circle
Fairfax Station, VA 22039
Telephone: (703) 643-2658
E-Mail: vpmjam@aol.com**

MEDICAL ADVISORY STAFF

**Colonel David G. McLeod, MC,
USA**

Jane Hudak, RN, PhD

Kimberly Peay, RN, NP

BOARD OF DIRECTORS

**James Thompson
(President)**

**Raymond Walsh
(Vice President)**

**James Collins
(Treasurer)**

**Vincent McDonald
(Secretary)**

**James Padgett
(Speaker Coordinator)**

David Bertrand

Robert Butterworth

Ben Hawley

Michael Pausic

Don Williford

◆ FROM THE EDITOR ◆

Do you know persons who would benefit from receiving this newsletter? Put them in contact with the editor as shown at the top, left, of this page.

◆ SPEAKER'S REMARKS - NOVEMBER 6, 2014 ◆

Our program featured a presentation by Dr. Valencia Clay, a Palliative Care/Quality of Life physician at WRNMMC, working with patients and their families dealing with advanced illness whose treatment goals emphasize quality of life. She was joined by Jerry Waddell PhD, Program Director of the Palliative Care Service, at WRNMMC, who promotes the physical, psychological, social and spiritual aspects of quality of life for non-curative cancer patients. Their topic was "Quality of Life in Disease Progression." A summary of their presentation begins on page 13.

◆ MEETING SCHEDULE FOR FEBRUARY 5, 2015 ◆

Colonel Robert C. Dean, MD, is our speaker for Thursday, February 5, 2015. He is the Director of Andrology (male sexual health) at WRNMMC. A graduate of the University of Rochester and the Uniformed 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 also welcome. Come join us.

(The presentation also may be viewed via video teleconference at the Fort Belvoir Community Hospital. Go to the Oaks Pavilion, 1st floor, Room 332, to participate.)

**SEE THE BACK PAGE OF THIS NEWSLETTER 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.

(Advances in PCa - continued from page 1)

Screening and Early Detection

The debate about the risks and benefits of screening for prostate cancer seems unending, with a major disconnect between what science has shown us and what many clinicians believe is the right thing to do. This year, the US Preventive Services Task Force reiterated its recommendations against routine screening for prostate cancer. A Canadian task force has made a similar recommendation. Both groups concluded that the benefits of screening are small at best, and they are outweighed by the harms. Both also acknowledge, however, that the recommendation not to screen men 55-69 years of age is based on somewhat flawed data, which results in less than robust conclusions.

Proponents of screening argue that screening has partly contributed to the significant decline in the death rate from prostate cancer and the lower incidence of metastatic disease at the time of diagnosis over the past 10 years, and therefore screening should continue to be offered. Proponents also contend that screening is not the problem; rather, it is the excess harm resulting from treating too many men with low-risk disease instead of placing them on active surveillance. Still others say that even if the benefit is negligible for the average man, screening should continue for high-risk individuals, such as African American men and those with a family history of prostate cancer. Unfortunately, that view is not based on any randomized data proving a benefit.

New data from Finland¹ challenge the belief that screening men with a family history is beneficial. Finland contributed the largest number of men to the European screening trial. In a recent subanalysis of their results, investigators found that men with a family history of prostate cancer had an increased risk of being diagnosed with low-grade cancer but a decreased risk of being diagnosed with high-grade disease, compared with men with an average risk of developing the disease. Most important, after 12 years, screening these men did not improve overall survival or reduce prostate cancer mortality. These researchers concluded that men with a family history of prostate cancer are not more likely to benefit from screening.

The limitations of the study are that testing was conducted every 4 years, and the men underwent biopsy if the prostate-specific antigen (PSA) level was higher than 4 ng/mL or between 3 and 3.9 ng/mL and the free PSA level was less than 16%. Of course, longer follow-up may lead to different results. Unless other studies are conducted, the concerns about these results cannot be addressed. This study further demonstrates the importance of not making recommendations in the absence of supporting data.

Despite attempts to properly assess the impact of screening, limitations of all the studies have left us with inconclusive results, making counseling patients very challenging. For now, the best course of action is to explain the findings from the various studies so that men can decide what they want to do.

