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

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♦ ZERO - The End of Prostate Cancer ♦

(Editor's Note. **ZERO - The End of Prostate Cancer** is a multi-faceted, non-profit organization dedicated to the eradication of prostate cancer. Among its activities is the creation of awareness to make prostate cancer research a national priority. It recently released this statement. You can learn more about **ZERO** by visiting its website at http://www.zerocancer.org.)

"On behalf of at-risk men and their families, we are extremely disappointed to learn of the recent budget proposal to eliminate $13.2M for prostate cancer activities at the Centers for Disease Control and Prevention (CDC). ZERO stands with the prostate cancer community and other organizations representing high-risk populations to advocate for greater awareness about prostate cancer and informed discussions among patients and their doctors about prostate cancer testing. We believe the CDC's prostate cancer program is critical in supporting education, outreach, and technical support to states that assist helping patients and providers in determining the best treatment pathway.

In coordination with other key stakeholders, ZERO is working to educate members of Congress about the impact the proposed cuts would have on the prostate cancer community and ensure that there is strong congressional support for maintaining the CDC program. Our advocates have had enormous success in securing congressional support for the $80M Prostate Cancer Research Program (PCRP) at the Department of Defense, which is designed to rapidly bring great ideas in cancer research to reality and has led to three new treatments for advanced disease in the last four years. While the PCRP program remains a priority, we look forward to using this same energy and focus to ensuring the CDC's prostate cancer program continues.

ZERO will continue to update our advocates and make you aware of action you can take as the situation progresses."

♦ *INSIDE THIS ISSUE* ♦

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♦ 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. Also, we solicit your recommendations for topics for our quarterly meetings. Contact the editor with your suggestions.

♦ SPEAKER'S REMARKS - FEBRUARY 5, 2015 ♦

Our February program featured a presentation by Colonel Robert C. Dean, MD, Director of Andrology, WRNMMC. His topic was "Sexual Health and Prostate Cancer." A summary of his presentation begins on page 8. (Dr. Dean also recommended the website sponsored by the Society of Sexual Medicine of North America at www.sexhealthmatters.org.)

♦ MEETING SCHEDULE FOR MAY 7, 2015 ♦

Our speaker for Thursday, May 7, 2015, is Dr. Timothy Donahue, Urologic Oncologist, Department of Urology, WRNMMC. His topic is "Rise in PSA after Treatment for Prostate Cancer," a subject of continuing interest to men dealing with prostate cancer. 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.

♦ PROSTATE-SPECIFIC ISSUES ♦

High-Dose Testosterone Therapy and Advanced Prostate Cancer: In a surprising paradox, the male hormone testosterone, generally thought to be a feeder of prostate cancer, has been found to suppress some advanced prostate cancers and also may reverse resistance to testosterone-blocking drugs used to treat prostate cancer.

Denmeade, et al., Johns Hopkins Kimmel Cancer Center, who did the small study of 16 patients with metastatic prostate cancer, warn that the timing of testosterone treatment used in this research was critical and difficult to determine, and say men should not try to self-medicate their cancers with testosterone supplements available over the counter. They add that previous studies have shown that taking testosterone at the wrong time - particularly by men with symptoms of active cancer progression who have not yet received testosterone-blocking therapy - can make the disease worse.

The researchers say the combination of drugs that block testosterone production and receptors, called androgen deprivation therapy, may make prostate cancer more aggressive over time by enabling prostate cancer cells to subvert attempts to block testosterone receptors. And many men on these drugs experience harsh side effects, including impotence, weight gain, muscle loss and intense fatigue.

For this study, the researchers enrolled 16 men who had been receiving testosterone-lowering treatment for metastatic prostate cancer. All had been treated previously with at least one type of androgen deprivation therapy and had rising levels of prostate specific antigen (PSA), and radiographic evidence their cancers were becoming resistant. The men were given three 28-day cycles of an intramuscular injection of testosterone and two weeks of a chemotherapy drug called etoposide. Men who showed decreases in PSA levels after three cycles were continued on testosterone injections alone.