Treatment of Localized Disease

Another ongoing controversy involves the impact of treating men with localized prostate cancer. The only two randomized studies reporting results are the Scandinavian trial and the PIVOT trial, with conflicting findings. Both studies compared watchful waiting with radical prostatectomy for localized prostate cancer.

After 12 years of follow-up, the PIVOT trial showed a 2.6% nonsignificant improvement in survival in men whose prostate cancer was detected primarily by screening. However, a significant reduction in mortality was detected in men with PSAs greater than 10 ng/mL.

By contrast, the Scandinavian trial reported updated 18-year results showing that men who underwent radical prostatectomy had significantly better overall survival, better cancer-specific survival, and a

lower risk for metastatic disease than those who did not undergo surgery. The surgery group had a 12.7% higher overall survival and 11% lower risk of dying from prostate cancer, and a 12.2% lower chance of developing metastatic disease at 18-year follow-up. The benefit was greatest in men younger than 65 years of age and those with intermediate-risk prostate cancer. The men older than 65 years, however, had no improvement in overall survival or cancer-specific survival.

Comparisons between the two studies are difficult because only a small proportion of cancers in the men in the Scandinavian trial were detected by screening and the mean PSA was 13 ng/mL, compared with a median PSA of 7.8 ng/mL in the PIVOT trial. In addition, the duration of follow-up was longer in the Scandinavian study, and the PIVOT trial was more likely to have found more non-life-threatening tumors.

Regardless, radical prostatectomy is clearly lowering mortality for some men; the challenge is to identify who they are. Genetic testing is improving and may offer a solution. We hope that other studies in progress will provide important information about the relative benefits of radical prostatectomy.

Treatment of Locally Advanced Disease

The management of locally advanced disease has been well-studied in previous years, with reports demonstrating that combining androgen deprivation therapy (ADT) with radiation results in improved overall survival compared with radiation alone. Ongoing work has been directed at determining the optimal duration of ADT, to improve survival while minimizing morbidity. Some experts have questioned whether the radiation is really necessary.

A Scandinavian study provided additional support for the value of including radiation with ADT. Men received 3 months of combined ADT using flutamide plus leuprolide, followed by daily flutamide. After the 3 months, these men were randomly assigned to receive radiation or no radiation. Prostate cancer mortality at 10 years was 39.4% for the ADT alone group vs. 29.6% for the men who also received radiation.

It is now clear that men with locally advanced disease need both ADT and radiation to maximize survival. The question of the optimal duration of ADT remains unanswered, however.

Treatment of Metastatic Disease

The management of men with metastatic prostate cancer has improved substantially during the past few years because of the availability of new drugs, but this has also presented new challenges. This year, the US Food and Drug Administration approved the use of enzalutamide before chemotherapy. Approval was based on results of the PREVAIL trial. Updated results demonstrate that the drug improved overall survival by 29% and radiographic progression-free survival by 81% compared with placebo.

Other pre-chemotherapy treatments already approved include abiraterone plus prednisone, sipuleucel-T, and radium-223. Important studies are needed to identify which patients do or do not benefit from these therapies and what is the best way to sequence the drugs.

Another trial, the CHAARTED study, compared ADT alone or in combination with docetaxel and found that chemotherapy improved median survival from 42.3 months to 52.7 months. In the men defined as having high-volume metastases (at least four bone or soft-tissue metastases), the improvement in survival was 17 months.

The study was well done, but because it began before the approval of the newer therapies, no stan-

standard approach was used to address progression in men in the control group. Therefore, we do not know whether using docetaxel along with ADT and delaying the use of these other options until the disease progresses would really be better than beginning with ADT, following with some sequence of these new treatments and then instituting docetaxel. The bottom line is that patients with metastases should be informed of the results from the CHARTED study and the availability of the other therapies.

Summary

Important studies were reported in 2014 that have significant implications for counseling men faced with detection or treatment of prostate cancer. We look forward to even more progress in the year ahead.

◆ PROSTATE-SPECIFIC ISSUES ◆

Adjuvant and Salvage Radiotherapy after Prostatectomy: The American Society of Clinical Oncology (ASCO) has a policy and set of procedures for endorsing clinical practice guidelines developed by other professional organizations. This item endorsed the American Urological Association (AUA)/American Society for Radiation Oncology (ASTRO) guideline on adjuvant and salvage radiotherapy after prostatectomy. The guideline on adjuvant and salvage radiotherapy after prostatectomy was reviewed for developmental rigor by methodologists. An ASCO endorsement panel then reviewed the content and recommendations.

The panel determined that the guideline recommendations on adjuvant and salvage radiotherapy after prostatectomy, published in August 2013, are clear, thorough, and based on the most relevant scientific evidence. ASCO endorsed the guideline on adjuvant and salvage radiotherapy after prostatectomy, adding one qualifying statement that not all candidates for adjuvant or salvage radiotherapy have the same risk of recurrence or disease progression, and thus, risk-benefit ratios are not the same for all men. Those at the highest risk for recurrence after radical prostatectomy include men with seminal vesicle invasion, Gleason score 8 to 10, extensive positive margins, and detectable postoperative prostate-specific antigen (PSA).

Physicians should discuss adjuvant radiotherapy with patients with adverse pathologic findings after prostatectomy (i.e., seminal vesicle invasion, positive surgical margins, extraprostatic extension) and salvage radiotherapy with patients with PSA or local recurrence after prostatectomy. The discussion of radiotherapy should include possible short- and long-term adverse effects and potential benefits. The decision to administer radiotherapy should be made by the patient and multidisciplinary treatment team, keeping in mind that not all men are at equal risk of recurrence or clinically meaningful disease progression. Thus, the risk-benefit ratio will differ for each patient. (Source: *J of Clin Onc*, December 1, 2014; 32(34):3892-8, via *UroToday*, January 2, 2015)

Recovering Sexual Intimacy after Prostatectomy: Interventions designed to help couples recover sexual intimacy after prostatectomy have not been guided by a comprehensive conceptual model. This study examined a proposed biopsychosocial conceptual model of couples' sexual recovery that included functional, psychological, and relational aspects of sexuality, surgery-related sexual losses, and grief and mourning as recovery process. It interviewed 20 couples preoperatively and 3 months postoperatively between 2010 and 2012. Interviews were analyzed with Analytic Induction qualitative methodology. Paired t-tests described functional assessment data and the study findings led to a revised conceptual model.

Couples' experiences were assessed through semi-structured interviews; male participants' sexual function was assessed with the Expanded Prostate Cancer Index Composite and female participants' sexual function with the Female Sexual Function Index. Preoperatively, 30% of men had erectile dys-

function (ED) and 84% of partners were postmenopausal. All valued sexual recovery, but worried about cancer spread and surgery side effects. Faith in themselves and their surgeons led 90% of couples to overestimate erectile recovery. Postoperatively, most men had ED and lost confidence in their ability to perform. Couples' sexual activity decreased. Couples reported feeling loss and grief: cancer diagnosis was the first loss, followed by surgery-related sexual losses. Couples' engagement in intentional sex, patients' acceptance of erectile aids, and partners' interest in sex aided the recovery of couples' sexual intimacy recovery. Unselfconscious sex, not returning to erectile function baseline, was seen as the goal of the study. The survey findings documented the participants' sexual function losses, confirming qualitative findings.

The study concluded that couples' sexual recovery after prostatectomy requires addressing sexual function, feelings about losses, and relationships simultaneously. Perioperative education should emphasize the roles of nerve damage in ED and grief and mourning in sexual recovery in order to prepare couples for the subsequent outcomes. (Source: *J Sex Med.* 2014 Oct 31, 2014 - via UroToday, January 1, 2015)

PSA Doubling Time and Salvage Radiation Therapy: A PSA doubling time of six months or less and seminal vesicle invasion were significant predictors of biochemical recurrence. The new study confirms that salvage external beam radiation therapy (EBRT) is effective in some patients with detectable and rising PSA levels following prostate cancer (PCa) surgery. PSA doubling time of 6 months or less and seminal vesicle invasion predicted an inadequate response to EBRT. Servoll, et al., of Sørlandet County Hospital in Norway said that for these high-risk PCa patients, androgen deprivation (ADT) could be considered.