Of the 16, two did not complete the study: One died of pneumonia and sepsis due to the etoposide, and the other experienced prolonged erection, a side effect of the testosterone. Of the 14 remaining in the trial, seven experienced a dip in their PSA levels of between 30 and 99 percent, an indication their cancers were stable or lessening in severity. Seven of the men showed no decrease in PSA. In addition, four of the seven men stayed on testosterone therapy for 12 to 24 months with continued low PSA levels. Of 10 men whose metastatic cancers could be measured with imaging scans, five experienced tumor shrinkage by more than half, including one man whose cancer completely disappeared.

Surprisingly, the researchers saw PSA reductions in all of 10 men, including four whose PSA didn't change during the trial, who were given testosterone-blocking drugs after the testosterone treatment. The scientists say these results suggest that testosterone therapy has the potential to reverse the resistance that eventually develops to testosterone-blocking drugs like enzalutamide. Three of the study participants have died since the study began in 2010; the rest are still alive. During the cycles of etoposide, many of the men experienced the usual side effects of chemotherapy, including nausea, fatigue, hair loss, swelling and low blood counts. In men receiving only the testosterone injection, however, side effects were rare among the men and usually low grade.

The researchers concluded that more study is required involving larger groups of patients. These are being planned at Johns Hopkins and other hospitals. (Source: News & Publications, Johns Hopkins Medicine, dated January 7, 2015)

New Studies Make Case for Prostate Cancer Drug before Chemotherapy. The pioneering prostate cancer drug abiraterone significantly extends the lives of men with advanced prostate cancer if given prior to administering chemotherapy, as shown in a major phase III clinical trial. The results demon-

strated that men with advanced, aggressive prostate cancer lived more than 4 months longer on average if they received abiraterone before chemotherapy than if they did not.

The trial in the UK led by de Bono, et al., The Institute of Cancer Research, London, United Kingdom, and The Royal Marsden National Health System (NHS) Foundation Trust, could fill an important gap in previous evidence for abiraterone's effectiveness pre-chemotherapy.

A 2013 analysis showed that abiraterone taken before chemotherapy increased the time before a man's cancer progressed, but did not prove an overall extension in life. These new results, led in the UK by the same researchers, shows it is possible to identify a subgroup of men with very aggressive prostate cancer who may benefit particularly strikingly from abiraterone before chemotherapy.

This first new study compared the average survival of 354 men given abiraterone before moving on to chemotherapy with 387 men who received a placebo instead. Both groups also received low-dose prednisolone, a treatment used alongside abiraterone. The men who received abiraterone lived significantly longer than those who did not: an average of 34.7 months, compared with 30.3 months. The trial results also further support the favorable safety profile of abiraterone, with relatively few patients experiencing severe side-effects.

The second new study of men from the same trial showed that a subgroup of patients with a very aggressive form of prostate cancer may benefit the most from treatment with abiraterone. The researchers cross-referenced data on how well 348 men on the trial responded to either abiraterone or a placebo. They looked in particular at whether changes to the *ERG* gene, which are often associated with faster cancer progression, correlated with abiraterone response. They found a clear link between major *ERG* mutations and response to abiraterone. Although abiraterone improved survival generally regardless of *ERG* mutations, a subset of patients with the most pronounced mutations to the gene, accounting for 15% of the men studied, responded particularly well These men lived for an average of 22 months without their disease progressing, compared with 5.4 months for men with the same *ERG* status who received a placebo.