The investigators reviewed the medical records of 76 hospital patients treated with salvage EBRT following radical prostatectomy. They examined PSA values, operative and pathology reports, and radiographic staging studies and then calculated PSA doubling time prior to salvage radiotherapy and chose a dividing line of 6 months because a previous study found it meaningful. Most patients were treated with a radiation dose of 70 Gy; eight received a dose of 60 to 64 Gy. None of the patients received androgen deprivation therapy (ADT). After a median of 82 months, 17 patients experienced biochemical recurrence, 7 developed metastatic disease, and 2 died of PCa. Biochemical-free recurrence rates after salvage EBRT at 50 months and 75 months were 84% and 79%, respectively. PSA doubling time of 6 months or less and seminal vesicle invasion in the prostatectomy specimen were significant predictors of biochemical recurrence.

The researchers noted that the RADICALS study, in progress, may further illuminate salvage treatment for PCa. It is exploring outcomes for patients randomly assigned to salvage radiotherapy with or without ADT. (Source: *Scand J Urol*, 2014; doi: 10.3109/21681805.2014.982168 via Renal & Urology News, December 12, 2014)

Bisphosphonate Therapy for Prostate Cancer: Many men on androgen deprivation therapy for prostate cancer aren't getting the bone-strengthening medications they may need, new Canadian research contends. The report was published in the December 3, 2014 issue of the *Journal of the American Medical Association*. Alibhai, et al., at the University Health Network in Toronto, said that there seems to be a clear mismatch between Canadian guidelines regarding bisphosphonate usage in men undergoing hormone therapy for prostate cancer and actual clinical practice. While the low rates of bisphosphonate prescriptions may be appropriate for patients who are at low risk for fracture, most men with osteoporosis or other bone conditions should be taking a bisphosphonate.

The researchers analyzed bisphosphonate prescriptions among all men aged 66 and older in Ontario receiving androgen deprivation therapy for prostate cancer between 1995 and 2012. They found that

new prescriptions for 35,487 men starting hormone therapy remained low throughout the study period. Even when focusing on those men who should be receiving bisphosphonates per Canadian guidelines due to their high risk for future fracture, prescription rates remained low. Moreover, new bisphosphonate prescriptions dipped between the 2007-09 and 2010-12 periods.

The researchers said that there is a need for further research to discern whether the low prescription rates are due to limited clinician awareness in regards to bone health management; fear at the hands of the patients due to the rare but over publicized serious side effects; pill burden --that is, taking too many medications already; or some other reason entirely. (Source: OncologyNurseAdvisor, December 8, 2014)

Daily Sildenafil During RT Improves Sexual Function in Patients with Prostate Cancer:

Daily adjuvant use of sildenafil citrate during radiotherapy to treat patients with prostate cancer improved overall sexual function vs placebo at all time points, a study presented during the recent American Society for Radiation Oncology's (ASTRO's) Annual Meeting has found.

The study was the first randomized, prospective trial to demonstrate utility of a phosphodiesterase type 5 (PDE5) inhibitor as penile rehabilitation in patients with prostate cancer undergoing radiation therapy, according to Zelefsky, et al., Memorial Sloan-Kettering Cancer Center, New York. The most significant improvements were seen at 6 and 12 months following treatment, with a slight dip at the 24-month mark, suggesting that future trials need to be conducted to demonstrate if a longer treatment duration can further improve patient outcomes.

A total of 290 patients with clinically localized prostate cancer treated with external beam radiation therapy and/or permanent interstitial implantation were randomly assigned to receive sildenafil citrate 50mg/day or placebo, which was initiated 3 days prior to treatment and continued daily for 6 months, after which the drug therapy was discontinued and taken on an as-needed basis.