Both studies were funded by Janssen, the manufacturer of abiraterone. (Source: Oncology Nurse Advisor, March 3, 2015)

Detectable PSA after Prostatectomy Requires Aggressive Radiation Therapy. Prostate cancer patients with detectable prostate specific antigen (PSA) following radical prostatectomy should receive earlier, more aggressive radiation therapy treatment, according to a recent study. The study is a 10-year post-treatment analysis of a German prospective clinical trial that compared a wait-and-see approach versus an adjuvant radiation therapy approach for patients with node-negative prostate cancer who underwent prostatectomy. The study followed 388 patients from 1997 to 2004 with pT3-4pN0 prostate cancer with positive or negative margins who had already undergone radical prostatectomy.

Prior to reaching an undetectable PSA postprostatectomy, 159 patients were randomized to a wait-and-see approach (Arm A) and 148 patients were randomized to receive adjuvant radiation therapy (Arm B). Seventy-eight patients who did not achieve an undetectable PSA were moved to Arm C. Four patients in Arm C refused treatment, and 74 patients were treated with salvage radiation therapy in Arm C.

All patients in the study had a pre- and postoperative PSA test, a bone scan, and chest radiography. Patients in Arm B received 60 Gy of 3D conformal radiation therapy. Patients in Arm C received 66 Gy of 3D conformal radiation therapy. Follow-up was conducted for all eligible patients in the trial quarterly

for the first 2 years, twice a year from 3 to 6 years post-treatment, and annually thereafter. The median follow-up time was 112 months (9.3 years). Overall survival was 86% in Arm A, 83% in Arm B, and 68% in Arm C.

The PSA of patients who undergo radical prostatectomy should fall below detection limits. The researchers said their study demonstrates that patients who have detectable PSA after prostatectomy may benefit from more aggressive, early, and uniform treatment that could improve survival outcomes. (Source: Oncology Nurse Advisor, March 2, 2015)

Surgery versus Radiation for High Risk Prostate Cancer. In this oft debated issue, Dr. Markus Graefen presented the case for radical prostatectomy (RP). He pointed out that RP in high-risk patients is effective as a single therapy, with up to 50% of patients not requiring a secondary therapy according to results of the IMPACT trial. Radiation therapy for high-risk prostate cancer, in contrast, requires the use of concurrent androgen deprivation therapy (ADT) for an extended period of time, which significantly impacts on patient quality-of-life. Dr. Graefen presented data from his own institution regarding the need for secondary therapies after RP in high-risk patients. He stressed the need to counsel patients about the possibility of the need for multimodal therapy, but also pointed out that, at his institution, two-thirds of patients did not require either adjuvant or salvage radiation or hormone therapy at 3 years after RP.

One of the significant advantages of RP was the ability to more definitively stage a patient's disease allowing for more effective tailoring of treatment. Referring again to the IMPACT trial, he noted that of patients who had clinically high-risk disease, 44% had organ-confined cancer. This not only has significant treatment implications, but also potentially impacts the patient's psychological well-being for the better.

Dr. Graefen also addressed surgical considerations in patients with high-risk disease. He noted that urinary continence rates are no different following RP for patients with high-risk disease when compared to low- or intermediate-risk disease. He highlighted the use of MRI in these patients for disease localization and assessment of extracapsular extension to aid in surgical planning and allow for nerve sparing where possible. He also discussed how the use of frozen sections to achieve close but negative margins ensures that nerve sparing is accomplished when possible. Using these techniques, he stated that nerve-sparing—either unilateral or bilateral—could be accomplished in up to two-thirds of patients with high-risk disease, a significant proportion of whom will maintain potency.

Dr. Graefen also quoted by a population-based study by Nam, *et al.* which looked at 30,000 patients treated with RP or radiation therapy and found that after accounting for age, comorbidity, and year of treatment, radiotherapy was associated with a significantly higher risk of complications in all 5 categories assessed compared to surgery. The complication categories included minimally invasive procedures (e.g., cystoscopy), hospital admission, rectal/anal procedures, secondary malignancy, and open surgical procedures.

Dr. Graefen concluded his talk by pointing out that assessment of relative efficacy in the future will require the usage of standardized patient-related outcome measurements which are used to assess patients both at baseline and post-treatment. He emphasized the need for these measures to be used across all treatment options in order for appropriate and accurate comparisons to be made. (Source: Presentation at the 30th Annual European Association of Urology (EAU) Congress, March 20 - 24, 2015; via UroToday, March 3, 2015)

Low-Grade Prostate Cancer and Metastasis. Prostate cancer (PCa) patients with a tumor grade of Gleason 6 or less at the time of radical prostatectomy (RP) are extremely unlikely to progress to metastatic disease or die from their cancer, according to a new study published online ahead of print in *BJU International*. Kweldam, et al., Erasmus Medical Center, Rotterdam, The Netherlands, studied 1,101 consecutive patients who underwent RP from 1985 and 2013. Of these, 449 (41%) had a Gleason score of 6 or less; 436 (40%) had a Gleason score of 3 + 4; 99 (9%) had a Gleason score of 4 + 3; and 117 (11%) had a Gleason score of 8–10 at surgery.

The median follow-up after surgery was 100 months, during which 197 patients (18%) died, 42 (2.8%) from PCa-related causes. No PCa-related deaths occurred among patients with Gleason 6 or less. Distant metastases occurred in 56 men (5.1%), none of whom had a Gleason score of 6 or less, the researchers reported. (Source: Renal & Urology News, March 10, 2015)

Active Surveillance Outcomes Vary by Disease Risk. Active surveillance for prostate cancer (PCa) is associated with decreased survival among men with intermediate-risk tumors compared with those who have low-risk disease, new findings presented at the 2015 Genitourinary Cancers Symposium suggest. In a study of 945 PCa patients managed with active surveillance, those with intermediate-risk cancer had a 3.7 times increased risk of dying from the cancer and a 2 times increased risk of death from any cause.

The study population included 237 patients with intermediate-risk disease (defined as men with a PSA level above 10 ng/mL or Gleason score 7 or clinical stage T2b/2c tumors), and 708 patients (76.1%) had low-risk disease. The median follow-up periods for the 2 groups were 6.9 and 6.4 years, respectively. The 15-year cancer-specific survival rates were 88.5% for the intermediate-risk patients compared with 96.3% for the low-risk patients; the 15-year overall survival rates were 50.3% and 68.8%, respectively. The differences between the groups were statistically significant.

The researchers concluded that for low-risk patients with prostate cancer managed with active surveillance, the risk of dying of prostate cancer is low, validating this approach for this group of patients. However, more research is needed to better characterize those intermediate-risk patients who can safely be monitored on an active surveillance program. (Source: Renal & Urology News, February 29, 2015)

Erectile Function Recovery and Robotic Prostate 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. Jens-Uwe Stolzenburg, et al., University Hospital Leipzig, Germany, studied 422 patients younger than 68 years who had normal preoperative 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 based on IIEF Question 10.

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. 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 And Urology News . January 12, 2015)

Vitamin D and Prostate Cancer. Taking vitamin D supplements may slow or even reverse the progression of low-grade prostate tumors, according to a new study. These are the tumors that many urologists recommend keeping under “active surveillance”.

Researchers identified 37 men with this less aggressive grade of prostate cancer who opted for elective surgery. During the waiting period between biopsy and surgery, the men were randomly assigned to receive either 4,000 units of vitamin D per day or placebo. The men’s prostate glands were removed 60 days later and examined. Participants who received vitamin D showed improvement in their tumors, while tumors in the placebo group stayed the same or got worse.

According to the lead scientist, vitamin D also caused dramatic changes in the expression levels of cell lipids and proteins involved in inflammation. He says vitamin D supplementation may improve low-grade prostate cancers by reducing inflammation, perhaps lessening the need for eventual surgery or radiation treatment but more research is needed. (Source: HealthDay News, March 23, 2015; via Medline Plus)

Smoking and Prostate Cancer. Smoking doubles the risk that prostate cancer will return after surgery for the disease, a new study suggests. "This is a new analysis, but it seems to confirm results we have seen in many other types of cancer: Basically, smoking increases the risk of cancer recurrence after initial treatment," said lead author Dr. Malte Rieken, of University Hospital in Basel, Switzerland.