Each patient completed the International Index of Erectile Function (IIEF)—which included the domains of erectile function, orgasmic function, sexual desire, intercourse satisfaction, and overall satisfaction—and International Prostate Symptom Score (IPSS) questionnaires pre-therapy at 6, 12 and 24 months post-treatment. Baseline characteristics were similar in each arm, including age, use of brachytherapy, androgen deprivation therapy, and baseline IIEF scores. (Source: Cancer Therapy Advisor, October 30, 2014)

Erectile Function and Robotic Surgery. Recovery of erectile function (EF) may be more likely among prostate cancer patients who undergo nerve-sparing radical prostatectomy by robot-assisted laparoscopy rather than open surgery, new findings suggest. Stolzenburg, et al., University Hospital Leipzig, Germany, and studied 422 patients younger than 68 years who had normal preoperative erectile function (EF) prior to nerve-sparing surgery for localized prostate cancer. In a 9-month double-blind trial, investigators randomly assigned patients to receive tadalafil (once daily or on demand) or placebo after surgery, followed by a 6-week drug-free washout and 3-month open-label once daily tadalafil treatment for all patients. The researchers defined EF recovery as an International Index of Erectile Function (IIEF)-EF domain score of 22 or higher and normal orgasmic function.

Of the 422 patients, 115 had robotic-assisted laparoscopy, 88 had conventional laparoscopy, and 189 had open surgery. For 30 patients, the type of surgery was classified as "other." Patients who had robot-assisted laparoscopy had a significant 2.4 times increased odds of EF recovery at the end of the drug-free washout compared with the open surgery group, the researchers reported. In addition, men who had robot-assisted laparoscopy had a significant 2-fold increased likelihood of EF recovery during the double-blind treatment compared with those who had open surgery. The investigators observed no favorable effect of conventional laparoscopy compared with open surgery. (Source: Renal&Urology

News, January 12, 2015)

Cancer Survivors and Unmet Needs. Cancer survivors have a number of needs that persist up to 10 years after diagnosis and treatment and are not being adequately addressed, according to a new study. The findings, from a American Cancer Society dataset, indicate that cancer survivors have physical, financial, educational, personal control, and other problems, with each patient experiencing an average of almost three unmet needs. Previous research has identified that a lot of cancer survivors have unmet needs, however, this analysis involved a large sample of people who used their own words about what they were experiencing.

One surprise was that so many men and so many minority survivors responded to an open-ended question, which gave a sense that more men are experiencing problems after cancer treatment, especially prostate cancers survivors, than had identified in the previous literature, and that more minority survivors are experiencing problems that have not been previously identified.

The research team examined 1514 responses from cancer patients who had survived for 2, 5 and 10 years who had responded to the following open-ended question: "Please tell us about any needs you have now as a cancer survivor that are not being met to your satisfaction." The mean age of the respondents was 62.5 years, 34.6% were men, 43.4% had breast cancer, 18.0% were nonwhite, and 40.0% were 2-year cancer survivors.

The most frequent unmet need, reported by 38.2% of respondents, was physical. This was followed by financial problems (20.3%), education and information needs (19.5%), and personal control problems (16.4%), which include needs related to an individual's ability to maintain autonomy in terms of the physical self (sexual function, evacuation, and ambulation) and the social self (ability to make plans and socialize). Other unmet needs identified were system-of-care problems, resource needs, emotional and mental health problems, social support needs, and societal concerns related to the patients' cancer experiences.

On average, individual patients had 2.88 unmet needs, with breast cancer survivors identifying a mean of 2.96 unmet needs. Skin cancer survivors reported the fewest unmet needs, at an average of 2.63. Men were significantly more likely than women to report physical and personal controls needs. In contrast, women were significantly more likely to report financial, system-of-care, and resource needs, emotional/mental health problems, social support needs, and communication problems.

Prostate cancer survivors and responders older than 65 years were particularly likely to report physical and personal control needs.

Younger survivors were more likely than older survivors to report financial, emotional/mental health, and communication problems. Black and Hispanic respondents reported more cancer-related financial problems than other groups.

The researchers suggested that, to a certain extent, the problem of unmet needs among cancer survivors is being recognized by the oncology community. There has been "a changing mindset over the last 10 to 15 years. People are living longer because cancer treatment is more effective than it was; we have more people to experience post-treatment needs over a longer period of time," they explained. Nevertheless, there remains a long way to go before the unmet needs are adequately addressed. For instance, men who had prostate cancer might have been told by the surgeon or the radiologist that they might have some problems with incontinence and impotence, but they will probably resolve themselves in time.. That's a fairly typical thing that is told and, to some degree, it's true, but for many men, it's not the case. They have continuing, permanent problems with those issues. Outcomes that are unexpected have more of an impact emotionally than they do when patients have some expectation of them. (Source: *Cancer*, published online January 12, 2015, via Medscape News, January 2, 2015)