Researchers followed nearly 7,200 men after they had their prostate gland removed because of cancer. About one-third were current smokers, one-third were former smokers and one-third had never smoked. During the roughly 28-month follow-up, current smokers and patients who had only quit smoking within the previous 10 years were about twice as likely to have their cancer return as those who never smoked, the international team of researchers found. Former smokers had to have quit more than 10 years in order to have a significantly lower risk of cancer recurrence.

"Prostate cancer mortality varies widely throughout Europe," Rieken said in an association news release. "The fact that cancer recurrence can vary so dramatically due to smoking is probably one of the factors which may contribute to differences in prostate cancer mortality. It's just another reason not to smoke at all, but the fact that the risk drops after 10 years means that anyone who has prostate cancer would be well advised to quit immediately." About one-third of all prostate cancer patients who have their prostate gland removed have a cancer recurrence within 10 years, the researchers noted.

The research presented at meetings is usually considered preliminary until published in a peer-reviewed medical journal. (Source: European Association of Urology, news release, March 21, 2015; via HealthDay News, Medline Plus, March 23, 2015)

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♦ SEXUAL FUNCTION AND PROSTATE CANCER ♦

by

Colonel Robert C. Dean, MD
Director of Andrology, WRNMMC

(A summary of a presentation to the WRNMMC Prostate Cancer Support Group, February 5, 2015)

Introduction

Good evening! Thanks for the opportunity to discuss a subject that is so important to the quality of life for men dealing with prostate cancer. There are new developments since I last spoke with you and I want to emphasize them tonight.

What is erectile dysfunction and how prevalent is it? Simply stated, erectile dysfunction is the inability to maintain an erection sufficient for sexual intercourse. This is a very common problem. One in five men have ED. That's over 30 million American men! In 90 percent of the cases the problem is a physical one, not a psychological one. Most men will have an occasional problem in getting an erection - that is perfectly normal and the problem resolves itself. But for many men, the problem will not go away. For these men ED is typically related to one or more physical causes. The physical causes include: diabetes, heart disease, surgery (prostate, colon, bladder), medications, spinal injury, and hormonal imbalance.

Then, too, ED is not solely the concern of older men. Many men in their thirties and forties can experience ED, although their causes are likely related to vascular disease rather than the aging process.

(Dr. Dean then showed a series of slides depicting the mechanisms for erections as a neurovascular event.)

Barriers to Identifying ED

Both the patient and the doctor may be sources of barriers to identifying the causes of ED. Typically, the patient is often reluctant mention ED due: to embarrassment, shame or sheer ignorance of normal sexual functioning, cultural beliefs about discussing sexuality, and simply discomfort. On the other hand, doctors may fear offending the patient or causing discomfort; they may lack confidence in diagnosing and treating ED; interpersonal differences in culture, religion, and ethnic matters; and concern about interest in the patient's sex life.

This patient/physician tendency to avoid discussion of sensuality went away somewhat with the advent of Viagra! Men with ED problems were eager to test the effect of Viagra, and when it didn't work for them, these same men were willing to try other therapies that might be helpful.

Oral Therapy for ED

Sildenafil (Viagra), vardenafil (Levitra), and tadalafil (Cialis), the so-called PDE5 inhibitors, are all competitive medications to overcome ED. They work by enhancing the relaxation of the smooth muscles of the corpora cavernosum which eventually results in a penile erection.

Avanafil is the newest addition to the PDE5 array. It was found to be effective, providing a quick response, and was well-tolerated in its major clinical trial. The PDE5 inhibitors have also had some success in enhancing erectile function recovery soon after radical prostatectomy.

ALTERNATIVES WHEN ORAL TREATMENT FOR ED FAILS

1. Vacuum Erection Devices (VED) are a well-known, noninvasive alternative when the PDE5 oral therapy is ineffective. No doubt, some of you here tonight have relied on them. It involves the placement of a cylindrical device over the penis. The VED mechanism relies on a battery-operated or hand-held pump that creates a vacuum causing blood to flow into the penis where it is sustained by a constricting band at the base of the penis. The VED is very safe and without any medicinal side-effects.

In one study the VED was found to be helpful in maintaining penile length when used soon after surgery. It did so for a large segment of the men participating in the study. By "exercising" the penis in this manner, so to speak, penile length was maintained by the men using a VED as compared to men in the study who did not use the VED.

2. Intracavernosal injections. The drug alprostadil (a smooth muscle-relaxing medication) is self-injected into the side of the penis, and it works directly on the blood vessels to produce a satisfactory erection for most men who use it.

3. MUSE (Medicated Urethral System for Erection) also delivers alprostadil to the penis, but uses an applicator to insert a small pellet about 1.0 to 1.5 inches into the urethra where it melts and is diffused into the penis, causing an erection. MUSE is less effective than the Intracavernosal injection method, and its attrition rate among users is high.

(Dr. Dean displayed several slides that portrayed the employment of MUSE and intracavernosal injection.)

4. Penile Prostheses Implantation. Penile implants are ideal for men who have tried other methods without success or with limited efficacy. They have been on the market for about 30 years and have demonstrated their effectiveness. Also, there have been substantial improvements over the years. Over 1.3 million implantations have been performed, and about 42,000 implantations are done annually.

Penile implants have the highest acceptance rate among patients and their partners. Overall satisfaction rates are 40% for penile injection; 51% for oral medications; and 93% for penile implants.

(Dr. Dean displayed several slides illustrated the several types of penile prostheses implants: the malleable/semi-rigid, the mechanical rod, and inflatable implants.)

RECUPERATIVE THERAPY

So when do you get your erection back? It can take up to three years to regain full erection, and for many men the post-therapy return of erections does not match their pre-therapy condition. But we don't wait three years to begin erectile recovery. We start very early after primary

treatment.. This more aggressive approach began about 2003. We start men on Viagra, Levitra or injection therapy right away post-therapy. This helps get their erections back sooner, and when they do return, the penis is healthier. Early recuperative therapy is an effective technique in combating post-therapy ED. Men facing primary therapy for prostate cancer should be made aware of it.

PEYRONIE'S DISEASE

i want to mention Peyronie's disease which is the curvature of the penis. We see it most often in younger men and Caucasian men after surgery or radiation for prostate cancer. There is still some debate about the cause of the disease, but it has been attributed to poor blood flow into the penis, causing more scarring in one area than another. Or it may be attributable to ED itself. We await a definitive explanation.

KEEPING INFORMED

In closing, I want to make you aware of an educational resource that may be useful to you. The Sexual Medicine Society of North America is an organization dedicated to the promotion of sexual-health education. Its website has a range of topics about issues that should be important to you. I encourage you to visit its website at www.sexhealthmatters.org.

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♦ WRNMMC US TOO COUNSELORS ♦ (As of May 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	2008 (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	

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 Func tion
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, MAY 7, 2015

7:00 - 8:30 PM

AMERICA BUILDING (2D FLOOR)
ROOM 2525
(DIRECTLY ABOVE THE LAB/PHARMACY)

WALTER REED NATIONAL MILITARY MEDICAL CENTER

♦ SPEAKER ♦

TIMOTHY DONAHUE, MD

UROLOGIC ONCOLOGIST, WRNMMC

TOPIC

"RISE IN PSA AFTER TREATMENT FOR PROSTATE CANCER"

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

Security: A military ID card 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, May 7, 2015, to arrange entry. Have a photo ID card ready when arriving at the gate.