INTENTIONALLY BLANK

◆ Quality of Life in Disease Progression ◆

by

Jerry Waddell, PhD, Director of Palliative Care, WRNMMC

and

Valencia Clay, MD, Palliative Care and Quality of Life Physician, WRNMMC

(A summary of a presentation to the WRNMMC Prostate Cancer Support Group, November 6, 2014)

INTRODUCTION - PART 1 (Dr. Waddell presents)

Have you noticed all the recent interest in palliative care? The popular media have frequent reference to it. What is palliative care anyway? The term comes from the Latin *palliat* which means "cloaked." The idea is that palliative care does not heal or treat, but rather it cloaks or covers up the pain and side-effects of disease and terminal illness; in other words, it serves to alleviate pain and side effects without curing. This is not to say that palliative care and healing therapy are completely exclusive, rather that the goal of palliative care is relief, not cure.

Patients with serious illnesses such as prostate cancer need medical treatments to survive. But they are increasingly taking advantage of a specialty known as palliative care which offers relief from symptoms, as well as stress management, and lifestyle management. Though often regarded as only for older patients with terminal illness before they enter hospice programs at the end of life, palliative care is increasingly being offered to patients at any age for a range of chronic illnesses such as cancer, multiple sclerosis, and Parkinson's disease. It may be provided at the same time as curative medical regimens to help patients tolerate side-effects of disease and therapy, and carry on with everyday life. Most people who can benefit from palliative care are not in fact dying, but have one or more chronic diseases which they may live with for years.

In addition to pain management and emotional support, palliative care teams offer patients help in navigating the medical system, making decisions about their care, and understanding what to expect from their medical conditions as they progress. The palliative care teams use a number of screening tools to determine what type of care, such as spiritual counseling, might help.

THE TEAM CONCEPT

The Medical Team provides integrated therapeutic measures to cure the disease; but candidly informs the patient when treatment is no longer effective; it then identifies those patients as candidates for palliative care consultation. The Palliative Care team provides ongoing palliative care. The Patient & Family Team decides to receive only, or primarily, palliative care and to discontinue life-prolonging treatment interventions, as appropriate.

The preferred mode is called "the individualized integrated model" wherein palliative measures begin at time of disease diagnosis and admission to the hospital and which continue concurrently with curative-restorative care. Over time, the palliative care may become the primary effort.

MAKING CHOICES ABOUT PALLIATIVE CARE

Persons dealing with advanced cancer likely will have varying goals for their care as they progress through the stages of grief associated with their disease (denial, anger, bargaining, depression and finally acceptance). Their decisions about treatment will be very personal ones that only they can make. In making them they should seek the help of their loved ones and their palliative health care providers.

Communication is very important at different points during cancer care, especially at: the initial diagnosis; at the time of treatment decisions; during post-treatment discussions of the efficacy of the cur-

rent therapy; when the goal of care changes from therapeutic to palliative; and decisions regarding advance directives, such as a living will. A major communication problem is a reluctance to ask questions due to the patient's deference to his doctor.

It is important to remember that when patients choose not to receive, or to stop, an ineffective ongoing treatment to promote their well-being, i.e., palliative care, continues. Palliative care includes treatment to manage pain and other physical symptoms, as well as support for psychosocial and spiritual needs of patients and their families.

MAKING ADJUSTMENTS

Patients with cancer need to make adjustments in their lives to cope with the disease and changes in treatment. These adjustments will likely cause anxiety and distress ranging from sadness and fear to more serious problems such as depression, panic, spiritual doubts and loneliness. Studies have shown that patients having trouble adjusting to the realities of their disease can be helped by certain kinds of emotional and social support, including:

- Relaxation training
- Counseling and talk therapy
- - Cancer education sessions
- - Social support in group settings

Benefits include lower levels of depression, anxiety and disease-related and treatment-related symptoms, and enhanced feelings of optimism.

There are other alternative approaches to coping with terminal illnesses. They include: acupuncture, hypnosis, biofeedback, massage therapy, mind-body therapy, meditation, yoga, tai chi, reiki, and therapeutic touch.

A Palliative Care team can conduct assessments to determine the patient's needs for emotional, social, and spiritual distress and then assist in making and coordinating the necessary arrangements for such care.

OTHER CONSIDERATIONS

There are legal documents that allow people to communicate their decisions about medical care to family, friends, and medical professionals. These are so-called advanced directives and the two main types are: (1) Living Will which allows the patient to specify what kind of medical care (especially life-sustaining care) they would or would not like to receive in the event that they are unable to speak for themselves. (2) Medical Power of Attorney which allows the patients to name the persons to make decisions about their medical care in the event that they themselves are temporarily or permanently unable to make or communicate these decisions.

Many persons associate advance directives with end-of-life decisions. Yet, ideally, these documents should be completed while a person is healthy. Making these choices early can reduce the burden on them and their loved ones

INTRODUCTION - PART 2 (Dr. Clay presents)

Palliative medicine is a medical subspecialty for the seriously ill that is intended to relieve pain and improve quality of life. What is the difference between palliative care and hospice care? Palliative care is whole-person care that relieves the symptoms of disease or disorder, whether or not it can be cured. Hospice care is a specific type of palliative care. Put another way, hospice care is always palliative, but not all palliative care is hospice care.

Palliative care is provided by an interdisciplinary team composed of doctors, nurses, chaplains, social workers, psychiatrists, and psychologists. The team concentrates on preventing and alleviating suffering and improving quality of life. On the other hand, your other doctors focus on your general health or your specific disease.

Of course, your other doctors are concerned with alleviating your pain and enhancing your quality of life, but palliative doctors have special training and expertise in pain and symptom control. They also help patients and their families cope with the burdens of serious illness, and assist them in dealing with difficult medical decisions. Your palliative care doctor does not replace your personal doctor, rather he/she coordinates your care with them.

EMOTIONAL AND SPIRITUAL SUPPORT

Serious illness may cause several types of suffering, e.g., physical, emotional, and spiritual pain. You may be asking "Why is this happening to me" or you may become frustrated with the limitations your illness imposes on your activities. Then there may be financial concerns, or concerns about the future of loved ones. The palliative care team listens to and empathizes with your fears and concerns, helps you to evaluate your options, and provides or arranges for community resources for assistance.

Many persons with serious illness begin to reflect on spiritual matters and the meaning of life as they define it, as well as other similar concerns. The palliative care team can bring to bear the resources and activities you may need to confront your spiritual concerns.

SETTING GOALS AND EXPRESSING WISHES

At the outset, your palliative care team will listen to your concerns, needs and desires in order to understand your wishes for care and quality of life. By understanding your personal preferences for dealing with your illness, both you and the team will be able to devise your treatment and care plan. The palliative care team is concerned about you as a whole person, not just the part of you that is sick. It helps you weigh the benefits and burdens of various therapies so you can make the decision that meets your preferred health plan.

Dr. Waddell has already mentioned the importance of advance directives such as a living will and a medical power of attorney in order that your goals and wishes be met in the event that you may be unable to express them yourself. As a supplement to these advance directives, another technique called "Five Wishes" has been developed. It covers: (1) Who you want to make health care decisions when you cannot make them; (2) The kind of medical treatment you want or don't want; (3) The comfort level you want to have; (4) How you want people to treat you; and (5) Specific information you want your loved ones to know. The Five Wishes are developed to cover legal end-of-life issues of comfort.

SUMMARY COMMENTS

- Palliative care addresses the multifaceted aspects of care for patients facing serious illness.
- Palliative care is appropriate at any stage of serious illness.
- Early integration of palliative care is becoming the new standard of care for patients with advanced cancer.
- Palliative care is not just for cancer. It is also beneficial for patients with other chronic diseases.
- Palliative care teams manage total pain.
- Patients with a serious illness have many symptoms that palliative care teams can address.

- Palliative care teams assist in complex communication interactions.
- Palliative care teams can address the emotional impact of serious illness on patients and their families.
- Clinicians should address the barriers to palliative care involvement. Patients' hopes and values equate to more than a cure.
- Palliative care enhances health care value.

GETTING A QUALITY OF LIFE CONSULTATION

If you or a loved one is coping with an advanced cancer condition (and are eligible for military health care), you can arrange a Quality of Life consultation by contacting Jerry Waddell or Valencia Clay (MD), at the Walter Reed National Military Health Center by calling 301-319-2147.

◆ **WRNMMC US TOO COUNSELORS** ◆ (As of February 1, 2015)

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

SURGERY

Tom Assenmacher	Kinsvale, VA	(804) 472-3853	
Jack Beaver	Falls Church, VA	(703) 533-0274	1998 (Open RP)
Rob Calhoun	Annapolis, MD	(410) 293-6635	2011 (Robotic Surgery)
Gil Cohen	Baltimore, MD	(410) 367-9141	
Richard Dorwaldt	San Antonio, TX	(210) 310-3250	(Robotic Surgery)
Michael Gelb	Hyattsville, MD	(240) 475-2825	(Robotic Surgery)
Robert Gerard	Carlisle, PA	(717) 243-3331	
Tony Giancola	Washington, DC	(202) 723-1859	2013 (Radical Prostatectomy)
Ray Glass	Rockville, MD	(301) 460-4208	
Monroe Hatch	Clifton, VA	(703) 323-1038	
Tom Hansen	Bellevue, WA	(425) 883-4808	1998 (Robotic Surgery)
Bill Johnston	Berryville, VA	(540) 955-4169	
Dennis Kern	San Francisco, CA	(415) 876-0524	
Sergio Nino	Dale City, VA	(703) 590-7452	
Ed Postell	Collegeville, PA	(610) 420-6765	(Robotic Surgery)
George Savitske	Hellertown, PA	(703) 304-3081	2000 (Open RP)
Artie Shelton, MD	Olney, MD	(301) 523-4312	
Jay Tisserand	Carlisle, PA	(717) 243-3950	
Don Williford	Laurel, MD	(301) 317-6212	2000 (Open RP)

PROSTATE CANCER AND SEXUAL FUNCTION

James Padgett	Silver Spring, MD	(301) 622-0869
George Savitske	Hellertown, PA	(703) 304-3081

RADIATION

Leroy Beimel	Glen Burnie, MD	(410) 761-4476	1987 (External Beam Radiation)
Bob Bubel	Grand Junction, CO	(970) 263-4974	2010 (Proton Beam Radiation)
Harvey Kramer	Silver Spring, MD	(301) 585-8080	1998 ((Brachytherapy)
Joseph Rosenberg	Kensington, MD	(301) 495-9821	2009 (Brachytherapy)
Barry Walrath	McLean, VA	(571) 969-8269	2001 (Brachytherapy)

WATCHFUL WAITING

Tom Baxter	Haymarket, VA	(703) 753-8583	Active Surveillance
------------	---------------	----------------	---------------------

SPOUSE SUPPORT

Renate Bubel	Fairfax, VA	(703) 280-5765
Karen Collins	Mechanicsburg, PA	(717-766-6464
Betty Kramer	Silver Spring, MD	(301) 585-8080
Ellen Rosenberg	Kensington, MD	(301) 495-9821
Nancy Wallrath	McLean, VA	(703) 915-8108

OTHER THERAPIES/MULTIPLE THERAPIES

Howard Bubel	Fairfax, VA	(703) 280-5765	1995,1996 (Hormonal, Cryosurgery, Sexual Function
Arthur E. Clough	Kerryville, TX	(830) 896-8826	1993 (Surgery and Radiation)
Pete Collins	Mechanicsburg, PA	(717) 766-6464	2007, 2009 (Surgery, Radiation, Hormonal)

◆ MEETING ANNOUNCEMENT ◆

THURSDAY, FEBRUARY 5, 2015
7 - 8:30 PM

AMERICA BUILDING (2D FLOOR)
ROOM 2525
(DIRECTLY ABOVE THE LAB/PHARMACY)
WALTER REED NATIONAL MILITARY MEDICAL CENTER

◆ SPEAKER ◆

ROBERT C. DEAN, MD
DIRECTOR OF ANDROLOGY

TOPIC

"SEXUAL HEALTH AND PROSTATE CANCER"

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 the CPDR front desk at 301-319-2900 **at least four business days prior to Thursday, February 5, 2015, to arrange for entry.** Have a photo ID card ready when arriving at the gate